HEARING ON WHY HEALTH CARE IS UNAFFORDABLE: ANTICOMPETITIVE AND CONSOLIDATED MARKETS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MAY 17, 2023

Serial No. 118–HL03

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
54–811 WASHINGTON : 2024

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C O N T E N T S

OPENING STATEMENTS

WITNESSES

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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
May 10, 2023
No. HL-03

CONTACT: 202-225-3625

Chairman Jason Smith and Health Subcommittee Chairman Vern Buchanan Announce Subcommittee Hearing on Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

House Committee on Ways and Means Chairman Jason Smith (MO-08) and Subcommittee on Health Chairman Vern Buchanan (FL-16) announced today that the Health Subcommittee will hold a hearing to identify how anticompetitive practices and consolidation negatively affect patient cost and access to health care. The hearing will take place on **Wednesday, May 17, 2023, at 2:00pm 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 Wednesday, May 31, 2023**. For questions, or if you encounter technical problems, please call (202) 225-3625.

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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.

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HEALTH CARE IS UNAFFORDABLE: ANTI-COMPETITIVE AND CONSOLIDATED MARKETS

WEDNESDAY, MAY 17, 2023

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

The subcommittee met, pursuant to call, at 2:02 p.m., in Room 1100, Longworth House Office Building, Hon. Vern Buchanan [chairman of the subcommittee] presiding.

Chairman BUCHANAN. The committee will come to order. Today's hearing will focus on healthcare marketplace and how it's become more consolidated and less competitive in recent years leading to higher prices and fewer options for patients. There are many facets that contribute to this problem, and we need to work together and find bipartisan solutions. Whether we are talking about insurers by and large, PBMs, pharmacies, or even medical practice to create huge corporations, insufficient site neutrality policies and Medicare, large nonprofit hospitals buying everything in sight, prohibition on physician-owned hospitals—we hear time and time again from our constituents that our healthcare system is failing patients since current Federal incentives make the system less competitive, and more expensive.

I represent one of the oldest districts in the country with about 250,000 seniors living there. Some of the best competition healthcare marketplace has found in Medicare Advantage and Medicare part D, with part D celebrating frankly its 20th anniversary this year. Initially, Republican ideas, these programs have found their ways to keep out-of-pocket costs down for seniors and have robust marketplaces where enrollees can shop for plans that work best for them.

On the other end of the spectrum, one of the worst examples of consolidation over the last few years is the increased and somewhat referred to as a vertical integration. This most often occurs when you have insurers, MM—PBMs and pharmacy-merged created a huge monopoly which decreases patient access and increases prices.

While the FTC allows these mergers to occur, there are different areas of healthcare. They nonetheless create problems. They result in fewer options for patients and reduce competition. We can all agree that prescription drugs cost too much, but while generics account for 90 percent of the prescriptions filled each year, the three

PBMs control about 80 percent of the market share. Competition isn't working how it should.

Unfortunately, consolidation like this isn't unique to insurers. And pharmacies, large hospital systems are moving into the area where they previously had no footprint, buying up smaller hospitals and independent practices in order to increase their size and stamp out competition.

The hospital care accounts for nearly one-third of all the healthcare spending over $1.3 trillion in 2021. The spending will only continue to increase if we don't find ways to create more site-neutral and increase competition in areas where one healthcare system buys up or drives out all the others.

Actions like these are a disservice to our constituents, and it is time we shine a light on them. We all want to preserve and promote access to high-quality healthcare for all Americans, but Congress has looked the other way too long, and we can't let this continue. I have worked with my colleague Speaker McCarthy on the Healthy Future Task Force to come up with ideas in how to address affordability and the lack of competition in healthcare. The findings and recommendations we released last summer are just a starting point. We must work together in this committee to find common ground and apply what we have learned to craft bipartisan solutions.

Any policies we should aim at should save patients money by paying doctors based on the care they receive rather than what they give, encourage greater competition, not consolidating, and ensure no one can gain assistance through anticompetitive behavior that harms our constituents.

It won't be easy, but our constituents are the ones hurt by the inaction, and we owe it to them to fix the problem. As I said, I am hopeful that we can find bipartisan solutions to the problems of consolidation in the healthcare market. I look forward to working with my colleagues from both sides of the aisle, to right this wrong.

I now am pleased to recognize the gentleman from Texas, Mr. Doggett, for his opening statement.

Mr. DOGGETT. Well, thank you very much, Mr. Chairman, for hosting today's hearing. I believe that you have a topic here on which we can get some bipartisan cooperation, consolidation, and competitive activity in the healthcare market. I look forward to working with you to address some of the recommendations that our witnesses are offering. I have always supported a competitive free market as the best way to ensure fair prices and promote innovation. Good old-fashioned American competition has brought us technologies that we rely upon today. And healthy markets mean reasonable prices for a wide range of products and services. When competition is reduced and whittled away, monopolies and oligopolies hike prices, ignore equality, and work to maintain the monopoly power rather than advancing new innovations.

Some of our greatest health market failures are occurring in the pharmaceutical space. With three pharmacy benefit managers, as you just mentioned, now controlling about 80 percent of the market, and all three consolidated with an insurer and a pharmacy, the PBM market is full of conflicts. Community pharmacists, like Mr. Moose who will testify, like my friend, Ray Carbajal in San An-

tonio, and many others are all too familiar with the problems proposed by consolidation. These community pharmacists are a vital part of our healthcare system, offering their patients invaluable professional counseling that they are not receiving anywhere else.

And just as hospital and provider consolidation is edging out independent providers, PBM and pharmacy consolidation is resulting in independent community pharmacies being blocked from networks or effectively edged out through anticompetitive contracts.

I don't believe that there is any single PBM reform that is a panacea. And I think some of those that are recommended will do more harm than good if implemented in isolation without reforms that are directed toward manufacturing prices.

We need the guardrails that harness the negotiating power of PBMs while ensuring a fair market. And recognizing that many drug prices are effectively nonnegotiable because of former monopolies, we need policies that ensure reasonable prices from the moment a drug is launched and timely generic competition to further reduce costs.

In the pharmaceutical space, government-sanctioned monopolies, group patents, have granted manufacturers lengthy periods of market exclusivity and monopoly pricing power. Big Pharma then manipulates our patent system to extend their monopolies and delay competition just as long as they possibly can. By one estimate, about $40 billion in taxpayer dollars were wasted in 2019 alone on drugs for which Big Pharma was able to delay competition.

Thanks to this anticompetitive behavior and monopoly prices, 30 percent of American adults report not picking up prescriptions or skipping doses because they couldn't afford the prescription. Last year, one single pharmaceutical manufacturer made over $100 billion in revenue. Where are those profits going? Well, we would like to think they are directed toward new cures. But, in fact, Pharma pours millions into lobbying this Congress to block even the smallest reform. And after years of denying that there was a drug-pricing problem, they began almost daily pointing their finger at their favorite bogeyman, pharmacy benefit managers.

I can't open a Capitol Hill newspaper without seeing a colorful Pharma ad attacking PBMs and there is a reason for that. Because despite their limitations and restrictions, PBMs are the only part of the supply chain that is pushing back on monopoly drug prices. Though, I am certainly not a defender of some PBM anticompetitive behavior, these so-called middlemen are one of the few tools available to contain outrageous manufacturer prices.

Since Big Pharma secured a law that began in this committee room to deny Medicare the right to negotiate drug prices, pharmacy benefit managers are among the few that are able to negotiate substantial discounts. And increasing healthcare consolidation combined with flawed system design and policies that sanction monopoly behavior is failing patients across the healthcare system. There is much more to say, Mr. Chairman, but I know we have witnesses to hear, and I look forward to working with you towards some solutions.

Chairman BUCHANAN. Thank you. I appreciate that. I will now introduce our witnesses. Mr. Richman is a professor at Duke Law School; Mr. Mulready is the Oklahoma Insurance Commissioner;

Mr. Moose is the community pharmacist in North Carolina; Mr. Isasi is executive director of Families USA; Dr. Rome is a Professor of Medicine at Harvard Medical School.

The committee has received your written statements, and they will be made a part of the formal hearing record. Mr. Richman, you are recognized.

STATEMENT OF BARAK RICHMAN, PROFESSOR, DUKE LAW SCHOOL

Mr. RICHMAN. Thank you.

Chairman BUCHANAN. Turn on your mic.

Mr. RICHMAN. Thank you, again, Mr. Chairman, and members of the committee. It is a distinct honor to testify before you today about a matter that is extraordinarily important to the Nation's long-term fiscal health, as well as its physical health. Precisely because the topic is so important, I am delighted to report that some things in healthcare are not complicated. One rudimentary principle of economics applies in healthcare as elsewhere, when there is less competition, prices go up, quality grows down, innovation is stifled. This has been especially true for America's hospitals. The title of today's hearing has the matter exactly right. Why is healthcare unaffordable? It is because of consolidated markets, and especially because of consolidated hospital markets. The cost of healthcare is unsustainable not because we consume too much healthcare, but because we pay too much for the healthcare that we do consume. Prices are the problem. The biggest problem is hospital prices, and hospital prices are high because of hospital monopoly power.

It took a long time to convince policymakers, business leaders, and judges that it was bad to allow hospitals to merge. Antitrust enforcement has beefed up in this area, and it has commendably earned some successes. It needs our further support. But competition policy and healthcare need to go beyond traditional prevention of hospital mergers. My testimony outlines three critical policy areas in need of attention.

Number one, any competitive conduct by current hospital monopolists. In other words, we need to limit the damage that is now being reached by monopolists that we were allowed to form. Number two, the rise of hospital physician mergers. Markets and patients alike suffer a variety of harms when hospitals acquire nearby physician practices. These acquisitions have been sweeping across the country for approximately the last 10 years. And third, the rise of hospital mega mergers, or so-called cross market mergers. These are also sweeping across the country, and they do not create benefits for patients, but do create significant harm on markets.

I offer three general suggestions to improve competition policy in healthcare sector, and especially to address the problem of hospital monopolies. First, I encourage charging CMS with more responsibilities in advancing competition policies and competition objectives. They have enormous capacity to help in competition policy. Second, private employers who are the primary purchasers of healthcare in the commercial market could do much more to improve the efficiency of markets and to the welfare of their employ-

ees. ERISA offers some productive tools in encouraging these purchasers to be more wise in their purchasing of healthcare, and more loyal fiduciaries to their employees.

And third, we need to confront a growing trend in which State legislators are immunizing hospitals from normal antitrust enforcement, and thus, shielding even the worst conduct from scrutiny.

I speak to you as a proud North Carolinian. So, this is with enormous dismay that I report that the North Carolina Senate recently approved a bill that would give full antitrust immunity to one of the State's major health systems. This bill would permit all of the monopolistic conduct that this committee and this hearing decries. This problem is not specific to North Carolina, but North Carolina is the most recent, and in many ways, the most brazen instance of this trend.

We cannot make any progress on competition policy if State legislatures block the antitrust laws at square one. Congress can prevent State legislatures from protecting their favorite hospital monopolies. But these actions and these recent developments suggest that we all have much work to do, not just in advancing the right policies, but also convincing policymakers nationwide of the real harms of consolidated hospital markets. Thank you.

[The statement of Dr. Richman follows:]

"Why Health Care Is Unaffordable: Anticompetitive and Consolidated Markets"

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

May 17, 2023

Barak D. Richman
Bartlett Professor of Law and Business Administration
Duke University

I. Introduction

Thank you, Mr. Chairman and members of the committee. It is an honor to testify before you on a topic that is extraordinarily important to our nation's long-term fiscal health.

Latest statistics reveal that the United States spends about 19% of its Gross Domestic Product on healthcare services. This is almost twice the average for OECD nations and far more than #2, which spends less than 13%. Viewed another way, the United States in purchase-adjusted dollars spends more than two-and-a-half times the OECD average per capita on health care and more than one-and-a-half times the second largest spender. Yet in spite of our leadership in healthcare spending, we are safely in the bottom half of OECD nations on most measures of health care outcomes.

We are spending too much and getting too little in return. All discussions about healthcare policy should begin with the recognition that curbing healthcare spending needs to be among our highest national priorities. The cost of private health insurance is bankrupting companies and families alike, and the cost of public healthcare programs are putting unmanageable burdens on the federal and state budgets.

I want to emphasize three main points before delving into specifics.

First, **our healthcare prices are too high**. Many studies suggest that the cost of healthcare is unsustainable not because we consume too much healthcare, but because we pay too much for the healthcare that we do consume. In other words, as one study put it famously, "It's the Prices, Stupid."[1]

Second, **the biggest problem is hospital prices**. We spend 31% of our healthcare dollars on hospital care. This is much more than we spend on physicians and physician clinics (20%) and pharmaceuticals (less than 10%). There is enormous evidence that the prices we pay for physician services and prescription drugs are also inflated and much higher than a rational market should allow, but the primary driver of excessive healthcare costs is spending on hospital care.

And third, **hospital prices are too high because of monopoly power**. One of the most severe contributors to the rise of healthcare prices has been the alarming rise in market power by healthcare providers. The past several decades have witnessed extraordinary consolidation in local hospital markets, and recent consolidation trends have seen hospitals acquire local physician practices. Both of these consolidation trends have been extremely costly to American patients and citizens, and the continued consolidation of healthcare providers requires an urgent rethinking of both American health policy and American antitrust policy.

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[1] Gerard F. Anderson et al., It's the Prices, Stupid: Why the United States Is So Different from Other Countries, HEALTH AFFS., May-June 2003, at 89.

Consolidation in the American health sector has brought with it many painful lessons, and one of them is that competition policy in the health sector has been at least one decade behind market trends. In other words, it is not enough to identify past errors and pledge not to repeat them. We need a competition policy that both recognizes the unfortunate reality that consolidation is a current reality and that is sufficiently forward-looking to anticipate current trends before they wreak more damage onto American healthcare markets.

II. Hospital Consolidation and the Gradual Emergence of 1990s Antitrust Policy

Consolidation by healthcare providers began with an aggressive wave of hospital mergers in the 1990s. By 1995, hospital merger and acquisition activity was nine times its level at the start of the decade, and by 2003, almost 90 percent of Americans living in the nation's larger metropolitan statistical areas (MSAs) faced highly concentrated provider markets.[2] This wave of hospital consolidation, predictably, was alone responsible for price increases for inpatient services of "at least five percent and likely significantly more," and similarly responsible for price increases of 40 percent where merging hospitals are closely located.[3] A second merger wave from 2006 to 2009 significantly increased the hospital concentration in thirty additional MSAs,[4] and for the past two decades, the vast majority of Americans have been subject to monopoly power in their local hospital markets.

It is hard to overstate how harmful this consolidation wave was to American patients and consumers, and an abundance of research examining hospital acquisitions over that period reveals some basic truths: When nearby hospitals merge, prices go up;[5] cities with fewer competing hospitals exhibit higher prices;[6] and even hospitals acquired

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[2] William B. Vogt and Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? (Robert Wood Johnson Foundation, Research Synthesis Report 9, February 2006), www.rwjf.org/files/research/no9researchreport.pdf; Claudia H. Williams, William B. Vogt, and Robert Town, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? (Robert Wood Johnson Foundation, Policy Brief 9, February 2006), www.rwjf.org/files/research/no9policybrief.pdf

[3] Gloria J. Bazzoli et al., "Hospital Reorganization and Restructuring Achieved through Merger," Health Care Management Review 27, no. 1 (2002):7–20; Martin Gaynor, "Competition and Quality in Health Care Markets," Foundations & Trends in Microeconomics 2, no. 6 (2006): 441–508.

[4] Cory Capps and David Dranove, Market Concentration of Hospitals (Bates White Economic Consulting Analysis, June 2011).

[5] Reed Abelson, "When Hospitals Merger to Save Money, Patients Often Pay More," *New York Times* (Nov. 14, 2018)

[6] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, *The Quarterly Journal of Economics*, Volume 134, Issue 1, (Feb. 2019) 51–107.

by distant health systems increase prices more than unacquired, stand-alone hospitals.[7] In fact, most of America's unsustainable health care costs are driven by hospital care, and most of that price inflation over the past decades has been due to hospital mergers.[8]

Although the Federal Trade Commission and other antitrust enforcers were aware of these developments, effective antitrust policy to counter this consolidation meaningfully began only in the late 2000s. Antitrust policymakers failed to halt the rapid consolidation of hospital markets in part because many judges[9] and health policy leaders[10] used to believe, falsely, that hospital consolidation led to efficiencies and better care delivery. It took years of painstaking academic research to arrive at this updated understanding of the market. Although hospital systems have continued to consolidate, policymakers are now armed with better analytical techniques and a wealth of evidence that they started employing can be used to stop the most egregiously anticompetitive mergers. Enforcement actions finally started credibly stopping mergers in the 2010s,[11] but these improved antitrust enforcement tools came after many local hospital markets were already consolidated.

Current antitrust enforcement actions in the healthcare sector continue this focus on preventing mergers between hospitals and hospital systems.[12] To be sure, halting these mergers saved consumers and patients from the typically severe costs of hospital market power, including extortive prices and declines in quality. But provider consolidation now takes a variety of different forms. These new consolidation trends, which are at least as costly as those in the 1990s, require a different policy strategy to counter. If policymakers continue relying on an antitrust policy that was forged from the experiences of a couple decades ago, it cannot address the market's current challenges.

III. Current Competition Challenges in Provider Markets

We encounter three distinct consolidation challenges, none of which can be halted with current policies or antitrust enforcement strategies.

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[7] Matthew S. Lewis, Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions, Rand Journal of Economics, vol.48, no.3 (Fall 2017): 579-610.
[8] Health Affairs Research Brief: The Role Of Prices In Excess US Health Spending (June 9, 2022)
[9] Barak D. Richman, Antitrust and Nonprofit Hospitals: A Return to Basics, Univ. of Pennsylvania Law Review, vol.156 (Feb. 2007).
[10] Adam Gaffney, What the Healthcare Debate Still Gets Wrong, Boston Review (Oct. 17, 2019).
[11] See, e.g., FTC v. ProMedica Health, 749 F.3d 559 (6th Cir. 2014)
[12] Federal Trade Commission, Congressional Budget Justification FY2024, at 33 https://www.ftc.gov/system/files/ftc_gov/pdf/p859900fy24cbj.pdf

Confronting Established Monopolies and Exclusionary Conduct. First, we must confront the reality that most local hospital markets are already highly concentrated, so greater focus should address anticompetitive conduct by these current hospital monopolies.

The most pressing competitive danger these current monopolies pose is the entrenchment of their dominance and their foreclosure of more efficient entrants. They are doing this through a variety of well-tested techniques. One is using their dominance to impose "all-or-nothing" contracts, which require insurers to pay for all of a hospital system's services or drop out of the market altogether. This strategy prevents insurers from contracting with select providers — creating so-called "narrow networks" — that can direct patients to higher-value providers and stimulate competition between rival facilities. Hospital monopolists bundle their services together, which forces patients to pay for a system's costly services if they want to rely on their critical services; for example, in order to have access to the only trauma center in town, patients must also commit to the hospital system's oncologists and cardiologists, practices that would be vulnerable to competition from other providers and telemedicine companies. And hospital monopolists work to squeeze out small, nimble providers that might offer lower-cost alternatives to the multi-specialty giants; and if they fail to drive them out, they purchase them.

Another tactic is through collaborating with dominant insurers. Conventional wisdom suggests that dominant insurers and dominant hospital systems would be at loggerheads over the price of medical services. In fact, these large entities often collude with each other to keep out other competitors. By promising each other that they won't give smaller entities more favorable terms — these arrangements are commonly called most-favored-nation, or "MFN" contracts — giant payers and giant providers secure each other's dominance. (This collusion-among-giants was discovered and challenged in Massachusetts and Michigan, but quiet cooperation between dominant payers and providers is widespread.)

The main lesson is that challenging hospital mergers do little to step the harm from already dominant systems, many of which are engaging in anticompetitive conduct that foreclose competition and enshrine their market power. A regular staple of healthcare policy must be to monitor these consolidated markets and ensure that their citizens can still benefit from the dynamism of competition.

Hospital Acquisitions of Independent Physicians. Second, we need to confront a new and equally harmful consolidation trend. Over the past decade – and especially once the Covid pandemic took hold – hospitals have been acquiring physician practices at a rapid rate. Nearly three-quarters of America's physicians are now employed by hospitals or corporate entities, compared to less than one third less than two decades ago.

Current antitrust policy considers hospital acquisitions of physician practices as "vertical" mergers that are largely innocuous because they do not increase the

concentration in either hospital or physician markets. But mounting evidence has shown that these acquisitions lead to higher costs, probably because many of these transactions are better described as mergers of substitutes rather than compliments. In other words, many outpatient clinics offer similar services as those offered in hospitals, so when hospitals acquire physician practices, they eliminate competition. Worse, outpatient care is less costly than similar services offered inside hospitals, and medical advances continually expand what can be done in outpatient settings. The loss of the independent physician practice means the loss of the often better and almost always less expensive alternative.

The dynamic consequences of these acquisitions — the harm to innovation — are probably even more costly. Controlling physicians means controlling referrals, and hospitals rely on referrals for their most lucrative services. Reciprocally, the biggest threat to hospital dominance is if physicians direct their patients elsewhere, and the current market now offers real alternatives to traditional hospital care: specialty providers, regional providers with telemedicine follow-ups, hospital-at-home care and even physician practices that expand into secondary care. Moreover, many of these new practice models are built atop digital analytics, virtual technologies and innovative financing that have the potential to produce new care models that might upend hospital monopolies altogether.

Perhaps what is most frightening to hospitals is that many of these innovations are designed to promote population health such that people are kept out of the hospital, i.e., they are intended to drastically reduce our need for hospitals altogether. So, when hospitals acquire the source of these potential innovations, they don't merely enshrine their monopoly position, they also engineer a future in which we continue our dependence on them.

"Cross-Market" Mergers. A third consolidation challenge emerging with greater frequency is the so-called "cross-market" hospital merger. These mergers are better described as "hospital megamergers" and include the union of Advocate-Aurora with Atrium hospital systems, which combined 67 hospitals and 1,000 sites of care, and Essentia Health with Marshfield Health, which joined 25 hospitals under one system.

Antitrust authorities describe these mergers as "cross-market" or "out-of-market" because they involve providers that do not compete within a single geographic hospital services market. As such, their treatment under current merger law is uncertain. Nonetheless, research indicates that out-of-market systems acquiring independent hospitals lead to price increases, with larger price effects when the merging hospitals are within close proximity of each other (while remaining in separate markets) and when the merging hospitals contract with common insurers.[13] Additional evidence suggests that

[13] Leemore S. Dafny, Kate Ho & Robin S. Lee, The Price Effects of Cross-Market Hospital Mergers (Nat'l Bureau of Econ. Research, Working Paper No. 22106, 2016), http://www.nber.org/papers/w22106

these mergers endow hospital systems with pricing power over regional insurers and large employers.[14]

Antitrust enforcement, when acting only with familiar models and with reliable predictions, is to be commended for its care and precision. But the experience of antitrust policy in hospital markets reveals not care but instead excessive caution. To be sure, the Federal Trade Commission can only pursue policies that are supported by our federal judiciary, and our federal judges have an unfortunate history of failing to block even the most egregious hospital mergers. Still, antitrust enforcement is, at least in part, designed to prevent market harm before it takes place. A competition policy that lags decades behind consolidation trends is doomed to fail.

IV. Suggestions for a Revived Competition Agenda in the Health Sector

New consolidation trends require new policy strategies. Continued vigilance in policing hospital mergers remains essential, but the enforcement techniques refined in the and 2000s and 2010s are inadequate to protect American patients and consumers from continued monopolistic harm.

I echo those who have asked Congress for continued and enhanced support of the antitrust agencies, which historically have simply not had the resources necessary to stem the steady waves hospital acquisitions. But in addition to the frequent and important requests for an invigorated and adequately resourced (traditional) antitrust policy, I offer three suggestions – tailored especially for this Committee – that could meaningfully bolster competition policy in the American health sector.

(1) Engaging CMS in Competition Policy.

Historically, the Centers for Medicare and Medicaid Services have focused their attention almost exclusively on policies that involve the financing of healthcare. Perhaps it is because Medicare enjoys pricing power that CMS paid little attention to the consolidation of healthcare providers, but this was an error. Even if hospital monopoly power does not directly impose higher prices onto the Medicare program, it does have two adverse consequences on the Medicare program.

First, a reduction in competition translates into a reduction in the quality of care, and Medicare beneficiaries have surely suffered because they lived in markets with little competition between hospitals. And second, because hospital monopolies enjoy enormous pricing power over private commercial insurers, they experience less pressure to economize on the costs of care. Accordingly, hospitals that enjoy monopoly power in

[14] Tim Greaney, Barak Richman, Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities, American Antitrust Institute Whitepaper (June 2018)

commercial markets exhibit higher costs and, indirectly, cause Medicare payments to increase for the same healthcare.

For these reasons, CMS' policy responsibilities and objectives are deeply shaped by the industrial concentration of US hospital markets, and it therefore should be armed and encouraged to advance pro-competition policies. Additionally, because it gathers enormous amounts of patient outcomes data, it is uniquely well-positioned to assess the costs of monopoly and to identify the benefits of competition.

CMS could contribute to healthcare competition policy in a number of ways. First, most simply, it could invest in an office of provider competition policy – this could either sit alongside or within CMMI, CMS' innovation center. Such an office could use CMS's wealth of data to issue reports, identify markets where competition is limited or is painfully needed, and offer suggested avenues for encouraging entry. And because payment is so central to the entry and survival of provider strategies, a competition policy that is integrated with payment policy would offer important complementarities.

CMS could also play a more central role in administering merger policy. Just as certain industry mergers must gain the approval of the Department of Transportation and the Federal Communications Commission, in addition to clearing the antitrust laws, CMS could either offer assessments or issue authorizations of proposed mergers. The hospital sector certainly would be more efficient and offer more value if hospitals had been required to pass through a more scrutinizing approval process.

(2) Confronting State Immunities from Federal Antitrust Enforcement

In the past month, the North Carolina Senate unanimously approved a bill that would give antitrust immunity to one of the state's major health systems. Just as there is consensus among health policy experts that hospital competition is desirable – that it brings value, improves quality, and reduces prices – there is consensus that antitrust immunity is undesirable, because it does the opposite.

Why would the state senate offer such a sweeping and harmful antitrust immunity? Sadly, this is a reflection of the political economy of healthcare, in which hospitals are often the largest employers and most powerful economic entities in the regions in which they are located. For these reasons, they often enjoy outsized political influence, at the expense of dispersed patients and consumers.

Over the past decade, just as the Federal Trade Commission increased its scrutiny of provider consolidation, hospitals have increasingly turned to their state legislatures to sanction them to pursue transactions that the antitrust laws would prohibit. So-called "certificates of public advantage" (COPA), which give permission to specific mergers under stated conditions, are one exercise of this state action immunity. Others, like the bill passed in North Carolina, are more sweeping.

Those who decry monopolies and seek competitive markets know that the state, particularly when it acts as a grantor of specific political favors, can be the most harmful impediment to meaningful competition policy. Congress should be aware that many states are using the "state action doctrine" to evade federal antitrust enforcement, and Congress should know that it has the power to preempt states' efforts to invoke the doctrine.

(3) Bolstering ERISA Fiduciary Duties

Because much of healthcare is purchased through intermediaries, such as insurers and employers, consumers and patients alike rely heavily on both the wisdom of and legal obligations imposed upon those intermediaries. Like all intermediaries, however, these healthcare purchasers are imperfect agents. For this reason, Congress passed the Employee Retirement Income Security Act (ERISA), which imposes a fiduciary duty on employers when they manage employee benefit dollars.

ERISA enforcement has historically focused exclusively on protecting employee pensions and retirement plans, but it equally applies to employee health benefits as well. That means that employers that administer an ERISA plan have a fiduciary obligation to be faithful stewards of their employees' healthcare dollars. Too frequently, employer-sponsored health plans do not invest in shopping for high value healthcare and instead pay the inflated prices that establish hospitals offer. This not only wastes employee dollars, it also allows lethargy to spread throughout the market.

ERISA offers legal levers to compel employer-sponsored plans to be more active, demanding, and creative shoppers for healthcare. Some employers have taken seriously their roles as careful fiduciaries for their employees' healthcare, and several have forged valuable programs that should become the norm for most American employers: teaming with centers of excellence programs, collaborating with local primary care providers, contracting in bulk for high-volume tertiary care, and similarly creative healthcare purchasing. America can learn from these innovations, and ERISA could compel many employers to do so.

V. Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving America's healthcare consumers exposed to monopolized healthcare markets. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their healthcare purchases.

Aggressive antitrust enforcement can prevent further economic harm and perhaps can undo costly damage from providers that in error were permitted to become monopolists. To be sure, such a policy includes aggressive hospital merger review, but it requires

much more, and greater attention – and an antitrust policy updating – is necessary to address new waves and types of provider consolidation.

Creative market and regulatory initiatives will be needed to unleash the competitive forces that consumers need. Where there is danger, there is opportunity, and competition-oriented policies can and should yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources that appear to become increasingly limited. This might involve including agencies (such as CMS) and legal authorities (such as ERISA) that have not been part of the traditional competition policy toolbox.

We ultimately need to understand how the American healthcare market works and the particular dysfunctions it nurtures. One dysfunction is that hospital monopolies are easily formed and rarely punished. A second is that lobbying state legislatures for protections against provider competition generates lucrative rewards. A third is that intermediary purchasers have shown little eagerness either to contest provider market power or to pursue meaningful innovations to how they purchase care for their subscribers. If Americans are to enjoy the fruits of a competitive healthcare marketplace, policymakers need to address all three of these market failures.

Chairman BUCHANAN. Thank you, Mr. Mulready, you are now recognized.

STATEMENT OF HON. GLEN MULREADY, COMMISSIONER, OKLAHOMA INSURANCE DEPARTMENT

Mr. MULREADY. Thank you. Good afternoon, Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee, my name is Glenn Mulready. I currently serve as the 13th elected Insurance Commissioner from the great State of Oklahoma. I have served in this role for the past 4 years, having just been reelected for another 4 years in November. Previously, I served in the State legislature. For 8 years, I chaired the insurance committee, and later served as the majority floor leader. This past year, I chaired the health insurance committee for the National Association for Insurance Commissioners.

I have basically been in the insurance business my whole life. This coming October will be 40 years since I was first licensed. The 27 years previous to me becoming Insurance Commissioner was solely focused in the health arena. Like my counterparts in other States, I work to maintain competitive markets for insurance in my State.

Competition is strong in Oklahoma. In our individual market, we have six insurers currently offering coverage. However, assuring competition for health insurance can be challenging to the complex interaction of State and Federal regulations. ERISA keeps the benefits of self-funded employer plans outside of State jurisdiction. Adding to the challenge is the complicated healthcare delivery system with many sources of coverage, providers of service, and middlemen, like PBMs that we have heard about already, some of which fall under our authority at the State insurance regulatory role, and some of which do not.

Today's topic is one I have worked on for more than two decades in Oklahoma. There are many facets in the healthcare delivery system. The one component that I have lived in during this time is the financing of healthcare.

Over my years in the business, we have seen a constant pull between hospitals and healthcare systems and health insurers who continue to try to constrain costs and manage care in order to try to keep premium costs down and affordable to consumers.

The consolidation of hospitals and healthcare systems have made this even more difficult. Our rural communities have specifically been hard-hit. I am a strong believer in the competitive free market system. However, the consolidation that has taken place has not helped in this constant struggle.

A specific area of great concern is the rising cost of prescription drugs. Over the past 20 years, we have seen this move from an average of mid-teens with health insurance premiums to now 22 percent, where it stands today. In Oklahoma, our legislature has specifically targeted PBMs, trying to reel in some of the market controls and trade practices that have become commonplace in that area. PBMs are companies that handle prescription drugs services for health insurance companies as well, as large, self-insured employers. It handles things like network to pharmacies, formularies, processing prescription drug claims, et cetera.

We have been enforcing this legislation since September 1 of 2020. During this time, we have received complaints of over 300,000 violations. We have issued fines of over $3.5 million, and have reimbursed back to local pharmacists over $700,000. We find ourselves on the tip of sphere on this nationally hot topic. And, in fact, just yesterday, landmark ERISA case, PCMA v. Mulready, was heard in federal appeals in the Tenth Circuit in Denver. This case involves the issue of State laws in pertaining to PBMs and ERISA plans.

The lower courts in this case have generally decided that there is not an ERISA preemption for our law. In an earlier case, it ended up at the U.S. Supreme Court. A similar decision was rendered in PBM v. Rutledge case.

The PBM market is controlled by three large PBMS as you have heard. These are very large. We are talking two of the three are in top Fortune 10 companies. This can lead to reduction in costs—I am sorry. They also have become vertically integrated. Meaning these companies own a health insurance company, they have a PBM, and in some cases, a chain of pharmacies. This can lead to a reduction in costs due to leverage with wholesalers and manufacturers, but also can lead to strategies to maximize profits, such as spread pricing, preferred formulary placement, and to regain that profit. In this area, as in much of what I would have to say and the broader conversation is that transparency is critical.

An important aspect of competition among health insurers is establishing a network of providers. The payment rates and other contract terms insurers negotiate with the providers who make up their networks. There is a long way of determining health insurance premiums and the level of competition for health insurance.

Another practice we have seen in our market is higher prices charged by hospitals for care delivered in outpatient departments. A hospital outpatient department that is located offsite might provide the same services in a physician's office in the same type of clinic but at a large facility fee because of the hospital affiliation. This raises prices with no benefit to the insured.

It also tends to limit competition because it creates a large incentive for hospitals to acquire visit practices so the hospital can start adding facility fees to their bills. And to expedite this, I will say in Oklahoma, we have been working hard to promote competition by protecting consumers' ability to use retail pharmacies when and where they choose.

We hope Congress will support us in our efforts to limit anticompetitive practices in healthcare by PBMs and other entities. It can do that by protecting State authority. Thank you for the opportunity to be here today as we work together to protect consumers and ensure access to affordable choices. Thank you.

[The statement of Mr. Mulready follows:]

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House Committee on Ways and Means
Subcommittee on Health Testimony of
Glen Mulready
Oklahoma Insurance Commissioner
Wednesday, May 17, 2023

Good afternoon, Chairman Buchanan, Ranking Member Doggett, and members of the Subcommittee. My name is Glen Mulready and I currently serve as the 13•h elected Insurance Commissioner from the great state of Oklahoma. I have served in this role for the past 4 years having just been reelected for another 4 years this past November. I previously served in the legislature for eight years where I chaired the insurance committee and later served as Majority Floor Leader. This past year, I chaired the Health Insurance Committee for the NAIC.

I have basically been in the insurance business for my whole life. This coming October it will be 40 years since I was first licensed. The 22 years previous to me becoming insurance commissioner were solely focused in the health area.

Like my counterparts in other states, I work to maintain competitive markets for insurance in my state. Competition is strong in Oklahoma's individual market for health insurance, where six insurers offer coverage. However, assuring competition for health insurance can be challenging due to the complex interaction of state and federal regulations- ERISA keeps the benefits of self-funded employer plans outside of state jurisdiction. Adding to the challenge is the complicated health care delivery system with many different sources of coverage, providers of services, and middlemen like pharmacy benefit managers, some of which fall under the authority of state insurance regulation and some of which do not.

Today's topic is one that I have worked on for more than two decades in Oklahoma. There are many facets to the healthcare delivery system. One of those key components is where I have "lived"...that is the financing of healthcare.

Over my years in the business, we have seen the constant pull between hospitals and healthcare systems and the health insurers who continue to try to constrain costs and manage care in order to try to keep premium costs down and affordable to consumers. The consolidation of hospitals and health care systems have made this even more difficult. Our rural communities have specifically been hard hit. I am a strong believer in a competitive free market system. However, the consolidation that has taken place has not helped in this constant struggle.

A specific area of great concern is the rising cost of prescription drugs. Over the past 20 years we have seen this move from an average of mid-teens ofthe health insurance premium to 22% where it stands today. In Oklahoma our legislature has specifically targeted Pharmacy Benefit Managers (PBM) and

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trying to reel in some of the market controls and trade practices that have become commonplace in this area. PBMs are companies that handle the prescription drug services for health insurance companies as well as large, self-insured employers. They handle things like contracting with a network of pharmacies, determining formularies and processing of prescription drug claims.

We have been enforcing this legislation since 9/1/2020. During this time, we have received complaints of over *300,000* violations. We have issued fines of over $3.5 million and have reimbursed back to local pharmacists over *$700,000.* We have found ourselves at the tip of the spear on this nationally hot topic and in *fact,* just yesterday the landmark ERISA case *(PCMA vs Mulready)* was heard in federal appeals court in the 10th Circuit in Denver. This case involves the issue of state laws pertaining to PBMs and ERISA plans. The lower courts in this case have generally decided that there is not an ERISA preemption for our law. In an earlier case that ended up at the Supreme Court, a similar decision was rendered in the *PCMA vs Rutledge* case. The Oklahoma law was mainly focused on allowing consumers to determine where they got their prescriptions. Some of the items it addressed *were,* steerage to any single pharmacy or mail order service, "any willing provider" language to allow all pharmacies that wish to join a network the ability to do *so,* transaction fees and generally the restriction on promoting any one pharmacy over another. Most recently we have run into an issue with the largest PBM restricting all prescriptions to only a 30-day supply. Though our law fully allows for 90-day prescriptions, their previous internal structure and contracting only allowed for this through their own mail order service. This has caused great disruption in the market and substantial inconvenience for consumers. The PBM market is controlled by three very large companies. Between the three of them they have about an 80% market share. These PBMs are VERY large. 2 of the top 3 are Fortune 10 companies. They have also become vertically integrated, meaning that these companies own a health insurance company and the PBM and in some cases a chain of pharmacies. This can lead to a reduction in costs due to leverage with wholesalers or manufacturers but also can lead to some other strategies to maximize profits such as spread pricing and preferred formulary placement in order to gain that profit. In this *area,* as in much of this broader conversation, transparency is critical.

An important aspect of competition among health insurers is in establishing networks of providers. The payment rates and other contract terms that insurers negotiate with the providers who make up their networks go a long way to determining health insurance premiums and the level of competition for health insurance. Providers sometimes seek to include provisions in contracts that help keep their payments high. These might be requirements to include all of a health *system's* facilities in-network or none at all or limits on putting providers into different cost sharing tiers. State insurance regulators can only regulate one side of those negotiations- the insurance side. The practices of health care providers -even if they stifle competition and raise prices- have not traditionally been under the purview of state insurance regulators.

Another practice we've seen in the market is higher prices charged by hospitals for care delivered in outpatient departments. A hospital outpatient department that is located off-site might provide the same service as a physician's office in the same type of clinic but add a large facility fee because of the hospital affiliation. This raises prices with no benefit to patients.

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It also tends to limit competition because it creates a large incentive for hospitals to acquire physician practices so the hospital can start adding its facility fees to the bills. The health system gets bigger and adds leverage in insurance negotiations. Medicare has limited this practice to some degree and state insurance regulators have been exploring their authority to do so, as well.

Pharmacy benefit managers (PBMs) have also often gotten in the way of competitive markets. They have reduced consumers' access to the pharmacies of their choice, hidden the true cost of drugs, and limited the ability to use cost sharing tiers to promote cost effectiveness.

In Oklahoma, we've been working hard to promote competition by protecting consumers' ability to use retail pharmacies when and where they choose. That has required a large effort to license and audit PBMs. Our PBM regulation has come under legal challenge, but we believe it provides important benefits to consumers, promotes competition, and complies with federal law under ERISA and *Rutledge vs. PCMA*. We hope Congress will support states in our efforts to limit anticompetitive practices in health care by PBMs and other entities. It can do that by protecting state authority.

Thank you for the opportunity to be with you today as we work together to protect consumers and ensure access to affordable choices.

Chairman BUCHANAN. Thank you. Mr. Isasi, you are now recognized.

STATEMENT OF FREDERICK ISASI, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. ISASI. Thank you very much and thank you for the opportunity to testify today. My name is Frederick Isasi. I am the executive director of Families USA, a national nonpartisan voice for helping consumers for over 40 years.

Simply put, our healthcare system has lost its way. We have incredibly expensive and unaffordable care. We are not delivering on the promise of health our families deserve. And we are creating terrible financial insecurity and debt for families across the Nation.

Consider, for example, that almost half of all Americans have to forego medical care due to outrageous costs. For a third, healthcare costs are interfering with basics, like heat or rent. And for over 40 percent of Americans, that is over 100 million people. They live with the crushing burden of medical debt. And this includes tens of millions with health insurance. They have been paying their premiums every single month, and still are being saddled with that. This financial crisis is occurring despite the fact that we spend two or three times more than other wealthy nations on healthcare. That is $13,000 for every woman, man, and child in this country, $13,000. And for all this money, what are we getting? Very often, we are getting low quality care that is hurting our Nation.

In fact, compared to other wealthy nations, Americans are much more likely to die when they enter the healthcare system when the system should have saved their life. Much more likely. And believe it or not, 250,000 people a year in this country die, not from their illness, but from the medical system itself. 250,000 moms and dads, children, friends and neighbors, grandparents die each year, because the medical system kills them, not their illness.

At its core, our Nation's healthcare affordability and quality crisis are driven by a fundamental misalignment between the business interest of the healthcare sector and the health and financial security of our Nation's families. Americans, in many communities, have watched for decades as their local hospitals became health systems, those health systems were then purchased and became part of large healthcare corporations. What most have not realized is how much this has destroyed any real competition in our healthcare sector, allowing hospitals to act as monopolies and abusively increase prices year over year.

In the most recent decade, hospitals have increased their prices four times faster than our paychecks. Four times faster. The American people need you to act now. First and foremost, we need the information to hold the healthcare sector accountable. We urge Congress to pass legislation to strengthen the hospital price transparency rule. How can a hospital probationer argue against patients being able to know in advance how much a service will cost us?

Second, the committee should address price gouging by sight of service. To understand what that looks like, let me tell you about a patient. Her name is Katy Young Lee.

Ms. Lee spent decades working at a dry cleaner, and at 72 years old has very painful arthritis in her hand. Once a year, she goes to the rheumatologist for steroid injections to relieve the pain. Typically, each round of injections cost about $30. And about 2 years ago she arrived at her usual appointment, and the rheumatologist had moved upstairs. Ms. Lee didn't think much about that. The rest of the appointment went as usual. But she received a bill for $1,394. That is right. Her bill is increased from $30 to $1,400. The clinic that Ms. Lee went to had been moved from an office-based practice to a hospital-based practice, and as a result, increased their prices by 4,000 percent.

This is crazy. It makes no sense. And it is an example of the corporate looting going on in our healthcare system. We urge the committee to implement site neutral payment policies as recommended by the Medicare Payment Advisory Commission.

And, finally, we urge the committee to ban anticompetitive practices and clauses in healthcare contracting agreements. You may have all seen the news this morning, it looks like about two-thirds of the healthcare workforce are all subject to these agreements. Two thirds.

Let me close by saying that these aren't just smart commonsense solutions, they are also wildly popular. The American people want action. Most voters on both sides of the aisle want this by a mile. Thank you, again, for holding this hearing today and inviting us to testify. I am happy to take any questions.

[The statement of Mr. Isasi follows:]

Testimony of Frederick Isasi, JD, MPH
Executive Director
Families USA

Before the House Ways and Means Health Subcommittee

Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

May 17, 2023

Families USA
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Chairman Buchanan, Ranking Member Doggett, members of the Committee, thank you for the opportunity to testify today at this hearing focused on *Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets*. It is an honor to be with you this afternoon. My name is Frederick Isasi, and I am the executive director of Families USA, a leading national, non-partisan voice for health care consumers. For more than 40 years, Families USA has been working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. As part of that work, Families USA launched *People First Care*, a new initiative for transforming health care payment and delivery that delves into key drivers of our nation's health affordability and quality crisis, exploring solutions in a series of papers addressing industry consolidation, hospital pricing, payment reform, health equity, and system transformation. The first two papers in that series, Our Health Care System Has Lost Its Way: Why U.S. Health Care Is Unaffordable and Low Quality[1] and Bleeding Americans Dry: The Role of Big Hospital Corporations in Driving Our Nation's Health Care Affordability and Quality Crisis[2] take particular aim at the key topics under consideration at today's hearing. I urge the Members of the Committee to read them in full, and I submit key excerpts below as part of my testimony.

Every person in the United States should have high-quality, affordable health care that prevents illness, allows them to see a doctor when needed, and helps to keep their families healthy. Yet, our health care system is in crisis, evidenced by a lack of affordability and poor quality.[3] Almost half of all Americans have reported having to forgo medical care due to the cost, a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing,[4] and over 40 percent of American adults – 100 million people – face medical debt.[5] Despite spending two or even three times more on health care than other industrialized countries, an astounding $13,000 for every woman, man, and child in our nation,[6] the United States has some of the worst health outcomes including some of the lowest life expectancy and highest infant mortality rates.[7,8]

These abysmal health outcomes and extraordinarily high prices are the product of broken financial incentives within the U.S. health care system. Our current system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, well-being and financial security of families and the community.[9]

Health Industry Consolidation Driving High Prices

At its core, our nation's affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer. These irrational and unjustifiable prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to flourish.[10] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[11] In fact, there are few truly competitive health care markets left, with 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets, and 58% of MSAs having highly concentrated insurer markets.[12]

- **Hospital consolidation:** Hospital mergers are occurring more frequently both within and across health care markets, leading to higher prices in both cases. According to the American Hospital Association, there were 1,577 hospital mergers from 1998 to 2017.[13,14] An estimated 40% of those mergers took place from 2010 to 2015.[15]

- **Insurance consolidation:** Insurance markets are not as highly concentrated as providers in individual markets but much more so as national entities. There is evidence of markets with little competition between insurers. Between 2006 and 2014, the four-firm concentration ratio —the extent of market control held by the four largest firms, Aetna, Blue Cross Blue Shield, United and Anthem — for the sale of private insurance increased from 74% to 83%.[16]

- **Vertical integration:** The number of hospital-acquired physician practices grew from 35,700 in 2012 to more than 80,000 in 2018.[17] Over this same time period, the percentage of physicians employed by a hospital or health system nearly doubled, from 25% to 44%.[18] Recent research found that over

55% of physicians are now employed in hospital-owned practices.[19] This trend was accelerated by the COVID-19 pandemic, which exacerbated the financial vulnerabilities of independent and smaller physician practices and threatened the near collapse of entire sectors of the health care system — particularly primary care.[20] Nearly 23,000 physicians left independent practice to work for a hospital or other corporate entity after the onset of the COVID-19 pandemic, while hospitals and other corporate entities acquired nearly 21,000 additional physician practices from 2019 to 2020, representing a 25% increase in corporate-owned practices.[21]

Nowhere is the negative impact of consolidation more evident than the rising cost of hospital stays and services, which have increased dramatically in the last decade and make up a large portion of increasing health care costs overall.[22,23,24] These cost increases have occurred despite lower hospital utilization and are largely due to escalating prices[25,26] Americans in many communities have watched as their local hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and policymaking community have not realized is how much this has destroyed any real competition in our health care sector; allowing hospitals to dramatically increase their prices every year.[27,28] Between 1990 and 2023, hospital prices have increased 600% - and just since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[29,30,31,32]

Congress Has the Power to Fix Our Broken System

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

deal more transparency around both the cost of care and health care outcomes, including for vulnerable populations living in rural America, people of color and people living with disabilities.

One crucial way this Committee can address provider consolidation and encourage competition in the health care system is through price transparency. Unveiling prices is a critical step towards achieving truly affordable health care, improved health, and more competitive health care markets across the U.S. health care system. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses.[33] Further, unveiling prices can specifically inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement more targeted policy solutions to bring down the cost of health care.[34]

We urge Congress to pass legislation to strengthen the Hospital Price Transparency Rule to push back on the industry gaming by sharpening data requirements and establishing uniform and machine-readable data standard formats, eliminating loopholes, and further increasing penalties to encourage greater compliance by hospitals.

The Committee also should address payment differentials across sites of service that incentivize further consolidation and are a major driver of unaffordable care for America's families. Market inefficiencies that come from site-specific payment rates are a significant problem and if addressed could save American families and payers billions of dollars.[35] These site payment differentials drive care delivery from physician offices to higher-cost hospital outpatient departments.[36] This shift is a major driver of higher spending on health care services which require lower resources such as office visits and minor procedures.[37] Additionally, these payment differentials create a financial incentive for hospitals to consolidate by buying physician offices and rebranding them as off-campus outpatient hospital departments (HOPDs) and facilities in order to receive higher payments.[38] This type of consolidation – vertical integration between hospitals and physicians – leads to a growingly anticompetitive market where hospitals increase market power to demand even higher prices from commercial payers.[39] These higher

commercial prices are then passed on to American families and come directly out of workers' paychecks, typically as monthly health insurance premiums.[40]

Currently, hospitals that own doctors' offices that have been rebranded as off-campus HOPDs are allowed to charge a "facility fee" in addition to the higher fees they bill for the physician services they provide.[41] The result is that consumers not only receive a bill for the visit with the physician but also for the use of the hospital facility where the visit occurred.[42] These bills together (the physician fee and the facility fee) amount to a higher total cost for the consumer than if the service was just provided in the physician's office.[43]

To understand what this looks like for patients, here is the story of Kyunghee Lee:

> *Kyunghee Lee has arthritis and once a year she would go to a rheumatologist for a steroid injection in her hand to relieve pain in her knuckles. For a few years, each round of injections cost her $30. In 2021, she arrived at her usual office and the rheumatologist she regularly saw had moved to a new floor of the building - just one floor up. She didn't think anything of it, as the rest of the appointment went as usual, until she received a bill for $1,394. The infusion clinic that Lee went to had been moved from an office-based practice to a hospital-based setting, and as a result the price of the same service she had been relying upon increased a staggering 4,546%. Lee's bill had a $1,262 facility fee attached, making up the majority of the increase in cost, even though she saw the same doctor and received the same treatment as the years prior. Lee and her family didn't know what they would do about the shot in the following year when the story was reported.*[44]

This kind of abusive pricing should not be allowed to continue. **We urge the Committee to implement site-neutral payment policies as recommended by MedPAC in 2022** (note MedPAC has recommended some manner of site-neutral payments for at least a decade),[45] and to eliminate site-dependent reimbursement distortions that indirectly incentivize acquisition of non-hospital patient access points.[46] The Congressional Budget Office (CBO) estimates that this policy could save Medicare approximately $140 billion over the next decade.[47] And, the Committee for a Responsible Budget projects that these policies could reduce health

care spending by $153 billion over the next decade including lowering premiums and cost-sharing for Medicare beneficiaries by $94 billion and for those in the commercial market by $140 -$466 billion.[48]

We also urge the Committee to take a close look at anticompetitive practices and clauses in health care contracting agreements, which occur in a variety of places including between providers and insurers and in clinician and health care worker employment arrangements.[49] In contracts between provider entities and insurers, large entities in highly consolidated markets have the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit access to higher-quality, lower-cost care. When anticompetitive terms are present in health care clinician and worker employment contracts, they can further stifle competition, lead to burnout exacerbating workforce shortages[50], impede patient access to preferred providers and care, and lead to higher prices for health care services[51].

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

The American people want action. Large majorities of voters support a range of policies to lower prices. Voters from both sides of the aisle broadly support:[52]

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

Thank you again for holding this hearing today. Congress should seize this momentum to immediately implement commonsense policies that rein in abusive health care prices and make health care more affordable for everyone. The journey to fully transform our health care system is long, but Congress holds

the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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Chairman BUCHANAN. Thank you. Mr. Moose, you are now recognized.

STATEMENT OF JOE MOOSE, OWNER, MOOSE PHARMACY

Mr. MOOSE. Thank you. I greatly appreciate the opportunity to speak with you about why healthcare is unaffordable. My name is Joe Moose. I am a pharmacist and co-owner of Moose Pharmacy in seven locations in North Carolina. My pharmacy was started by my great grandfather in 1882 in Mount Pleasant, and is still there today in the same location, where I practice with my brother as fourth generation pharmacists. I am a member of the National Community Pharmacist Association. Over the past 140 years of our pharmacy, our community pharmacies in rural North Carolina have been the primary access point for those in need of healthcare. We are the only pharmacy for miles in many communities. This is now being jeopardized by the pharmacy benefit managers that determine who has access to our pharmacy, what prices patients pay, what reimbursements pharmacies receive, and what mediations are on the formulary. This is all being done under the guise of pricing drugs lower.

The most expensive patient to the healthcare system is not the patient with diabetes, hypertension, and high cholesterol who takes ten medications a month. It is that same patient who takes zero medications a month because the PBM has put up barriers limiting their access to care.

What about the senior who is not comfortable driving 15 miles to the big city that has a PBM-owned pharmacy so that patient must pay cash for the full price of their medication at our pharmacy, because we are not in network? How much cost savings is there to the patient who does not have transportation and goes without medicine? Is there really a savings if a higher price preferred brand drug by the PBM sends the Medicare patient into the donut hole faster and the patient is now paying out of pocket? Who is recognizing these savings? The PBM. Not the patient, not the payer. These are not exceptions like they will have you believe. These happen daily in our community.

As you know, the PBMs own drug plans, the pharmacy, the physician's office. They steer patients to utilize their PBM-owned pharmacy. Today the top three PBMs: Paramount, owned by CVS, which owns Aetna; Express Scripts, owned by Cigna; and Optima, owned by United, control 80 percent of the market.

I hear many patient experiences with PBMs every day where people in my existing customer base have received letters, phone calls, and even gift cards encouraging them to transfer their prescription, making them believe that they don't have the option to come to my pharmacy anymore. This happened to a family member of one of my pharmacists just this week. Keep in mind that the clientele that the PBMs are targeting are often seniors who have selected Medicare plans. This type of marketing and coercion can be very confusing and troubling to seniors. Many times, they have come to me in great distress. They don't want to leave our pharmacy where they know the pharmacist, and the pharmacist knows their healthcare situation, but they feel pressured to change. The PBMs act like a toll booth collecting fees from local pharmacies, in-

cluding harmful pharmacy direct and indirect remuneration, or DIR fees, for which are getting worse. Pharmacies continue to see take-it-or-leave-it Medicare part D contracts where the reimbursement rates are significantly below our cost to purchase brand-name drugs.

Pharmacists also see these low reimbursement rates in Medicaid while the PBMs turn around and bill the States a higher rate and keep the excess. This practice is known as spread pricing. And more and more States are waking up and banning this.

The claim of the PBM is that they are saving the patient and the healthcare system millions of dollars. Millions of dollars of what price. I could offer any of you 50 percent off if you come in my pharmacy today. The question should be, 50 percent off of what price? A price that is made up.

If the PBM industry continues to go unchecked and is not transparent in the operation, you run the risk of putting businesses like Moose Pharmacy and thousands of other pharmacies out of business. If these pharmacies that operate in underserved areas are forced to close, you will be left with a deficit of care for patients, which will ultimately drive up the cost even more of care for those individuals, as well as delay in care. Decreased access and less competitive marketplace with higher prices. The patients lose and the taxpayers lose.

You ask why healthcare is unaffordable, PBMs act like toll booths on the highway of healthcare. They collect fees which they get to make up from who they want based off pricing schemes that they create. Community pharmacies are eager to work with the committee to address anticompetitive practices and consolidated PBM market that has worsened with vertical integration. Congress must consider legislation to address PBM practices and Medicare and Medicaid, especially as prescription drug prices continue to increase at an alarming rate.

I applaud the committee. A applaud the committee for holding this hearing and looking forward to congressional action to reform PBM practices in a way that will lower drug prices at the pharmacy counter for our patients. Thank you.

[The statement of Mr. Moose follows:]

Written testimony of Joe Moose, PharmD

United States House Committee on Ways and Means Health Subcommittee Hearing:
"Why Health Care is Unaffordable:
Anticompetitive and Consolidated Markets"

May 17, 2023

Chairman Buchanan, Ranking Member Doggett, and members of the subcommittee:

Thank you for conducting this hearing and for the opportunity to testify on my experiences as a pharmacist with firsthand knowledge dealing with pharmacy benefit manager (PBM) practices and their effects on patients and taxpayers.

My name is Joe Moose. I am a pharmacist and co-owner of Moose Pharmacy and its seven locations in North Carolina. Moose Pharmacy was started by my great-grandfather in 1882 in Mt. Pleasant, North Carolina and is still there today in the same location, where I practice with my brother as fourth generation pharmacists. I am a member of the National Community Pharmacists Association (NCPA), which represents America's community pharmacists, including the owners of more than 19,400 independent community pharmacies. Additionally, I serve as the director of strategy and luminary development with CPESN® USA, America's first clinically integrated network of pharmacy providers with more than 3,500 community pharmacies participating in 49 local networks in 44 states.

Over the past 141 years, our community pharmacy in rural North Carolina has been the first stop for those in need of health care. In many of the communities where we are located, our pharmacy is the only pharmacy for miles. This is now being jeopardized by PBMs, which determine who has access to our pharmacy under the guise of lower-priced drugs. If the anticompetitive practices and consolidation continue to go unchecked, you run the risk of putting businesses like Moose Pharmacy and thousands of other community pharmacies out of business. If these pharmacies that operate in underserved areas are forced to close, patients will be left without access to care, which ultimately will drive up costs for patients because of delays in care. It will also result in a less competitive marketplace with higher prices where both the patients and taxpayers lose.

Independent pharmacies and the patients we serve have long had concerns about PBMs, their anticompetitive practices, and the role they play in ever-increasing drug costs. These concerns have been further exacerbated because of the COVID-19 pandemic's effects on small businesses. Independently owned pharmacies have served as lifelines as essential businesses during the pandemic. However, PBM practices are causing these small businesses to struggle to remain viable and keep doors open to provide continued access and care.

Pharmacies have faced significant closures in recent years. From 2012 to 2019, over 1,000 independent pharmacies closed, going from approximately 23,000 to less than 22,000. Although chain and independent pharmacy closures contribute to creating pharmacy shortage areas, in

most states, independent pharmacy closures create greater patient access issues than chains.[1] Independent pharmacies are at greater risk of closure than chains in urban and non-urban areas. Additionally, pharmacies serving disproportionately low-income and uninsured populations are at greater risk of closure.[2] *Kaiser Heath News* cited a Rural Policy Research Institute study showing that 630 communities are without a pharmacy due to over 1,000 pharmacy closures since 2003.[3]

NCPA and the University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics have collaborated to develop a web tool that generates information on pharmacy closures and populations affected and shows pharmacy shortage areas at the neighborhood level. This collaboration has demonstrated that 25 percent of the U.S. population (81,203,948) lived in pharmacy shortage areas across urban, suburban, and rural areas in 2020. Only one-third of pharmacy shortage areas calculated within the web tool carry the Health Resources and Services Administration designation of Medically Underserved Areas, or MUAs. This means that two-thirds of pharmacy shortage areas are unaccounted for when considering low access to health care in geographical areas under the MUA definition. The populations with the highest pharmacy shortage areas were Black (37.1 percent), Medicaid (33.2 percent), and low-income (36.7 percent). States with the highest percentage of census tracts calculated as pharmacy shortage areas are Alaska, Mississippi, Montana, New Mexico, North Dakota, South Dakota, and Wyoming. Independent pharmacies were the most dynamic factor in terms of creating and resolving pharmacy shortage areas.

Today, the top three PBMs (Caremark, Express Scripts and Optum) control 80 percent of the market.[4] PBMs determine which pharmacies will be included in a prescription drug plan's network and how much said pharmacies will be paid for their services. PBMs, which are vertically integrated with the largest Part D plan sponsors, entice those same plan sponsors to incentivize beneficiaries to use a mail-order, retail or specialty pharmacy – often one owned and operated by the PBM.

Independent pharmacies have one mission and that is to serve patients, but they are at an inflection point with increased stress from egregious PBM practices, including pharmacy direct and indirect remuneration (DIR) fees. According to MedPAC's March 2023 Report to Congress, pharmacy DIR fees were $12.6 billion for 2021, which represents a $3.1 billion or 33 percent increase in just two years. That kind of financial stress is unsustainable, especially when it comes to providing health care to seniors. Harmful DIR trends are only getting worse. We continue to see take-it-or-leave-it Medicare Part D contracts where the reimbursement rates are significantly below our cost to purchase brand drugs. Rates such as this coupled with year-over-year double-digit increases in DIR fees will make the first 3-6 months of 2024 unbearable for independent pharmacies, as they continue to pay DIR fees from contract year 2023. The intended effect of

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[1] Data from 2018 to 2020, from University of Southern California School of Pharmacy and Leonard D. Schaeffer Center for Health Policy and Economics.
[2] Jenny S. Guadamuz, MS, G. Caleb Alexander, MD, MS, Shannon N. Zenk, PhD, and Dima M. Qato, PharmD, MPH, PhD. "Assessment of Pharmacy Closures in the United States From 2009 Through 2015." JAMA Internal Medicine. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6806432/.
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such contracts and discriminatory pricing can only be to force independent pharmacies to opt out of the Medicare Part D networks or stay in them only to face financial ruin. The end result is the strengthening of PBM-affiliated mail-order, specialty, and retail pharmacies at the expense of independent pharmacies.

PBMs are not transparent about the rebate process and their profit margins. To achieve real transparency in government programs like Medicare Part D, we need greater clarity on: complicated and opaque methods to determine pharmacy reimbursement; methods to steer patients towards PBM-owned or affiliated pharmacies; fees and clawbacks charged to pharmacies; potentially unfair audits of independent pharmacies; the prevalence of prior authorizations and other administrative restrictions; the use of PBM-defined specialty drug lists and associated specialty drug policies; and the effect of rebates and fees from drug manufacturers on formulary design and the costs of prescription drugs to payers and patients. Moreover, there is little to no insight into how much PBMs make on administrative service fees and spread pricing (the difference between how much they reimburse the pharmacy and the higher price they charge the plan for the same prescription).

For years, community pharmacists have said that PBMs have been playing spread pricing games, contributing to higher drug costs to the detriment of patients and the taxpayer-funded programs the PBMs are supposed to serve. Studies of multiple state Medicaid managed care programs have indicated that PBMs are overcharging taxpayers for their services in Medicaid managed care, reimbursing pharmacies low for medications dispensed, billing the state Medicaid program high for the cost of those medications, and retaining the difference, called "spread." Arkansas, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Texas, and Virginia now prohibit spread pricing in their Medicaid managed care programs.

PBMs protect profits at the expense of competition and consumer welfare. With vertical integration both upstream and downstream, there is a need to level the playing field between community pharmacies and PBM-affiliated pharmacies to protect patients from paying too much at the counter. The vertical integration of PBMs into monoliths with an affiliated upstream insurance provider and downstream pharmacies has only increased the incentives for PBMs to disfavor independent pharmacies and steer patients to their own affiliated pharmacies. PBMs use a variety of methods to steer patients away from unaffiliated pharmacies. They create differential cost-sharing structures and arbitrary lists, such as specialty and aberrant drug lists, among other schemes, to limit independent pharmacies' access to patients. The arbitrary lists require patients to obtain certain drugs from a PBM-affiliated pharmacy.[5]

PBMs operating in the Medicare Part D, Medicaid, and commercial spaces alike contribute to artificially inflating drug costs using expensive name brand medications when less expensive generic alternatives are available. To do this, PBMs claim that they secure large rebates from the manufacturer to bring the net cost of the product down to below the cost of the generic. Even if this were true (which would require complete transparency and a 100 percent pass-through of all monies that flow from a pharmaceutical manufacturer to a PBM), it does not negate the

[5] Fein, A. (2022). *Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?* Drugchannels.net. Retrieved 11 May 2023, from https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

consumer harm that exists to patients when they are in the deductible phase and are paying more out of pocket for their medication costs. PBMs blame these formulary placements on plan sponsors, but plan sponsors like others in this industry are at the mercy of PBMs and their constant threats of rate hikes.

I am glad this committee recognizes the black box within which PBMs operate. Community pharmacies are eager to work with the committee to discuss the anticompetitive practices and the consolidated PBM market that has worsened with vertical integration. Given the above, NCPA hopes the committee and Congress will consider legislation to address PBM practices in Medicaid and Medicare. Prescription drug prices continue to grow at an alarming rate, while transparency and competition are decreasing. As I have described, vertically integrated PBMs acting as "middlemen" that employ a litany of anticompetitive practices are contributing to increased health care costs for patients and taxpayers, while threatening access to local community pharmacies that patients depend on. I applaud the committee for holding this hearing and look forward to congressional action to reform PBM practices in a way that will lower drug prices at the pharmacy counter for our patients.

Chairman BUCHANAN. Thank you. Dr. Rome, you are now recognized. Dr. Rome.

STATEMENT OF BENJAMIN N. ROME, M.D., M.P.H. INSTRUCTOR IN MEDICINE, HARVARD MEDICAL SCHOOL

Dr. ROME. Chairman Buchanan, Ranking Member Doggett, members of the subcommittee, my name is Ben Rome. I am a practicing primary care physician and instructor in medicine at Harvard Medical School and health policy researcher in the Division of Pharmacal Epidemiology and Pharmacal Economics at Brigham Women's Hospital in Boston.

My research focuses on the use, regulation, and cost of prescription drugs. And I am honored to be here today to talk with you about how to make medications more affordable to patients.

One out of every four Americans has difficulty affording their prescription drugs. This has serious consequences, because effective medications do not work when patients cannot afford them. The main driver of high drug prices in the U.S. is simple. We grant drugmakers patents and other government protections that prevent competition during periods of market exclusivity. During this time, we let drugmakers freely set and raise prices as high as the market will bear. As a result, we have seen prices for new drugs skyrocket. The average price for a year supply of a new drug entering the market has soared from $2,000 in 2008 to more than $180,000 in 2021.

The most important actions that Congress can take to make prescription drugs more affordable is to address the high prices set by manufacturers. For example, Congress could expand the authority for Medicare to negotiate prices that was included in the Inflation Reduction Act. And Congress should promote policies that encourages timely generic competition, such as preventing manufacturers' abuse of the patent system.

Recently, there has been a lot of concern among Members of Congress about the role pharmacy benefit managers play in prescription drug prices. Most health insurance plans contract with PBMs to manage their prescription—to manage prescription drugs. To control costs, PBMs create formularies that steer patients for its less expensive medications. And to do this, they charge patients higher out-of-pocket costs, or they restrict access to high-cost medications. These formulary tools can be frustrating for clinicians and for patients, particularly when they prevent or delay the appropriate use of medications.

For policymakers, it can be tempting to enact rules that protect patients by capping out-of-pocket costs or blocking utilization management tools like step therapy.

However, PBMs use these formulary tools to negotiate discounts from drug manufacturers. And enacting policies that restrict PBMs' ability to manage formularies will impede their ability to negotiate lower prices for some drugs. To avoid this, such policies need to be paired with other policies that directly address the root problem. High prices set by manufacturers. That is it.

There are several practices with how PBMs conduct business, and Congress should address these. I will discuss three today that have clear policy solutions. First, rather than directly negotiating

for lower drug prices, PBMs negotiate rebates that are paid by drug manufacturers after the point of sale. In some cases, PBMs retain some of the rebates as profit. In addition, the out-of-pocket costs for patients using expensive medications are usually based on manufacturer list prices that do not include rebates, even in cases when PBMs have negotiated substantial discounts.

Congress should fix this by requiring PBMs to pass 100 percent of the rebates they negotiate onto plan sponsors, and to require the plan sponsors use these rebates to lower premiums and offer more generous coverage. In addition, Congress should prohibit PBMs and insurers from tying patient out-of-pocket costs to list prices that exclude rebates. Second, PBMs sometimes contract with health plans and use the strategy called spread pricing, in which the PBM charges insurance plans more than they pay pharmacies, allowing them to pocket the difference. This misaligns financial incentives, allowing PBMs to profit from higher prices. Congress should prevent PBMs from engaging in spread pricing.

Finally, each of the major PBMs now owns or affiliates with a mail-order specialty pharmacy. Increasingly, PBMs are steering patients to purchase medications at their own pharmacies. And this is a serious conflict of interest, because PBMs are negotiating prices that are paid to their own pharmacy. To address this, Congress should ask the Government Accountability Office to investigate the impact of vertical consolidation between PBMs and pharmacies, and additionally, PBMs should be required to disclose markets when they fill medications at their own pharmacy.

Despite these problems with PBMs, it is important to remember that the primary driver of prescription drug prices in the U.S. is high brand-named drug prices set by manufacturers. Drug companies love to point fingers at PBMs, and there are some problems with how PBMs conduct business. But to really make medications more affordable to patients, Congress needs to address the skyrocketing prices set by drug companies. Thank you for the invitation, and I look forward to your questions.

[The statement of Dr. Rome follows:]

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Causes of unaffordable prescription drugs: monopolies, rebates, and misaligned incentives

Testimony of:

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United States House of Representatives
Committee on Ways and Means
Subcommittee on Health
Wednesday, May 17, 2023
Washington, D.C.

Summary of Major Points

- High prices for prescription drugs have resulted in many patients struggling to afford necessary medications. Medications do not work when patients cannot afford to take them.
- The main driver of high drug prices in the US is the fact that we allow brand-name drug makers to freely set and raise prices during periods of government-granted monopolies; prices are much lower in other advanced countries with more sensible drug pricing policies.
- Pharmacy benefit managers (PBMs) negotiate rebates from drug manufacturers in exchange for preferred formulary position and removal of utilization management tools.
- PBMs have negotiated increasing rebates that have partially offset the striking growth in manufacturer list prices, although rebates vary between drugs and health plans.
- Rebates negotiated by PBMs in aggregate can lower premiums, but rebates do not necessarily flow to patients; out-of-pocket costs for individual drugs are frequently based on list prices that exclude rebates.
- PBMs sometimes charge insurance plans and patients more than they pay pharmacies (i.e., spread pricing) and encourage patients to fill medications at their own pharmacies; these practices may be resulting in unnecessarily high prices, particularly for generic medications.

Summary of Policy Recommendations

- The most important policies Congress can enact to lower prescription drug costs are those that address high brand-name drug prices set by manufacturers and encourage timely generic competition.
- Enacting policies that place excessive restrictions on PBMs' abilities to manage formularies, such as out-of-pocket caps and restrictions on utilization management tools, will impede PBMs' abilities to negotiate rebates and result in higher net drug prices for some drugs. To avoid this, such policies should be paired with other policies that directly address the high prices set by manufacturers.
- In addition to addressing high prices set by manufacturers, Congress should take several actions related to PBMs to optimize medication affordability and accessibility, such as:
    - Prohibiting PBMs and plan sponsors from tying patient out-of-pocket costs to high manufacturer list prices that do not include rebates.
    - Requiring PBMs to pass 100% of rebates they negotiate to plan sponsors and requiring plans to use these rebates to lower premiums and offer more generous benefits.
    - Preventing PBMs from engaging in spread pricing or collecting fees that depend on the prices of medications.
    - Asking the Government Accountability Office to investigate the impact of vertical consolidation between PBMs and pharmacies.
    - Requiring disclosure of markups when medications are filled at a pharmacy that is owned by or affiliated with the PBM.

Chairman Buchanan, Ranking Member Doggett, and Members of the Committee,

My name is Benjamin Rome. I am a practicing primary care physician, an Instructor in Medicine at Harvard Medical School, and a health policy researcher in the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women's Hospital in Boston. Within the Division, I am a faculty member of the Program On Regulation, Therapeutics, And Law (PORTAL), an interdisciplinary research group that studies the intersections between evidence-based use, regulation, and affordability of prescription medications. I am honored to be here today to talk with you about how Congress can make medications more affordable for patients.

Medications do not work when patients cannot afford them.

The high cost of prescription drugs harms patients. One in 4 US adults reports having difficulty affording their medications, and 3 in 10 report not picking up prescriptions or skipping doses due to high cost.[1]

Even among those with insurance, patients frequently owe high out-of-pocket costs that limit access to essential medications. Patients with higher out-of-pocket costs are less likely to pick up prescriptions for new medications[2] and are less likely to stay on medications for chronic diseases like diabetes and cardiovascular disease.[3] When patients cannot afford prescription medications to control symptoms or treat or prevent disease, their health suffers.

Origins of high drug prices.

In the US, new brand-name drugs are granted patents and other statutory protections that prevent direct competition during periods of market exclusivity. Often, companies add layers of additional extraneous patents that prevent competition for longer than anticipated. These periods of protection against competition typically last 12-17 years,[4] during which drug companies are free to set and raise prices as high as the market will bear. As a result of this dynamic, we have seen prices for brand-name drugs skyrocket. The average launch price for newly marketed brand-name drugs has been increasing by approximately 20% per year, from $2,000 per year in 2008 to $180,000 per year in 2021.[5] After drugs are introduced, manufacturers frequently hike prices each year above the rate of inflation, without any evidence that the drugs are becoming safer or more effective. These price increases averaged 4.5% per year from 2007 to 2018.[6] For example, the price of adalimumab (Humira), an anti-inflammatory medication used to treat rheumatoid arthritis and several other conditions, increased by 470% from 2003 to 2021.[7]

Compared with the US, other developed countries have far more sensible policies for regulating brand-name drug prices. Most countries systematically evaluate new drugs, negotiate fair prices that are aligned with drugs' benefits to patients, and have mechanisms to lower prices

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[1] Hamel L, Lopes L, Kirzinger A, Sparks G, Stokes M, Brodie M. Public Opinion on Prescription Drugs and Their Prices. KFF. Published October 20, 2022. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.

[2] Dusetzina SB, Huskamp HA, Rothman RL, et al. Many Medicare Beneficiaries Do Not Fill High-Price Specialty Drug Prescriptions. *Health Affairs*. 2022;41(4):487-496. doi:10.1377/hlthaff.2021.01742

[3] Rome BN, Gagne JJ, Avorn J, Kesselheim AS. Non-warfarin oral anticoagulant copayments and adherence in atrial fibrillation: A population-based cohort study. *American Heart Journal*. 2021;233. doi:10.1016/j.ahj.2020.12.010.

[4] Rome BN, Lee CC, Kesselheim AS. Market Exclusivity Length for Drugs with New Generic or Biosimilar Competition, 2012–2018. *Clinical Pharmacology and Therapeutics*. 2020;0(0):1-5. doi:10.1002/cpt.1983.

[5] Rome BN, Egilman AC, Kesselheim AS. Trends in Prescription Drug Launch Prices, 2008-2021. *JAMA*. 2022;327(21):2145-2147. doi:10.1001/jama.2022.5542.

[6] Hernandez I, San-Juan-Rodriguez A, Good CB, Gellad WF. Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018. *JAMA*. 2020;323(9):854. doi:10.1001/jama.2020.1012

[7] Drug Pricing Investigation: AbbVie—Humira and Imbruvica. U.S. House of Representatives Committee on Oversight and Reform. May 2021.

over time.[8] As a result, average prices for brand-name drugs are twice as high in US, compared to peer countries.[9] For the first time, the Inflation Reduction Act of 2022 will allow Medicare to begin negotiating prices for certain high-cost drugs. This policy is a landmark achievement, although the scope is limited; manufacturers will still be free to set and raise prices for at least 9 years after FDA approval, and negotiated prices will only apply to Medicare, not the half of Americans with private insurance plans.[10]

Currently, the most important strategy for controlling high drug prices in the US is ensuring timely generic competition after market exclusivity periods expire. Effective generic competition can lower prices by 80% or more.[11] This direct competition is effective because states allow pharmacists to automatically substitute generics in place of the brand-name drug.[12] Generics account for 97% of prescriptions among drugs for which they are available.[13] Generic competition saved the US health care system an estimated $8.8 billion in 2017 alone.[14]

Brand-name manufacturers have developed numerous strategies to delay generic competition and extend their periods of monopoly protection.[15] For example, companies protect their drugs with thickets of patents related to the manufacturing, formulation, and use of the drug; generic drug makers must dispute these patents, and the resulting litigation can delay generic market entry. In other cases, brand-name drug makers introduce and heavily market new, only slightly modified versions of their drug with additional patent protection, just before the original drug nears the end of its exclusivity period; this strategy is known as "product hopping." In one example, the drug maker Teva introduced a new version of the multiple sclerosis medication glatiramer acetate (Copaxone) that could be injected 3 times weekly instead of once a day; this maneuver delayed effective generic competition by more than 2 years, costing $4-6 billion in unnecessary health care spending in the US.[16]

Summary and Policy Recommendations

- The main driver of high drug prices in the US is the fact that we allow brand-name drug makers to freely set and raise prices during periods of government-granted monopolies; prices are much lower in other advanced countries with more sensible drug pricing policies.
- The most important policies Congress can enact to lower prescription drug costs are those that address high brand-name drug prices set by manufacturers and encourage timely generic competition, such as:

[8] Emanuel EJ, Zhang C, Glickman A, Gudbranson E, Dimagno SSP, Urwin JW. Drug reimbursement regulation in 6 peer countries. *JAMA Internal Medicine*. 2020;180(11). doi:10.1001/jamainternmed.2020.4793.
[9] Mulcahy AW, Whaley C, Tebeka MG, Schwam D, Edenfield N, Becerra-ornelas AU. International Prescription Drug Price Comparisons: Current Empirical Estimates and Comparisons with Previous Studies. RAND Corporation; 2021. doi.org/10.7249/RR2956.
[10] Hwang TJ, Kesselheim AS, Rome BN. New Reforms to Prescription Drug Pricing in the US: Opportunities and Challenges. *JAMA*. 2022;328(11):1041-1042. doi:10.1001/jama.2022.15268.
[11] Dave CV, Hartzema A, Kesselheim AS. Prices of Generic Drugs Associated with Numbers of Manufacturers. *N Engl J Med*. 2017;377(26):2597-2598. doi:10.1056/NEJMc1711899.
[12] Rome BN, Sarpatwari A, Kesselheim AS. State Laws and Generic Substitution in the Year After New Generic Competition. *Value in Health*. 2022;25(10):1736-1742. doi:10.1016/j.jval.2022.03.012.
[13] Congressional Budget Office. Prescription Drugs: Spending, Use, and Prices.; 2022:222-229. https://www.cbo.gov/publication/57772#:~:text=The%20share%20of%20prescriptions%20for,to%2090%20percent%20in%202018.
[14] Conrad R, Liu W, Tillman Z, et al. Estimating Cost Savings from Generic Drug Approvals In 2017. US Food and Drug Administration; 2017. https://fda.report/media/113500/Estimating-Cost-Savings-From-Generic-Drug-Approvals-In-2017.pdf.
[15] Vokinger KN, Kesselheim AS, Avorn J, Sarpatwari A. Strategies That Delay Market Entry of Generic Drugs. *JAMA Intern Med*. 2017;177(11):1665-1669. doi:10.1001/jamainternmed.2017.4650.
[16] Rome BN, Tessema FA, Kesselheim AS. US Spending Associated with Transition from Daily to 3-Times-Weekly Glatiramer Acetate. *JAMA Internal Medicine*. 2020;180(9):1165-1172. doi:10.1001/jamainternmed.2020.2771.

- Promoting greater scrutiny of pharmaceutical patents by the US Patent and Trademark Office to prevent drug companies from obtaining dozens of irrelevant patents to extend their monopolies.
- Encouraging the Federal Trade Commission to investigate and prosecute anti-competitive behaviors such as product hopping that delay competition and result in higher prices for consumers.

Pharmacy benefit managers use formulary tools to negotiate lower drug costs.

To manage their prescription drug plans, most health insurers contract with pharmacy benefit managers (PBMs). To control spending, PBMs typically create a tiered formulary and impose utilization management rules to steer patients toward lower-cost medications and away from more expensive ones. Tiered formularies mean that patients pay lower out-of-pocket costs for drugs on preferred tiers. In 2022, 84% of workers with private insurance had pharmacy coverage with three or more tiers, and average copayments ranged from $11 in the lowest tier to $116 in the fourth tier.[17]

In addition to tiered formularies, another cost-containment strategy used by PBMs involves limiting access to expensive medications with utilization management tools. One such tool is prior authorization, which requires insurance approval before a medication can be covered. In a recent study, my colleagues found that 2 out of 3 new brand-name drugs had a prior authorization requirement by at least 1 of the 8 largest health insurers administering Medicare Part D plans, and 40% of these prior authorizations imposed requirements that were more strict than the FDA-approved labeling.[18] Another utilization management tool, called step therapy, requires patients to try a less expensive medication before a more expensive medication is covered.

Tiered formularies and utilization management tools can be frustrating for clinicians and patients, particularly when they prevent or delay the use of medications that are appropriate and aligned with evidence and standard clinical practice. Prior authorizations can be burdensome and time-consuming for busy clinical practices, and variations in these policies among plans can be confusing and difficult to navigate. By one estimate, physicians devote $27 billion worth of time each year navigating utilization management tools.[19]

Although these formulary management strategies are frustrating and costly, they are essential tools used by PBMs and health plans to negotiate lower prices from drug manufacturers. Brand-name drug manufacturers rely on formulary placement for patients to be able to access and use their expensive medications. As a result, PBMs can sometimes negotiate discounts from manufacturers in exchange for preferred formulary placement.

This negotiation process means that patients who need expensive medications sometimes face high out-of-pocket costs or restricted access to some medications. For policymakers, it can be tempting to enact rules that protect patients from this process, such as capping out-of-pocket costs or preventing step therapy restrictions. However, enacting such policies will impede PBMs' abilities to negotiate discounts, thereby resulting in higher net prices for some medications. As a

[17] 2022 Employer Health Benefits Survey. Section 9: Prescription Drug Benefits. *KFF*. https://www.kff.org/report-section/ehbs-2022-section-9-prescription-drug-benefits/.
[18] Naci H, Forrest R, Zhai M, Stofesky AR, Kesselheim AS. Characteristics of Prior Authorization Policies for New Drugs in Medicare Part D. *JAMA Health Forum*. 2023;4(2):e225610. doi:10.1001/jamahealthforum.2022.5610.
[19] Howell S, Yin PT, Robinson JC. Quantifying The Economic Burden of Drug Utilization Management on Payers, Manufacturers, Physicians, And Patients. *Health Aff (Millwood)*. 2021;40(8):1206-1214. doi:10.1377/hlthaff.2021.00036.

result, any such policies must be accompanied by other policies that address the high prices set by drug manufacturers.

Summary and Policy Recommendations

- To control prescription drug spending, PBMs negotiate lower prices from drug manufacturers in exchange for preferred formulary position and removal of utilization management tools.
- Enacting policies that place excessive restrictions on PBMs' abilities to manage formularies, such as out-of-pocket caps and restrictions on utilization management tools, will impede PBMs' abilities to negotiate lower prices for some drugs. To avoid this, such policies should be paired with other policies that directly address the high prices set by manufacturers.

Rebates negotiated by PBMs vary and do not always reach patients.

Although negotiation by PBMs is an important strategy for combating the rising prices set by drug manufacturers, the negotiation process does not always ensure that medications are affordable for patients. Rather than directly negotiating for lower drug prices, PBMs traditionally negotiate rebates that are paid retrospectively by drug manufacturers after the point-of-sale.[20] Most of these rebates are passed on to the plan sponsor, and can be used to lower premiums or provide more generous pharmacy benefits. However, PBMs are not transparent about the size of these rebates and often keep a portion of the rebates they negotiate as their own profit.

Additionally, rebates do not directly lower the out-of-pocket costs for patients using expensive medications; these costs are based on the list prices set by manufacturers, even in cases when PBMs have negotiated substantial rebates. This is particularly true when plans require patients to pay deductibles (i.e., paying the full cost of medications up to a threshold) or coinsurance (i.e., a percentage of a drug's cost). In a recent study, my colleagues and I studied commercially insured patients using one of 79 brand-name drugs; we found that 58% paid coinsurance or deductibles; for these patients, their out-of-pocket costs increased each year when manufacturers raised drug prices.[21]

In recent years, increasing rebates negotiated by PBMs have partially offset the striking growth in manufacturer list prices. This has resulted in a widening gap between the list prices set by manufacturers and the net prices paid by health insurers after rebates. In Medicare Part D, for example, the share of brand-name drug spending offset by rebates and other discounts increased from 25% in 2014 to 37% in 2018.[22] The ability of PBMs to negotiate rebates varies widely by drug. For brand-name drugs for which there are multiple competitors in the same therapeutic class, PBMs can negotiate steep discounts by offering preferred formulary position to only one drug in the medication class. For example, many insulin products have average rebates exceeding 70%.[23]

In some cases, however, PBMs have limited leverage to negotiate rebates. This can occur either when a drug lacks competition from therapeutic alternatives, or when federal or state law

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[20] Dusetzina SB, Bach PB. Prescription Drugs - List Price, Net Price, and the Rebate Caught in the Middle. *JAMA*. 2019;321(16):1563-1564. doi:10.1001/jama.2019.2445.
[21] Rome BN, Feldman WB, Desai RJ, Kesselheim AS. Correlation Between Changes in Brand-Name Drug Prices and Patient Out-of-Pocket Costs. *JAMA Network Open*. 2021;4(5):218816. doi:10.1001/jamanetworkopen.2021.8816.
[22] Feldman WB, Rome BN, Raimond VC, Gagne JJ, Kesselheim AS. Estimating Rebates and Other Discounts Received by Medicare Part D. *JAMA Health Forum*. 2021;2(6):e210626. doi:10.1001/jamahealthforum.2021.0626.
[23] United States Senate Finance Committee. Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug. January 2021. https://www.finance.senate.gov/chairmans-news/grassley-wyden-release-insulin-investigation-uncovering-business-practices-between-drug-companies-and-pbms-that-keep-prices-high.

requires insurance companies to cover a particular class of drug. For example, Medicare Part D plans are required to cover all medications that fall into six protected classes, which limits plans' ability to negotiate rebates for drugs in these protected classes.[24] One of the protected classes is cancer drugs, which had Medicare Part D rebates averaging 2% in 2016.[25]

There is also variation in the ability of PBMs to negotiate rebates. For example, in Colorado, average rebates for commercial insurers in 2018 ranged from 2% to 27%.[26] Presumably, this is because PBMs have greater leverage to negotiate rebates when they contract with larger insurers with greater market share.

Summary and Policy Recommendations

- PBMs have negotiated increasing rebates that have partially offset the striking growth in manufacturer list prices, although rebates vary between drugs and health plans.
- Rebates negotiated by PBMs in aggregate can lower premiums, but rebates do not necessarily flow to patients; out-of-pocket costs for individual drugs are frequently based on list prices that exclude rebates.
- Congress should prohibit PBMs and plan sponsors from tying patient out-of-pocket costs to high manufacturer list prices that do not include rebates.
- Congress should require PBMs to pass 100% of rebates they negotiate to plan sponsors and require plans to use these rebates lower premiums and offer more generous benefits.

Spread pricing and vertical integration between PBMs and pharmacies may be raising prices for generic drugs.

While there are dozens of PBMs, the three largest – Express Scripts, CVS Caremark, and Optum – control approximately 80% of the market.[27] This consolidation in the PBM market has raised concern among policymakers. However, PBMs argue that their large market share affords them greater leverage to negotiate lower drug prices from manufacturers. In other words, consolidation by PBMs is not inherently problematic, and, in fact, could help lower drug costs.

Beyond general concerns about consolidation, however, there two legitimate concerns have been raised about the way PBMs conduct business. The first centers around how PBMs contract with health plan sponsors. In some cases, PBMs use a strategy called spread pricing, in which they charge plan sponsors more than they pay pharmacies, allowing the PBM to pocket the difference. This pricing model misaligns financial incentives, allowing PBMs to profit from higher reimbursed prices. If the spread is large, patients may also end up overpaying for medications. In an infamous example, PBMs charged Ohio's Medicaid managed care organizations a "spread" of 31% for generic drugs, which amounted to $208 million of excess spending in 1 year.[28]

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[24] Hwang TJ, Dusetzina SB, Feng J, Maini L, Kesselheim AS. Price Increases of Protected-Class Drugs in Medicare Part D, Relative to Inflation, 2012-2017. *JAMA*. 2019;322(3):267-269. doi:10.1001/jama.2019.7521.
[25] US Government Accountability Office. Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization. July 2019. https://www.gao.gov/products/gao-19-498.
[26] Center for Improving Value in Health Care. Colorado Prescription Drug Spending and the Impact of Drug Rebates. January 2021. https://civhc.org/wp-content/uploads/2021/01/CO-Drug-Rebate-Report_1.8.2020.pdf.
[27] Fein AJ. The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger. Drug Channels. April 5, 2022. https://www.drugchannels.net/2022/04/the-top-pharmacy-benefit-managers-of.html.
[28] Yost D. Ohio's Medicaid Managed Care Pharmacy Services: Auditor of State Report. Auditor of State; August 16, 2018. https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf.

The second problem is that PBMs have become more vertically consolidated. Each of the major PBMs has now merged with or is operated by a health insurance company.[29] Perhaps more concerningly, the major PBMs each own or are affiliated with their own mail-order and specialty pharmacies. Increasingly, PBMs are steering patients to purchase drugs at their own pharmacies. This practice raises serious concerns about conflict of interest; PBMs are supposed to negotiate the lowest prices possible for health plans and consumers, but PBM-owned pharmacies profit from high reimbursement by health insurers that exceeds the cost of acquiring medications. The problems with this vertical consolidation seem to be particularly pronounced among specialty pharmacies. In a recent analysis of Florida's Medicaid managed care plans, the five largest specialty pharmacies – all of which were owned by or affiliated with PBMs – accounted for 0.4% of dispensed claims but 28% of prescription drug profits in 2018.[30]

These two issues – spread pricing and vertical consolidation with pharmacies – may be leading PBMs to over-charge patients and health plans for some medications. The problem seems particularly prominent for generic drugs, for which competition by multiple generic manufacturers is supposed to result in lower prices for patients. Evidence for this has come from comparing average generic drug prices in Medicare Part D with prices for the same drugs at two pharmacies that sell generic medications directly to patients. My colleagues and I found that Medicare Part D plans could have saved more than $3 billion on 108 generic drugs by paying the prices available from the Mark Cuban Cost Plus Drug Company.[31] Similarly, Trish et al. found that Part D plans could have saved more than 20% on 184 common generics by purchasing these drugs at Costco pharmacy prices.[32] These two examples highlight the problem of overpayment for generics; however, it is unreasonable to expect patients to shop around at multiple retail pharmacies to find the best prices for generic medications; PBMs should be doing this work on patients' behalf.

One notorious example is the cancer medication imatinib (Gleevec), used to treat chronic lymphocytic leukemia. After Gleevec's market exclusivity ended in 2016, three generic competitors entered the market. By the end of 2017, however, the average prices paid by commercial insurers had only fallen 10%, far less than expected based on that degree of competition.[33] Medicare Part D plans paid an average of $2500 for a 90-day supply for a generic imatinib; in 2023, Mark Cuban's pharmacy began selling a generic version of imatinib for 20 times less, with a current price of under $100 per 90-day supply.[34]

This degree of overpayment for generic drugs is shocking and unacceptable. However, it is important to remember that even with these problems, generics account for just 10% of US prescription drug spending, despite representing more than 90% of filled prescriptions.[35] As a

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[29] Fein AJ. Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: A May 2023 Update. *Drug Channels*. https://www.drugchannels.net/2023/05/mapping-vertical-integration-of.html.
[30] Sunshine in the Black Box of Pharmacy Benefit Management: Florida Medicaid Pharmacy Claims Analysis. 3Axis Advisors; January 30, 2020. https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management.
[31] Lalani HS, Kesselheim AS, Rome BN. Potential Medicare Part D Savings on Generic Drugs from the Mark Cuban Cost Plus Drug Company. *Ann Intern Med*. 2022;175(7):1053-1055. doi:10.7326/M22-0756.
[32] Trish E, Gascue L, Ribero R, Van Nuys K, Joyce G. Comparison of Spending on Common Generic Drugs by Medicare vs Costco Members. *JAMA Internal Medicine*. 2021;181(10):1414-1416. doi:10.1001/jamainternmed.2021.3366.
[33] Cole BAL, Dusetzina SB. Generic Price Competition for Specialty Drugs: Too Little, Too Late? *Health Affairs*. 2018;37(5):738-742. doi:10.1377/hlthaff.2017.1684.
[34] Lalani HS, Kesselheim AS, Rome BN. Potential Medicare Part D Savings on Generic Drugs from the Mark Cuban Cost Plus Drug Company. *Ann Intern Med*. 2022;175(7):1053-1055. doi:10.7326/M22-0756.
[35] Aitken M, Kleinrock M. Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023. IQVIA Institute; May 9, 2019. https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023.

result, policies that target these PBM practices will not lower spending as much as policies that address high manufacturer prices for brand-name drugs.

Summary and Policy Recommendations

- PBMs sometimes charge insurance plans and patients more than they pay pharmacies (i.e., spread pricing) and encourage patients to fill medications at their own pharmacies; these practices may be resulting in unnecessarily high prices, particularly for generic medications.
- To address these concerns, Congress should:
  - Prevent PBMs from engaging in spread pricing or collecting fees that depend on the prices of medications.
  - Ask the Government Accountability Office to investigate the impact of vertical consolidation between PBMs and pharmacies.
  - Require disclosure of markups when medications are filled at a pharmacy that is owned by or affiliated with the PBM.

Chairman BUCHANAN. I want to thank you for your testimony. I want to thank all our witnesses for being here, taking time out of your schedule. This makes a huge difference to the subcommittee. Well, I would like to proceed now to questions-and-answer session. I will begin.

Mr. Mulready, you took on the PBMs in Oklahoma, and one paved the way for States to regulate benefits to design. Given your success, what would you recommend? What would be a couple of things to fix the broken system of incentives that PBMs create in order to drive down the cost in terms of our constituents and pay for prescriptions?

Mr. MULREADY. Thank you for the question. You know, the Oklahoma legislation, I didn't get to that in my opening statement, but attacked things like transaction fees, outlaw the ability of PBMs to charge transaction fees. A very black-and-white thing that could be addressed. Also, it did a lot in regards to steerage. Steering to, as we have heard from the panel here, much of the panel, steering towards owned pharmacies and limiting that choice. Our law says that you are not allowed to steer. Any in-network pharmacy and any pharmacy can be in network; that they could be utilized within that. If you are going to mention the pharmacy by name, you have to mention all pharmacies. So those are some things that were addressed in Oklahoma law.

Chairman BUCHANAN. Thank you. Mr. Moose, according to the incredible story of how your family being in business, according to some estimates, there are just 1,900 independent pharmacies in the U.S., but they do employ 240,000 people.

If you were to change a couple of things as it relates to BPMs that adversely affect your business in the industry, what would they be? Could you expand or expound a little bit on what you said a little bit earlier?

Mr. MOOSE. Yeah, absolutely. Thank you for the question. Transparency. There is no transparency. We have a mechanism for pricing roles which is NADAC. So, when they have their price, it is a made-up price. And then also have the ability to give us something called a maximum allowable cost on a drug where they throw out all the rules, and they make up their own price for that.

So, to make pricing based off NADAC, a published transparent pricing model, and then a dispensing fee on top of that, would be a great start for it.

Chairman BUCHANAN. Well, thank you. I now recognize the ranking member, Mr. Doggett, for any questions he might have.

Mr. DOGGETT. Thank you, Mr. Chairman. And thanks to the testimony all of you provided. My concern—and I will direct this to Dr. Rome—is I want to address the problems that Mr. Moose so effectively described without wrecking the ability of the only participant in this process to push back against Big Pharma manufacturing costs or prices. You mentioned several specifics, and I am pleased you have been so specific. I think one of them, getting the Governmental Accountability Office to investigate the impact of vertical integration ought to be something we can do as a bipartisan request, even without legislation. And I think we should do that.

On the other ones that you mentioned, the three or four specifics that you have, of which I suppose the most significant is requiring that 100 percent of rebates be passed on; if we were to do all of that, as you recommend, without doing anything about the anti-competitive practices of manufacturers, what would the impact be on the system? Is that what you are recommending, or is there some portion of these you are recommending? How do we avoid the system becoming even more imbalanced than it is today?

Dr. ROME. Thank you for the question, Mr. Doggett. I do think that we—that Congress and this committee should pay attention to PBMs and think about some reforms that really put the patient and the consumer at the center of the legislation. And that includes avoiding gaming and avoiding the made-up prices, essentially the prices that were being passed on to patients.

Now those list prices are set by drug manufacturers. And to your point, PBMs are negotiating lower prices for some drugs. Now, for brand-name drugs, there is no direct competition. Drug manufacturers do as much as they can to extend the period by which—during which there is no competition. In some cases, PBMs have the ability to leverage competition between different brand-name drugs. And if you do impose restrictions on their ability to do that, such as, you know, sort of just restricting their ability to use tools to do that, you do risk prices going up. But, ultimately, they are negotiating off the price set by manufacturers, so you should be tackling both problems at the same time.

So, the Inflation Reduction Act does both. It addresses high prices by manufacturers, and it redesigns Medicare part D to make it more effective and a more generous coverage for patients. So that is the type of policy that when you combine those things together could be very powerful.

Mr. DOGGETT. Well, the problem we have is that even what I view is extremely modest and narrow reforms on Medicare price negotiation that were adopted last year, even those are under attack. The ability of this Congress to break free of the stranglehold of Big Pharma is just not there. We are not going to expand that negotiating authority. And my concern is how much of this PBM reform we can accept and adopt, hopefully, on a bipartisan basis without leading to even higher drug prices than we have today?

Dr. ROME. Yeah, I mean, I think that some of the practices would benefit from a lot of transparency. So, if there is one thing that the committee can do, I agree with some other recommendations here on the panel. As a researcher and for people who purchase healthcare, we just need more transparency in the prices. The rebates that are negotiated by PBMs are completely confidential.

Both the PBMs and the manufacturers seem to argue in favor of the confidentiality. It is not clear to me that making those confidential will necessarily have a major effect on prices. And I don't know a lot of research that shows that.

So just shining some light on the prices that are actually being paid, making it clear where the problems are in the PBM business model would be extraordinarily helpful as a first step as you consider some of these proposals.

Mr. DOGGETT. We have talked about these three vertically integrated companies that have 80 percent of the market. Is there much competition between the three of them?

Dr. ROME. Sure. I mean, I think that, you know, the answer is yes, that there is competition between the PBMs. Right, they do—they are very consolidated. But there are still three of them. So inherently, consolidation with PBMs does not necessarily, by itself, lead to higher prices, right? They are serving as an effort to push back on higher prices by the drugmakers. The monopolies by the drugmakers are the thing that are keeping prices high.

So, the consolidation does have other concerns in terms of how they practice their business. So, I would look at those. And in terms of, you know, how do we make sure we regulate? Again, we kind of put guardrails in place as you so nicely said. So, they can negotiate, they can do their jobs, but they can do it without harming patients. They can't charge patients, you know, more than the cost of the drug. In the case of generic that they can't charge patients based on a price that they don't pay much attention to, they are allowing the manufacturer to go up unregulated. Those are the practices that need to be addressed.

Mr. DOGGETT. Thank you, Dr. Rome. And thanks to all of you.

Chairman BUCHANAN. I now recognize Mr. Smith of Nebraska.

Mr. SMITH. Thank you, Mr. Chairman. Thank you to our witnesses for sharing your perspective. We are building off of yesterday's hearing on price transparency, obviously, and we examined, I think, that in an effective way. We know that healthcare consumers can't plan for health expenditures or even compare prices if they don't have access to accurate cost information, although price transparency can empower consumers who only have limited choices of plans or providers. We know that most communities only have one hospital and a limited number of providers. Over-consolidation can put other areas, even those with more providers in the same situation. We must find ways to ensure competition remains alive and well, while also expanding options in communities.

Mr. Richman, when it comes to over-consolidation and the growth of large health systems, would you say there is a geographic pattern, in urban, suburban rural areas? Is it more common in certain regions of the country as well.

Mr. RICHMAN. I think the best answer is that most hospital markets throughout the Nation are highly consolidated. And both urban and rural areas are homes to hospital monopolies. I don't think this is a distinctly urban or rural problem.

Mr. SMITH. Okay. Thank you. Now, I would like to combat over-consolidation and create more consumer options. I will say we need policies to foster diverse local, regional, and national competition. Obviously, reflecting on your concerns, Mr. Richman. I believe that—so this includes Medicare flexibilities, which give beneficiaries more provider options. For example, legislation I recently introduced, the Equitable Community Access to Pharmacist Services Act or ECAPS would allow for Medicare to pay a pharmacist for the testing and treatment for vaccination for common respiratory diseases.

I believe that increasing provider pull gives local pharmacists more ways to benefit their communities and can be done while re-

specting State level scope of practice rules as well. Actually, I think it is exciting to see the manifestation of pharmacists bringing more value, more opportunities, more information and insight for patients, especially at the local level.

Increasing number of services that they can provide those, what many would say a lifeline of many pharmacies which operate in this increasingly challenging environment.

Mr. Moose, over-consolidation and a lack of negotiation leverage has been cited as a contributor to pharmacy closures, which itself leads to further consolidation and decreased consumer options. Can you tell us how a pharmacy closure actually impacts community and especially a rural community.

Mr. MOOSE. Yes, absolutely. When you look at a lot of these communities out there, especially the rural communities, that is the health center of that community. That was the entity that stayed open during COVID. That was the entity that immunized that entire community during COVID; that also tested those individuals and got treatment during that time. That is the same entity out there that is taking care of that community. And those are the social determinants that help with those individuals. Those other community resources that they could go to. You can't have that through mail order. You know, you can't have that through technology or call centers. You know, the church down the road offers Meals on Wheels or maybe some copay assistance. So, when that pharmacy drives up and leaves that community, those individuals in that community suffer.

And there is a direct relation with the increase of healthcare costs when that resource is not in the community. They no longer have access to the same quality of healthcare that they have. So, they have to go farther, seek more expensive care. And that is if they do that. And in a lot of cases, they don't do that, because they don't have the ability. So, you are actually talking about increasing the total healthcare spend considerably. If you look at what community-based pharmacies do is they fill very cheap generic drugs. You are looking at less than 1 percent of the $3.6 trillion budget to keep that pharmacy in business.

Mr. SMITH. Is it fair to speculate that you would receive a call from a patient who received their prescriptions through another mail order perhaps, but they would expect you to answer questions as well?

Mr. MOOSE. Every single day. We pick up the slack of what the mail order—the void it leaves; the person who didn't receive their prescription in the mail. If we have to try to fill—we had an individual that had an antibiotic just last week that had an antibiotic that was two doses, 3 days apart. They got the first one filled, came in 3 days later to get the second dose filled, and the insurance rejected it saying it needed a prior authorization. When we spent 2 hours to get that prior authorization—and the reason they didn't get it is because they thought it was supposed to be coming in the mail. When they didn't receive it in the mail, then we had to spend 2 hours to get that prior authorization for that individual. So, you see that daily.

Mr. SMITH. Yeah, thank you very much. My time has expired.

Chairman BUCHANAN. I now recognize the gentleman, Mr. Thompson, from California.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for having this hearing. And thank you to all of the witnesses. First, I would like to ask Dr. Rome a question. How is it that prescription drugs through the VA are so affordable vis-à-vis the private sector?

Dr. ROME. Sure. The prices at the VA are a lot lower than they are in Medicare or in the private sector because the VA is a single healthcare system that negotiates prices and sets a clear formulary. They are basically able to have a very strong leverage to negotiate low prices on a smaller number of drugs for their patient population.

Mr. THOMPSON. It is substantially different. And I use the VA for my cholesterol drug. And it is hundreds of dollars versus a few dollars. And it seems to me that we could be moving more in that direction, negotiating, using our tremendous buying power to negotiate these prices.

Dr. ROME. Yeah, absolutely. Medicare has tremendous buying power. You see the power that it has on 10 drugs that are going to be announced in September. My guess is we have done simulation exercises of that law, and we expect that Medicare could reduce its drug spending within the first 3 years by 5 percent. That is backed up by the CBO estimates. So, if you do negotiate prices, you can make substantial lower prices for patients.

Mr. THOMPSON. Thank you. I hope we look to the VA for a model in this regard. For the other witnesses, I am having trouble trying to reconcile the issue of consolation as it pertains to keeping the doors open in some of the hospital facilities that we have and providing access to closing up the facility.

And it seems right now it is a real struggle for a lot of folks—and I don't think just in my district. I am seeing it in the suburban part of my district and in the rural parts of my district. Folks are really struggling. And I think there is a difference in trying to consolidate to be able to provide services to consolidate in order to maximize profits.

And so, in the instances when a facility has to consolidate in order to continue to provide access, what should we be doing, those of us on this dais, to make sure that they are doing it for the right reasons, and that people in our community aren't going to lose access? And we just had one, it is in a county that I share with another member about a hospital consolidated and promised to keep their birthing center open, something that is really important to the community, for 5 years. And within the first year, they temporarily closed it because they can't find a doctor or something. And their response to the community is, well, you can just drive to this next city for birthing practices. And in traffic, it is an hour's drive away. It doesn't work. So I would have liked to get some direction from you expert witnesses, on what we can do to prevent that type of behavior.

Mr. RICHMAN. Yeah, Congressman, your story is very, very common. I can't think of a single proposed hospital merger where lots of promises for both efficiencies and access have been made. I can't think of any hospital merger where prices have not significantly increased afterwards. There is a lot of empirical evidence of

this as well. Whatever the intentions are, when hospitals merge, prices go up. It doesn't matter if the hospital is for profit or non-profit. It doesn't matter if they are large or smaller community-based. And the only thing I could say as a matter of prospective policy would simply be to recognize, especially when hospitals are delivering lots of promise benefits, to know that there almost is not a counter example of any hospital post-merger not increasing prices whatever the market can bear.

Now, I will say one additional thing. I think that the policy objective is not to keep the hospital door open, but to keep a provider's door open. Mr. Moose gave a terrific example of how he, as a pharmacist, provided, and continues to provide, a variety of different healthcare services. The same can be said for nurse practitioners, for physician groups. And by and large, especially in rural years, hospitals give the highest, the most intensive care, and very often the most quality care. And to the degree that we really think about patients in rural communities and think about how we can maintain access to care, we have to think beyond access to hospital care. We have to think about more effective community and less intensive kind of care.

Mr. THOMPSON. Thank you very much.

Chairman BUCHANAN. I now recognize Mr. Kelly from Pennsylvania.

Mr. KELLY. Thank you, Mr. Chairman. Thank you all for being here. So, I have been in the retail business all my life, and I know I infuriate some people by comparing selling cars and trucks and servicing cars and trucks as to what we face in the medical field and the prescription field.

So, I did bring a window sticker. And I don't give a darn where you price up this traverse. This one happens to be on our showroom floor. If I were to go to Anchorage, Alaska, it would be the same window sticker. If I were to go to Miami, Florida, it would be the same window sticker. And Dr. Murphy and I talk about it all the time. It is not the same market. And I get that. But it is the same market for Chevrolet products. It is the same market for Ford products. It is the same market for Chrysler products and Toyota and every one of them. Whatever it is they have to offer, it is the same price no matter where you go to get it.

Now, this was a huge problem in the United States, and this is where it comes in. I don't know how we regulate what you all do. Honest to God. I mean, but in 1953, Senator Mike Maroney came up with an idea. You couldn't know what the price of any car was because there was no window sticker.

So, depending on where it is that you got access to it, it could be anything. And they could be thousands of dollars apart.

So, I am thinking with these PBMs, now when I bid on vehicles for the local cable TV, they are going to buy 50 trucks. I call Chevrolet and I say, I am going to need bid assistance on this because they are buying 50. And they will say, you know what, just count in another $2,000. We will reduce your price $2,000 because you are selling them 50 at a time.

I don't know how PBMs do it, but I think it was—Mr. Moose, you said it. It doesn't matter what the discount is, it is where did you start? How much did you inflate the list price to give you a bigger

discount? I mean, look at any newspaper any Sunday, and you will find jewelers who say we are going to take 40 percent off our already 40 percent off price. You say, God, I am getting 80 percent off. No, that is not what they said. They said we are giving you 40 percent off the already 40 percent, and you have no idea what the ring cost. But depending on where you are in life, and if you are in love for the first time, it doesn't matter what the cost is. You are going to pay whatever it is.

So how in the world would we begin to come up with some type of normalcy when it comes to purchasing drugs? Now, in the first department, we have genuine equipment price on parts, which is OEMs, right, and we also have generic parts, which oftentimes are made by the same company, but put a different sticker on it, and they are considerably less.

So, I look at the marketplace, and usually the marketplace is what decides on where people will actually buy at whatever price. What can you help us with that any way the government—which I think is the worst-run business in the country right now with $32 trillion in the red, and nobody is caring—what would you—if you were where we are, what is the something to fix the problem? Because you can't fix something with nothing. And we have these conversations. We don't get any conclusions. You guys do it every single day, what would you suggest?

Mr. ISASI. I would say there are two very clear solutions to this. And let's just start with your opening solutions.

Mr. KELLY. Dr. Murphy says in 10 words or less, but I have already violated that rule, so please go ahead.

Mr. ISASI. So, the first thing to say is it is very important to remind ourselves that PBMs are, in fact, negotiating a better price for the drugs that are already outrageously priced. That is a very important function. But when we talk transparency, I think what a lot of people don't realize is, say, PBM is doing that for a large employer who is providing healthcare insurance for their employees, a large employer is not getting information on the PBM about all the money flow. The large employer does not know what did you actually pay for this drug? What was the rebate that you got? All of those things.

So, this transparency is really powerful. The PBM must be required to allow their client, in this case, the large employer, to know the money flows that occurred and what did it actually save the employer? I think that is the first thing.

The second thing is—and this is where you see these terrible examples where people are paying cost sharing, and it doesn't make any sense. PBMs should not be able to negotiate price and then use a different price, the list price, for cost-sharing requirements for consumers. If you are only paying $5 for a drug, you cannot put a $50 copay on that drug. Those are two very straightforward issues.

Mr. KELLY. Before you go any further, Mr. Moose, somebody just slipped you a note. Is this about this issue?

Mr. MOOSE. Yes.

Mr. KELLY. Okay. Please. You are like—listen, I am a small retailer.

Mr. MOOSE. So, my answer to it was like my statement earlier, it is NADAC. We have a price if it is a transparent price that everybody knows. NADAC plus your dispensing fee. So that gets the pricing part. That gets the sticker in the window.

Now, how do you negotiate the price on it? It is transparency. Before PBMs were around, your physician wrote the prescription, and the patient went in there, and the pharmacist told him how much it was going to cost. They paid for it out of their pocket, or charged it, kept their receipt, turned it in, and the insurance paid them whatever their relationship was, 80 percent of that. Like my colleague said, the drug comes out, and it is $100,000, nobody is buying that. The only reason somebody buys a $100,000 drug is because they don't know what they are buying. They don't know the cost of what they are buying on it. So, if it is transparent all the way through, here is the cost of it. And people's eyes will get open, people will wake up to what that pricing actually is. Is there $100,000 value to that or is there a $29 drug that will do just as good.

Mr. KELLY. So, the insulin in this pen that I take was developed by the University of Toronto, I believe, in 1933 or 1934. And the people who developed this lot were so valuable to human beings that they sold the patent for a dollar. Quite a big price increase. But I have Silver Scripts, so I get it for a lot less money. But I take it four times a day. So, this is an incredibly complicated issue. It is not the same as buying a car or truck. It is not same about buying brake pads or anything else. But it is something we need to look at because it is off the charts, and it makes no sense to most Americans. Thanks for staying alive in a really tough business.

Mr. MOOSE. Thank you.

Chairman BUCHANAN. I now recognize Mr. Blumenauer, Oregon.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

I am listening to Mr. Kelly. I think at times trying to purchase an automobile is every bit as complex.

Mr. KELLY. You have got to come to the right dealer.

Mr. BLUMENAUER. I would like to acknowledge that there seems to be a great deal of agreement about problems, and there seems to be some assessment of solutions. I am mystified that it is hard as it has been for us being able to move forward.

Your point, Mr. Moose, about nobody pays $100,000 for some sort of pharmaceutical product, they do if somebody else pays for it. And what we are seeing is there is an effort to try and stick the Federal Government with these extraordinary price increases that we are not going to be able to sustain.

We have talked a little bit before in this committee about the trajectory we are on in terms of healthcare costs, and this is one that I am absolutely convinced that a little competition and common sense would help us move forward. And I really appreciate your clarity, from your perspective, about what we should do.

I am interested in a couple of the other Federal players here. Dr. Rome, Mr. Richman, you want to talk for a moment about the role that CMS could play to cut through this challenge and take a little bit of the burden off Congress?

Mr. RICHMAN. Thanks for the question, Congressman. We see in a number of other policy areas how different agencies are assisting the Department of Justice and the Federal Trade Commission in competition areas. Department of Transportation, for example, helps with airline mergers and other competition policies in transport.

And we don't see that with CMS, but certainly CMS has the capacity to do that. They have an extraordinary amount of data. They know very well patient flows. They know very well the delivery system, the infrastructure in the delivery system. So not only would they be able to assess what happens after certain transactions—you know, the anticompetitive effects of certain things that, for the most part, the Federal Trade Commission is required to guess on—but they also would be able to identify which markets create better value, which areas of the country create better value, and which don't.

So simply from a purely analytical perspective, CMS could offer a lot of insight and policy guidance. Of course, CMS also controls the spigot for a lot of dollars, and it could be more forceful in that sense as well.

Mr. BLUMENAUER. Dr. Rome. Do you want to talk about the control of the spigot, Dr. Rome?

Mr. RICHMAN. Well, I mean, to the degree that CMS, like anybody else, would be able to identify——

Mr. BLUMENAUER. I am directing the question to Dr. Rome.

Mr. RICHMAN. I apologize.

Dr. ROME. Sure. Thanks for the question. I mean, I do think that, you know, CMS—on the prescription drug side, you know, CMS has been sort of hand-tied for the last two decades. We talked about the two-decade anniversary of Medicare part D.

So, you know, for Medicare part D, it is a privatized program. So essentially, the market was broken up, and they were all trying to compete—you know, to negotiate with the same manufacturers. The manufacturers have a monopoly.

So, we have finally broken through that, and CMS is going to have some ability to negotiate drug prices. If they are able to do that successfully—if CMS is able to negotiate prices successfully, it takes pressure off the PBMs. The PBMs no longer have to do that work, and it frees you all up to make sure that they are doing their job in making sure to drive patients towards effective, safe medications that are high value and are going to help their care.

That is the job they should be doing. They are, right now, focusing on doing the work of negotiating prices when they are really sometimes not able to do so. For cancer drugs, they are almost unable to negotiate prices. The average rebates that they get from—that Medicare plans are able to negotiate for cancer drugs is 2 percent.

So, there are situations where they are just not able to negotiate, period. And so, you know, we do need to provide some more ability for them to do that.

Mr. BLUMENAUER. And do you want to make a comment about the Federal Trade Commission's role in this?

Dr. ROME. Sure. I mean, absolutely. I mean, I think—on the brand-name drug side, brand-name drug manufacturers will do as

many things as they can to extend their monopolies as long as possible. We see this time and time again. We studied drug after drug where we have seen this case.

There was a multiple sclerosis drug, glatiramer, where the company essentially changed the product from a once-a-day injection to a three-times-a-week injection. They were able to relaunch the product and charge Americans $4 billion to $6 billion extra by essentially delaying competition on the product, by getting an extra patent. The patent was struck down, but it took time.

So, we need, prospectively, to review these things. The Federal Trade Commission needs to—you know, needs to—you need to work with the Federal Trade Commission to make sure we are avoiding those sort of anticompetitive behaviors.

Mr. BLUMENAUER. Thank you.

Thank you, Mr. Chairman.

Chairman BUCHANAN. I now recognize Dr. Murphy, North Carolina.

Mr. MURPHY. Thank you, Mr. Chairman.

First, I would like to ask unanimous consent to enter into the record a statement from a pharmacist, fellow member, GOP Doctors Caucus, Congressman from Georgia, Dr. Buddy Carter. It is about PBMs.

Oh, well, he did it too. So, take my time back from him.

So, thank you guys. This is obviously an immensely complicated issue.

May I have 30 minutes? Just kidding there, sir.

Chairman BUCHANAN. Without objection.

Mr. MURPHY. Mr. Richman, let me just ask you. You know, the thing that is going on in North Carolina right now, it seems to me that every—across every—in the Nation now, it is, hey, who is the next person can we acquire or pull something together?

The only time I actually ever see that that is being appropriate—I live in east North Carolina. We have a lot of rural hospitals. And by the way, they charge more because their payer mix stinks because Medicare, Medicaid, and no insurance doesn't pay anything. It doesn't pay anything. And those people are much sicker than the average urban population.

But if you look in Charlotte, you look in Greensboro, there are these massive collusions with these massive hospitals. And you are right, you mark up the prices as soon as you walk in.

And one of the problems I have seen, private equity should never have been allowed in medicine. But that is a whole different issue. More physicians become employed. The prices go up. I have my office a mile from a hospital, but if I have a CAT scan worth $600 in my office, it is $3,000 in the hospital. We need to fix that, absolutely.

So, let me just ask you: Why do we—why is the consolidation other than to raise prices these days? Can you give me an idea?

Mr. RICHMAN. Congressman——

Mr. MURPHY. Microphone, please.

Mr. RICHMAN. I keep getting that wrong.

Congressman, I don't think the data has suggested any reason other than to gain leverage over private payers.

Mr. MURPHY. And what it is doing, it really is, it is creating these massive monopolies where people really don't have a choice.

I am in a rural part of North Carolina. I don't have a choice. I have a great hospital. I have worked there for 30-plus years. We own—yeah, we own in our system like nine other hospitals, which would not exist if we didn't make a profit at ours and keep those other rural hospitals alive. But the fact that other institutions are doing this worldwide—I mean, United States-wide—you know, like in Houston, some of these other things—is an absolute ridiculousness for our country.

Mr. RICHMAN. There is one thing that you said that I think really is worth highlighting. I do think that the consolidation phase, which, of course, has been fueled by private equity, really is creating a crisis for the medical profession. Physicians, really since the founding of the Nation, have been independent, and we have relied heavily on that physician independence. And now—very, very recently—three-quarters of physicians are now employed.

Mr. MURPHY. Yeah.

Mr. RICHMAN. And that is something that I think the healthcare sector hasn't fully absorbed yet, and it is going to have some very significant long-term consequences.

Mr. MURPHY. It is bad. I have spent many a night on Friday night looking for paper clips to figure out how I was going to pay the staff next week, but that was the most efficient and best care rather than being an employed physician and by having a huge barrier between you and the patient.

Let me just quick to Dr. Rome, one of my colleagues.

And by the way, Mr. Moose, I feel sorry for you. I think PBMs have screwed the independent pharmacists in this country. I think it is wrong what they have done. I know a lot of guys in our district that have fallen apart.

Dr. Rome, you have a much nicer view of PBMs than I do. I agree our pharmaceutical companies have taken a great, great amount of profit. But for every 10 drugs they put out, one of them works. They have got to recoup some of that loss somewhere.

I think the IRA went too far. We have had at least 50 lines of drugs that have been taken off. So, if an ALS patient is looking for a cure, good luck, because you are not going to have that on the line.

So let me ask you. The PBMs negotiate. They pull money from the pharmaceutical companies. Those don't get passed on to patient. Tell me what a coupon aggregator is and why that is good or bad. Because that is another level the PBMs use to gather more money.

Dr. ROME. So all of this is a game back and forth between the PBMs and the drug manufacturers.

Mr. MURPHY. Yep.

Dr. ROME. And patients are stuck in the middle between this negotiation match and are harmed by this negotiation.

So the drug companies set high prices. The PBMs negotiate rebates. The PBMs do so by trying to charge higher out-of-pocket costs to patients for expensive medicines. Then the drug companies come back with coupons, the coupons that they give to patients to

offset those out-of-pocket costs. And then the PBMs, in response to that, try to not count that amount of money.

Mr. MURPHY. It is a game. It is an absolute shell game that is happening.

Dr. ROME. It is a game.

Mr. MURPHY. Personally, Mark Cuban came to visit us at the Doctors Caucus the other day. He just put the PBMs to the side. He is going straight to the pharmaceutical companies. I think that is what we are going to have to do.

The PBMs were started out with a great idea, but they have absolutely extorted the American public in doing so with their actions.

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

Chairman BUCHANAN. I now recognize Mr. Higgins, New York.

Mr. HIGGINS. Thank you, Mr. Chairman.

So CVS Health, CIGNA, United Healthcare Group account for 80 percent of the total claims in 2021 for prescription drug benefits through their pharmacy benefit managers.

CVS Health, the salary of the president and CEO is $21 million, 7 percent of which is salary. The rest is stock options and other incentives. CIGNA president and CEO has a salary of $1.5 million and $12.6 million in stock awards. United Healthcare Group, the CEO has a total salary of $20.8 million, $12 million of which were stocks.

And I was just kind of curious as to why stock options in any company—the stock option compensation is an incentive to max out on profits, which, you know, makes sense, by cutting costs and competition.

The three of these companies account for 80 percent of the total claims for prescription drug benefits. It would seem to me that they are behaving like monopolies.

The Federal Trade Commission is supposed to take action to stop and prevent unfair business practices that reduce competition and lead to higher prices.

Now, Mr. Moose, I presume that your family of pharmacies is not associated with any of the three companies that I had mentioned. How does this sit with you?

Mr. MOOSE. Actually, we are. We are slave labor to all three.

I mean, those numbers aren't anything that we can even comprehend. And so, when you have companies like that and that vertical integration, it gets to make up their own rules.

All we are asking for in business is a level playing field. We don't let the Yankees use aluminum bats. Everybody gets to use a wooden bat. And that is what we are asking for in the pharmacy field. If you are a community-based pharmacy, you have a level playing field.

Mr. HIGGINS. Well, three entities, as I previously mentioned, accounting for 80 percent of the total claims, that doesn't seem to be a level playing field.

Mr. MOOSE. No.

Mr. HIGGINS. Dr. Rome.

Dr. ROME. Yeah. No, I mean, I agree with what you are saying. I think that, you know, the PBM industry needs—just like every industry where there is a lot of money being made in healthcare—

needs to be regulated to make sure that, you know, that consolidation is benefiting patients and not harming them by reducing their choices of where to pick up their medicines.

I am a primary care physician. I see this all the time. My patients are, you know, struggling to figure out where to fill their medicines. Patients should not have to shop around for medicines. That is what the PBMs are supposed to be doing. They are supposed to be doing the work of negotiating prices on behalf of the consumer, right?

So, we just have to make the PBMs work for patients. We have to make sure that they are able to do their job. But that requires us to have, you know, prices that are reasonable, you know, for them to start with.

Mr. HIGGINS. Okay. Speaking about negotiating prices to benefit the consumer, the Inflation Reduction Act includes a provision to allow the Federal Government to negotiate drug prices under the Medicare program. What will the benefit of that be?

Dr. ROME. The benefit is likely to be enormous. It is a very limited set of drugs that are going to be negotiated. It is up to 20 drugs per year, and it is just the highest-spending drugs. But even in the first few years, we expect the CBO—and we have done a similar study. I expect that this will lead to massive savings within the Medicare program by lowering costs.

Again, just to be clear, there is competition in the pharmaceutical industry for generics. There is no competition for brand-name drugs for 12 to 17 years——

Mr. HIGGINS. The Veterans Administration negotiates drug prices. You know, what is a reasonable expectation relative to the savings that will result directly from using the leverage that they have with drug companies?

Dr. ROME. I mean, the VA prices are about half of those in Medicare.

Mr. HIGGINS. Yeah.

Dr. ROME. Yeah. So, I mean—so I think that you can—I think that there is a lot to be negotiated. You know, I think that, you know, we want the pharmaceutical industry to make money. We want them to—we want everyone in the healthcare field to make enough money to incentivize them to do their job. We just want to make sure that patients can afford what we get out of that.

Mr. HIGGINS. Great. Just a final thought, Mr. Chairman. Keep in mind that, a lot of drug development, as you know, is a result of a public-private partnership. And the Federal Government typically will fund the early basic research that leads to eventual drug development. But it is the Federal Government, the public side, that really expends the costs at very little or no compensation. It is the drug companies that come in in the latter stages of drug development that are also the most profitable.

With that, I will yield back.

Chairman BUCHANAN. I now recognize Dr. Wenstrup, Ohio.

Mr. WENSTRUP. Thank you, Mr. Chairman.

And thank you all for being here.

As Dr. Murphy said, you know, can I have a half hour, or an hour, or maybe we can sit here for a week, because we really should be doing that, in my mind. But I am just concerned about

so many things as a practicing physician in private medicine for 27 years. My, how things have changed.

You know, my first year in practice, if someone was just there for an office visit—no procedure, you know, nothing surgical, nothing at the hospital, just an office visit—I gave them their bill and they paid it. And they submitted it to their insurance company. And nobody was complaining. Nobody thought that was a problem.

And I was a solo practice at first and then in a large group of 26 doctors. Solo practice, I had two employees, when I started. It just kept growing. It just kept growing. And it is this institutional creep from government, from insurance company demands. It is all these things.

And they really, they don't have too much to do with the patient outcomes, to be honest with you. You know, I never really cared what Washington thought about how I was practicing, but I did care about how my patients thought I was practicing and the results that I was getting and my referring doctors. I didn't need Washington. I didn't need to check boxes for Washington.

You know, recently, Doctors Caucus—bipartisan—we meet with the Surgeon General, and he wanted to meet with us. You know what he wanted to talk about? Physician burnout. Understandably. And, you know, we have got a nurse shortage. We have got physician burnout. Why are we burned out? Because everybody else knows how to treat your patients and interferes between the doctor-patient relationship. And then you have, you know, these consolidations, and, you know, the doctor is just a go-between, really.

I mean, I am going to ask Dr. Rome. You see a patient. You examine them. You work them up. You do labs. You do X-rays, whatever else it takes. CAT scan, whatever. You have had hands on. You look them in the eye. You sit down and discuss their problem with them, and you make a plan with them.

And then somebody who has never seen the patient, you have to get on the phone with, who may not even be in your specialty, and go through. And, you know, I have been on there, and I think you are looking at a screen, aren't you?

You know, to me—I want to ask you. Do you think it is medical malpractice for people to be treating patients they have never seen?

Dr. ROME. So, thanks for the question. You know, I agree with your sentiments. I am one of the 75 percent of doctors who is employed by a hospital.

I think that, you know, from the case of prescription drugs, when I prescribe a medicine, I obviously think that that patient needs that medicine. If there is a system solution to make sure the patient has a more affordable version of that medicine, I would like that to be the case.

But, you know, I do think that, you know, this is where the temptation comes in. The temptation is, you know, just allow sort of physicians to prescribe whatever they want. In most cases, that is going to be the appropriate thing. We do need system solutions——

Mr. WENSTRUP. No, I don't believe that in doctors. I don't think people go through that much schooling and training to not do what is best for their patients.

And I have never bothered—if a pharmacist called and said, hey, you prescribed X, but Y is on their formulary. And you say, well, they are similar, and this patient, it doesn't matter. That is cool. But not fatal first. Not have to do something you don't think is right. And that is why we have a bipartisan bill, Safe Step Act, that we are trying to get through to cut through that so that you can actually treat your patients.

And you know—you know if a patient has to wait to get their medication because you are going through all this hassle, administrative hassle, and it delays their care, that is not good for them. And that is what is happening. And then that usually drives up costs.

And so, these are problems that patients face. But the interference to the doctor-patient relationship—the now really—you would think there is more entrepreneurship. There is actually less entrepreneurship for physicians as they come out of residency. They are thinking who they are going to go work for. They don't think about, I am going to go out to my rural town and hang out in my shingle. Why? Because it is almost impossible. And that is the system that we have in place.

So, I have experienced the burden of working through the red tape, drug plan, that, or just even ordering an MRI. And somebody who has no idea about my specialty is telling me I can't get it. Well, I ask for their license number, and I ask for the patient to be able to see them. But this is what we have gone through.

So how can this practice be improved to ensure doctors don't burn out from paperwork and patients don't suffer worse outcomes waiting for the medication that they need? And I will have any one of you who wants to answer that question.

Mr. RICHMAN. I mean, I will say that we spend about $1 out of every $4 in administrative overhead costs. And to the degree that we can focus our attentions to simply reduce those totally without value expenditures, I think that is really valuable. And there might be some solutions there. I have done some research that I would be happy to share with the committee.

Mr. ISASI. I think the other solution that is very important to discuss is when you talk to docs who are tired of the system, the fee-for-service grind on volume, and the never-ending, you know, referral wagon train they are on.

And part of the effort is also thinking about how to redesign the economic incentives in healthcare so that a patient goes to a doctor, and the doctor is getting paid to do the best thing possible for that patient. And a lot of the new approaches of trying to change the payment incentives, trying new global payment experience—that is about saying, let the doctor—let her do what she has learned to do, and don't put economic incentives in front of her that are in direct conflict with the patients' interests and the interests of the country.

Mr. WENSTRUP. And reward prevention, if I do say so.

Mr. ISASI. Yes. Yes.

Mr. WENSTRUP. My time is up. And thank you all very much. I yield back.

Chairman BUCHANAN. I now recognize Ms. Sewell, from Alabama.

Ms. SEWELL. Thank you, Mr. Chairman.

I want to thank our witnesses for their testimony today.

Prescription drugs continue to increase in this country. Drug costs grew almost $380 million in 2021. Let me say that again. Drug costs grew to almost $380 billion in 1 year, according to the National Health Expenditure Data.

High drug prices continue to create barriers. Health benefit prescription drugs were created to provide access and healthcare to patients. We have all heard the stories of Americans of all ages who continue to encounter barriers to lifesaving drugs, and yet drug prices continue to climb with, Americans paying almost three times as much for the same drug as other countries. Three times as much. It is evident that we need reform.

The historic Inflation Reduction Act, for the first time, allows Medicare to negotiate prices. The Congressional Budget Office has stated that similar policies are responsible for increased use of prescription drugs, which led to reduced hospital and physician costs. And as you said, Dr. Rome, the Inflation Reduction Act will have a huge impact in benefit to patients.

Simply put, Medicare's ability to negotiate drug prices will increase access to affordable prescription drugs, which is a key to fighting chronic illness.

At the heart of accessible and affordable drug prescriptions, Mr. Moose, are independent pharmacies. These pharmacies are key to ensuring that citizens in rural and underserved communities can access those lifesaving drugs.

I represent a district that includes both urban and rural. The similarity is they are all underserved and vulnerable communities. So, I am particularly supportive of independent pharmacies. It is my hope to see independent pharmacies continue to provide those critical clinical services like vaccinations that was so vital to the folks that I represent during COVID.

Mr. Moose, as a community pharmacist in North Carolina, can you explain how rural and underserved communities are impacted by the closure of independent pharmacies resulting from the consolidation of PBMs and insurers?

Mr. MOOSE. Yeah. We are already starting to experience these pharmacy deserts. And we are seeing it in rural areas because of—they are driven to close because the reimbursement model, they can't remain open. And where you have these pharmacy deserts, you have the increase in cost, and the increase in cost comes from delaying care.

So, the patients who may be newly diagnosed with diabetes, that is getting put off years. So, all the damage that would be happening while that patient is going untreated with diabetes is happening. So, they show up outside of that zone—when they finally do get to care, they show up at a higher risk or a higher—or more severe—or more progressed disease state, which is a more expensive place to treat them.

Ms. SEWELL. Absolutely. And I have to tell you that my State of Alabama, for example, didn't extend Medicaid. And, frankly, a lot of the rural hospital closures over the last 10 years have predominantly been in States that did not expand Medicaid.

Dr. Rome, with the remainder of my time, can you talk to us about what this consolidation is doing for rural and underserved communities?

Dr. ROME. Sure. I mean, I think we have talked about consolidation of a lot of different entities in healthcare today. And it is just important to keep in mind that, you know, ultimately, there is, you know—you know, rural communities need access to healthcare. They need access to prescription drugs from their pharmacies. They need access to doctors. And ultimately, we need to figure out a way that is equitable, that is fair to pay for that level of service and to not design a healthcare system that sort of drives that away.

Ms. SEWELL. Absolutely.

I yield back the balance of my time.

Chairman BUCHANAN. Pursuant to committee practice, we will now move to 2-to-1 questioning.

I now recognize Mr. Hern, Oklahoma.

Mr. HERN. Thank you, Mr. Chairman. I really appreciate you for hosting this hearing on consolidation in the healthcare industry and for including an old Okie, my dear friend, Glen Mulready, who is a fellow business leader in Tulsa.

And it is great to have you here today, friend. It is good to see you.

As most of you know, before coming to Congress, I owned and operated several businesses for 35 years. And during that time, I saw incredible consumer benefits coming from mergers and acquisitions. But I believe the point of this hearing should be the discovery, at what point is integration unhealthy. At what point does it cease benefiting the patient and the taxpayer?

As a free-market conservative, there are some key components Congress should adhere to when examining unhealthy consolidation.

First, Congress needs to identify which government policies promote unhealthy consolidation, namely through Medicare and Medicaid, and how that wastes the taxpayers' money and reduces beneficiaries' quality of care.

Second, if Congress pursues legislative solutions in this space, policies should create more competition in the market for patients, not stymie the growth of entrepreneurs.

I mention these two principles because it concerns me that legislative proposals from other health committees in Congress approach consolidation by finding ways to attack industries, not solve problems. This committee should approach this problem by identifying current policies that limit the ability for smaller companies to grow and compete.

That is why today and every day I want to get down to what the real issues are. And for this hearing, the question is, what policies are limiting competition in the healthcare industry, and what policies are creating real value for patients and beneficiaries?

As an example,—my friend mentioned this early on, what PBMs' purpose was. And for instance, as a former businessowner, my perspective on the drug supply chain is different from some, having experienced working with PBMs long before I got into running for Congress and hearing from the independent pharmacies.

But as a McDonald's franchisee with over 1,000 associates for 24 years, we contracted with a large PBM through our national insurance company and saved a significant amount of money on prescriptions. And the PBMs' customer is the employer and their employees. I have yet to come across an employer—an employer—who has expressed concerns to me about the PBMs. So, we have got some work to do.

And while I am on that topic, I think I would be remiss not to mention the hospital ban on competition. We are way overdue to repeal the ban on new physicians' own hospitals who offer patients more choice and drive down prices through competition.

It is time for us in Congress to get the courage to take on more than just drug pricing, which is only 10 percent of healthcare's spending, by the way. We need to look at which government policies are creating a system where 50 percent of healthcare spending is driven by our doctors and our hospitals.

We know that hospital consolidation in marketplaces is anywhere—overnight—driven prices 25 to 75 percent increases overnight. Overnight. Not over a period of 10 years, overnight. And we have got to get down to that.

Fortunately, Glen and I live in an area where we have a lot of competition in the hospital space, but that is just not so across America, and we need to take a look at that and see how we get back into a free-market competitive space. And I would argue one of those ways is physician-owned hospitals. We need to remove that ban.

And, Glen, you have spent 22 years in the healthcare industry. Your testimony highlights the impact of hospital consolidation on Oklahoma specifically in rural areas, of which we have many rural areas in Oklahoma.

What are some of the policies we should explore to increase competition in this sector? If you could help us out, that would be great.

Mr. MULREADY. Thank you. Thank you for the question, Congressman.

I think you have heard about it with this panel a number of times here this afternoon. But the facility fees being charged and for certainly, in my opinion, no additional benefit with the physician offices versus outpatient. We have seen facility fees of anywhere between $300 to $1,500. Same service being provided in an outpatient setting versus a physician.

I am not saying we do away with facility fees. Those are appropriate in the appropriate setting. I mean, the original idea of that was to take care of some of those issues that hospitals encounter, right? To stand by personnel, NICU units, things like that. We don't want to throw the baby out with the bathwater, if you will, but I do think we need to look at some site neutrality as a key issue but without throwing that whole thing out.

Mr. HERN. I appreciate that. You know, a hospital buy up there family's physician practice, the next day, the prices will increase overnight. Literally overnight. I think it is just unacceptable.

And I will tell you that is why today I introduced the Facilitating Accountability and Improve Reimbursements Act, FAIR Act, with Congresswoman Kuster, to ensure that hospitals have different

billing IDs for their off-campus practices so we can identify where those costs are actually being associated.

And, you know, over the past decade, the amount of physician practices owned by hospitals—it was just talked about—have doubled and are increasing to create a problem in lack of competition in our area.

Mr. Chairman, again, I thank you for this hearing, and I yield back.

Chairman BUCHANAN. I now recognize Mrs. Miller of West Virginia.

Mrs. MILLER. Thank you, Mr. Chairman.

Thank you all for being here.

And speaking of throwing the baby out with the bathwater, 44 years ago, I became a new mother. I didn't know much, as most new mothers don't. And when my second son arrived about 3 years later, I knew a lot more. And I would call my family pharmacist, Mr. Moose, before I called the doctor, because sometimes the questions that mothers ask, you don't really need the doctor, you need to know what the pharmacist knows. And so, I always appreciated—he was just right around the block, and he could answer questions that I had over sometimes silly things and sometimes over medicine.

But what I really want to talk to you about is how troubled I am with the rapid market consolidation in healthcare. And we are just seeing way too much of that in West Virginia.

Part of the hospital consolidations that we are seeing is a function of our rural hospitals are having to choose between closing their doors or selling their practice to a large healthcare system. And while I am sympathetic to the difficult choices rural hospitals often have to make in order to maintain access for care for patients, I really wish they didn't have to be in that position.

We need to empower our rural hospitals to be able to provide care for the most vulnerable populations, such as most of my constituents in southern West Virginia.

I introduced the Assistance for Rural Community Hospitals Act last year, alongside Representative Sewell, that would have extended the Medicare-dependent hospital and Medicare low-volume hospital price adjustments for 5 years. These two programs provide critical assistance to rural hospitals and allow more hospitals to keep their doors open, particularly in southern West Virginia. We were able to get these programs extended through 2024, but more work needs to be done. And I look forward to working with Representative Sewell on extending these programs further to provide certainty for our hospitals.

Now, on to consolidations in the PBM market. One of my top priorities is improving care for patients in end-stage renal disease. We have a lot of that in West Virginia. And I have heard from a pharmacist in my district recently that kidney transplant patients are having trouble accessing the immunosuppressant drugs that they need to keep their transplant viable. PBMs consider antirejection drugs to be specifically specialty drugs and that they require the drugs to be mail-ordered from their own specialty pharmacies.

I am not sure if you all have been to West Virginia, but it is not like living in Kansas. The mountains make it extremely difficult for

mail to be delivered, sometimes in a timely manner. And transplant patients cannot go without these drugs for even a day for fear of transplant rejection. Patients in rural communities need to be able to get their drugs from their community pharmacist.

My State has been a leader in reforms that would tackle some of these PBM issues. In West Virginia, PBMs must have a mix of brick-and-mortar pharmacy options and mail order. A hundred percent mail-ordered drugs are not permitted. Price cannot be used to determine whether a drug is a specialty drug, and all rebates must be passed through to the consumer at the point of sale. And if for some reason they can't be, they must be sent to the plan and used to lower the plan's rate for the next year.

While I understand that not all of these reforms might be practical on a national scale, I really think that they are a good place to start.

Commissioner Mulready, Oklahoma, like my State, has been a leader in reforming PBM practices. Can you elaborate on the positive impacts for patients from Oklahoma's reforms, and have there been any negative impacts or missed opportunities that you would like to comment on?

Mr. MULREADY. Thank you for the question. You know, our bill that was passed in 2019 was called the Patient Pharmacy Choice Act. I think the keyword there is "choice." And so, our bill, in the State of Oklahoma, has focused on choice and patients having the ability to choose where and when they get their prescriptions.

I mentioned earlier, the transaction fees are outlawed in our State, and some of the things you have just mentioned as well. I think something additional that could be done—and I think it was Mr. Kelly that had a presentation up there previously—is on transparency and with the contracts with PBMs with the employers that they are contracting with, just in a more full, transparent manner.

The Affordable Care Act—we came out with a benefit summary, right, that every plan has to utilize that same format, much like the analogy of the window sticker. I think, with employers, that will be extremely helpful in future legislation. But transparency is key.

Mrs. MILLER. Thank you. I am sorry. I have got more questions, but I have run out of time.

I yield back.

Chairman BUCHANAN. I now recognize Ms. Chu, California.

Ms. CHU. Dr. Rome, I want to start on an issue that you touched on in your testimony, that the average prices for brand-name drugs are twice as high in the United States compared to other countries.

I can tell you there is no other issue in healthcare that I hear about more from my constituents than the skyrocketing costs of prescription drugs. Year after year, drug companies are setting prices so high that they are simply beyond the reach of patients.

And you used the example of Humira, an anti-inflammatory medication used to treat rheumatoid arthritis, which increased in price by 470 percent from 2003 to 2021. And in 2018, Humira made more revenue than every NFL team combined.

Well, Dr. Rome, you referred to what other countries do to keep drug prices low. I am proud that in the Inflation Reduction Act we

did allow Medicare to begin negotiating the prices for the costliest drugs out there.

Is this in line with what other countries do? Will it bring down the cost of new drugs and ultimately lower health costs for patients? And would expanding these provisions beyond Medicare help more Americans? Also, do these other countries have PBMs?

Dr. ROME. Thank you for the question, Congresswoman. I do think that the Inflation Reduction Act and the Medicare negotiation provisions are a step in the right direction. Even under the Inflation Reduction Act's new policy, Medicare is prohibited from negotiating from drugs for the first 9 years—or 13 years that they are on the market. And so, the pharmaceutical industry will still be able to set high prices for those periods of time.

Most other countries negotiate at the time that drugs enter the market. This includes most of our peer countries in Europe, in Canada. And they do so by examining how well the drug works, looking at the prices of what is already out there, and making sure that the price is fair. And this allows, then, the healthcare system to use those products, you know, aligned with value and aligned with good patient care. So, we do have a way to go to get towards that.

Ms. CHU. And do they have PBMs?

Dr. ROME. That is a good question. I would yield to somebody with knowledge of this if they know if there are PBMs in other countries. There are definitely some intermediaries that are making these decisions and health insurers, but I don't know if they are specifically PBMs.

Ms. CHU. Well, I would like to ask, then, going to another thing that you raised, which was generics. Generics are used as a way to manipulate the system to keep the cost high.

For example, the drugmaker Teva introduced a new version of its multiple sclerosis medication that could be injected three times weekly instead of once a day. This means generic competition was delayed by more than 2 years, which resulted in billions of dollars of profits for the company, paid for on the backs of patients and the taxpayer.

So how does delaying generic drugs from coming to the market impact patients, and what changes have to be made to stop this manipulation?

Dr. ROME. Thank you for the question. Lots of changes need to be made to make sure that the drug industry isn't able to manipulate existing rules like patents and extend their monopoly periods.

Competition works in the pharmaceutical industry. It works for generics. Prices do go down, usually very quickly, by up to 80 percent if there is effective competition. Many products that could have generic competition don't have enough generic competition. And for brand-name drugs, companies use any strategy they can to extend the period of monopoly before competition begins because that is the period of time when they can make money.

We just saw Humira finally face its first competitor this year after two decades and after many—you know, filing, basically, thickets of dozens of patents to protect that product. And so, if we can tackle that problem and we can get competition to the market sooner for some of these products, we would see prices come down.

Mr. ISASI. And just to put a number on that, the top 12 best-selling drugs in this country have over 125 patents that have been filed on them, and the estimate is 38 extra years of exclusivity. And this is a complete game.

Ms. CHU. And can you say a few words about private equity and its role in keeping prices high?

Dr. ROME. Sure. I mean, private equity is outside of my area of expertise in terms of the pharmaceutical space, so maybe somebody else can comment. But in the prescription drug market, I am not sure if private equity is responsible for high prices of prescription drugs. You know——

Ms. CHU. In healthcare in general?

Dr. ROME. Yeah. I mean, healthcare in general, you know, is not my area of expertise. I will defer to—you know, maybe Mr. Richman can answer or somebody else can answer, if you would prefer.

Ms. CHU. Well, I ran out of time.

Mr. ISASI. I mean, the one thing I would say about private equity that we know is that, in general, there are time periods between 3 to 5 years in terms of making high yields for their investors.

What does it mean for a company to purchase a healthcare hospital or a physician group and turn a giant profit in 3 to 5 years? Is that good for people? No. Is that good for the system? Is it good for health? No. So, their business model does not align with the interest of the people that are being served by the healthcare sector.

Ms. CHU. Thank you for that.

I yield back.

Chairman BUCHANAN. I now recognize Mr. Fitzpatrick, Pennsylvania.

Mr. FITZPATRICK. Thank you, Mr. Chairman.

Thank you to all of you for being here.

In 2019, patients filled more than 3.7 billion retail prescriptions, and approximately three-quarters of these prescriptions were filled through PBMs. Based on the data our committee has received, three PBMs—three—control 80 percent of the prescription drug market, and six PBMs control 96 percent of the prescription drug market.

My first question for Mr. Moose. PBMs have excluded over 1,300 unique medications from formularies for at least a year. And of this, nearly half are single-source drugs. In your work as a clinical pharmacist, what impact have you seen from this practice on clinical outcomes for your patients?

Mr. MOOSE. Yeah, we see this daily. They use the tool called prior authorization. So, when the physician sees the patient, determines what the patient needs, writes that prescription, the prescription comes to the pharmacy. It gets rejected at the point of sale, saying this drug needs to be prior approved. We don't cover it. Or it is not on the formulary at all. You will have to choose another drug altogether.

It starts the path back again. We have to contact the physician that wrote it, tell them that it needs a prior authorization. They have to jump through hoops saying why they need this drug versus a drug that is on the formulary or a drug that they get a higher

rebate on or whatever reason they have chosen to not leave that drug—or not add that drug to their formulary.

What it does, it leaves the patient sitting there in limbo. While all of this is happening, somebody is trying to make a decision on, you know, what medication can we get for that patient, while the patient is sitting there in limbo waiting on some option—that it was the prescriber's second option.

Mr. FITZPATRICK. Mr. Moose, turning to transparency, how can requiring price transparency for PBM practices such as rebates and fees help people like you do your job better, and do you believe this would help patients better understand the cost of their drugs and gain—ultimately, get better access to medications?

Mr. MOOSE. Yeah. The whole transparency thing is, is we—you know, a lot of times, up until recently, we didn't have a clue of what we would even be paid for the drug. But if you use a pricing like NADAC, we know what the drug costs from the wholesaler. We know what the pricing is going to be.

So, with the part D plan, surveying pharmacy colleagues of mine, 50 to 65 percent—that is over half of the prescriptions that are filled for part D patients—we are filling for less than our acquisition cost of that medication.

So, we are paying that patient to come in there and let us fill that prescription for them, or paying that PBM or that insurance for that half. So that is just not a sustainable model. So having that transparency in there would allow you to see that.

Also, to have the ability with the PBM to opt out of that drug. If they are not going to go with NADAC pricing, and that drug is—we are underwater in that drug, we can tell the PBM that we won't fill it. But now they bind us contractually to not not fill the drug. We have to fill the drug, whether we are losing $1 or $500.

Mr. FITZPATRICK. Thank you, Mr. Moose.

Mr. Mulready, I just want to get your thoughts on one question. In my district, our community pharmacists have reached out to my office many times to offer their concern about pharmacy benefits, specifically regarding the impact of copays for Medicare beneficiaries.

In your experience, what steps do you think this committee should take, this Congress should take, to further examine the roles that PBMs play in driving up prescription drug costs for patients across the board?

Mr. MULREADY. Well, I think you have heard a number of ideas here today. You know, you have got that play between Medicare State laws that are passed, that we have got in Oklahoma, that do not apply to Medicare-type programs, and the courts have ruled on some of that. It is still to be played out. But I think some of those same measures could be taken into account that have been done at the State level as would be done federally.

I think the question that I would ask or be concerned about would be, when you got a State like Oklahoma that has taken aggressive steps in regulating PBMs is, how does that interact with what gets passed to the Federal level? We wouldn't want to lose any of those measures that have taken place so far.

Mr. FITZPATRICK. Thank you, sir.

My time has expired. I yield back, Mr. Chair.

Chairman BUCHANAN. I now recognize Ms. Tenney, New York.

Ms. TENNEY. Thank you, Mr. Chairman. And thank you, Ranking Member.

And thank you to our witnesses. All of you have been terrific.

And this is a huge issue in my district. I am from New York, where this is a unique problem. And over the past 30 years, our healthcare sector has seen an unprecedented number of mergers and acquisitions, particularly in New York, where a lot of the rural community hospitals are under siege or have closed or can't survive.

From 1983 to 2014, we saw the percentage of physicians practicing alone halve, while the percentage moving to practices of 25 or more quadruple. So, we are seeing this consolidation on that level as well.

On top of this—and I know everybody has heard this number—but I hear from every one of our local pharmacists that the PBMs that manage the prescription drug insurance companies—as we know, only three control 80 percent of the marketplace, and nearly 70 percent of prescriptions are covered by vertically-integrated PBMs which control their own pharmacy chains.

We know these trends are not good, you know, for our communities. And I have heard from our local community pharmacists—and I echo the sentiments of Representative Miller. I mean, I had parents who had catastrophic illness, and I cared for them. I lived across the street when my parents were in their final years.

And, you know, I am grateful to the people at Parkway Drugs, a local community-based pharmacy, for all that they did to help us with their catastrophic illness. My dad was paralyzed, in a wheelchair, from a dissecting aortic aneurysm that he survived, and he was blind. So, he had all kinds of multiple organ failure and issues. And this local pharmacy, you know, was phenomenal.

And so, Mr. Moose, I am going to address my question to you. We spent a fortune on drugs, even though my dad was a retired justice, a New York State justice, who had access to, you know, a top-level plan through the State of New York.

So, we know that PBMs—I think you can see that they can play a role in bringing negotiated prices and lowering them. But in your experience, what can we do to make this balance right? Because I will tell you, our local pharmacies are stocking their pharmacies with all kinds of consumer goods to make up for the hole that you described earlier.

Can you explain to me what we can do to put the PBMs in check and also to not put our pharmacies into quasi-convenience stores so they can make up for what is happening on the drug market?

Mr. MOOSE. Yes. Thank you for the question. And it is even getting to the point that the convenience store items are not making up for the losses. So, as I mentioned, 50 percent or more of the claims that we fill for Medicare part D we are actually selling at less than they cost us. So that is not sustainable.

By having that transparency level in there—the rebates are a great place to start. Rebates drive the cost, whether it is hospital rebates, drug rebates, any of those out there——

Ms. TENNEY. How can we implement that? So, like, legislative leaders, what can we do in Congress? What can we do on the Ways

and Means Committee to implement that to make your life more fair so you can compete and the PBMs don't dominate and continue this consolidation that drives competition away?

Mr. MOOSE. I was talking to a municipality that we fill a lot of prescriptions for. And my average cost for one of the recipients of that insurance was $55 for the prescription. And he laughed and he goes, you have got to be kidding. He said, my average cost that the PBM charges me for is $89 a prescription.

I ask you, where does that delta—where does that difference in price go to? That goes to the PBM. There is no transparency. They didn't tell the PBM that they were only——

Ms. TENNEY. How do we get that money back? I mean, can we require that price to—that delta to not exist? I mean, how do we do that?

Mr. MOOSE. They have to report that out. They need——

Ms. TENNEY. Okay. So, we can actually see that.

Mr. MOOSE. They need to show that. There is a point where you say, they are a business too. They deserve to make money. But they don't deserve to extort money from me.

If you see what you are paying—as a person buying insurance, if you see how much you are paying for that and how much that price is inflated, then you can establish, okay, am I actually getting value from them? Or could I strike a deal, as a payer, directly with the pharmacies—which is what we try to do on the care side—and cut out that entire middleman there?

They don't bring any healthcare value on it. We have got technology, and we have got NADAC pricing. We can do the majority of what PBMs do now. Back when they started back in the day, we didn't have those luxuries.

Ms. TENNEY. I just want to say thank you to Mr. Mulready, Commissioner, for all your hard work and for doing this.

One quick question, if I can get in, with Mr. Richman. What guardrails would you put on any antitrust reforms to ensure that unscrupulous players in the industry do not continue to bypass the rules? And we know that FTC, the Federal Trade Commission, has somewhat of a checkered past in this. I have got about 5 seconds. What would you do?

Mr. RICHMAN. I have got a long answer. Maybe I should just give your staff some of my writings.

I do think that the biggest problem right now in the healthcare space is immunities to antitrust law that are being established by State legislators. But there are lots of other things even outside those immunities that we can do under antitrust law.

Ms. TENNEY. Great. Thank you. I appreciate all of your time and all of your expertise.

I yield back.

Chairman BUCHANAN. I now recognize Mr. Evans, Pennsylvania.

Mr. EVANS. Thank you, Mr. Chair.

Thanks to the Affordable Care Act, more Americans have healthcare than ever before. The most recent passed Inflation Reduction Act extended ACA premium tax credit created under the American Rescue Plan until 2025. These tax credits allow more than 8,000 Philadelphians in my district to newly enroll in

healthcare plans under ACA and save hundreds of dollars per year in healthcare premiums.

Mr. Isasi, can you speak to how these potential cuts would impact the impressive gains we have made in the ability for individuals to access care?

Mr. ISASI. Thank you very much, Mr. Evans, for the question. I was born in Philadelphia, so it is wonderful to get it from you.

At the end of the day, you have got it just right. We have done a yeoman's work to provide health insurance to Americans with the lowest rate of uninsurance in the country in the history of the Nation. The Inflation Reduction Act increased subsidies to make sure that healthcare was affordable for all families that receive coverage through the exchanges.

At the end of the day, what we hear today is that healthcare affordability is a crisis, right? It is a crisis for the Federal Government. It is a crisis for State government. It is a crisis for employers who are paying for it.

What we can't do is put that crisis on the backs of America's families. We cannot repeal the support through the exchanges for affordable healthcare. We have to tackle the problem itself, which is anticompetitive behaviors. It is monopolistic pricing, things like that. That is what we have to do.

And the other thing I was going to point out is Inflation Reduction Act also did something very important. If finally allowed the Federal Government to negotiate a fair price from drug companies, and then it used those savings to do things like cap the amount of money that a senior would have to pay for their drugs in Medicare. So, it reinvested the savings to make healthcare more affordable. That is the kind of reforms we need.

Mr. EVANS. Are you optimistic?

Mr. ISASI. I am very optimistic. I think the American people—what we know for sure is that, during COVID, we saw the largest decrease in employer-sponsored coverage in the history of this country. More people lost health insurance than ever in the history of this country because the economy came to a grinding halt. And guess what? People's access to coverage was maintained. The only place where we saw people lose health insurance coverage on that were the States that refused to extend Medicaid to their most vulnerable people.

The structure of the Affordable Care Act works. It protected people during the pandemic. People expect that now from this country, and I think we are in a really solid place, and we have got to keep that success going.

Mr. EVANS. I thank you, Mr. Chair. I yield back the balance of my time.

Chairman BUCHANAN. I now recognize Mr. Moore, Utah.

Mr. MOORE. Thank you, Chairman.

The Congressional Budget Office forecasted the Medicare Hospital Insurance Trust Fund will be depleted by 2033, reducing benefits for Medicare beneficiaries. However, this projection only represents a fraction of Medicare's financial challenges.

The sections of Medicare covering physicians and medications are on track to face a shortfall of $447 billion this year, and it is predicted to exceed $1 trillion within the decade.

I was a little more emotional yesterday. I think my voice was raised when I made the point that expenditures are escalating at an unsustainable rate, and that rather than—everything we tend to do just redistributes the financial burden.

We must focus on reducing costs. That is the point where we are at now. There are no more easy decisions with respect to how we go about doing this. We have to reduce costs. If we don't, we will continue to do what we have done in small businesses. Americans will continue to pay an outsized portion of their percentage of their own individual budgets towards healthcare.

And promoting competition is a viable strategy to achieve this, and there are so many different ways. And there really is innovative groups out there that are trying to tackle this, right? They are doing it far better than us Members of Congress are probably even allowing them to do. And I encourage us to constantly take a look at that.

Professor Richman, you mentioned in your testimony that consolidation is leading to higher expenditures for Federal programs and creating unsustainable burdens on Federal and State budgets. You also provided a ray of hope by indicating that new innovative practice models could disrupt these consolidated markets and help reduce costs.

Can you expand on how these innovative models could lead to cost savings and promote value-based care?

Mr. RICHMAN. Yeah. Thank you, Congressman. So, there are a number of different proven delivery systems that have proven to bring costs down. I think the one commonality across all of them is that they are not run by hospitals. And there is a very simple logic behind that.

If a hospital manages a health system, to a large degree, their revenue model depends on filling the hospital. If you are a physician group, an independent physician group, whether you have an insurance product with you or not, your business model is all about keeping people out of the hospital. Not only is it a more cost-effective model, but, frankly, it is also more consistent, more aligned with the interest of the patient, about maintaining health for long-term perspectives and investing in preventative care.

So, one observation is that there are a lot of creative models out there.

The second observation is that it is extremely difficult to foster those models if hospitals are controlling all of the inputs, all of the referral flows. And that is one of the biggest problems with hospitals purchasing physician practices. It is not just that there are automatic price increases because of consolidation. It also cements the hospital at the epicenter of the health system and precludes exactly the kind of innovation that you are describing.

I will say, also, it is true that three PBMs dominate 80 percent of the market. That is a high degree of concentration. There are economic problems with that. But give me a hospital market with three options.

If you have a hospital market—and by the way, a hospital's care—the hospital expenditures is twice that of pharmaceuticals. If you give me a hospital market with three options, I think you can

see a lot of the innovation that you are describing that really would benefit care and critically bring costs down.

Mr. MOORE. Yeah, I think you speak to value-based care better than most. And I appreciate that approach. And I would argue that in hospitals, they truly do want to care for patients. They do want the best in line. And they will adjust. We will make adjustments as we go through this. But we have to figure out a way to target those costs. And there will still be a market for this. There absolutely will be.

Mr. Moose, in your testimony, you discussed how direct and indirect remuneration fees strained your business. Last year, CMS proposed a rule to forbid these fees in Medicare part D. Do you anticipate this rule will alleviate the burden of DIR fees by moving the collection of fees upfront.

Mr. MOOSE. No. They didn't do away with the fee. They didn't make where the fee came from or how much the fee could be. That is all still determined by the PBM. They just are telling me how much they are going to take upfront as opposed to telling me after the fact how much they took. So, it is still there. We have seen the rates. We have seen what the contracts look like. They are worse this year than they are previously.

And put that on top of the fact that in the first quarter of 2024, not only will they be taking the fee, they will be taking the 2023 fees out too. So, we will be getting double taken away in that first quarter of 2024.

Mr. MOORE. Thank you so much for your time. I appreciate it, Chairman. I yield back.

Chairman BUCHANAN. I now recognize Mrs. Steel from California.

Mrs. STEEL. Thank you, Chairman Buchanan, and thanks to all the witnesses today for participating in this meeting. We should all agree that transparency in healthcare is an important step to addressing rising costs of prescription drugs for the patients. I believe we need greater transparency throughout the pharmaceutical distribution system, and there must be clarified on the potential of artificially inflating these prices that includes greater understanding on pharmacy benefit manager, PBM. We have made process for the public to analyze as well as ensuring PBM business practices are not blocking patients' access to competing lower-costs drugs for my constituents.

My question to Mr. Moose is that PBMs are increasingly owning pharmacies, and yet, only 70 percent of the prescriptions filled are covered by a vertically integrated PBM. Can you elaborate on how this vertical integration has impacted most pharmacies and your competitiveness to serve your patient? And do any of these practices result in patients spending more out of pocket? And before you answer that, you tried to answer under Congresswoman's Chu's question that other countries have PBMs in their countries. I thought I saw you that you were about to answer, and then we went on to other questions. If you know, just yes or no before you——

Mr. MOOSE. Yes, it is my understanding that we pay the most in the world for drugs, and we are the only country that has a PBM managing that force.

Mrs. STEEL. Thank you for that answer. And could you answer my questions?

Mr. MOOSE. Yes, so vertical integration, how it affects me day-to-day is, well, it starts when you get your insurance card in the mail. And you open that envelope, and you pull out your insurance card, and it says, CVS Caremark. So, most consumers think, well, I have got great insurance, but I can only use it at what is on the card. So, they feel that, first of all, that they are forced to change to one of those pharmacists. But when they come into my pharmacy—and we are not in network—that means they have to go to a pharmacy outside of us that is in network. And one of the practices that is done—and this is kind of driven by this DIR thing—is, you know, DIR was put in place to increase the quality of the pharmacy and to measure quality and to make sure that patients got the highest quality pharmacies. And you would get a bonus if your pharmacy quality, if you were meeting metrics. But the PBMs were really good at turning that around from a bonus to a takeaway, and not necessarily based on true quality.

So that same patient that walked in my pharmacy couldn't get their medication there, but they could go to another pharmacy that was in network, get the medication and maybe they would give that patient a 90-day supply. Well, if you are on one drug, and you are fairly healthy, maybe you need something for ADHD, and you are fairly healthy, and you go there and get that drug, that is fine. Because some patients just need a drug. But some patients need a pharmacist. Some patients need a pharmacist. And those are the patients that are hurt. The patients I will spoke of earlier with diabetes, hypertension, and liver problems needs a relationship with a pharmacy that they can have a face to face with.

So, they go to that pharmacy. They tell them that they are going to give them a 90-day supply. So, there is less communication. Now, it is once every 3 months as opposed to monthly or maybe multiple times a month. Our data says a complex patient in North Carolina sees their primary care physician 3½ times a year. They see their community pharmacist 35 times a year. So we are leveraging all of those touch points to get a better outcome for that patient. But they are making that patient get a 90-day supply so they can check the box on the DIR thing and not get dinged on that.

So, the DIR is there to serve them to check the box to get higher payment, not to help the patient. So, we are actually doing a disservice to the patient by allowing that to happen.

Mrs. STEEL. Thank you very much. Mr. Chairman, I have more questions, but my time is almost up, so I am going to do in writing for the record. I yield back.

Chairman BUCHANAN. Thank you. I now recognize Mr. Davis of Illinois.

Mr. DAVIS. Thank you, Mr. Chairman. And let me thank you and the ranking member for these very profound discussions that we have been having relative to healthcare. I also want to agree and thank all of the witnesses and agree with my colleagues who have suggested that these are very difficult and complex issues. I am thinking of my own engagement relative to health. And ever since I have been paying attention, we have been talking about

how do we reduce the cost? In that sense, the late 1960s and early 1970s. And I don't think we have been able to do so yet. We have tried everything that you can think of. We have made some progress. And we do have a very decent system. But notwithstanding everything that we have tried, we still have not come to the point where we agree and think we ought to be.

So, when I am engaged in these discussions, I am often wondering, What do we really expect to accomplish? What are we really trying to do? And I know individuals who suggest that we do fairly well in healthcare. But we are really dealing with sickness care, and not the overall healthcare in a sense of the word that many public health experts would suggest that we ought to be. And I guess that is one of the reasons that I believe that what we really need is a national health plan, Medicare for all, a plan that everybody is in and nobody is out.

Because when I think of my own community where life expectancy in one area might be in the nineties, in another area, a few miles away, it is in the sixties. Are we trying to reduce the disparities that exist? Are we trying to get at this question of what life expectancy ought to be?

There is a guy in the community where I live, we call him Dr. Know. And he often says that if you keep doing the same things that you have always done, you are going to keep getting the same results that you have always gotten.

And he also says that you can't get blood out of a turnip. You can squeeze it, you can tease it, you can stick holes in it, but you are still going to get turnip juice.

Dr. Rome, let me ask you, are you suggesting in your testimony that we need to have a far more aggressive system of negotiating with the pharmaceutical world as one way of reducing the price of drugs that we use? Another part of that, but go ahead with that, and that is going to take up all of my time.

Dr. ROME. Yes, I mean, I do think we need more aggressive ways of negotiating prices with drug manufacturers. Other countries that do that achieve prices that are half of what we pay in the United States for the same brand-name drugs.

We have talked about a lot of complex issues. I agree with you about that here today. Just keep in mind that 10 percent of brand-name drugs make up 90 percent of spending. So, it is a small fraction of the fills. We are talking about the fills for PBMs. They are making up most of the spending. That is where we need to target. That is where the issues of monopoly pricing are really causing problems. Once we have generic competition, all of this complexity around PBMs which we can talk about. So, we do need to do a lot of things, but certainly that is at the root of the problem. That 90 percent of the dollars are spent on these brand-name drugs. We need to negotiate the prices better.

Mr. DAVIS. Thank you. And thank you, Mr. Chairman. I yield back and keep these hearings coming.

Chairman BUCHANAN. Yeah, we will. I now recognize Mr. Pascrell from New Jersey.

Mr. PASCRELL. Thank you, Mr. Chairman. I would like to start off with a question to Mr. Isasi.

Mr. ISASI. Yes.

Mr. PASCRELL. In my hometown—I was listening very carefully to Mr. Moore's questions, which were very on target. In my hometown of Patterson, New Jersey, the median wage for a family of three is $49,701. A two-bedroom apartment is about 1,800 bucks a month. Twenty percent of the people who live in the city I have lived in all my life under 65 do not have health insurance.

So, what do you think Congress should pursue to incentivize care delivery in the community at local physician offices and save American families precious dollars? What do you recommend we do?

Mr. ISASI. Well, I think, first of all, no family in this country should go bankrupt if they need care. So, the first thing we have to do is make sure people have access to healthcare and financial security to do it. So, if you have got 20 percent of the folks in your community who don't have access to health insurance, we have got to solve that problem first. That is the first thing we do.

Second piece is that we have to understand that underneath all of this, all of this complexity, the financial incentives that healthcare corporations are responding to are not aligned with the families and the patients that they treat. They are not aligned. They are literally, in many cases, oppositional to their interests. And so, we have to address the economic incentives that are driving the waste, that are driving the poor outcomes, that are resulting in the 250,000 people a year who are dying from the system and not from their illnesses.

Mr. PASCRELL. Thank you. Mr. Richman, in your testimony, I read it, you cite that nearly three quarters of all physician practices are now owned by corporations or healthcare systems. That is a huge number. Fewer are independently owned and operated by doctors in the community. I am very concerned about that. I know you are. Why does this statistic concern you? And can you tell me how private equity has driven these consolidation efforts and limited access to community care?

Mr. RICHMAN. Thanks, Congressman. First of all, I think private equity has accelerated the process. I don't think private equity is necessarily responsible for it. I think what drives it is that because of—in large part, because of what Mr. Isasi just said, the incentives that we have in the system reward inpatient care and inpatient control. Part of it is because we don't have site neutral payments, but there are other reasons also.

The most significant part of your question, to me at least, is why am I concerned about this? I am deeply concerned. I am deeply concerned for at least three reasons: Number one, when physicians are employed by hospital systems, the cost of care is up. It is also lower quality, but it is just higher up. And it is not just because of facility fees. You also have a much more intensive course of treatment.

Number two, the direction of care truly is not in the direction of the patient. We get less—lower quality care if we don't have independent physicians.

Number three, you know, we really don't know what the long-term consequences are of diluting physician independence. This is a profession that has been deeply dedicated to research, to patient care. They are thoroughly bound by a code of ethics. And certainly, that is not the case for private equity. And I am not so sure it is true for corporations that employ physicians. I think it is a very,

very significant development that really could transform American medicine.

Mr. PASCRELL. Thank you. Thank you. And I think today's conversation on the state of healthcare affordability is essential and is long overdue. I thank the chairman for putting us together today.

Last Congress, our Oversight Committee shined a bright light on how private equity's ownership in our healthcare system affects patients' safety, consumer costs, and jobs. Thank you all for your testimony today. Thank you, Mr. Chairman, for putting this together.

Chairman BUCHANAN. Thank you. I now recognize Mr. Schneider from Illinois.

Mr. SCHNEIDER. Thank you, Chairman Buchanan. I want to thank you and the ranking member for calling this hearing to discuss why healthcare is unaffordable for so many people in the United States. I want to thank the witnesses for your patience and endurance. It looks like I'm last, which I believe meant I get to go until 5 p.m.

Chairman BUCHANAN. Not least.

Mr. SCHNEIDER. Not least. But, no, thank you, and I will try to make the most of my 5 minutes. When I came to Congress more than a decade ago, now, the goal was clear: Get more people with access to quality care; get them the insurance they need; increase their access to doctors they can trust when they need it where they are; lower the cost of prescription drugs.

I am proud to say that more Americans than ever have health insurance. And for the first time in history, Medicare will have the ability to negotiate lower prescription drug prices thanks to the Inflation Reduction Act. And yet, American life expectancy remarkably is on the decline. And I am seeing the nodding heads. I have a hard time getting my head around the fact that in my lifetime we are seeing not a constant increase in life expectancy, but seem to have peaked, which I hope is an aberration that we can turn that curve back.

A quarter of U.S. adults say that they have difficulty affording their medications. In fact, 30 percent are skipping pills due to the costs of their medicines. No one's contending with new cancer diagnosis or facing chronic pain or recovering from surgery should be put in a position of deciding whether or not to ration their medicines or pay their bills.

Now, while we are at the forefront of global healthcare innovation, and a lot of this innovation takes place in my district, and drug development in this country is something we can be very proud of. The American people who rely on these drugs continue to lack access. What I tell people is that great innovation is only art unless it gets to the hands of the people who need it. The question is why?

With so much of every dollar being spent on drugs going to PBMs, wholesalers, and so on, it seems patients are getting the short end of the stick, either paying too much or skipping medications altogether.

So, Dr. Rome, let me ask you. You talked about how PBMs negotiate rebates to offset manufacturer list prices, but those savings often don't get passed down to patients as lower out-of-pocket costs. At times, you say PBMs even charge insurance plans of patients

more than then pay pharmacies. And, Mr. Moose, I heard you talk about that as well.

How common are these practices? Do we even know what cost savings, if any, is typically making it all the way to the patients at the time they pay their bills? And are there specific disclosures you think should be required?

Dr. ROME. Yeah, thank you, Congressman, for the question. The rebates have grown substantially. So as the prices of drug—or brand-name drugs have gone up, rebates have gone up and partially offset that. So now in Medicare, you know, rebates are 37 percent in 2018. Offset 30-some percent spending in Medicare. So, you know, this is a game back and forth between the PBMs and the manufacturers and patients that you said are stuck in the middle. It is very common for patients to pay list prices or pay either deductibles or coinsurance based on these prices.

We did a study of several dozen drugs, and the half of patients for paying coinsurance or deductible were basically as soon as the manufacturer raised prices, their out-of-pocket pocket costs went up directly proportional to that.

So, if that is a problem, we absolutely need better transparency over those rebates. We know where they are. And it is not okay practice. We want PBMs to be able to negotiate. We don't want them to be able to pass those costs on to the patient in a way that is unfair based on a price that they are not paying attention to.

Mr. SCHNEIDER. So last year I spent not an insignificant amount of time trying to peel back, or open up the black box, trying to dig in, understand it, peel layer after layer after layer and still ended up with a black box.

From your perspective—and I will ask anyone else—are there things we should be trying to peel back to understand how this system works? Because it is not just confusing to patients, I think it is confusing to almost everyone who tries to look at it.

Dr. ROME. Yeah, so I mean we should definitely peel back the curtains on what those rebates cost. We should peel back and understand how much, especially in the generic space, you know, how much the drugs cost. There the prices are even more out of sync, where the list prices don't really mean anything in that space. So, we absolutely need more transparency. We need, you know, on all levels, as a researcher, I struggle with this every day, too. I mean, I try to do research on prices that aren't available so.

Mr. ISASI. And so just to be really clear about what we are talking about, because I think most of you don't realize this, if you owned a business and you paid for a PBM to negotiate a drug price for you, it is in poor response to you covering all the costs, right? Right now, you can't know what did the PBM actually pay, what rebates were flowing? You don't have information as an employer whose footing the bill. That is what we are talking about. Those arrangements must be understood.

The second piece, which is also in your question, is when you are saying that the list price is what is being charged. Just to be really clear, the list price is $100, say, but the PBM negotiates the drug for $20, when your employee walks in, or the Medicare beneficiary walks in the door, they are getting charged cautioning for $100, right? That is crazy. That has to end.

Mr. SCHNEIDER. Thank you. And we need more transparency. Mr. Chairman, we need more time, but I thank you both, the chair and the ranking member, for this hearing. I think it is critically important. I look forward to continuing our work together to address this challenge.

Chairman BUCHANAN. Thanks. Well, I want to thank you, but I didn't ask as many questions upfront. But now that I have got you—because I want to get off in a little bit different direction, because you all have expertise in given areas. And something we don't talk about enough personally is my own feeling. As Chairman of the subcommittee, you know, we got a factor of 40 percent obesity in our country. We are spending $700 billion in Medicare. Obesity leads to type 2 diabetics. I don't think you say—in terms of Medicare is only good for another 4 or 5 years because it is going to run out of money. I don't think—if people don't take more responsibility—some can or won't, maybe they have other issues—but we have to figure a way to get more into preventative care.

I had a doctor when I first kind of moved from Michigan to Florida, and he was telling me the story of he picks up a lot of people, 60, 70 years old, 80 years old. He moved to Florida. He is in private practice type thing. And they come in. They are on six or seven pills. There are a lot of different issues. And he tells them, he said, they will talk to him and have a consultation. The doctor will say: Do you want to get off half the pills or two-thirds of them? He says, What are you talking about? I can't get off these pills, I have been on them for 10 or 15 years. You know, I understand some of that too. And he says, well, what are you talking about? He says, well, I want you to start walking a mile or two a day for 5 days, and I want you to get on a little bit more of a reasonable diet. Eat more vegetables, a little less on everything else. And he said, I will start to take you off half of these pills that you are on. And I think there is a lot of said for that.

What are we doing about talking about preventative medicine? People being CEO of their own health. And you can eliminate a lot of that. A lot of this stuff that I see is a lifestyle situation. Now, part of it is—and people don't want to hear it—but I think it is the quality of our food. It is heavily, heavily over-processed. And so, it is not anybody's fault in the sense that way. But there is—makes a lot of sense. I had one guy that is an author, I can't think of the name of the book, but it changed my thinking on everything. He had an equation that he had in this book. And, you know, I will get you the name if you want it. But he had an equation. And the equation at the top of the line was the nutritional value in the food that you are eating. For example, spinach, kale, some of those things. And underneath it was the calories. That makes a lot of sense. He had every food rated. And I got on that and lost 25 pounds, because, you know, over the years we are all on YoYo diets. This one, that one, the best latest diet. But it changed my whole life. And it was just simply where I made better choices. And I have always been somewhat of a cyclist now, but I have always done some cycling and stuff. I am not just saying myself, but I think there is a lot that can be said for preventative thing.

I am concerned about children. I have got nine grandkids, 9, 8, and under. You know, what are we feeding them? What are they

getting? You know, you hear about the—nobody likes to talk about the 20, 32 ounces of Coca-Cola are something else. You know there is real issues with that.

So, I think fruits and vegetables—and that is why Whole Foods have done fairly good. I think a lot of people are moving somewhat more in that direction. But to encourage. Not everybody is going to do it. They are going to make their own choices. They are an adult. But for their children and for—see my daughter-in-law. She is pretty heavy on that where they come in, and you got a big bowl of fruit sitting out there, and they are giving the kids more vegetables, and stuff like that.

So, my point is what is your thought on that? I mean, is there—doesn't that have a place? And I just think if it is true, I've been told 40 percent of people are obese in the country, the big 30. Thirty years ago, it was probably 10 percent. But I think a lot of it is the quality of the food we're eating. And just, you know, just a combination of all of the above.

So, one of the things that I wanted to go down the road on is preventative care. The second thing is that when you have fee for service, you know, you have got to be very careful. I had 1,200 employees before I got here. You have got to be very, very careful about what pay plan you put somebody else on. I am not against the doctors or anybody else. If you have fee for service, the tendency is not that they mean to do it, but the tendency is to do more, you make more. That is not the right incentive you want. You know, my idea is I don't want them to get on the drugs in the first place. They say that if a person has a heart attack, 50 percent don't see the next day. I don't want to have a heart attack to begin with. And there is a lot of stuff that you can do to minimize that, a lot of that.

So, I throw that out because I am just interested in your take on it. That I personally believe is the way we need to be going. As the gentleman said a few minutes ago, that it is kind of surprising in this lifetime whether people are living longer. And we should ideally because we have got opportunities out there. So, I just kind of flow that out. That is where my thinking is because it is applicable in my life and a lot of other people's lives, but I realize it is a choice. I can't tell anything. But I got to tell you, I took my kids to the fairground ground the other day, my grandkids, they hadn't been there in a long time. I am a blue-collar kid that grew up. These are my people out there. A lot of them. I look around, and 90 percent, 80 percent got to be 50 to 100 pounds overweight.

I don't want to be judgmental, but the point is do we have enough money to take care of all the people that are sick as a result of processed foods and everything else? And we are not going to get everybody off it, but we could get some off of it and start moving in that direction. Because we are spending close to—we collectively add up what the government spent $1 trillion a year. You just can't keep spending money like that unless we make some changes in our own behavior, I think, as a country. And I think we are as high as anybody in the world in terms of obesity. But yet, we spend this year $4.3 trillion in healthcare. And we are the sickest. It doesn't add up.

So let me just throw it out to you just because we have talked about other things. But I didn't want to start the meeting this way because some people say, Vern, where are you going on all of this? But I do want to kind of get your thoughts on, you know, briefly give everybody a minute or two, or whatever.

Mr. MULREADY. Mr. Chairman, thank you for bringing that up. Something I would like to talk more about in this session. I think you have heard a lot from here about transparency. But I think a lot that goes along with that is consumer engagement, which is a lot of you are talking about. And I think we have seen that play out well with restaurants and menus, things listing out the calories, and that sort of thing.

You know, part of the problem with the opaque world of healthcare—you know, I could go online when this meeting ends and learn more about replacing my $200 watch than I can about a $15,000 medical procedure and making decisions on how to go along with that. We have made some improvements, but there is a lot that could be done within that space.

I think the other issue you deal with here is—I have three sons, 19 to 23 years old, and I have used this example with them. You know, when you go out to eat, you are looking at the menu. You just look at that differently. It is human nature. If you are paying, or if there is a third party paying. It is just human nature. And I think you are dealing with that issue as well here as that transparency and a third-party payer system. Thank you.

Chairman BUCHANAN. Yeah, what I am talking about is being the CEO of your own health, your responsibility. So I am going to give everybody 2 minutes, if you want it.

Mr. ISASI. And, Chairman, great question. And I do have to say I think that when you look at the literature on this, you are putting your finger right on a very serious problem that we are facing as a Nation. There are economic consequences, and it has consequences for people's happiness and the ability to thrive.

Just to start kind of in reverse order, the fee for service. I just want to say this really clearly. In part, what you are describing is a problem that fee for service has created. We do not have a system that incentivizes the healthcare sector to make us healthy. Right? It is a sick system that is basically built off what is the highest margin procedure I can do, and I am going to just crank away at that thing and make money. And so, the new payment models that are being explored—the Centers for American Innovation, the risk-based payment, it is about saying to a group of doctors or a community of providers, you keep these people healthy and you get these people healthy, and you get them healthy if they get sick, efficiently, and you can make money from doing that, not from the bottom to——

Chairman BUCHANAN. You have got to set up the right pay plan, the right incentives——

Mr. ISASI. Right. That is the first thing.

Chairman BUCHANAN. And then companies that I have had, the most important thing was getting pay plan right. Go ahead.

Mr. ISASI. That is the first thing. You have to get these incentives right that go into the healthcare sector. The second thing on preventative care—I did a lot of this with the governors when I

was running Healthcare National Governors Association. And it was this really basic concept. There is so much waste in the system right now. And so, we helped—governors look around and saw that there were communities where they were spending too much time in the emergency room. One thing they figured out. They closed the clinic, after hours, that people needed to use. They reopened it; they saved money.

So, there is basic principal when we save money by pulling waste out of system. Let's take a percent of that, like 10 percent, and invest it upstream to actually address the reasons people are going to emergency rooms. So, the idea of making a lake when we—and all of this work we need to do in the next decade, drive waste in healthcare, how do we find a portion of that and reinvest to prevent the health problems we are having? The third idea was, you know, there is a lot of literature in public health, I come from a public health background, about why people make decisions and how people live a healthy life. Part of it is knowledge. And you are describing when you know, you actually looked at that formula and you said, well, wait a second, calories and nutrition, let me find the things that I have that—the greatest ratio of nutrition for calories.

That is knowledge. And the second piece is, what does the community around you support? What is the environment that you are operating at? Just that knowledge itself isn't enough. And the third is instrumental, like, do I have fresh fruits and vegetables in my community? Can I get to the store, right? We have to hit all three things if we really want to change people's behavior. It is not just knowledge.

Chairman BUCHANAN. And I am saying we can pay for all that because people won't be as sick.

Mr. ISASI. That is right.

Chairman BUCHANAN. You know from my standpoint. I want to—Dr. Rome, why you don't you——

Dr. ROME. Sure. Yeah, I will be quick because we have been here a while, but I do think—I know, I am a primary care doctor. I spend time in the rooms with patients. And I spend a good portion of time talking about exactly the topics that you are talking, which is, you know, sort of, how to keep them healthier about, or how to keep them away from me and away from the hospital system that I work in. And so, it is absolutely, you know, crucial.

We also have—you know, there are a lot of barriers that the patients face in those things. I have patients who run out of food at the end of the food. I have patients who don't have stable housing. So, we have a lot of social problems that, you know, we need to—we separate. We think about healthcare spending versus everything else. But on this committee, you think about spending up everything. And maybe we have to think about the way we are financing healthcare, the way that we were thinking about health, and redefining more broadly the way you are talking about. If we can invest in those social support services, maybe we can——

Chairman BUCHANAN. I would say you will have more money for those support services. We won't be spending it on everything else.

Dr. ROME. I agree, yeah.

Chairman BUCHANAN. Mr. Moose, anything you want to add.

Mr. MOOSE. I think the key word is an investment here. We have to look at this as a business proposition. There is an ROI for investing dollars upfront for better access to high-quality foods, for exercise programs. Somebody who is physically active has less propensity to have behavioral health, mental health issues, saving money on the back end. So we have got to look at it as, hey, there is a true ROI. Let's put some money upfront for preventative-type activities, preventative-type services on it so we can expect the——

Chairman BUCHANAN. I think we are going to be in trouble if we don't start figuring out a way to get people more preventative and set up the right incentive. Did you get a chance to——

Mr. RICHMAN. I will just say a version of Amen in the sense that we spend one out of every $5 on healthcare, but that healthcare that we spend money on contributes to maybe 20 percent of our health outcomes. The other 80 percent are the things that Frederick was talking about. The environment that we have, the family we have, the social networks we have, and the neighborhood we live in.

Congressman Davis described a 30-year life differential in his district. That is not because of differences in access to healthcare. They are all social determinants.

Chairman BUCHANAN. Yeah, there is different factors, and I am not—but if we can change it 10 percent or a percentage of people being healthier, it would make a big difference for their life, their family, and the community, and everything else.

Mr. RICHMAN. I think the science is there to suggest of what we can do. Certainly, it would be a much better use of our existing dollars. And to a large degree, it really does require confronting the payment models that we have and recognizing that we are just spending money on the wrong things.

Chairman BUCHANAN. To me, you have got to pay for the results you want. And we want a healthier society, not a sicker society. I think the incentives are all screwed up personally myself. They need to be relooked at.

So let me just say in closing, we have received many statements in support for this hearing. And without objection, I will submit this into the record.

I would like to thank our witnesses. I want to thank all of you. It has been a long day today. So, thank you very much. And any more inputs you give for appearing before us today, please be advised members have 2 weeks to submit written questions to answers later in writing. These questions and your answers will be part of the formal hearing record. With that, the committee stands adjourned. Thank you very much.

[Whereupon, at 4:40 p.m., the subcommittee was adjourned.]

PUBLIC SUBMISSIONS FOR THE RECORD

Congress of the United States

Washington, DC 20515

Statement for the Record

The Committee on Ways and Means

Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

Subcommittee on Health

May 17th, 2023

Chairman Buchanan, Ranking Member Doggett, and Members of the Committee,

Thank you for the invitation to offer this Statement for the Record and for holding this important hearing on the harmful consequences of health care consolidation and the misaligned incentives that distort the market and make it more difficult for patients to get lower cost medications.

As a pharmacist for over four decades, I have seen firsthand the rising costs of prescriptions drugs and the impact it has on patients and families. I was the one who was on the other side of the counter who had to tell the patient how much their insulin costs. I was the one who watched the senior citizens trying to decide whether they were going to buy insulin or buy groceries. I was the one who watched a mother cry because she couldn't afford the medication for her child. I was the one who watched all this happen, and I knew behind the curtain that Pharmacy Benefit Managers ("PBM") are the root cause of high prescription drug costs and inaccessible health care.

PBMs act as middlemen between pharmacies, drug manufacturing companies, and health insurance plans to administer prescription drug benefits. They have vertically integrated, creating health care conglomerates that control pricing with little competition. The three largest PBMs - CVS Caremark, Express Scripts, and OptumRx - control over 80% of the market. Using their size, leverage, and negotiating power, PBMs play a large role in determining which prescription drugs are covered by insurance plans and how much they cost, while keeping themselves mostly hidden from the American public.

PBMs have stated that their role in the marketplace is to control costs. However, over the past thirty years the cost of health care has steadily risen by almost 5% annually. Employers experienced a 1,553% increase in drug benefit costs over that same time for employer-sponsored insurance benefits offered to employees. Fast forward to 2021, health care costs eclipsed $4 trillion annually, amounting to roughly $13,000 per person. If PBMs argue they keep drug costs low, then the question naturally arises: why have drug costs gone up so much?

As many experts have noted, PBMs are not really just PBMs anymore. They have been allowed to consolidate and reach into almost every aspect of our health care system at the expense of patients. PBMs are mail-order pharmacies. PBMs own prescribers and physician practices. PBMs own specialty pharmacies. In the case of a company like CVS Caremark, they are a retail pharmacy.

The chart below from the Drug Channels Institute shows the extent of the vertical integration involved. Note that the integration includes mergers with health providers too, not just insurers and pharmacies. This integration presents opportunities for PBMs to lock competing pharmacies, insurers, or even providers out of the market. With less competition, PBMs can continue raising prices and stealing profits from other entities, again leading to increased drug costs.

PBMs have also merged with specialty pharmacies, which were established to manage the extreme growth of specialty medication use and the extra precautions required to dispense them. Specialty medications are complex drugs that treat chronic, difficult-to-treat, or rare conditions. These medications have driven large spikes in health spending in recent years. They often have high prices and usually require special handling, storage, additional training for pharmacists, and intensive patient monitoring.

PBMs that own specialty pharmacies participate in a little-known practice called “patient steering,” where the PBM forces patients, through their insurance network, to use a specialty pharmacy the PBM owns. The PBM unilaterally decides what medications will be covered as part of a patient’s drug formulary. This presents an opportunity for PBMs to spike costs because patients have limited options to access the medication elsewhere.

We’ve heard countless stories about how these middlemen drive up drug prices and steer patients to use their own pharmacies, forcing independent pharmacies out of business. Last year, my office rushed to action when we heard that Cigna/Express Scripts was planning to remove almost 15,000 local independent pharmacies out of the military’s TRICARE network, depriving our servicemembers and veterans of access to their trusted local health care provider. Plain and simple, PBMs’ market consolidation and integration has enabled these unfair and deceptive practices, resulting in decreased competition and higher prices.

The consolidation and vertical integration of our health care system is not limited to PBMs. Rather, our entire health care has become consolidated. Hospitals, physicians, and health insurer markets have become increasingly consolidated. There have been almost 1,800 hospital mergers between 1998 and 2021, leading to about 2,000 fewer hospitals throughout the country. Larger health systems are also buying physician practices at record rates. More than 80,000 physician practices were acquired in 2018, a marked increase over the more than 35,000 acquired in 2012.

Take UnitedHealth Group as an example. This conglomerate has a stronghold on every type of health care service. It is the single largest employer of physicians, while also one of the biggest insurance companies, meaning it gets to choose how much to pay the doctors who rival its own. It also controls its PBM, its own mail-order pharmacy, and recently acquired a hospice and home health service provider.

Undoubtedly, these companies will say their moves to acquire other businesses and grow are intended to save money. However, I recently asked the Director of the Congressional Budget Office, Phill Swagel, to name one example of a health care consolidation that has benefited patients and taxpayers. His response, "Sir, I cannot think of one example."

It's past time for Congress to examine how more competition can help lower health care costs.

I want to again thank Chairman Buchanan, Ranking Member Doggett, and the members of this Subcommittee for holding this hearing today. I believe this is a perfect opportunity to show the American people that we care about them and are working towards solutions that increase the accessibility, affordability, quality of health care.

Sincerely,

Earl L. "Buddy" Carter
Member of Congress

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Health

of the

U.S. House of Representatives

"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets"

May 17, 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 to the Ways and Means Subcommittee on Health to provide the hospital perspective on how hospital mergers and acquisitions can expand and preserve access to quality care.

MERGERS AND ACQUISITIONS HELP HOSPITALS MANAGE CURRENT FINANCIAL PRESSURES

Hospitals and health systems have faced historic challenges in the last several years. Mergers and acquisitions are one of the most important tools that some hospitals use to manage financial pressures and increase access to care for patients.

A recent report released by the AHA details the extraordinary financial pressures continuing to affect hospitals and health systems, as well as access to patient care. The report found expenses across the board saw double digit increases in 2022 compared

to pre-pandemic levels, including for workforce, drugs, medical supplies and equipment, as well as other essential operational services such as IT, sanitation, facilities management, and food and nutrition.

Among other findings, the report showed:

- Overall hospital expenses have increased by 17.5% between 2019 and 2022. This far outpaced Medicare reimbursement, which only increased 7.5% during the same time.
- Labor costs, which on average account for about half of hospitals' total budget, have increased by 20.8% between 2019 and 2022.
- For the first time in history, the median price of a new drug exceeded $200,000 — more than triple the median annual household income in the U.S. At the same time, price increases for existing drugs continue to outplace inflation, which helped drive a 19.7% increase in drug expenses per patient between 2019 and 2022.
- Hospital supply expenses per patient increased 18.5% between 2019 and 2022, outpacing increases in inflation by nearly 30%. Specifically, hospital expenses for emergency services supplies — which include ventilators, respirators and other critical equipment — experienced a nearly 33% increase during the same period.

In addition, a major source of financial pressure for hospitals are the costs of complying with a complex web of local, state and federal regulations, excessive commercial payer administrative requirements, and the chronic underpayments by the Medicare and Medicaid programs. It is well-documented that neither Medicare nor Medicaid covers the cost of caring for its beneficiaries, and hospitals often struggle to make up for these financial losses. On average, Medicare only pays 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries. Exacerbating this pressure is the fact that Medicare and Medicaid account for most hospital utilization. In fact, 94% of hospitals have 50% of their inpatient days paid by Medicare and Medicaid and more than three quarters of hospitals have 67% Medicare and Medicaid inpatient days.[1]

Merging with a hospital system can help some hospitals ease these financial burdens and improve patient care by providing scale to help reduce costs associated with obtaining medical services, supplies and prescription drugs, and enable health systems to reduce other operational costs.

This is particularly important for rural hospitals, where mergers and acquisitions have played a critical role in preserving access to care for these patients and communities. An AHA analysis of the UNC Sheps Center rural hospital closure data between 2010

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[1] https://www.aha.org/system/files/media/file/2022/05/fact-sheet-majority-hospital-payments-dependent-on-medicare-or-medicaid-congress-continues-to-cut-hospital-reimbursements-for-medicare.pdf

and 2020 shows that slightly more than half of the hospitals that closed were independent. Health systems typically acquire rural hospitals when these hospitals are under financial distress. Research has shown that rural hospitals are less likely to close after acquisition compared to independent hospitals and that mergers have improved access and quality of care for rural hospitals.[2]

BENEFITS OF HOSPITAL MERGERS AND ACQUISITIONS

Hospital mergers and acquisitions bring measurable benefits to patients and communities, including lower health care costs, improved quality and better access to health care.

Lower Health Care Costs

Acquisitions and mergers help reduce health care costs and create a fiscally sustainable environment for health care delivery for patients and communities. Mergers with larger hospital systems can provide community hospitals the scale and resources needed to decrease costs by increasing administrative efficiencies and reducing redundant or duplicative services. A Charles River Associates analysis for the AHA shows that hospital acquisitions are associated with a statistically significant 3.3% reduction in annual operating expenses per admission at acquired hospitals, along with a 3.7% decrease in net patient revenue per adjusted admission.[3]

The same report shows that additional substantial savings come from improved IT systems and advanced data analytics. Consolidated hospitals can often better invest in IT infrastructure for both clinical and financial data that can be used to identify best practices for more cost-effective, integrated and streamlined care. These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals.

Improved Quality

Emerging research has demonstrated a clear association between consolidation and quality improvement. For example, one study found that a full-integration approach is associated with improvements in mortality and readmission rates, among other quality and outcome improvements.[4] Another study found significant reductions in mortality for a number of common conditions — including acute myocardial infarction, heart failure, acute stroke and pneumonia — among patients at rural hospitals that had merged or been acquired.[5]

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9250050/
[3] https://www.aha.org/guidesreports/2021-08-18-hospital-merger-benefits-econometric-analysis-revisited-executive-summary
[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652
[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342

Better Access to Care

Mergers and acquisitions help hospitals improve access to care by expanding the types of specialists and services available to patients. According to an analysis by the health care consulting firm Kaufman Hall, nearly 40% of affiliated hospitals added one or more services post-acquisition. Almost half of all hospitals acquired by an academic medical center added one or more service. Patients at hospitals acquired by academic medical centers or large health systems also gained improved access to tertiary and quaternary services.[6]

Mergers and acquisitions also are a vital tool that some health systems use to keep financially struggling hospitals open, thereby averting bankruptcy or even closure. When hospitals become part of a health system, the continuum of care is strengthened for patients and the community, resulting in better care and decreased readmission rates.

This is particularly true in rural and underserved communities. Partnerships, mergers or acquisitions are a means for creating more cohesive care, making it easier for patients to access specialists or services in the acquiring system. In this way, consolidation ensures that care remains in the community.

Insurers Leverage Their Market Power

Hospitals and health systems face pressure from health insurance companies and private equity firms, which are leveraging their market power to drive up hospital and health system costs. For example, in nearly half of all markets, a single health insurer controls at least 50% of the commercial market.[7] Health insurers can use this market power to implement policies that compromise patient safety and raise costs, such as prior authorization delays, denying medically necessary coverage, or forcing patients to try potentially ineffective treatments or therapies.[8]

Moreover, commercial insurers and private equity have spent billions of dollars acquiring physician and other clinical practices. For example, UnitedHealth, under its subsidiary Optum, has acquired Crystal Run, Kelsey-Sebold and Atrius Health in the past three years. In 2023 alone, CVS Health has announced plans to spend over $15 billion to acquire both Signify Health and Oak Street.

Once acquired, they raise the rates that hospitals pay for these services, driving up costs. Studies have shown that highly concentrated insurer markets are associated with higher premiums and that insurers are not likely to pass on to consumers any savings achieved through lower provider rates.[9] Though many contend that insurers like

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[6] https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefits-of-Hospital-Mergers-Acquisitions-2021-10-08.pdf
[7] https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-care-research
[8] https://www.aha.org/white-papers/2022-07-28-commercial-health-plans-policies-compromise-patient-safety-and-raise-costs
[9] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0548

UnitedHealth Group (over $324 billion in revenue in 2022, covering over 46 million Americans) and Elevance (over $155 billion in revenue over the same period, covering over 47 million Americans) are helpless in their dealings with local hospitals and health systems, the truth is far more complex.

CONCLUSION

Hospitals and health systems have faced historic challenges in the last several years. They will need continued flexibility to seek strategic opportunities and partners as they work to recover from the pandemic, overcome massive increases in the cost of caring, adjust to changing patient and community demographics, adopt new care delivery and payment models, and innovate for the future. Mergers and acquisitions have been a vital tool to allow hospitals and health systems to reduce costs, improve quality and better serve patients where they live.

The AHA appreciates your efforts to examine this issue and looks forward to continuing to work with you.

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Ways & Means

Subcommittee on Health

Re: Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

May 17, 2023

Division of Legislative Counsel

202-789-7426

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Ways & Means

Subcommittee on Health

Re: Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

May 17, 2023

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Ways & Means Subcommittee on Health as part of the hearing entitled, "Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets." The AMA commends the Subcommittee for focusing on the critically important issue of consolidation in health care markets and the consequences for patients. This particular statement utilizes data to illustrate the harmful effects of health insurance and pharmacy benefit manager consolidation, as well as the importance of lifting the current ban on physician-owned hospitals. In addition, the AMA is pleased to highlight a collection of bipartisan legislation that can help alleviate many of the negative effects of these interconnected policy issues.

I. Health Insurance Competition Study

An important question of public policy is whether health insurance markets are competitive or whether health insurers possess market power. If insurers exercise market power, health plan premiums would be higher, and payments to providers and the quantity of health care would be lower, in comparison to competitive health insurance markets. High market concentration tends to lower competition and facilitate the exercise of market power. Unfortunately, the majority of U.S. health insurance markets are highly concentrated, as documented in a comprehensive study of U.S. markets.[1] In fact, the share of highly concentrated commercial markets in metropolitan statistical areas (MSA) rose from 71 percent to 75 percent between 2014 and 2021.

There is high concentration among health insurers in most Medicare Advantage (MA) markets, as well. Seventy-nine percent of MA markets were highly concentrated in 2021. While MA markets have undergone a consistent, though gradual, decrease in average concentration since 2017, the decrease in average MA market concentration masks some merger activity that took place. By acquiring an insurer in another market where they do not already provide coverage, some MA insurers have been able to get bigger. Anthem accomplished this in commercial markets through its 2004 acquisition of WellPoint, as well as each of those merging parties' acquisition of other Blue Cross Blue Shield insurers before that.

[1] Guardado, J., Kane, C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. American Medical Association Division of Economic and Health Policy Research. 2022. Available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf. Accessed March 16, 2023.

Most health insurance markets are ripe for the exercise of health insurer market power, which, in turn, harms consumers and providers of care. These findings should prompt federal and state antitrust authorities to vigorously examine the competitive effects of proposed horizontal and vertical mergers involving health insurers.

Given the uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed cause competitive harm. For example, in 2008 regulators authorized a merger between UnitedHealthcare and Sierra under the condition that UnitedHealthcare divest most of its MA business in the Las Vegas area. Nonetheless, premiums in the commercial health insurance markets in Nevada increased in the wake of the merger.[2]

After years of largely unchallenged consolidation in the health insurance industry, a few subsequent attempts to consolidate have received closer scrutiny. Most notably, in 2015 two mergers involving four of the largest health insurers in the country were announced. Anthem attempted to acquire Cigna, and Aetna sought to acquire Humana. To help identify markets where mergers would cause competitive harm, the AMA used data from previous editions of the *Competition in Health Insurance* study (referenced above in footnote 1) to assess their competitive effects. Specifically, the AMA calculated the changes in market concentration that would result from the mergers and, according to the Department of Justice (DOJ)/Federal Trade Commission (FTC) Horizontal Merger Guidelines, classified markets based on how anti-competitive the mergers would be. The AMA's analysis found that the mergers would be deemed anticompetitive in numerous markets across the United States.[3] Consistent with the findings and after close to a year of antitrust scrutiny, the DOJ and attorneys general from multiple states sued to block both acquisitions.[4] The DOJ and state attorneys general ultimately prevailed after an intense battle in the courts, which found that the mergers would cause harm to consumers and violate antitrust law. As a result, both mergers were abandoned by the merging parties. The AMA's studies will continue to monitor competition in health insurance markets and be used to assess the competitive effects of proposed mergers among health insurers, as well as vertical mergers with firms in other parts of the supply chain such as PBMs.

II. Physician-Owned Hospitals

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[5] This is partly the result of significant consolidation occurring in hospital markets around the country.[6] Many markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[7] Consolidation has real-life consequences, as clearly laid out in a new book by Professors David Dranove and Lawton R. Burns about health care

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[2] Guardado, J., Emmons, D., Kane, C. *The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra*. HMPI. 2013;1(3):16-35. Available at https://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf. Accessed March 16, 2022.

[3] See https://www.ama-assn.org/about/competition-health-insurance-research. Accessed March 16, 2023.

[4] See lawsuits announcement at https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s. Accessed March 16, 2023.

[5] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, *Antitrust Applied*).

[6] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/. (Accessed March 16, 2023), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[7] Martin Gaynor, *Antitrust Applied*, at 2.

"megaproviders."[8] They found that in markets "where megaproviders dominate…, health care spending is higher, often much higher, and health care quality is no better, and sometimes lower."[9] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[10] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[11] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[12]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health care costs.[13] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[14] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[15] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[16] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[17] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[18] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[19] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[20] Many of the witnesses testifying before the House Ways and Means Health Subcommittee echoed these views.

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[8] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021).
[9] Dranove, *supra,* at 178.
[10] Martin Gaynor, *Antitrust Applied*, at 5.
[11] Dranove, *supra,* at 178.
[12] Dranove, *supra,* at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.
[13] Martin Gaynor and Robert Town, *supra*.
[14] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.
[15] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages,* RAND Corporation, 3 (2020).
[16] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).
[17] Martin Gaynor, *Antitrust Applied*, at 4.
[18] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 International Journal of the Economics of Business 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems,* 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.
[19] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed July 14th, 2021), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/.
[20] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service,* 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

Increased Hospital Concentration is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets has a role to play in reducing the growth of disparities in health care access.[21] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[22] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[23] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

Antitrust Enforcement has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. In their new book, Professors David Dranove and Lawton R. Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[24] The antitrust response has been inadequate, notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[25] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot take action against anticompetitive conduct by not-for-profit entities; this presents a significant problem, considering how many hospitals are run as not-for-profits.[26] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the United States requires new remedies.

Congress Should Lift the Ban It Placed on Physician-Owned Hospitals

Fortunately, there is something Congress can do. Low-hanging fruit would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023" in order to remove a crucial barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs). As explained by Joshua Perry, in *An Obituary for Physician-Owned Specialty Hospitals,* 23 Health Lawyer 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law—meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 U.S.C. 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, under current law the POH cannot expand its treatment capacity unless certain restrictive exceptions are met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new POHs that depend on Medicare reimbursement.

A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin entitled, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human

[21] Town, et al., *supra,* at page 10.
[22] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?,* 115 Q J Econ. 2, 577 (2000).
[23] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).
[24] Dranove, supra, at 178.
[25] Martin Gaynor, *Antitrust Applied*, at 17.
[26] Martin Gaynor, *Antitrust Applied*, at 18.

Services, U.S. Department of Treasury, U.S. Department of Labor (2020), recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[27] Congressional action would be especially welcome because **POHs have developed an enviable track record for high quality and low-cost care**.[28]

Opponents of POHs argue that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" which they ascribe to the physician owners. However, the evidence indicates that POHs do *not* cherry pick patients. For example, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[29] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[30] Importantly, new economic research supports those findings. It finds strong evidence *against* cherry-picking by physician owners.[31]

Unfortunately, the POH ban forecloses the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models.[32] Benefits of self-referral in integrated delivery models include "one-stop shopping," improved sharing of clinical information, and better care delivery experienced by consumers. Critically, the ban on POHs is the wrong policy prescription to address potential concerns with self-referral models. There are other policy recommendations that do not sacrifice the benefits of POHs.[33]

Reversing the ACA-imposed ban on new construction or expansion of existing POHs will both stimulate greater competition and provide patients with another option to receive high quality health care services. An April 12, 2021 *Health Affairs* article entitled, *Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals*, explains how.

Much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law is the right prescription. As a result, enactment of H.R. 977/S. 470 is essential to facilitating greater competition and permitting POHs to continue to provide high quality care to a broader patient population.

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[27] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).

[28] *Id.*

[29] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (2005) (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.

[30] *Id.*

[31] Ashley Swanson. *Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care.* 80 J Health Econ. (2021).

[32] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

[33] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

III. Pharmacy Benefit Managers

The lack of transparency surrounding pharmacy benefit managers and the impact it has on pharmaceutical costs to patients and the practice of medicine

The role of pharmacy benefit managers (PBMs) as "middlemen" among payers, pharmaceutical companies, and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. PBMs also build retail pharmacy networks, adjudicate pharmacy claims, manage drug formularies (including tiering of drugs), design pharmacy benefits, and operate mail-order and specialty pharmacies. These capacities seem to give them much power in determining which drugs consumers take. The ability of patients and physicians to have the information they need to make key decisions regarding medications, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by these arrangements. A lack of transparency and competition in PBM markets could be driving drug prices up. Patients are facing insurmountable costs and administrative barriers to obtaining prescription drugs from a pharmacy, PBM, or through physician-administered treatments. The burden, however, is not solely caused by the escalating prices of pharmaceuticals, but the increase in medication utilization management policies, as well.

As a result, patients, unfortunately, may take greater clinical risks when treatments are cost prohibitive. If patients delay, forgo, or ration their pharmaceutical treatment, their health status may deteriorate, eventually requiring medical interventions in more costly care settings when their condition is at a more advanced stage of disease. Additionally, market-driven barriers to care perpetuate disparities rather than promote equity for marginalized populations.

Issues and concerns surrounding the impact of unfair conduct related to medication prices and access are not new. Not only is patient ability to afford medications affected, but the negative impacts on those affected by disparities have been exacerbated.[34] In a 2020 article published in the *Journal of Managed Care + Specialty Pharmacy*, the author notes that there has been a response to racial or ethnic disparities in medication use by placing a greater focus on social determinants of health. However, it is also acknowledged that "medication cost remains a formidable barrier to closing the disparities gap in medication use between Blacks and Whites, including both the uninsured and those having a pharmacy benefit." The author points to the significant correlation between wealth and race in this equation, and, furthermore, notes that racial disparities have been documented in the utilization of essential evidence-based drug therapies, including but not limited to antidepressants, anticoagulants, diabetes medications, drugs for dementia, and statins. The U.S. Bureau of Labor Statistics reports further reflect this trend. In fact, in 2018, patients earning poverty-level wages were likely to prioritize rent payments or costs for food as a necessary trade-off to out-of-pocket prescription costs that consume a higher percentage of their weekly earnings. The author notes that, while patient cost sharing may be lower than it was comparably in the 1990s, the comparison of costs "does not take into account prices paid by those without health insurance, or the deviation in patient out-of-pocket spending that is associated with current pharmacy benefit designs."

These barriers also undoubtedly impact the physician's ability to provide uninterrupted optimal patient-centric care. In these scenarios, physicians are forced to navigate complex, and resource intensive requirements imposed by health insurers and PBMs.

As a result, the AMA urges Congress to pass legislation that seeks to rein in unscrupulous PBM business

[34] Kogut SJ. *Racial disparities in medication use: imperatives for managed care pharmacy.* J Manag Care Spec Pharm. 2020 Nov;26(11):1468-1474. doi: 10.18553/jmcp.2020.26.11.1468. PMID: 33119445; PMCID: PMC8060916.

practices. For example, the AMA supports S. 127, the "Pharmacy Benefit Manager Transparency Act of 2023," a bipartisan bill that promotes greater transparency of PBM operations and prohibits PBMs from engaging in unfair and deceptive reimbursement and payment practices.[35] The opaque nature of PBM negotiations and operations makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to step therapy. We emphasize that this ultimately may lead to delays in necessary medication treatment, as well as a lack of clarity regarding specific formulary and cost-sharing responsibilities, which can lead to an inability to afford and access necessary medications.

In general, the AMA also strongly supports efforts on the part of Congress, the FTC, and the U.S. Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. In that vein, the AMA endorses S. 113, the "Prescription Pricing for the People Act," bipartisan legislation that requires the FTC to report about the anticompetitive practices, as well as other trends, within the pharmaceutical supply chain that impact the cost of pharmaceuticals.[36] The legislation also requires the FTC to provide recommendations to increase transparency within the drug supply chain in order to prevent anticompetitive practices. This bill is consistent with the bipartisan call for increased oversight and studies to prevent unfair or anticompetitive PBM practices.

Finally, the AMA supports H.R. 830, the "Help Ensure Lower Patient (HELP) Copays Act."[37] This bipartisan legislation helps ensure copay assistance counts towards patient cost-sharing requirements in individual, small group, and employer-sponsored health plans. This crucial bill has a particularly positive impact on patients seeking specialty drugs and, in general, further protects individuals from harmful insurance and PBM practices that raise out-of-pocket prescription drug costs.

Market concentration and competition in PBM markets and the implications for drug prices

PBMs were created in the 1960s to help health insurers contain drug spending. PBMs can stimulate price competition among drug manufacturers by shifting demand among competing substitute drugs. In turn, manufacturers offer rebates to PBMs for their drugs to be placed favorably in a drug formulary, which PBMs are then supposed to pass on to insurers or employers. However, the PBM market needs to be competitive for rebates to be fully passed on to final consumers. Thus, it is critically important that PBM markets are competitive. Unfortunately, it is not clear whether PBMs are (fully) passing on those rebates. Indeed, some economists argue that consolidation in the PBM market, combined with opaque pricing, is one cause of higher pharmaceutical prices.[38]

In October 2022, the AMA released the findings from a new analysis[39] that suggests low levels of competition in local PBM markets across the United States where PBMs provide services to commercial health insurers. This analysis is the first to shed light on variations in market shares and competition

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[35] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-Senate-re-S-113-and-127-Acts-v3.pdf.

[36] Ibid.

[37] https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfrd.zip%2F2023-3-13-Letter-to-House-re-HR-830-HELP-Copays-Act-v2.pdf

[38] Garthwaite C., Scott Morton F. Perverse Incentives Encourage High Prescription Drug Prices. Chicago, IL: ProMarket. 2021.

[39] José R. Guardado, Competition in Commercial PBM Markeys and Vertical Integration of Health Insurers with PBMs, AMA Policy Research Perspectives (2022), https://www.ama-assn.org/system/files/prp-pbm-shares-hhi.pdf.

among PBMs and on the extent of vertical integration between health insurers and PBMs at the local (state and MSA) levels.

According to the analysis, commercial insurers largely use an external PBM for three services: rebate negotiation; retail network management; and claims adjudication (rather than conducting them in-house). The analysis assessed market competition for those three PBM services and concluded that, at the national level, a handful of PBMs have a large collective market share. The 10 largest PBMs had a collective share of 97 percent; the four largest PBMs had a collective share of roughly 66 percent.

At both the state and MSA-levels, the analysis found a high degree of market concentration for each of the three PBM services assessed by the study. Specifically, more than three of four (about 78 percent) states had highly concentrated PBM markets; and more than four of five (85 percent) of MSA areas had highly concentrated PBM markets.

In terms of the extent of vertical integration between health insurers and PBMs, the study found that 69 percent of drug lives at the national level are covered by an insurer that is vertically integrated with a PBM. On average, 63 percent of state-level drug lives and 65 percent of MSA-level lives are vertically integrated. Six of the 10 largest PBMs are used exclusively by one insurer or a set of Blue Cross Blue Shield affiliates. Vertically integrated insurers may not allow non-vertically integrated insurer competitors to access their PBMs, or they could raise the cost of those PBM services. This could adversely affect non-vertically integrated insurers and ultimately patients through higher premiums.

Other research notes the increasing vertical integration of insurers, PBMs, specialty pharmacies, and providers, and provides an illustration of the major vertical business relationships among the largest companies in U.S. health care markets.

At this juncture, protecting patients and physicians from anticompetitive harm warrants attention as Congress and the Administration continue their work to protect patients and ensure prescription drugs remain affordable and accessible. The AMA urges careful monitoring, and intervention when needed, of both horizontal and vertical integration to ensure competition in PBM and health insurance markets and patient access to care. Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have and continue to impose on their patients' care and remain concerned about the detrimental impact PBM business practices have on patients' access to and the cost of prescription drugs.

Conclusion

Competition is critical for well-functioning health care markets. When markets are not competitive and firms have market power, society is at a loss. Unfortunately, the majority of health insurance, hospital, and PBM care markets are not competitive. Mergers and acquisitions have contributed to these low levels of competition. Strong antitrust scrutiny of mergers in these markets is warranted. Also needed are policies that promote market entry, including lifting the statutory ban Congress imposed on physician-owned hospitals. These various policy interventions will promote greater competition, lower drug prices, and improve health care outcomes.

AMERICAN PHARMACISTS ASSOCIATION
STATEMENT FOR THE RECORD

BEFORE THE U.S. HOUSE COMMITTEE ON WAYS AND MEANS
HEALTH SUBCOMMITTEE

WHY HEALTH CARE IS UNAFFORDABLE: ANTICOMPETITIVE AND CONSOLIDATED MARKETS

WEDNESDAY, MAY 17, 2023

2215 Constitution Ave. NW
Washington, DC 20037

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Chair Buchanan, Ranking Member Doggett and Members of the Health Subcommittee:

On behalf of our nations over 310,000 pharmacists, the American Pharmacists Association (APhA) is pleased to submit the following Statement for the Record to the U.S. House Ways and Means Health Subcommittee hearing, "Health Subcommittee on Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA applauds the Subcommittee's ongoing leadership and recognition federal legislation must be passed to address pharmacy benefit managers' (PBMs) harmful business practices that are increasing prescription drug costs at the expense of patients and creating 'pharmacy deserts' in minority and underserved communities, where the neighborhood pharmacy may be the only health care provider for miles.[1] PBMs' business practices have undermined the community pharmacy business model, resulting in many pharmacies having to make the challenging choice of taking a loss when filling a prescription to ensure patients are not denied access to their needed medications. As the most accessible healthcare professional, pharmacists should be able to provide the high-quality care they are trained to provide without fear it will cause them to go out of business. In a February 2023 national survey conducted by APhA, 91.5% of respondents reported that current PBM practices negatively impact their practice and ability to provide patient care.[2] As explained during APhA's recent PBM 101 briefing for congressional staff,[3] there are already mountains of data for Congress to take action from Medicare, Medicaid and commercial plans on PBMs' uncompetitive and deceptive trade practices that target patients with chronic conditions, and force them to use PBM-owned specialty and mail order pharmacies rather than their local pharmacy. It's way past time to put patients over PBM profits, and Congressional action is overdue.

Background

- PBMs originally emerged over 40 years ago as middlemen between health plans and pharmacies to adjudicate claims.

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[1] https://www.japha.org/article/S1544-3191(22)00230-8/fulltext

[2] https://www.pharmacist.com/APhA-Press-Releases/apha-releases-survey-results-quantifying-the-impact-of-pbms

[3] https://nam10.safelinks.protection.outlook.com/?url=https%3A%2F%2Fapha.msgfocus.com%2Fc%2F11HbcOknPGFkG5EnaeGtUL.x9O4KoUj&data=05%7C01%7Cmbaxter%40aphanet.org%7C93f200d5701a4088bcde08db21aed8a7%7C6577def6f03f4adba697e1535f172506%7C1%7C0%7C638140807069554809%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=hhBrgcsMgLnW4Sg4%2F%2ByGVtZf6qC9XtdCzkz66e0l7UY%3D&reserved=0

- Over the years, three PBMs have come to control 80% of the total market share[4] and have vertically integrated with insurers, chain pharmacies and specialty pharmacies.
- Numerous reports from pharmacists and media over the years have documented unfair and anticompetitive practices from PBMs on community pharmacies. These include clawbacks (known under Medicare as direct and indirect remuneration (DIR) fees which PBMs often assess weeks, or even months, after Part D beneficiaries' prescriptions are filled, resulting in pharmacies realizing only long after the prescription was filled that they did not recoup their costs), gag clauses (preventing sharing cash prices with patients), spread pricing (overcharging the payer, underpaying the pharmacy and keeping the spread), patient steering to PBM-owned pharmacies, mandatory mail-order raising patient safety concerns, and many other concerning practices.
- In December 2020, the U.S. Supreme Court unanimously ruled on Rutledge v. PCMA in the pharmacy communities' favor, opening the door for state oversight of PBMs.[5]

Why PBM Reform is Needed

- The pharmacy reimbursement and drug pricing scheme in the U.S. has grown out of control, with misaligned incentives that neither benefit the patient nor lead to better health outcomes. These misalignments are causing pharmacies across the country to shut their doors, leaving patients without access to their local pharmacies.
- As a result of the predatory practices of PBMs:
    - Patients' access to medications from their local pharmacist across the country has declined[6],
    - Taxpayer dollars have been funneled into corporate profits,[7] and
    - Generationally owned community pharmacies have been driven out of business.[8]
- Patients' access to their medications and their trusted healthcare professional, the pharmacist, should not be jeopardized due to misaligned incentives in the PBM industry that prioritize profits over patients.
- The unsustainable reimbursement model for medications caused by PBMs has contributed to negative workplace conditions for pharmacists and pharmacy teams.

PBMs are Costing Medicare and the U.S. Taxpayer

- Between 2010 and 2020 the Centers for Medicaid and Medicaid Services (CMS) reports that pharmacy direct and indirect remuneration (DIR) fees increased by more than 107,400 percent.[9] The increase in point-of-sale and retroactive pharmacy price

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[4] Pharmacy Benefit Managers: Market Landscape and Strategic Imperatives. Hirc. Available at https://www.hirc.com/PBM-market-landscape-and-imperatives

[5] Supreme Court of the United States. RUTLEDGE, ATTORNEY GENERAL OF ARKANSAS v. PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION. Available at https://www.supremecourt.gov/opinions/20pdf/18-540_m64o.pdf.

[6] Rose J, Krishnamoorth R. Why your neighborhood community pharmacy may close. *The Hill*. Available at https://thehill.com/blogs/congress-blog/healthcare/530477-why-your-neighborhood-community-pharmacy-may-close

[7] 3 Axis Advisors. Analysis of PBM Spread Pricing in New York Medicaid Managed Care. Available at http://www.ncpa.co/pdf/state-advoc/new-york-report.pdf

[8] Callahan C. Mom-and-pop pharmacies struggle to hang on. *Times Union*. Available at https://www.timesunion.com/hudsonvalley/news/article/Mom-and-pop-pharmacies-struggle-to-hang-on-16187714.php

[9] Medicare Program; Contract Year 2023 Policy and Technical Changes

concessions have contributed to an unsustainable environment for community pharmacies to keep their doors open.

- **The Medicare Payment Advisory Commission's (Medpac) March 2023 report found that pharmacy DIR payments to PBMs in Medicare Part D were an astounding $12.6 billion for 2021—which represents a $3.1 billion (+33%) increase from the 2020 figure of $9.5 billion.**[10]
- It's also important to note that despite PBM claims, CMS found that "actual Part D program experience has not matched expectations" "less than 1 percent of plans have passed through any price concessions" and "the amount passed through is less than 1 percent of the total price concessions those plans receive."[11]

Congressional Ask

- **Transparency:** APhA supports transparency and accountability in reimbursement and pricing to ensure consistent practices throughout the drug supply chain.
- **Sustainability:** APhA supports pricing models that allow for the fair reimbursement of drug products and dispensing fees that can support a sustainable business model within community pharmacies.
- **Accountability:** APhA encourages appropriate oversight from state and federal agencies to prohibit pricing manipulations and anti-competitive practices that hurt market competition and harm patient access to their medications and their pharmacist.

Legislation

- APhA supports the Drug Price Transparency in Medicaid Act (H.R. 1613), which would reign in PBMs' unfair use of "spread pricing." Spread pricing is a practice in which a PBM charges the state or health plan more than they pay the pharmacy for a medication and then keeps the "spread" as a profit, often reimbursing the pharmacy for less than their cost to acquire the drug. This hurts pharmacies' ability to stay in business and provide care to the vulnerable Medicaid beneficiaries whom they serve. This legislation would also move all state Medicaid managed care programs to a market-based reimbursement model that more closely reflects the true acquisition costs of prescription drugs in Medicaid plus a fair professional dispensing fee. APhA previously sponsored a study that found that utilizing a model of Medicaid's National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee offered an overall point-of-sale spending decrease for prescription drugs at pharmacies, which would result in billions of projected savings to Medicare beneficiaries as a result of their reduced cost-sharing obligations.[12]

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[10] Medpac. March 2023 Report to Congress – Medicare Payment Policy. Page 399. https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf#page=427

[11] https://www.federalregister.gov/documents/2018/11/30/2018-25945/modernizing-part-d-and-medicare-advantage-to-lower-drug-prices-and-reduce-out-of-pocket-expenses

[12] https://www.pharmacist.com/About/Newsroom/new-study-medicare-could-save-seniors-billions-by-fixing-part-d-incentives

Patient Need

- Patients are harmed by insurer and PBM practices that mask the real prices of medications, increase the amount they pay at the pharmacy counter, and interfere with pharmacists' ability to provide patient care.
- As a result of anti-competitive practices, PBMs have caused pharmacies to close, contributing to pharmacy deserts which are especially prominent in racial and ethnic minority communities.[13]
- These practices impact taxpayers as they contribute to inflated prices of medications reimbursed under public health plans. **A study found that PBM tactics forced Oregon Medicaid to overpay $1.9M on a single drug, where PBMs marked up the drug by 800 percent**.[14]

APhA would like to thank the Subcommittee for the opportunity to comment on the importance of Congress to pass PBM reform legislation. APhA looks forward to working with the Subcommittee to restore transparency, accountability, competition, and equity to our nation's supply chain and health care marketplace. Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org if you have any additional questions or additional information.

[13] Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007–15. *Health Affairs*. Available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01699.
[14] https://oregonpharmacy.org/2022/10/27/oregon-report/

CYSTIC FIBROSIS FOUNDATION®

May 31, 2023

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The Honorable Vern Buchanan
Chairman, Health Subcommittee
Committee on Ways and Means
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The Honorable Lloyd Doggett
Ranking Member, Health Subcommittee
Committee on Ways and Means
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Statement for the Record
"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets."

On behalf of the nearly 40,000 children and adults with cystic fibrosis in the United States, we write to share additional perspectives on the topics discussed at the recent hearing on hospital markets and pharmacy benefit managers (PBMs), including concerns about vertical integration and the opaque influence and practices of PBMs.

The Cystic Fibrosis Foundation is a national organization dedicated to curing cystic fibrosis (CF). We invest in research and development of new CF therapies, advocate for access to care for people with CF, and fund and accredit a network of specialized CF care centers. Cystic fibrosis is a life-threatening genetic disease that causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage, and the associated symptoms of CF lead to early death, usually by respiratory failure. Transformative therapies—such as CFTR modulators—have been paramount in changing what it means to live with CF. However, PBM cost containment strategies have created a convoluted system that patients struggle to navigate and often results in significant barriers to care.

PBMs manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers. By negotiating with drug manufacturers and pharmacies to determine drug coverage and reimbursement, PBMs can exert significant control over total drug costs for insurers, patients' access to medications, and how much pharmacies are paid.[1] PBMs often focus cost mitigation

[1] https://www.healthaffairs.org/do/10.1377/hpb20171409.000178/full/healthpolicybrief_178-1660136543567.pdf

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strategies on specialty drugs because of their high cost but low utilization within the overall population. PBM practices and the opacity of the system are extremely problematic and burdensome for chronic conditions like CF that primarily use specialty drugs.

CF Community's Experience with PBMs

Overall, PBMs cause significant barriers to care for people with CF in navigating insurance. This is largely due to the lack of understanding of the role of PBMs in coverage decisions and evolving strategies that PBMs put in place to mitigate their own costs and those of their clients, which add out-of-pocket costs or administrative burden for patients.

Transparency

There is a lack of transparency on the role of PBMs, insurers, and subcontracted third-party entities in coverage and cost-sharing decisions, especially in the self-funded insurance market. This causes confusion on the appropriate point of contact for coverage decisions, increasing administrative burden on both patients and their care teams, and causing gaps in access to important therapies. PBMs and insurance companies both regularly claim that the other entity makes the final determinations on coverage for a therapy, resulting in an avoidance of responsibility from both parties and delays and confusion for the patients they cover. Patients and care teams frequently report being "passed back-and-forth" between the two entities when seeking to understand coverage decisions. The result is that people with CF do not know who is ultimately responsible for decisions about their drug coverage, or where to appeal in order to access their essential treatments.

Third-party entities such as maximizers—many of which are owned by PBMs—and alternative funding programs add complexity to an already opaque system. Maximizers often outsource a patient's drug coverage to a third-party entity that sets the patients' cost-sharing at a level to maximize use of manufacturer copay assistance. Alternative funding programs also rely on third-party entities that seek to enroll patients in manufacturer patient assistance programs that provide free drugs, which are usually intended for people without insurance. Without transparency on the decision-maker (PBM vs. payer vs. third-party), patients often face unnecessary, confusing, and time-consuming administrative barriers and unacceptable and inappropriate treatment gaps. New coverage tactics emerge frequently, requiring patients and care teams to consistently learn and adapt to new, opaque, and confusing policies. PBMs are often at the center of these challenges.

Increased Out-of-Pocket Costs

In addition to maximizers and alternative funding programs, PBMs and insurers are increasingly implementing accumulator programs—which prevent third-party payments from counting towards deductibles and out-of-pocket limits and therefore increasing out-of-pocket costs for patients. Many people with CF rely on third-party financial assistance to cover some of the costs associated with their care, as CF is an expensive disease. The CF Foundation recognizes that copay assistance programs mask bigger cost and affordability issues; however, cost containment strategies like accumulator programs that further burden patients are unacceptable.

Recommendations

The CF Foundation appreciates the committee's attention to this issue. We urge Congress to ensure that the legislative proposals seek to improve the experience for patients, in addition to regulating the business and financial structure of PBMs. We provide the following recommendations:

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HELP Copays Act: The CF Foundation recommends including the Help Ensure Lower Patient Copays Act (HELP Copays Act; H.R. 830) into any PMB reform legislation. This bill reduces patient administrative and financial barriers imposed by PBMs and payers by 1) requiring payers to apply third party assistance to out-of-pocket maximums and other patient cost-sharing requirements; and 2) ensuring any item or service covered by a health plan is considered part of their essential health benefits (EHB) package. Together, these policies would prohibit accumulators, maximizers, and alternative funding programs in federally-regulated insurance plans, eliminating some of the most problematic PBM practices for patients.

Transparency: CF Foundation recommends Congress direct the FTC and HHS to expand transparency measures for PBMs and insurers to ensure patients receive better information about coverage policies for specialty drugs, including relationships with third-party entities. Specifically, Congress should direct the FTC and HHS to require PBMs and payers to provide enrollees with notices and disclosures on which entity is responsible for coverage determinations and provide clear contact information.

Oversight & Enforcement: The CF Foundation supports efforts by Congress to require the FTC to determine whether there is more information about PBMs that should be available to consumers and whether there are any legal or regulatory obstacles the FTC currently faces in enforcing the antitrust and consumer protection laws in the PBM marketplace.

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Thank you for highlighting the importance of transparency in this hearing and for your leadership on this important issue. The CF Foundation stands ready to work with you to ensure patients' health and financial wellbeing are not sacrificed in the ongoing systemic debate among payers, PBMs, and drug manufacturers.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

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Health Care Consolidation

The Changing Landscape of the U.S. Health Care System

Cheryl L. Damberg

CT-A2770-1

Testimony submitted to the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health on May 17, 2023

For more information on this publication, visit www.rand.org/t/CTA2770-1

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Published by the RAND Corporation, Santa Monica, Calif.

Health Care Consolidation: The Changing Landscape of the U.S. Health Care System

Testimony of Cheryl L. Damberg[1]
The RAND Corporation[2]

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

May 17, 2023

Chairman Buchanan, Ranking Member Doggett, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony for the record. My name is Cheryl Damberg, and I am a senior economist at the nonprofit, nonpartisan RAND Corporation. My research focuses on tracking the evolution of health systems and examining their cost and quality performance. I appreciate the opportunity to discuss the important topic of health care consolidation, a phenomenon that is dramatically reshaping the structure of health care markets in the United States. Consolidation in any industry raises concerns about reducing competition, because without competition, prices go up, incentives to innovate are reduced, and quality goes down, reducing value for consumers.[3] In health care, consolidation is a key factor contributing to the exponential growth in health spending by U.S. taxpayers, employers, and consumers.

I will first describe the state of consolidation across four key sectors of the U.S. health care market: providers, insurers, pharmacy benefit managers (PBMs), and private equity. Then, I will share what is known about the impacts of this consolidation on cost, quality of care, and health

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[3] M. Susan Ridgely, "Does Vertical Integration Improve or Imperil U.S. Health Care?" *RAND Blog*, November 16, 2021, https://www.rand.org/blog/2021/11/does-vertical-integration-improve-or-imperil-us-health.html.

outcomes. While proponents of consolidation have argued that consolidation leads to increased efficiency, lower administrative costs, and improved quality of health care, our research (and that of other investigators) has not shown any consistent evidence of cost or quality benefits to consumers.

How Is Consolidation Reshaping U.S. Health Care Markets?

Over the past several decades, the health care delivery landscape has undergone rapid and continual change. Consolidation in the health care market is endemic and is happening in all parts of the health care delivery system. Across the United States, health care markets are dominated by a few large players, and the footprints of these players continue to expand.[4]

Consolidation can occur in different forms.[5] One form is **horizontal consolidation**, in which two "like" organizations come together and integrate. One example is two hospitals consolidating through a merger. Another example is two health systems consolidating, such as the 2022 merger of Advocate Aurora Health and Atrium Health. This particular merger created a mega health system that operates 67 hospitals and more than 1,000 ambulatory care sites in six states.[6]

Hospital consolidation has been occurring over multiple decades.[7] Between 1998 and 2021, the American Hospital Association reported 1,887 hospital mergers.[8] By 2017, in most markets, a single hospital system had more than a 50-percent market share of hospital discharges,[9] reducing competition.

Another form of consolidation is **vertical consolidation**, in which different types of health care organizations consolidate. In economics, *vertical integration* is defined as the combination of two or more stages of production normally operated by separate companies into one company. In health care, this term is often applied, for example, when hospitals or health systems employ physicians or acquire physician practices.

While both horizontal and vertical consolidation are occurring among providers, hospital consolidation has largely been supplanted by what is now the dominant trend in the market: vertical integration, in which health systems have been acquiring physician groups, other acute care providers (such as ambulatory clinics and ambulatory surgery centers [ASCs]), and post-

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[4] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs*, Vol. 36, No. 9, September 2017.

[5] Jodi L. Liu, Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi, "Consolidation Trends and Impacts in Health Care Markets," RAND Corporation, RR-A1820-1, 2022, https://www.rand.org/pubs/research_reports/RRA1820-1.html.

[6] Samantha Liss, "Advocate Aurora and Atrium Complete Merger, Creating $27B System," Healthcare Dive, December 2, 2022.

[7] Martin Gaynor, "New Health Care Symposium: Consolidation and Competition in US Health Care," *Health Affairs*, March 1, 2016.

[8] Hoag Levins, "Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality: A Penn LDI Virtual Seminar Unpacks the Challenging Contradictions of This Continuing Trend," University of Pennsylvania Leonard Davis Institute of Health Economics, January 19, 2023.

[9] Medicare Payment Advisory Commission, *Medicare Payment Policy: Report to the Congress*, March 2020.

acute care providers (such as home health agencies). Furthermore, insurers have been vertically consolidating with provider entities over the past decade. Currently, the largest employer of physicians in the United States is not a health system, but rather Optum, a subsidiary of the insurer UnitedHealth Group with more than 700,000 employed or aligned physicians.[10]

In addition to mergers and acquisitions, new, "softer" forms of vertical consolidation are emerging that are largely invisible to policymakers and for which we do not understand the impacts. Instead of buying practices and directly employing physicians, health systems are entering into contractual relationships with physician groups, independent physician practices, and hospitals to form clinically integrated networks, allowing the health systems to expand and increase the flow of patients to the health system to garner more revenue and to allow previously independent hospitals and providers to obtain higher payment rates negotiated by the larger health system with insurers. RAND recently published a report on clinically integrated networks, noting that these softer forms of consolidation pose similar risks of furthering spending growth without yielding improved quality performance.[11] These soft forms of consolidation are not commonly captured in the regulatory filing data, leaving regulators and researchers blind to monitor their impacts.

I will now describe the state of consolidation across four key sectors of the U.S. health care market: (1) providers, (2) insurers, (3) PBMs, and (4) private equity.

Providers

A key trend over the past decade is the substantial vertical consolidation of previously independent physician groups and physician practices into hospitals and health systems. This trend has dramatically increased over the past decade and continues unabated. Research conducted by my colleague Christopher Whaley indicates that the percentage of physician practices owned by hospitals and health systems has doubled over the past decade, nearing half of all physicians—both primary care and specialty physicians (see Figure 1).[12] A key reason for provider consolidation is so that hospitals and health systems can accrue bargaining leverage and, in turn, achieve higher prices from commercial payers, as well as direct patient volume to higher-priced system hospitals and providers.

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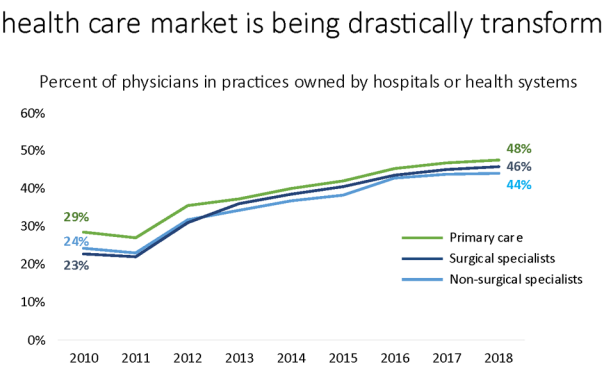
[10] Jakob Emerson, "Meet America's Largest Employer of Physicians: UnitedHealth Group," Becker's Healthcare, February 16, 2023.

[11] M. Susan Ridgely, Justin W. Timbie, Laura J. Wolf, Erin Lindsey Duffy, Christine Buttorff, Ashlyn Tom, and Mary E. Vaiana, *Consolidation by Any Other Name: The Emergence of Clinically Integrated Networks*, RAND Corporation, RR-A370-1, 2020, https://www.rand.org/pubs/research_reports/RRA370-1.html.

[12] 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, December 2021.

Figure 1. Consolidation of Physician Practices into Hospital and Health Systems



SOURCE: Adapted from Whaley et al., 2021.

Insurance Market

Although a substantial amount of insurer consolidation occurred in the 1990s and early 2000s, insurer horizontal merger activity continues to take place. Most insurance markets are concentrated, as described in a 2022 American Medical Association study, which found that 75 percent of metropolitan statistical area–level commercial insurance markets were highly concentrated: Ninety-one percent of the markets had one insurer holding at least 30 percent of the market share, and 46 percent of the markets had one insurer holding at least 50 percent of the market share, restricting competition.[13] Yet insurers are trying to further consolidate, making concentration worse. For example, in 2015, Anthem announced a $54 billion merger deal with Cigna, while Aetna announced a $38 billion merger deal with Humana. (Both deals were blocked.) While insurance concentration can enhance insurer bargaining power with providers, it also limits the incentives to develop innovative insurance products and pass savings to patients and premium holders.[14]

Beyond insurer-to-insurer horizontal consolidation, insurers over the past decade have been vertically integrating with providers, including hospitals, physician practices, nursing homes, home health agencies, pharmacies, and ASCs. This form of integration between insurers and providers raises concerns of price increases and access barriers for patients covered by rival insurers.

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[13] American Medical Association Division of Economic and Health Policy Research, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, 2022.

[14] Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review*, Vol. 102, No. 2, April 2012.

Pharmacy Benefit Managers

Consolidation has also been occurring among PBMs, which have been merging horizontally with each other and vertically with insurers and with pharmacies. Over the past few years, the PBM market has become highly consolidated, with three PBMs—CVS Health, Express Scripts, and OptumRx—controlling more than 76 percent of the market. The three firms each operate their own mail-order pharmacies, and CVS owns the nation's largest drugstore chain. In 2017, CVS acquired health insurer Aetna, while, in 2019, Cigna acquired Express Scripts.

PBMs have vertically integrated with Medicare Part D prescription drug plans. As MedPAC recently reported, the share of total Medicare Part D enrollment attributable to the top five plan sponsors increased from 53 percent in 2010 to 74 percent in 2021. One key function of PBMs is to negotiate discounts with drug manufacturers to reduce the drug costs for payers and consumers. Having the plan, the PBM, and the pharmacy consolidated under one entity potentially creates conflicting incentives that may raise health spending by driving patients to use higher-priced drugs in exchange for discounts from the drug manufacturers and preferred placement on the plan's formulary or might lower costs through greater leverage in negotiations with drug manufacturers. Currently, there is a lack of visibility into prices between the upstream and downstream entities because PBMs are not required to disclose the rebates they receive from drug makers or the spread between what they are paid by insurers to fill a prescription and how much they pay to the pharmacy filling the prescription. PBMs also engage in anticompetitive behavior, as they steer patients to their own pharmacies and reduce reimbursements to independent pharmacies to drive them out of business.

Private Equity

Lastly, private equity has taken a large and growing stake in the American health care system, with investment growing from $41.5 billion in 2010 to $119.9 billion in 2019.[15] Private-equity firms have acquired physician practices, ASCs, hospitals, nursing homes, and home health care providers. Much private-equity activity reflects leveraged buyouts in which a private-equity firm relies heavily on loans to acquire ownership of an organization (such as a hospital system), takes the organization private, attempts to improve the value of the organization, and aims to sell it at a profit within three to seven years. A key concern with private-equity acquisition is that the owners are focused on short-term revenue generation by engaging in financial arbitrage. They do so by providing more services, shifting toward a more highly compensated mix of services and procedures, or raising prices.[16] Private-equity firms consolidate health care providers to gain bargaining leverage to obtain higher payment rates from payers, thereby driving increases in health spending and undermining competition, rather than making investments to deliver higher-quality care more efficiently. Because of their private nature, most private-equity acquisitions

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[15] Richard M. Scheffler, Laura M. Alexander, and James R. Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, American Antitrust Institute and Petris Center, May 18, 2021.

[16] Medicare Payment Advisory Commission, "Congressional Request: Private Equity and Medicare," *Report to the Congress: Medicare and the Health Care Delivery System*, June 2021.

operate without effective oversight, as the acquisitions are not reportable to antitrust or financial regulatory authorities under current law. A recent study examined the effects of private-equity investment in dermatology practices, a commonly targeted specialty for private-equity firms.[17] Private-equity acquisition was associated with dermatologists seeing up to 17 percent more patients after two years and charging 3 to 5 percent more for routine visits. The private-equity firms targeted their acquisitions at larger practices that saw more commercially insured patients—where the private equity–owned practice can negotiate higher prices, unlike in Medicare.

Why Are Providers Vertically Integrating?

In a recent study, we asked C-suite executives of health systems why they were vertically integrating by acquiring physician practices. They gave the following reasons:

- To gain size—that is, more patients to be able to spread financial risk so that the health system can successfully participate in value-based payment contracts, such as Accountable Care Organizations. However, a recent study found little evidence to support the idea that providers have responded to the rapid growth of new payment models by forming larger organizations to assume financial risk and succeed under these models.[18]
- To have greater leverage in price negotiations with payers. The potential for increased payments motivates independent physicians to vertically integrate. Independently practicing physicians have little bargaining power, and they can boost the payments they receive when they are part of a health system that has more negotiating power.
- To direct more patient traffic to their hospitals to offset loss of revenue due to policy changes, such as financial penalties for hospital readmissions, and the pressure that value-based contracts place on systems to reduce the total cost of care—reductions that come through reduced hospital utilization.
- To improve their ability to coordinate patient care across multiple settings and providers and to manage population health. Although improvements in care coordination and clinical quality are often stated as motivations for consolidation, the existing research finds no improvements in quality and potentially worse outcomes for vulnerable patient populations.[19]
- To gain leverage in highly concentrated markets and because they cannot afford to be left behind as their competitors gain size and market share.

From the perspective of those being acquired, mergers with hospital and health systems allow them to obtain higher payment rates and to deal with increasing regulatory requirements—such

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[17] Robert Tyler Braun, Amelia M. Bond, Yuting Qian, Manyao Zhang, and Lawrence P. Casalino, "Private Equity in Dermatology: Effect on Price, Utilization, and Spending," *Health Affairs*, Vol. 40, No. 5, May 2021.

[18] Hannah T. Neprash, Michael E. Chernew, and J. Michael McWilliams, "Little Evidence Exists to Support the Expectation That Providers Would Consolidate to Enter New Payment Models," *Health Affairs*, Vol. 36, No. 2, February 2017.

[19] Jonathan S. Levin, Swad Komanduri, and Christopher Whaley, "Association Between Hospital-Physician Vertical Integration and Medication Adherence Rates," *Health Services Research*, Vol. 58, No. 2, April 2023.

as having certified electronic health record and quality reporting requirements—that affect the costs of operating small practices. A potentially important driver of physician consolidation is that recent regulations (both federal regulations and insurer requirements) make it very hard to run a practice. Consolidating is a way to outsource that component and focus on practicing medicine.

However, the research by Christopher Whaley and colleagues shows that there is no direct financial benefit to physicians of vertically integrating, as vertical integration with hospitals or health systems is associated with, on average, 0.8 percent lower income compared with income received by independent physicians.[20] Vertical integration of physician practices with hospitals or health systems is associated with lower income for nonsurgical specialists, no difference in income for primary care physicians, and slightly higher income for surgical specialists.

Why Are Insurers Vertically Integrating?

Over the past decade, insurers have been shifting away from solely providing insurance to reinventing themselves as health care delivery organizations. This transformation has been spurred by several factors, including periodic threats of a single-payer health system putting private insurers out of business; the ongoing shift to value-based payments, which require the ability to manage financial risk and coordinate care delivery across the continuum of care; and competition from fully integrated, full-risk population-health delivery systems, which have achieved high levels of quality performance in both the commercial insurance market and Medicare Advantage, allowing these integrated delivery systems to gain market share and substantial quality bonuses under value-based payment arrangements.

However, the major reason why insurers are vertically integrating with providers of all types of care delivery is to control more of the production of health care and, in turn, capture the revenues created along the production path.[21] UnitedHealth Group is one example of an insurer that has expanded into the delivery of health care through vertical integration, with its Optum, Inc., subsidiary that includes pharmacy and care delivery services. In 2017, Optum accounted for 44 percent of UnitedHealth Group's profits.

Federal law requires insurers to spend 80 to 85 percent of the premium dollar on health care services, known as the *medical loss ratio* (MLR), while retaining 15 to 20 percent for administrative costs and profit. Insurers can retain more of the premiums they collect when they own the providers that are paid by the total premium dollar. Vertically integrated insurers are accruing more revenue than the 15 to 20 percent of the MLR by using an accounting tool called *intercompany eliminations*,[22] which allows the parent organization in a vertically integrated organization to transfer revenue earned from one part of the company (such as physician groups or a specialty pharmacy) back to the parent organization—in this case, the insurer. The insurer

[20] Whaley et al., 2021.

[21] Bob Herman, "Profits Swell When Insurers Are Also Your Doctors," Axios, July 16, 2021.

[22] AccountingTools, "Intercompany Eliminations Definition," February 6, 2023; Code of Federal Regulations, Title 26, Internal Revenue; Chapter I, Internal Revenue Service, Department of the Treasury; Subchapter A, Income Tax; Part 1, Income Taxes; Effects on Corporation; Section 1.1502-13, Intercompany Transactions.

eliminates from its financial statement revenues, costs of goods sold, and profits from one entity to another within the insurer's group of organizations. This creates strong incentives for the insurer to steer its members toward its own providers to maximize profit.

What Is Known About the Impact of Consolidation on Cost and Quality of Health Care?

Proponents of vertical integration have argued that integration will lead to benefits, including increased efficiencies through the lowering of administrative costs through economies of scale; the ability to devote more resources to improving care delivery infrastructure, such as clinical care redesign, more quality-improvement staff, investment in interoperable health information technology capabilities to improve communication, and investment in enhanced analytics; and improved clinical integration and coordination of care across providers within a health system, resulting in improved quality of care and better patient outcomes.

However, evidence shows that vertical integration of hospitals or health systems with physician practices does not lower spending and does not improve quality of care.[23] Instead, vertical integration leads to increased spending due to shifts from lower-cost to higher-cost treatment settings and due to increases in payment rates to providers because of increased negotiating power.[24] Increases in payment rates can translate to higher premiums paid.[25] Quality does not improve.

Let me share a few examples of what our research has found:

- Shifting care to the hospital outpatient department following vertical integration creates an "arbitrage opportunity" to increase payments to the health care organization.[26] For many types of services, such as imaging procedures, cataract surgeries, and colonoscopies, providing the same service in the hospital is much more expensive than providing it outside the hospital, such as in a freestanding imaging center or an ASC. This is because the hospital receives both the physician professional fee and the hospital

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[23] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending," *Health Affairs*, Vol. 33, No. 5, May 2014; Levin, Komanduri, and Whaley, 2023; J. Michael McWilliams, Michael E. Chernew, Alan M. Zaslavsky, Pasha Hamed, and Bruce E. Landon, "Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries," *JAMA Internal Medicine*, Vol. 173, No. 15, August 2013; Ridgely, 2021; Kirstin W. Scott, E. John Orav, David M. Cutler, and Ashish K. Jha, "Changes in Hospital-Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care," *Annals of Internal Medicine*, Vol. 166, No. 1, January 3, 2017.

[24] Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics*, Vol. 59, May 2018; Hannah T. Neprash, Michael E. Chernew, Andrew L. Hicks, Teresa Gibson, and J. Michael McWilliams, "Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices," *JAMA Internal Medicine*, Vol. 175, No. 12, December 2015.

[25] Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs*, Vol. 37, No. 9, September 2018.

[26] Michael E. Chernew, "Disparities in Payment Across Sites Encourage Consolidation," Health Services Research, Vol. 56, No. 1, February 2021.

facility fee for the service provided. To illustrate, having cataract surgery performed in the hospital outpatient department costs about $6,200, as compared to $1,500 in an ambulatory surgery setting. These site-of-care payment differentials are larger among commercial payers. In a recent study by Christopher Whaley and colleagues, vertical integration changed patient referrals, shifting them away from ASCs to hospital outpatient departments, where providing the treatment was more expensive.[27] After integration, vertically integrated surgeons were 10 percent less likely to send patients to an ASC and 18 percent less likely to use an ASC at all.

- We observe similar changes for the Medicare population. For ten common lab and imaging services, vertically integrated physicians shifted referrals from freestanding testing providers to hospital-based testing facilities, which were more expensive. Across the ten procedures, vertical integration led to a $73 million increase in Medicare spending.[28]
- In unpublished research, my team compared the quality and total cost of care performance of physician organizations that were vertically integrated with health systems to physician organizations that were independent. Our study used Medicare data, and we examined physician groups nationally. In brief, we found no differences in quality performance. Total cost of care was similar between physician groups that were vertically integrated and those that were not, averaging $10,000 per year per beneficiary.

Studies examining the effects of horizontal consolidation of hospitals show that consolidation leads to higher commercial prices. The literature largely shows no effect on or declines in quality of care,[29] even though the stated goal of consolidation is to improve clinical outcomes. I provide examples from two studies:

- A 2019 study examined the cost and quality impacts on rural hospitals following horizontal consolidation with hospital systems.[30] After consolidation, rural hospitals experienced a significant reduction in on-site diagnostic imaging technologies, the availability of obstetric and primary care services, and outpatient nonemergency visits, losing important access to these services. No changes were observed in patient-reported experience with care and 30-day all-cause readmissions to the hospital. However, rural hospitals experienced a significant increase in operating margins (by 1.6 to 3.6 percentage points from a baseline of −1.6 percent).

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[27] Michael R. Richards, Jonathan Seward, and Christopher Whaley, "Treatment Consolidation After Vertical Integration: Evidence from Outpatient Procedure Markets," RAND Corporation, WR-A621-1, 2020, https://www.rand.org/pubs/working_papers/WRA621-1.html.

[28] 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, May 2021.

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- In another recent study of hospital horizontal consolidation, the researchers found that hospital acquisition was associated with a decline in patient-reported experience with care and no improvements in quality (as measured by hospital readmissions, mortality rates, and clinical processes of care).[31]

Studies examining the effects of horizontal consolidation of insurers show that as insurers gain market power, they are able to obtain lower prices from providers.[32] While lower prices paid to providers should translate into lower premiums, evidence shows that insurers with greater market share charge higher premiums when faced with less competition.[33]

Why Are We Not Seeing the Promised Benefits of Vertical Integration in Improving Quality of Care and Health Outcomes?

Consolidation is not clinical integration, which requires sharing of information, coordinated and streamlined transitions between care settings, and effective handoffs.[34] Organizations have figured out how to financially and structurally integrate, but clinical integration has proven challenging.

Health system leaders told us that clinical integration largely has not been achieved and that care is not standardized across entities within their systems, despite the promise of better integration and care coordination when the different actors delivering care operate under one organization.[35] They stated that changing physician practice patterns is challenging, involving changes in leadership and culture, as well as information transfer. Executives recognize that they need to advance clinical integration, but accomplishing it is many years out, and in the meantime, we will be paying more for care with no improvement in quality. Executives emphasize that they continue to operate in a fee-for-service payment world; the pace at which value-based payment is being implemented may be too slow to support the desired transformation of health care delivery.

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Conclusion

In closing, health care consolidation is a major problem in the U.S. health system. It reduces competition and contributes to increased health care spending. It also has not yielded improvements in quality or health outcomes for patients. When hospitals and doctors face less competition, they charge higher prices without improvements in quality. This is also true for insurers, which charge higher premiums when faced with less competition. Lack of competition stifles innovation that could reduce spending or improve patient outcomes. Competition creates incentives to have both lower prices and higher quality; consolidation removes the quality-improvement incentive and, thus, leads to worse outcomes.[36]

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THE VOICE FOR HEALTH CARE CONSUMERS

Our Health Care System Has Lost Its Way: Why U.S. Health Care Is Unaffordable and Low Quality

June 2022

Every person in the United States should have high-quality, affordable health care that prevents illness, allows them to see a doctor when needed and helps to keep their families healthy. Americans should never have to choose between going to the doctor and putting food on the table for their family, regardless of their color, their gender or where they live. Yet, nearly half of all Americans have reported having to forgo medical care due to the cost, and a third have indicated that the cost of medical care interferes with their ability to secure basic needs like food and housing.[1] The rising cost of American health care has created an affordability crisis for our nation's families, workers and consumers. Simply put, our health care system has lost its way.

For far too long, high and rising health care costs have crippled the ability of working people to earn a living wage. Today's real wages — wages after accounting for inflation — are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[2] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[3]

NEARLY **1/2** of all Americans have reported having to forgo medical care due to the cost.

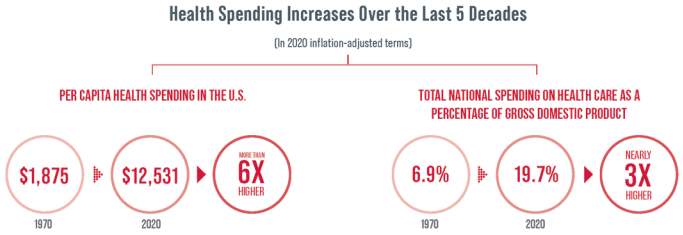
1/3 of Americans say the cost of medical care interferes with their ability to get basic needs met like food and housing.

The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries.

While the availability of affordable health care has decreased, medical debt has increased for our nation's families. Nearly 18% of people in the U.S. have medical debt that has been turned over to a collection agency, and for the first time, the amount of medical debt in collections surpassed that of nonmedical debt.[4] Clearly, the United States is losing the battle on health care affordability.

Per capita health spending in the U.S. has increased more than sixfold over the last five decades, from $1,875 per person in 1970 to $12,531 per person (in 2020 inflation-adjusted terms). During that same time period, total national spending on health care as a percentage of gross domestic product (GDP) increased from 6.9% in 1970 to an astounding 19.7% in 2020.[5,6] That means that health care accounts for about one-fifth of the nation's economy.[7] This excessive growth in costs is primarily driven by paying higher prices than anywhere else in the world for health care, including prescription drugs, hospital stays, specialty care, MRIs, CT scans, births and time in the intensive care unit.[8]

Notably, the high cost of health care generally does not buy Americans higher-quality care or even higher volumes of care. In fact, the opposite is true. The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries. One of the best indicators for health outcomes is amenable mortality — the measure of treatable and preventable deaths that could be avoided with timely and effective interventions. The U.S. has a score of 81, faring far worse than most other industrialized countries and tied with Estonia and Montenegro.[9] In other words, despite the fact that the U.S. spends nearly one-fifth of its economy on health care, the system fails to provide timely and effective interventions to save Americans' lives. Health care acquired infections (HCAIs) are another indicator of health outcomes and are one of the top 10 causes of death in the U.S., causing more



ABOUT 1/5 of the nation's economy is spent on health care, and yet the U.S. has some of the worst health outcomes.

72,000 PATIENTS DIE every year in the U.S. from preventable health care acquired infections.

than 72,000 patients to die each year.[10] Furthermore, the U.S. has the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[11] These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[12]

These abysmal health outcomes and extraordinarily high prices are the product of broken financial incentives within the U.S. health care system. The health care system siphons money out of workers' paychecks and into building C-suites of big health care corporations to then increase health care prices. The health care system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, well-being and financial security of the community. As a result, the economic freedom of Americans is being eroded. We cannot afford to retire when we want, live in the home of our choice, send our children to college or even meet basic needs, like paying for rent, heat or food.[13,14]

This economic waste resulting from excessive health care spending also has created an economic crisis for the federal government, state governments and taxpayers.[15] Every day the waste in our health care system limits our ability as a nation to educate our children, protect our neighborhoods, care for our elderly and build critical infrastructure like bridges and roads.

The problem: Broken financial incentives

There are two principal financial drivers of unaffordable, inequitable health care and poor health for the American people:

1. **High health care prices driven by big health care corporations and medical monopolies.**
2. **Fee-for-service economics as the predominant payment model in the U.S. health care system.**

High health care prices

There is long-standing evidence that the excessive cost of health care in the United States relative to peer countries is driven by paying much higher prices than in any other country, rather than receiving better health care. These high prices have gotten worse in recent years because of health care industry consolidation that has eliminated competition and led to monopolistic pricing. This consolidation has taken place without meaningful regulatory oversight or intervention.[16] These higher prices result in $240 billion annually coming out of workers' paychecks and becoming profits for large health care corporations.[17,18,19]

These unjustified prices in America occur across health care goods and services, including prescription drugs, hospital stays, MRIs and CT scans. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in the U.S. as in the United Kingdom and almost twice as expensive as in Germany.[20] The average price of a hospital-based MRI in the U.S. is $1,475.21 That same scan costs $503 in Switzerland and $215 in Australia.[22] These higher prices for an identical service are the main driver of the dramatic increase in per capita health care spending in the U.S., where health care accounted for nearly 20% of the nation's GDP in 2020, far exceeding health care spending by any other industrialized country.[23]

Health Care Industry Consolidation Has Led to Uncontrolled Price Hikes That Families Are Left to Bear

Hospital Costs Are:

NEARLY 1/3 of national health care spending.

Growing 6X FASTER than Americans' paychecks.

Hospital costs, in particular, have increased dramatically in the last decade and make up a large portion of increasing health care costs.[24,25] These overall cost increases have occurred despite lower hospital utilization and are largely due to higher prices, which are the result of hospitals buying other hospitals and community doctors to eliminate competition and form big health care corporations and medical monopolies.[26,27] Americans in many communities have watched as hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and policymaking community have not realized is how much this has destroyed any real competition in our health care sector; and even fewer realize that hospitals are dramatically increasing their prices every year.[28,29] In fact, in the last 10 years, hospital prices have increased as much as 31% nationally, and hospital costs account for nearly one-third of national health care spending and are growing six times faster than Americans' paychecks.[30,31,32] Importantly, these higher prices have not improved our nation's health.[33]

Despite its flaws, the only real effort to establish a fair price for health care in this country is through the Medicare program.[34,35] In most instances, the prices established for Medicare services become the basis for the prices paid by Medicaid and commercial insurers, expressed as a percentage of the Medicare price (for example, 100%, 150%, etc. of the Medicare established rate).[36,37]

Most people in our nation of working age receive health care through their employers and private insurance.[38] Unfortunately, private health insurance companies have done a terrible job

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negotiating a fair price for health care services, and these health plans often have their own conflict of interest because their long-term margins or profits are directly proportionate to the total amount of money collected for health care services.[39]

As a result, study after study shows that commercial health care prices that drive up premium costs for most working-age people and families are growing much faster than Medicare payments. In 2020, privately insured consumers and employers paid on average nearly two and a half times what Medicare would have paid for the same hospital and outpatient services.[40,41,42] In some states, employers and private health plans paid on average nearly three and a half times what Medicare pays for hospital inpatient and outpatient services.[43]

Even among private insurers, health care prices vary widely without justification. For example, commercial insurance prices for the exact same hospital or physician services in monopolistic markets like Florida, South Carolina, Tennessee and West Virginia can be almost twice as much as the exact same services in Arkansas, Michigan and Rhode Island.[44] The average price for a knee replacement for a patient in Tucson, Arizona, is $21,976, while the same procedure would cost about $60,000 in Sacramento, California.[45] Even prices in a single hospital system vary significantly across payers. For example, the price of an MRI at Massachusetts General Hospital in Boston, Massachusetts, ranged from $839 to $4,200 depending on the insurance carrier.[46]

This unchecked increase in what health care corporations charge insurance plans results in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance through their employer or directly from a health plan.[47,48] The irrationality and out-of-control growth in commercial health care prices also underscore the broken economic incentives within the health care system that allow plans, providers and drug companies to amass unchecked market power and unscrupulously increase prices to generate profit or margin without any link to improving the health of the people and communities they serve.

Price for a Knee Replacement

$21,976

PATIENT IN TUCSON, ARIZONA

$60,000

PATIENT IN SACRAMENTO, CALIFORNIA

This unchecked increase in what health care corporations charge insurance plans results in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance through their employer or directly from a health plan.

Fee-for-service economics

The fee-for-service (FFS) payment model has long been the predominant model for how health care in the U.S. is reimbursed and is used to pay doctors, hospitals, nursing homes and other health care providers. In this model, health care providers are paid for each service or health care product they provide. The health care industry often argues that FFS payments allow providers to do what they think is best for patients — that FFS does not create any conflict of interest between providers and patients. However, this simply is not true. FFS economics are a major driver of unaffordable, inequitable and low-quality care, and they are at odds with the interests of families and consumers.[49]

FFS payment incentivizes providers to make money by doing more, particularly high-profit or high-margin procedures, rather than allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.[50] For

Fee-for-service payment incentivizes providers to make money by doing more, particularly high-profit or high-margin procedures, rather than allowing providers to generate a profit or margin based on keeping people healthy and reducing disparities.

WHAT FEE-FOR-SERVICE LOOKS LIKE IN PRACTICE

Payment for Physician-Administered Prescription Drugs

Medicare payments for physician-administered drugs, like those that can treat cancer or serious autoimmune problems, demonstrate the distortions created by FFS economics. Under this model, Medicare bases payment for physician-administered drugs on the prices charged for products grouped into a single billing code. Then an additional 6% of the average sales price of the drug is added to the price for that billing code. This means that if a patient goes to the doctor's office to receive a drug, the doctor makes more money when the doctor chooses the more expensive drug[51] — and these drugs can be very expensive.

For example, Ipilimumab — a drug that treats melanoma — costs $120,000 for four doses.[52] The result is that physicians with unilateral control over which medicines they use are paid more when they choose a drug and billing code with a higher price. Providers are incentivized to make decisions about which drugs to administer to their patients based on the ability to generate higher reimbursement rather than the clinical effectiveness and value of that drug to the consumer. **Research indicates that doctors, and oncologists in particular, chose the drugs that give them the most money.**[53,54,55]

A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.

example, the U.S. health care system incentives more surgeries, hospital admissions and tests, without any real link to the quality of care. Fees for hospital admissions, procedures, office visits and tests are priced too high, and fees for answering patient questions or sending a health worker to the home are priced too low or at zero.[56] Patients can be billed for each additional service, driving up the cost of their care.[57] A 2017 survey of physicians found that 25% of tests and 11% of procedures were considered unnecessary medical care, and over 70% of physicians believed that doctors are more likely to perform unnecessary procedures when they profit from them.[58]

It is well established that 80% to 90% of what drives variations in peoples' health is determined by the health-related socioeconomic and environmental factors in their lives, yet the predominant model for how health care is paid for in the U.S. offers no payment for addressing the social determinants of health.[59] By definition, FFS payment provides a very narrow view of health and health care by signaling to providers that they can only be reimbursed for delivering the clinical care that drives

WHAT FEE-FOR-SERVICE LOOKS LIKE IN PRACTICE

Choosing Wisely to Avoid Expensive and Useless Care

The Choosing Wisely initiative — created by the American Board of Internal Medicine's ABIM Foundation — highlights how FFS payment encourages health care providers to prescribe unnecessary health care services. The goal of the effort is to identify and reduce overused tests and treatments to improve the quality of health care. Through the initiative, more than 600 recommendations of overused tests and treatments were identified by more than 80 medical specialty societies in an effort to reduce the prevalence of low-value health care. For example, the effort resulted in reducing the use of low-value imaging for lower back pain by up to 60% in some medical centers and clinics.[60,61]

Almost all the providers reimbursed by Medicaid managed care or Medicare Advantage are still faced with the same perverse incentives to do more — often low-value care — to drive up profit or margin.

10% to 20% of health.[62] By offering no payment for services that address the social determinants of health and paying so much for hospital admissions and procedures, the economic incentives of FFS actually work against the professional responsibilities and desires of providers to improve health or reduce disparities.

Despite these flawed incentives, FFS continues to be the predominant payment model for health care services across payers. Importantly, even those health insurers that purport to use value-based contracts, such as Medicaid managed care plans and Medicare Advantage, are still using FFS as the underlying reimbursement system for the vast majority of care delivery.[63] This means that almost all the providers reimbursed by Medicaid managed care or Medicare Advantage are still faced with the same perverse incentives to do more — often low-value care — to drive up profit or margin.

It is critical for policymakers to closely examine supposed value-based care contracts to understand if they fundamentally shift away from FFS economics or if those payers actually have built new service delivery on top of broken FFS incentives that only serve to drive unaffordable, low-quality care that fails to meet health needs and increases economic instability for our nation's families.

CASE STUDY

The Impact of COVID-19 on the Health Care System

During the pandemic, health care providers and organizations worked to respond quickly to provide an effective COVID-19 response. Health care providers who are reliant on fee-for-service payment experienced dramatic and persistent revenue shortfalls as a result of the severe disruption of face-to-face visits caused by the pandemic. These revenue shortfalls threatened the collapse of entire sectors of our health care system, primary care being the most notable example. Primary care practices experienced declines of up to 50% in service volume, putting nearly 30% of these practices at risk of going out of business,[64] thereby jeopardizing access to primary care at a critical time.

Throughout the pandemic, FFS payment — payments based on the number of services or tests ordered — offered no protection to health care providers when the number of in-person visits dropped, putting access to health care at risk at a time when people needed it most.

Providers and health systems participating in efforts to transform their compensation structure to what is referred to as value-based payment have been more financially stable during the pandemic, particularly those that use alternative payment models, which allow providers to receive upfront, ongoing payments not tied to FFS. Practices receiving these alternative payments were able not only to have a more effective pandemic response but also to build a wide range of capabilities critical to effective prevention of COVID-19 hospitalizations and deaths that are not well supported under the current volume-based payment structure of FFS. These preventive measures included paying for care coordination staff; addressing the social determinants of health; spending more time with patients to discuss pandemic risks and vaccines; creating patient engagement tools, including mobile phone apps and 24/7 help lines; performing robust data analysis; and building infrastructures to support telehealth, remote monitoring and home-based care.[65]

Providers who are reliant on the existing FFS payment system have had to rely on Congress and the federal government to make policy changes to have an effective COVID-19 response and to move forward with such innovations.[66] COVID-19 has been a stark reminder that we need to transform the way we pay for health care to better support the delivery of high-quality, affordable health care to improve the health of our nation's families.

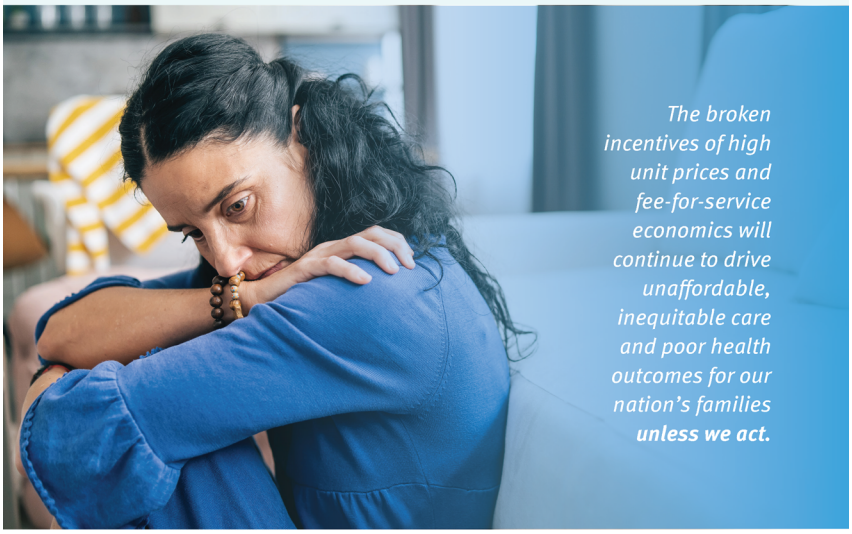
The need for policy solutions

As described above, health care payments are largely driven by Medicare and other payment policy. It is past time to implement policy changes that will make health care affordable and allow our nation's families to get the health and health care they deserve. These new policy efforts need to happen in the U.S. Congress and the federal administration as well as in state capitols and by governors. There are both short- and long-term policy solutions that will begin to fix the broken incentives in the health care system that are driving the nation's health care affordability and quality crises.

In the short term, policymakers should focus on ending the health care sector's pricing abuses and introducing real competition by reining in monopolistic behavior in the health care industry, a result of industry consolidation. Policymakers should also ensure there is a great deal more transparency around both the cost of care and health care outcomes, including for vulnerable populations living in rural America, people of color, etc. **In the intermediate to long term,** policymakers should focus on redesigning the economic incentives of the health care sector to be aligned with consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

Policy Solutions Already Underway

- Passage of the No Surprises Act and current implementation efforts.
- Authority for Medicare to negotiate prescription drug prices.
- Development of all-payer claims databases and other efforts to ensure data are available to understand health care costs and outcomes.
- Implementation of the Hospital Price Transparency and the Transparency in Coverage Regulations.
- Prohibition of anti-competitive behaviors like "gag" clauses through passage of the Consolidated Appropriations Act of 2021, and efforts to ban other anti-competitive behavior like "all-or-nothing" clauses and "anti-steering" or "anti-tiering" clauses.
- Proliferation of state affordability and cost boards and all-payer claims databases.
- State efforts to codify hospital price transparency regulations into law.
- Implementation of new payment and delivery reform models, such as Primary Care First; the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) model; and the oncology bundled payment model.
- Global hospital budgets and all-payer rate setting models in Maryland, Pennsylvania and Vermont.
- Increased oversight and enforcement over mergers and acquisitions by the Federal Trade Commission and the U.S. Department of Justice.
- Development of new community-based entities, like coordinated care organizations in Oregon, to establish health care targets and redistribute health care dollars into community-identified needs, with cost and quality targets.



Conclusion

There are so many talented women and men who work in the U.S. health care system. But, because of the underlying financial incentives, we continue to spend much more on health care than other nations and have poorer outcomes, and our nation's and families' economic security is threatened. It is clear our health care system has lost its way. The broken incentives of high unit prices and fee-for-service economics will continue to drive unaffordable, inequitable care and poor health outcomes for our nation's families unless we act. Given the entrenched interests of health care corporations in maintaining the status quo, it will require a national consumer-driven movement to make needed policy change. Almost every year, the percentage of our national spending that flows into the health care sector grows and makes it politically harder for policymakers to change the status quo. We must act now if we are going to redesign our health care system to ensure it serves the needs our nation's families.

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Our health care has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills

Peoples First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high quality care for all.

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VAL2022-59

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Bleeding Americans Dry: The Role of Big Hospital Corporations in Driving Our Nation's Health Care Affordability and Quality Crisis

September 2022

Hospitals are essential to the U.S. health care system and to the communities they serve. They provide lifesaving services for acute and complex conditions. They also provide critical training for doctors, nurses and other health care providers, and are an important source of jobs for our nation's workers. But the role of hospitals in our economy has shifted in disturbing and destructive ways over the last 60 years.[1] What were once local charitable institutions built to serve the community have now become large corporate entities focused on maximizing revenue rather than improving health.[2] Fundamentally, the business interests of the hospital sector are not aligned with the interests of the patients they serve. These misaligned incentives are a fundamental driver of our nation's health care cost and quality crisis.

There is long-standing evidence that the excessive cost of health care in the United States relative to peer countries is driven by Americans paying much higher prices than any other country rather than receiving better health care.[3] These high prices have gotten much worse in recent years because of health care industry consolidation — particularly among hospitals — that has eliminated healthy competition and led to monopolistic pricing. Consolidation has taken place without meaningful regulatory oversight or effective intervention.[4] Importantly, these higher prices result in more than $240 billion of waste annually and account for more than one-quarter of total wasteful spending — $900 billion — that is generated in the U.S. health care system on an annual basis.[5] This wasteful spending resulting from high prices

ultimately comes directly out of workers' paychecks (typically as annual increases in employer-sponsored health insurance premiums and cost sharing) and becomes profits or margins for large health care corporations.[6] The rising cost of American health care is crippling our nation's families forcing more than 100 million people into health care debt across the nation with 63% having to cut spending on food, clothing and other basic necessities because of this debt.[7]

What makes the extraordinarily high cost of our hospitals particularly egregious is how little that money buys us. The U.S. has some of the worst health outcomes, lowest levels of access to care and greatest inequities compared with other industrialized countries. One of the best indicators for health outcomes is amenable mortality — the measure of treatable and preventable deaths that could be avoided with timely and effective interventions. The U.S. fairs worse than most other industrialized countries and is tied with Estonia and Montenegro with a score of 81.[8] In other words, despite the fact that hospital and physician care account for half of U.S. health care spending,[9] the system fails to provide timely and effective interventions to save Americans' lives. Given that hospitals are on the front lines of providing care to our nation's families, it is even more jarring that health care acquired infections (HCAIs) are one of the top 10 causes of death in the U.S., with more than 72,000 patients dying each year, despite billions of federal and state dollars being spent to reduce hospital infections.[10] Our health care system also has worse health outcomes than other advanced countries as evidenced by having the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[11,12] These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[13] Our current system is simply not acceptable. We can do better.

U.S. Health Care Industry Consolidation Has Led to

UNCONTROLLED PRICE HIKES THAT FAMILIES ARE LEFT TO BEAR

+

WORSE HEALTH OUTCOMES

Example

72,000 DEATHS PER YEAR FROM HOSPITAL ACQUIRED INFECTIONS

+

(COMPARED TO OTHER ADVANCED COUNTRIES)

Examples

HIGHEST RATES OF INFANT MORTALITY

HIGH RATES OF PREVENTABLE DEATHS FROM HEALTH SYSTEMS FAILING TO PROVIDE TIMELY & EFFECTIVE CARE

The business model of big hospital corporations is in conflict with the interests of our nation's families

We have all watched in our communities as hospitals have become health systems, and those health systems have been bought by large health care corporations. These large health care corporations have destroyed competition in our health care sector, and hospitals are dramatically increasing their prices year after year.[14, 15] The core business model of health care corporations is to generate high volumes of tests and procedures through fee-for-service payment, the predominant payment model in the U.S. health care system, and to generate the highest possible fees (price) for each service.[16] A key strategy in hospitals' current business model is to generate profit by buying up other hospitals and doctor's offices to become large corporate health care systems that maximize service volumes and increase health care prices. The financial incentives of the hospital business model — to buy up local competition so that the hospital can engage in anticompetitive behavior, price gouging and to increase volume on fee-for-service payment — is costly, wasteful and bad for our communities' health.[17, 18, 19] The imperative to generate lots of the priciest hospital services is in direct conflict with ensuring that consumers and patients have the best health and the affordable health care they deserve.

This "revenue above all" business model has been in full swing over the last 30 years. There has been dramatic consolidation in the health care sector, which has resulted in most geographic areas across the country being dominated by large corporate health care systems that can unscrupulously drive up health care prices.[20, 21, 22] Since 2010, more than 1,600 hospitals have merged, and the number of doctor's offices being bought by health care monopolies has increased dramatically, with more than half of all physicians now being employed by hospital-owned practices.[23, 24, 25, 26, 27] This growth in big health care corporations is the primary cause of the high and variable health care prices that are driving our nation's affordability crisis. Since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[28, 29, 30, .] Unfortunately, these higher prices have not improved our nation's health.[31, 32, 33]

High and variable hospital prices

The prices that health care systems charge for medical tests and procedures should reflect their cost, efficacy and quality, not whatever hospitals can get away with charging for those services. Ultimately, hospitals should be allowed to generate revenue because they are providing the best care and have the best health outcomes for the patients they serve. Yet this is not how the hospital business model currently operates. The U.S. spent nearly 20% of its gross domestic product on health care in 2020, far exceeding spending on health care by any other industrialized country.[34] These high costs have occurred despite lower hospital utilization and are largely due to price increases, which are the result of industry consolidation and the expansion of big health care corporations described above.[35, 36]

Consider how health care prices in the U.S. compare with other wealthy nations, which enjoy much better health outcomes. For example, the average price of a hospital-based MRI in the U.S. is $1,475.[37] That same scan costs $503 in Switzerland and $215 in Australia.[38] Or take the price of coronary bypass surgery. Despite the fact that the U.S. performs fewer bypass surgeries compared with other industrialized countries, the average price of coronary bypass surgery in the U.S. is $78,318. That same procedure costs $28,888 in Australia and $24,059 in the United Kingdom.[39] These higher prices for an identical procedure are the main reason that U.S. per capita health care spending is so much higher than that in other countries and has increased so quickly.

The High Price of U.S. Health Care Compared With Other Wealthy Nations

Average Price for an MRI

$1,475

UNITED STATES

$503

SWITZERLAND

$215

AUSTRALIA

The prices that health care systems charge for medical tests and procedures should reflect their cost, efficacy and quality, not whatever hospitals can get away with charging for those services.

THE STORY OF SUTTER HEALTH: NORTHERN CALIFORNIA'S DOMINANT HEALTH SYSTEM

Over the course of several decades, the not-for-profit Sutter Health system consolidated and bought its way into becoming a major health care system with dominant control in the northern part of California. The system includes 24 acute care hospitals, 36 ambulatory surgery centers, and 16 cardiac and cancer centers. As Sutter gained market power, the health system engaged in hard-nosed business practices that had the effect of limiting its competition, including "all or nothing" contract requirements, which require an insurer to contract with all health system's facilities or none (driving up volume and price), and opaque pricing that resulted in prices in Northern California growing four times faster than prices across the rest of the state between 2004 and 2013.[40] In fact, hospital prices in Northern California are some of the highest in the country and substantially higher than in neighboring Southern California.[41]

As a result, Sutter was sued for engaging in anti-competitive business practices, including two major recent antitrust lawsuits: one in federal court and one in state court. The first, *Sidibe v. Sutter Health*, was a class-action lawsuit filed in 2012 in federal court in San Francisco.[42] Before the case was tried in early 2022, the district court dismissed it twice, but both dismissals were then reversed on appeal.[43] The second case, *UEBT v. Sutter Health*, was a class-action lawsuit filed in 2014 in state court in San Francisco. Additionally, *The People of California v. Sutter Health* was filed by then-Attorney General Xavier Becerra in 2018 in state court and was then consolidated with the UEBT case.

At a high level, these cases made similar allegations: Sutter had gained unfair market advantage and was engaging in anti-competitive practices to abusively set and increase prices in contract negotiations.[44, 45, 46] Facing two lawsuits, one backed by the state attorney general (a very rare occurrence), Sutter settled the consolidated state case with UEBT and the attorney general in 2019, agreeing to compensate plaintiffs in a cash settlement of $575 million and to change its anti-competitive and monopolistic business practices.[47] This was a major victory for consumers and an important demonstration of the anti-competitive and monopolistic behavior of large hospital systems and how that behavior hurts access to care. Sutter won the second case, the federal case, which was focused more narrowly on the legality of the contract terms as opposed to the state case that focused more broadly on the impact of these practices over time and the anti-consumer effect.[48, 49] The plaintiffs in the federal case have filed an appeal.[50] The outcomes of these two landmark cases will now be used in antitrust case law moving forward.

High hospital prices increase costs of employer-sponsored health insurance

Most Americans of working age receive health care coverage through their employers and through private insurance.[51] Unfortunately, private health insurance companies have failed to negotiate a fair price for health care services, and these health plans often have their own conflict of interest because their long-term margins are directly proportional to the total amount of money collected for health care services.[52] Each year price gouging by hospitals continues to be allowed by insurers and policymakers, and families and individuals then must pay more in health insurance premiums and cost sharing, which come directly out of their paychecks. Premium increases in particular are often "hidden" from workers because premiums are automatically deducted from their paychecks, and workers almost never know the total cost of health insurance. In the end, pricing abuses in health care, including high hospital prices, cost American workers an estimated $240 billion in wasteful spending alone each year.[53] As a result, workers see smaller or no increases in their salaries, and it becomes more difficult for them to afford where they live, pay their day-to-day expenses, send their children to college and be able to retire.[54, 55, 56]

Study after study shows that commercial health care prices — prices negotiated between hospitals and insurers — are growing much faster than Medicare payments, which involve a federal administrative price-setting process. In 2020, privately insured consumers and employers paid on average nearly two and a half times what Medicare would have paid for the same hospital inpatient and outpatient services.[57, 58, 59] In some states, employers and private insurance plans pay on average nearly three and a half times what Medicare pays for hospital inpatient and outpatient services.[60]

Health care prices are driven by market power abuses. For example, commercial insurance prices for hospital or physician services in more monopolistic markets like Florida, South Carolina, Tennessee

Price Range for an MRI

$839 – $4,200

Price range for an MRI in a single hospital system (Massachusetts General Hospital, Boston, Massachusetts)

Health Care Prices Are Driven by Market Power Abuses

and West Virginia cost almost twice as much as the exact same services in more competitive markets in Arkansas, Michigan and Rhode Island.[61] The average price for a knee replacement for a patient in Tucson, Arizona, is $21,976, while the same procedure would cost about $60,000 in Sacramento, California.[62] Similarly, prices for identical clinical lab tests such as blood tests are three times higher in hospital outpatient departments than the prices of those same lab tests in a physician office and independent laboratory.[63]

An even more dramatic indicator of how market power drives hospital pricing is that prices in a single hospital system vary significantly across insurers. For example, the price of an MRI at Massachusetts General Hospital in Boston, Massachusetts, ranged from $839 to $4,200 depending on the insurance carrier.[64] These unchecked increases in what health care corporations charge insurance plans result in higher premiums, lower take-home pay and higher cost-sharing requirements for the more than 176 million Americans who obtain health insurance through their employer or directly from a health plan.[65, 66]

Nonprofit tax-exempt status

Unfortunately, the abuses carried out by these medical monopolies include many "nonprofit" hospital corporations. Under federal tax law, nonprofit hospital corporations are granted tax-exempt status premised on the assumption that they provide a community benefit and a public good.[67, 68] By definition, tax-exempt hospital corporations are prohibited from generating and distributing profits. In exchange, tax-exempt status protects billions of dollars in revenue for these institutions.[69] While the Affordable Care Act included new requirements that tax-exempt hospitals report on community need and limit some charges and billing, many nonprofit hospitals continue to charge exorbitant prices for their services, put families' unpaid medical bills in collections and invest in new services

More than 80% of nonprofit hospitals and health care systems spend less on charity care and community investment than the amount they receive through their tax breaks as nonprofit institutions.

and technologies that expand their revenue in lieu of meeting the needs of their communities.[70, 71] More than 80% of nonprofit hospitals and health care systems spend less on charity care and community investment than the amount they receive through their tax breaks as nonprofit institutions — referred to as the "fair share deficit."[72] In 2019, the fair share deficit for those hospital systems totaled more than $18 billion.[73]

When hospitals first received tax-exempt status, they were not the large medical monopolies and revenue centers that they have become today. Historically, community hospitals provided free care to people living in poverty and were primarily funded by donations and staffed with volunteers. But today, these nonprofit hospitals rake in substantial profits. In 2016, seven of the 10 most "profitable" hospital systems were nonprofits, each earning more than $163 million in operating margins from patient care services.[74] Moreover, many of these health systems received hundreds of millions of dollars in COVID-19 relief payments from the CARES Act and ended 2021 with record high incomes and operating margins despite the COVID-19 pandemic.[75, 76] Importantly, many nonprofit hospitals funnel their excess margins into salaries, new equipment, new buildings and lobbying rather than improving the health of their community and providing affordable care. This unchecked revenue also grants hospitals significant political power to preserve their current business model. In 2018, hospitals and nursing homes spent over $100 million on lobbying activities and spent about $30 million on campaign contributions.[77]

High salaries of hospital CEOs

Nowhere is excess in hospital payments more evident than the salaries paid to hospitals' top executives, in both nonprofit and for-profit hospital sectors.

While far too many Americans are making impossible decisions between seeking medical care and feeding their family, the CEOs of many large hospital corporations are raking in millions of dollars in compensation every year.[78] In 2019, the Chief Executive Officer and President of nonprofit Banner Health earned $21.6 million.[79] The health care industry has now become one of the highest-paying nonprofit industries in the country.[80] In 2018, eight of the 10 highest-paid CEOs at nonprofits were from large health care corporations.[81]

While Families Must Decide Whether to Eat or Seek Medical Care, Large Hospital Corporation CEOs' Paychecks Have Skyrocketed

President of nonprofit Banner Health, 2019 Salary

$21.6 MILLION

CEO of HCA Healthcare, 2020 Salary

OVER $30 MILLION

The ability of payment reform to fulfill its promise to transform health care payment and delivery hinges on moving away from fee-for-service (FFS) economics and creating new financial incentives that reward providers for keeping patients healthy and hold providers accountable for the cost of care.

To make matters worse, for-profit companies have taken on a larger role in the hospital industry. The CEOs of for-profit health care systems are earning even more than their nonprofit counterparts. These higher earnings are driven by significant profits and revenue amassed from buying up the competition in communities across the country. For example, Samuel Hazen, the CEO of HCA Healthcare, a 185-hospital system based in Nashville, Tennessee, brought in over $30 million in earnings in 2020, while the hospital system ended 2020 with a profit of $3.8 billion on revenue of $51.5 billion.[82,83] These billions of dollars in hospital profits were accrued while nearly half of Americans had to forgo medical care due to the costs of care and a third had health care costs that interfered with their ability to secure basic needs like food and housing.[84] Moreover, as the CEO salaries of these medical monopolies increase, the wages of the health care workers in their hospitals go down. For example, wages for nurse and pharmacy workers have been shown to decrease by nearly 7% after mergers of these large health care corporations.[85]

In the end, these outrageous salaries are factored into hospitals' costs and used as a justification for pricing abuses — one of the important ways that hospitals can "build" to the abusive prices they want to charge. This is a national scandal.

Exaggerated value-based payment claims by hospital corporations

While hospital corporations have been price gouging and paying their CEOs tens of millions of dollars, many of these same hospital corporations and other actors in the health care sector have been aggressively lobbying policymakers and patients about their movement away from fee-for-service and toward important new value-based payment models.[86]

The ability of payment reform to fulfill its promise to transform health care payment and delivery hinges on moving away from fee-for-service (FFS) economics and creating new financial incentives that reward providers for keeping patients healthy and hold providers accountable for the cost of care. Importantly, **non-FFS-based payment reform does hold the promise** of effectively addressing broken hospital incentives that drive unaffordable, low-quality and inequitable care.

However, most hospital claims of engaging in value-based payment are exaggerated or even misleading. Across the nation, the vast majority of hospital payment arrangements are still anchored in fee-for-service economics.[87] For example, over 1,000 hospitals participating in Medicare's voluntary bundled payment program continue to receive fee-for-service payments under this

model.[88] Even more troubling, providers that engage in bundling often aggressively increase volume both in the Medicare and private sectors (for example, putting up billboards in their communities to advertise newly bundled knee replacement services) and have been able to easily "align" with doctors in the bundle and capture more and more market share.[89,90,91] Another example of faux value efforts by the health care sector can be pay-for-performance (P4P) efforts. These types of value-based payment initiatives are heavily anchored in FFS payment and often tie bonus or penalty payments to clinical process measures rather than health outcome measures. Consequently, many P4P programs do little to nothing to reorient financial incentives away from FFS and produce mixed results on improving quality or affordability, despite claims about value.[92,93] In addition, several studies have shown that P4P actually reduces access to care for socioeconomically disadvantaged populations because it incentivizes providers to avoid treating low-income patients who may have unique barriers to achieving improvements in their health.[94] Yet a significant portion of value-based payment efforts are in these types of FFS models.[95]

Further, current estimates indicate that 6.7% of all health care services are flowing through truly redesigned, non-FFS economic incentives that drive toward better care, lower costs and healthier patients.[96] Moreover, only 7% of hospitals have made the switch to population-based payment models or integrated delivery systems.[97,98] As a result, many "value" claims are mostly a spin. These claims about value allow the health care sector to abuse a monopolistic or quasi-monopolistic bargaining position and demand outrageous prices by aligning with doctors for referrals and driving up the volume of tests and procedures. These cynical value claims also distract the public from the pricing abuses that drive revenues.[99]

In the end, despite the promise of payment reform and all the spin about value by the health care sector over the last 10 years, American hospitals continue to buy other hospitals and doctor's offices to increase prices and increase the volume of high-margin services, all at the expense of the health and economic security of our nation's families.

Key solutions are underway to rein in pricing and quality abuses

American families should not be struggling to pay skyrocketing health care costs while health care corporations and CEOs extort skyrocketing profits, salaries and bonuses. It is past time to implement policy changes that will make the health care sector more competitive, make health care more affordable and allow our nation's families to access the health and health care they deserve. Because health care operates through federal, state and local systems, policy solutions must be implemented in the U.S. Congress, the federal administration, state capitols and by governors.

Reining in hospital prices and fixing the broken financial incentives that allow hospitals to drive unaffordable care will require multipronged policy solutions that tackle different sides of the problem: the fee-for-service pricing abuses as well as the underlying financial incentives that are at odds with the interests of patients and families. In the short term, policymakers should focus on implementing policies that rein in abusive health care prices, making health care more affordable. In the intermediate to long term, policymakers should focus on redesigning the economic incentives of the health care sector to be aligned with consumers and families. Congress, state governments and the federal Centers for Medicare & Medicaid Services should work together to reorient health care payment and delivery to the goal that we all have — improved health care for ourselves and our families that is affordable and economically sustainable.

For example, policymakers will need to pursue price transparency polices that work to unveil the underlying price of health care services, which has been hidden as proprietary information in contracts between providers and insurers for far too long. Policymakers will also need to pursue solutions that block hospitals from taking actions that reduce competition in health care markets and result in higher health care prices and premiums, more narrow provider networks and restricted data flow. Other policy solutions will need to focus on challenging hospitals' nonprofit status to ensure these entities are not allowed to make undue revenue while the communities they serve have poor health and are unable to afford care. Policymakers should address abusive hospital pricing by setting hospitals on a "global budget" and leveraging health care cost containment commissions to ensure hospitals are being held accountable for reducing costs while improving population health outcomes.

We must build the consumer movement around these policy solutions to ensure that consumers, employers, workers, health equity leaders and others are coming together as a counterweight to the entrenched business interests and political influence of the hospital industry.

The good news is that elements of these approaches are already underway in Congress and the federal administration as well as in state capitols. Now we must build the consumer movement around these policy solutions to ensure that consumers, employers, workers, health equity leaders and others are coming together as a counterweight to the entrenched business interests and political influence of the hospital industry. Examples of current policy solutions underway include:

Reining in abusive prices and increasing competition to lower health care costs

- Passage of the No Surprises Act in 2020. This law implemented a national ban to protect consumers against the practice known as surprise billing. Surprise medical bills are an important example of the ways large health care corporations engage in abusive pricing practices that increase their profit margins while leaving consumers with unexpected medical bills.
- Prohibition of "gag" clauses passed through the Consolidated Appropriations Act of 2021. Gag clauses were often used as a key tactic by large health care corporations in contract negotiations with health plans to prevent consumers and other payers from seeing doctors' cost and quality data.
- Anti-competitive behavior bans. There are additional national efforts to ban other types of anti-competitive behavior like "all or nothing" clauses and "anti-steering" or "anti-tiering" clauses in contracts between large health care corporations and health plans through the 2019 Lower Health Care Costs Act passed by the U.S. Senate Health, Education, Labor and Pensions Committee.
- Expansion of site-neutral payments. Through passage of the 2015 Consolidated Appropriations Act and subsequent implementation by the Centers for Medicare & Medicaid Services through the annual Hospital Outpatient Prospective Payment System rule, equalizing payments across sites of services has helped to correct long-standing broken financial incentives that allow outpatient hospitals and facilities to receive higher payment for delivering the same services that could be safely performed in a physician's office.
- State cost and affordability boards. A growing number of states are either implementing health care cost and affordability boards or working to pass legislation to establish them. There are various ways to structure affordability boards, but in general these entities establish statewide health care cost targets and analyze market trends in an effort to reduce health care costs and make care more affordable for consumers. Currently, Maryland, Massachusetts and Oregon have some form of affordability board or state health care cost growth targets. California is the latest state to establish an affordability board and includes the strongest enforcement mechanisms to slow state cost growth.[100] Connecticut, Minnesota and Rhode Island are considering legislation on different forms of affordability boards.[101]

- Global hospital budgets. All-payer global hospital budgets are an alternative payment model used to control hospital costs. Under this model, hospitals are paid a prospective amount for all inpatient and outpatient services provided for a patient population and are held accountable for the total cost of care and population health outcomes. Both Maryland and Pennsylvania operate global hospital budget models.[102, 103]

Increasing price and quality transparency to create a more efficient, fair and equitable health care system

- All-payer claims databases (APCDs). APCDs are a critical tool to increase price, cost and quality transparency at the state and national level, and they are an important catalyst for the transformational change needed to drive high-value care in health care markets while lowering consumer costs. Nearly half of states have set up some kind of APCD, with 17 states having mandatory APCD reporting and seven states having voluntary APCD reporting. Another seven states are currently developing APCDs.[104] There have also been efforts to pass federal legislation to establish a national APCD through the 2019 Lower Health Care Costs Act, which passed the Senate Health, Education, Labor and Pensions Committee.
- Hospital price transparency regulation. This regulation requires all hospitals to disclose on their websites the following: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges, as well as a consumer-friendly display for 300 "shoppable" services.[105] Several states are now working to pass legislation to codify the federal regulation into state law. Both Colorado[106] and Virginia[107] have now passed legislation to strengthen state oversight and enforcement of the hospital price transparency regulation.
- Transparency in coverage regulation. This regulation requires group health plans and insurers in the individual and group markets to disclose cost-sharing estimates to consumers and to publicly release negotiated rates for in-network providers, out-of-network allowed amounts and billed charges.[108] The rule was finalized in 2020 and went into effect in July 2022.
  - Both the hospital price transparency and transparency in coverage regulations mark an important step forward in unveiling the underlying prices of health care to ensure that consumers, workers and employers are able to make informed decisions about the cost of health care and that the system is centered on delivering high-value care.

Conclusion

There are so many hardworking doctors, nurses, health care professionals and other front-line workers employed by large health care corporations. So many have committed their life's work to improving the health of our nation. At the same time, they are working for hospital corporations whose business interests are in direct conflict with the health and financial well-being of families across the nation. Because of the way the hospital business model is structured, the lives and financial security of the American people hang in the balance. Americans have worse health outcomes than many other industrialized countries, yet we continue to pay outrageous and ever-escalating health care prices. With each year that passes, hospital corporations consolidate, charge higher prices, consume more of our nation's economic activity and increase their political power.

Given the entrenched interests of hospital corporations to maintain the status quo, it will require a consumer-driven movement to make needed policy changes. It is time to act if we are truly going to ensure the health care system serves the needs of our nation's families.

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Our health care has become so focused on dollars that it undermines the best interest of patients. We need to dramatically rethink how we deliver care so that the focus is on positive health outcomes for patients rather than an endless flow of bills.

Peoples First Care is a series of publications over the coming year that addresses the systemic problems in health care payment and delivery that drive unaffordable, low quality care and poor health, and lays a blueprint for reorienting the health care system to deliver health and affordable, high quality care for all.

People First Care Series: Publication 2

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VAL2022-60

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May 17, 2023

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Large Urology Group Practice Association Testimony for the Ways & Means Health Subcommittee Hearing:
"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets"

Chairman Buchanan and Ranking Member Doggett, the Large Urology Group Practice Association (LUGPA) is honored to submit this testimony to the Ways & Means Committee on how to strengthen the health care system. LUGPA represents 150 urology group practices in the United States, with more than 2,100 physicians who, collectively, provide more than one-third of the nation's urology services. But our focus on public policy is on assisting all independent physician practices and the patients we care for.

The U.S. health care system is becoming increasingly consolidated by large hospital systems, which are buying up their competition, driving up prices and shrouding the cost of care from patients who are paying an increasing share of the bill. Congress and the Biden Administration can help reverse these troubling trends by pursuing several fundamental policies:

1. Enforce the hospital transparency rule, which will empower patients to make prudent decisions on where to get their health care;
2. Support independent physician practices by equalizing payments for similar services across different sites-of-service;
3. Require a minimum level of charity care (e.g. 3.8% -- the average amount provided by for-profit hospitals) for a hospital to earn a non-profit designation to be exempt from taxation and eligible for the 340B drug program;
4. Repeal the inpatient only list;
5. Reform the Stark law to eliminate the prohibition of physician ownership of hospitals and codify and simplify the reforms to value-based entities implemented through regulation in 2020.

American Patients Are Bearing the Brunt of Increasing Hospital Power

An increasing share of healthcare expenditures is being transferred to patients. Individual healthcare expenditures in 2023 are double what they were in 2016. Individual healthcare spend is estimated to increase at 9.9% per annum. The US ranks 19th of the G20 nations in share of healthcare costs borne by patients; only the Czech Republic is higher, with patients paying approximately 50% higher than average—in addition, the rate of increase in the US is amongst the highest in the world.[1]

These healthcare costs are severely economically burdensome to patients. A report from the Kaiser Family Foundation found that nearly 1 in 4 patients diagnosed with cancer will declare bankruptcy or lose their home within 5 years of their diagnosis. In 2022, 38% of Americans report delaying important healthcare decisions due to cost concerns. Even more concerning is that these burdens are disproportionately borne by socioeconomically disadvantaged groups.[2]

Hospital mergers and acquisitions are contributing to rising costs of care[3] Once acquired, physicians have been shown to alter referral patterns to use more expensive hospital services.[4,5] Hospitals have focused on acquiring physician practices because that strategy simultaneously quashes competition in the local market for services such as outpatient surgery and radiation therapy and creates downstream revenue through referrals for surgery and ancillary services. This downstream revenue a physician generates for a hospital employer far surpasses the cost of the employed physician's salary.[5] A few examples, as presented in the Merritt Hawkins 2019 Physician Inpatient/Outpatient Revenue Survey, include urologists generating $2,161,458 while receiving an average salary of $386,000, gastroenterologists generating $2,695,277 while receiving an average salary of $487,000, and ophthalmologists generating $1,440,217 while receiving an average salary of $300,000.[6]

Sadly, patients are not aware that hospitals can mandate that their employed doctors use hospital-owned services that are vastly more expensive and yet may be less convenient and offer no better care.

Site of service payment differentials are an artefact of historical realities that did not anticipate the tremendous technological and clinical innovations which have advanced the complexity and types of care available in outpatient settings and, concomitantly, reduced costs associated with the delivery of that care. Yet, the policy of paying hospitals substantially more (often more than twice as much) for the identical services provided in a physician office, infusion center or ambulatory surgery center (ASC), paradoxically, acts as a disincentive to pursuing innovations that shift care out of the higher cost hospital setting, thereby perpetuating inflationary cost trends and inhibiting patient access.

These payment differentials waste taxpayer and beneficiary dollars and provides mega-hospital systems with additional resources and incentives to acquire physician practices, promote consolidation, limit competition and restrict treatment options for patients. A recent study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70% from July 2012 through January 2018. During that timeframe, hospital acquisitions of physician practices more than doubled. In 2017 and 2018 alone, an additional 8,000 physician practices were acquired by hospitals. The trend is disturbing—with the proportion of independent physicians steadily dropping from 48.5% in 2012 to 31.4 percent in 2018.

This trend should be of great concern to policymakers. The hospitals site of service is vastly more expensive than physician practices, even when furnishing the identical health care services.2[7] As an example, Medicare pays hospitals more than twice the amount as physician offices for the

infusion of the identical drug that requires the same nurse staff time and technical training; i.e. for the CPT code 96413 "Chemo admin; intravenous infusion; up to 1 hr." the HOPD rate is $325.64 vs. the in-office rate of $140.16.

Nonprofit hospitals are abusing their tax-exempt status

Nonprofit hospitals enjoy sizable federal, state and local tax exemptions in exchange for meeting requirements to provide services such as free care for the poor.[8] These hospitals also have access to special federal programs, like the 340B drug discount program, in exchange for the expectation that they adhere to their non-profit obligations and use these programs to support vulnerable patients in underserved communities. Today, about 50 percent of the hospitals in the United States are nongovernment not-for-profit community hospitals.[9] In exchange for their substantial tax savings and goodwill, these hospitals are expected to provide services in the public interest, including free or discounted care and financial assistance to patients who are unable to pay.

We commend the Ways and Means Committee for investigating this issue during last month's Oversight Subcommittee hearing on "Tax-Exempt Hospitals and the Community Benefit Standard." During this hearing, Oversight Subcommittee Chair David Schweikert noted a report by the Kaiser Family Foundation has found that the value of charity care provided by hospitals varies substantially across facilities ranging from 0.1% of operating costs to 7% or more. He also noted that some studies show significant deficits in the community benefits provided as compared to the value of some hospitals' tax-exempt status. Ways & Means Committee Chair Smith also expressed concerns about 340B hospitals providing sufficient community benefits, including charity care for vulnerable patients, and criticized the multimillion-dollar salaries of non-profit hospital CEOs. Several of the hearing witnesses offered recommendations for addressing these issues, such as revising the information included on the Form 990 Schedule H form that hospitals fill out to get a clearer picture of community benefit information.

Recent public reporting by investigative journalists in the New York Times,[10] the Wall Street Journal,[11] and other prominent outlets demonstrate that many not-for-profit hospitals are not fulfilling their mission to serve America's neediest patients.[12] To the contrary, these public reports clearly show that some hospitals are going after the most vulnerable patients through financial duress during hospital intake process and abusive collections practices for unpaid medical bills.[13,14] These stories are even more remarkable when you consider that compliance with recent transparency rules are abysmal, nearly two years after implementation began.[15] A majority of hospitals aren't complying with a CMS rule on price transparency, according to a study published in JAMA. Under the rule, which was finalized in 2019 and took effect in January 2021, hospitals have to publicize their negotiated rates with payers for common services. But early data shows that's often not the case. The study, conducted by researchers at Harvard Medical School, randomly sampled 100 hospitals, as well as the 100 highest-earning hospitals of 2017. Of the randomly selected facilities, 83% were noncompliant with at least one of the rule's requirements. The top-earning hospitals were more compliant but not by much, with 75% noncompliant with at least one requirement.[16]

Even as they do not comply with their obligations borne from their not-for-profit status, these hospitals are increasingly taking advantage of mergers and other business decisions that can actually reduce access and drive up costs for all consumers, without verifiable increase in quality

of care.[17] These types of mergers can deprive communities of critical care and result in workforce wages reductions,[18] even as many hospital executives are seeing massive growth in their income.[19]

Recommendations to Congress and the Biden Administration

1) Enforce the hospital transparency law

The hospital transparency rule had two laudable requirements. First, hospitals have to publish discounted cash prices applicable to all uninsured patients and payer-specific negotiated rates for all services. Additionally, hospitals have to publish price data, including expected out-of-pocket costs, for "shoppable services" such as an X-ray that can be scheduled in advance, in an easily understandable format to facilitate shopping across different sites of care, such as a price estimator tool. Hospitals who fail to comply are theoretically liable for $100 per day per patient. But the law has been rarely enforced. CMS should raise the penalty to $500 per infraction and actually enforce the law for the vast majority of hospitals that remain out-of-compliance.

2) Establish a threshold of charity care in the tax code for non-profit hospital status.

Currently, hospitals do not have to provide a specified level of charity care in order to be categorized "non-profit" and thus exempt from state, local and federal taxation and to be eligible for the 340B drug discount program. A recent study in Health Affairs, whose author testified at Ways & Means in April, documented that for-profit hospitals actually provide about 50 percent more charity care than non-profit hospitals (3.8 percent vs 2.3 percent)[20]. Congress should establish a minimum threshold of bona fide charity care for hospitals to reap the many benefits of their non-profit status, including not paying taxes and being made eligible for hugely profitable 340B drugs which they dispense at substantial markups. What metric for a hospital's non-profit status can be more important than providing indigent patients, needed free care? We suggest a threshold equal to the amount for-profit hospitals provide: 3.8 percent.

3) Close the site-of-service payment disparities

Medicare pays substantially more for services performed on an outpatient basis at hospitals than it does for the same services performed in physician offices and ambulatory surgery centers. This fuels consolidation where these sites can be acquired by hospitals and designated as part of a hospital and paid as such. Congress could eliminate these payment disparities and save $141 billion over 10 years in Medicare. But Congress need not entirely equalize payments to make progress in this area. For example, it could raise physician payments for identical treatments by 25% and lower hospital payments by 50%. This would still provide substantial net savings to the program, but importantly provide much needed resources to physician practices which have received cuts in recent years and confront a decade of payment freezes while hospitals receive compounding market basket payment updates. We do not support the MedPAC recommendation that would cut ASC payments to the physician office rate if just a plurality of volume is provided in the physician office setting. Rather, we recommend keeping the majority rule of physician office volume to trigger lower ASC payments, as is currently the case. The real opportunity for savings is the higher cost procedures that could migrate from HOPD to ASC, where no current site-neutrality payment structure applies.

4) Repeal the Inpatient Only (IPO) List.

CMS recently reversed the reform the Trump Administration had initiated and that was only in the

first year of a three-year phase-in by reinstating the inpatient only list of 298 procedures. CMS simultaneously removed 256 procedures that had been added to the ASC-payable list. This reversal occurred despite the acknowledged blistering pace of technological innovation and the sustained trend of increased volume and complexity of cases safely moving into the outpatient setting such that the healthcare intelligence firm Sg2 projects that 85 percent of all healthcare procedures will be performed on an outpatient basis by 2028. Arbitrarily defining an IPO list creates an unnecessary barrier and presumes that the government knows better than practicing physicians when it comes to determining the appropriate site of service in which to perform a procedure.

Not only does the elimination of the IPO list and expansion of the ASC Covered Procedures List (CPL) promote beneficiary access to safe and convenient sites of care while expanding access to innovation, but it also contributes to significant savings in Medicare spending as surgical procedures in the ASC are paid half the amount as the hospital. ASCs have already saved Medicare $28 billion from 2011 to 20188 and could save much more if physicians had the ability to move appropriate procedures to that setting. This can occur in a more robust way by eliminating the inpatient only list and restoring those procedures to the ASC-payable list. This reform should also include necessary new APC payments in the HOPPS for these procedures, or there will be no way to pay for these procedures.

5) Simplify and Modernize the Stark Self-Referral Law

It has been shown that competition in the healthcare market improves outcomes and reduces costs.[21] Regrettably, acquisition of physician practices by hospitals and the increasing trend of hospitals to form monolithic health systems serves only to stifle that competition. An additional example of this is that physicians are barred from owning hospitals and are subject to antiquated laws enacted 35 years ago. The Affordable Care Act permanently barred new physician-owned hospitals and barred growth of current physician-owned hospitals – as a payoff to the hospital industry, which was asked to accept market basket payment reductions to help fund the insurance expansion.

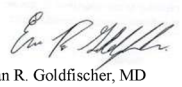
Brian Miller noted as a result of ACA's statutory ban, "more than $275 million of planned economic activity spread across 45 hospital expansion projects ceased. More than 75 new hospitals either planned or under development were prematurely terminated, representing more than $2.2 billion in economic losses. Intangible losses include the loss of the "physician entrepreneur" and user-driven innovation in the face of increasing corporatization of medical practice, both likely contributing to the increase in physician professional dissatisfaction… Premature foreclosure of the POH marketplace inhibited the development of the US version of the "focused factory" model of specialized hospitals or integrated Reversing Hospital Consolidation: model of specialized hospitals or integrated practice units, a feature seen in other markets."[22]

LUGPA worked closely with aligned stakeholders to encourage updating existing regulations governing the Stark statute and strongly supports the administrative reforms made by both CMS and the HHS Office of the Inspector General (OIG) in December of 2020. The OIG administrative changes created three new safe harbors to encourage value-based care models: (1) care coordination arrangements without requiring the parties to assume risk; (2) value-based arrangements with substantial downside financial risk; and (3) value-based arrangements with full financial risk. Essentially simultaneously, CMS adopted revisions to the Medicare self-referral statute also designed to support value-based payment arrangements in the Medicare program. Although these regulatory changes were helpful in advancing the adoption of payment

arrangements that reward value over volume, they remain constrained by the underlying statutes and furthermore, these regulations are complex and hard to understand by providers. As a result, practitioners have been reluctant to enter new or innovative payment arrangements for fear of triggering inadvertent violations of the underlying statutes or investigations by overzealous prosecutors. In addition, adoption of these programs is hampered by logistical challenges for practices remain as compliance is carried out while dealing with real-time patient pressures and practice resource constraints.

LUGPA looks forward to working with the Committee to help improve access, enhance quality and reduce costs for our patients. please feel free to contact Dr. Mara Holton (mholton@aaurology.com) if LUGPA can provide additional information to assist the committee as it considers these issues.

Respectfully submitted,



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[14] See Letter from Senators Warren and Wyden to McKinsey. A recent investigation by the *New York Times* uncovered a deal between Providence and McKinsey that resulted in a plan to use predatory tactics to pressure patients into paying for their care, no matter their income or ability to pay. As a result, more than 55,000 patients were pursued by debt collectors when they should have been offered discounts due to their socioeconomic status. Available at https://www.warren.senate.gov/download/20230220-letter-to-mckinsey-re-nonprofit-hospitals
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NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement
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For

United States House
Committee on Ways and
Means and Subcommittee on
Health

On

"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets"

May 17, 2023
2:00 PM

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Introduction

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record for the Ways and Means Subcommittee on Health's hearing, "Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets." NACDS appreciates the subcommittee's work to explore Pharmacy Benefit Managers' (PBMs) lack of transparency and standardized performance measures, inflationary effects on drug prices, restrictions on patient access, and unfair pharmacy reimbursement practices that threaten pharmacies and the patients who rely on them for access. The prescription drug supply chain is largely controlled and manipulated by the three largest PBM-insurers ("the Big Three"), which has created an unleveled playing field with significant consequences for patients and taxpayers.

Retail pharmacies are critical healthcare access destinations for patients to improve population health. A poll of adults conducted March 4-6, 2022, by Morning Consult and commissioned by NACDS found that retail pharmacies received the highest ratings for ease of access among the destinations tested. Due to the essential access points created by pharmacies, the nation called on pharmacies to deliver COVID-19 testing, vaccinations, and other critical care services to communities during the pandemic. Pharmacies seamlessly rose to the challenge, in large part due to more than a decade of pandemic preparedness and collaborative planning. Consider, the nation's pharmacies administered over 300 million COVID vaccines, performed more than 42 million tests, dispensed nearly 7 million antiviral courses, and were the top provider of over-the-counter COVID tests in CMS' demonstration program. Using conservative estimates, pandemic interventions by pharmacists and pharmacy personnel averted more than 1 million deaths, more than 8 million hospitalizations, and $450 billion in healthcare costs.

America's pharmacies have been dealing with PBM's abusive and manipulative practices for decades that force patients and others to pay more for their medicines, that limit patients' access to their pharmacist, that restrict patients' access to the medicines right for them, and that jeopardize the pharmacies on which patients rely. Furthermore, these legacy issues have been exacerbated by the absence of oversight and understanding of the offensive and competition-eroding practices of these vertically integrated PBMs, especially the Big Three, that impact timely patient access, inhibit fair market competition, and stifle innovation in pharmacy to empower patients' total health and wellness.

NACDS applauds House Committee on Ways and Means Chairman Smith, Subcommittee on Health Chairman Buchanan, and Ranking Member Doggett for keeping this bipartisan issue throughout Congress top of mind for Americans and for their continued commitment to make health care affordable and protect market competition for pharmacies and others in the prescription drug supply chain. We believe these are steps in the best direction for patients and want to stress the importance and need for the subcommittee to pursue comprehensive PBM reform in the 118th Congress. PBM reform has taken on different forms and meanings this Congress and for these reasons, we have included our Principles of PBM Reform below to outline solutions to the legacy

issues inflicting harm on patients and pharmacies. Comprehensive reform must increase transparency and accountability for PBMs, help ensure the economic viability of pharmacies, and foster increased access to care, affordability, and improved health outcomes for the patients.

The Pharmacy Benefit Manager Marketplace and Impact on Pharmacies

Prescriptions filled by patients who are paying cash without any form of insurance or discount card account for only about 3% of the total volume of prescriptions.[1] While approximately 91% of prescriptions filled have a payment component coming from Medicare Part D, Medicaid, or a commercial insurance plan, these plans are ordinarily administered by PBMs. The top three PBMs manage about 80% of the volume.[2] The top six PBMs and plans manage about 96% of the volume.[3] Five of those six PBMs are owned by large national health insurers. This business environment makes it very difficult for pharmacies to negotiate fair business practices and transparency because the PBMs and health insurers have more commercial market power and leverage in the relationship due to their size and scale. This creates a one-way street with negative consequences for patients, pharmacies, employers, taxpayers, and communities – seemingly for all but the PBMs and payers.

Retail pharmacies are facing a crisis, subject to unsustainable financial pressures as they are increasingly reimbursed by payers below the cost of buying and dispensing prescription drugs. Dire financial pressures have forced an alarming number of pharmacies to take drastic steps, such as possibly paring back hours and placing on hold innovative care services that otherwise could improve health outcomes. Payers have increasingly reduced reimbursements; in many cases, pharmacies dispense prescriptions below cost. Retroactive fees and claw backs often occur weeks or months after a transaction closes, when a payer decides to recoup a portion of the pharmacy's reimbursement. These fees have made the economic viability of community pharmacies increasingly difficult, due to the unpredictability of reimbursement and the increased damage to bottom lines.

It is important to look at the pre-COVID pharmacy closures. According to IQVIA, between December 2017 and December 2020, almost 2,200 pharmacies closed nationwide.[4] Some of the PBMs' abuse of pharmacies were abated during the pandemic and the nation's reliance on pharmacies over the past three years further mitigated pharmacy closures. However, the ominous situation for pharmacies is worse than ever before.

The epidemic of pharmacy closures is reducing access to vital healthcare services, especially in rural areas where options are already limited. Communities across the nation depend on neighborhood pharmacies among all healthcare destinations. A recent study published in the Journal of the American Medical Association also found that pharmacy closures led to a significant drop in medication adherence for older adults taking cardiovascular medications, which has obvious implications for patient health and healthcare costs. Preserving patient access to robust pharmacy provider services and networks like health screenings, disease state management,

[1] Source: IQVIA, National Prescription Audit & RxInsight, June 2022; Approximately 5.4% of patients use a discount card to assist with payment.
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[3] Id.
[4] IQVIA Data, 2020. Closures disproportionately impacted rural areas.

vaccinations (e.g., flu, COVID-19), patient counseling, medication adherence, and testing – all in addition to essential medication access can help improve health outcomes and generate overall healthcare savings for Americans.

To that end, please see below NACDS' Principles of PBM Reform. These policies aim to increase transparency, ensure market competition for pharmacies, and help support comprehensive reform of harmful PBM tactics and practices:

I. Help to Preserve Patient Access to Pharmacies by Addressing PBM's Retroactive Pharmacy Fees

Retroactive DIR Fees/Claw Backs – Pharmacy access can be undermined when health plans and their middlemen, PBMs, arbitrarily "claw back" fees retroactively from pharmacies weeks or months after a claim has been adjudicated/processed. This manipulation of pharmacy reimbursements may diminish access to care *(e.g., pharmacies being forced to close their doors or pare back hours and healthcare services)* when PBMs are unpredictable, not transparent, and payment falls below a pharmacy's costs to acquire and dispense prescription drugs. Policymakers should consider enacting laws that prohibit payers or PBMs from retroactively reducing and/or denying a processed pharmacy drug claim payment and obligating them to offer predictable and transparent pharmacy reimbursement to better protect pharmacies as viable and reliable access points of care for patient services.

II. Provide Fair and Adequate Payment for Pharmacy Patient Care Services

Reasonable Reimbursement & Rate Floor – Pharmacy access remains at risk when PBMs reimburse pharmacies below the cost to acquire and dispense prescription drugs. Pharmacy reimbursement that falls below the costs to acquire and dispense prescription drugs threatens future sustainability for pharmacies to continue providing valuable medication and pharmacy care services to communities. Policymakers should enact laws to adopt a reimbursement rate floor that requires PBMs to use comprehensive reimbursement models that are no less than the true cost to purchase and dispense prescription drugs to help maintain robust public access to pharmacies.

Standardized Performance Measures – A crucial part of comprehensive DIR fee reform is advancing pharmacy quality that improves outcomes for beneficiaries and drives value in care which are essential to controlling costs in the healthcare system. Arbitrary performance measures developed by PBMs assess the performance of the pharmacy without pharmacies' input and create a moving target for pharmacies to show value and improve health outcomes. Measures vary across the various plans and dictate DIR fees (or claw backs at the State level) imposed on pharmacies, as well as help create substantial system dysfunction and unnecessary spending in the Part D program. Policymakers should enact laws to standardize PBM's performance measures for pharmacies to help set achievable goals for pharmacies before signing a contract to promote harmonization in the healthcare system and improvements in health outcomes.

III. Protect Patient Choice of Pharmacies

Specialty – Some PBMs require patients with rare and/or complex diseases to obtain medications deemed "specialty drugs" from designated "specialty pharmacies" or mail-order pharmacies which impedes patient access to their convenient local neighborhood pharmacies where specialty drugs are filled as well. Prescription drugs should not be classified as "specialty drugs" based solely on the cost of the drug or other criteria used to limit patient access and choice—instead, should focus on clinical aspects such as requiring intensive clinical monitoring. Policymakers should enact laws to establish appropriate standards for defining and categorizing specialty drugs to ensure comprehensive and pragmatic patient care and access and prohibit PBMs from steering patients to only specialty pharmacies, including those owned by the PBMs, for their prescription needs.

Mail Order – Medication access and care can be weakened when PBMs manipulate the system by requiring patients to use mail-order pharmacies only. Some plans impose penalties such as higher copays or other financial disincentives for choosing a retail pharmacy instead of a mail-order pharmacy which is often owned by the PBM. Policymakers should support patient choice and access by enacting laws to prohibit PBMs from requiring or steering patients to use mail-order pharmacies.

Any Willing Pharmacy - Due to PBMs' network and contract barriers, pharmacies willing and ready to serve patients may be ineligible to provide important pharmacy services and patients may experience unnecessary delays and interruptions in patient care. Patients should have the choice and flexibility to utilize the pharmacy that best meets their healthcare needs. Policymakers should enact laws that require PBMs and plans to include any pharmacies in their networks if the pharmacy is willing to accept the terms and conditions established by the PBM to help maximize patient outcomes, and cost savings and ensure patient access to any willing pharmacy of their choice.

IV. Enforce Laws to Stop PBM Manipulation and Protect Pharmacies and Patients

Audits – PBMs routinely conduct audits to monitor a pharmacy's performance and reverse or claw back pharmacy payments when there are alleged issues with a particular pharmacy claim. PBM audits interrupt the pharmacy workflow, can extend wait times, and detract attention from the quality-of-care patients receive. Policymakers should enact laws that support fair pharmacy audit practices to ensure timely patient care delivery at community pharmacies and bring efficiency, transparency, and standardization to the PBM audit process.

Oversight Authority – There are growing concerns that pro-pharmacy and pro-patient legislative successes might be undercut if PBMs fail to comply with such laws and/or states fail to fully enforce these laws. Such failure could significantly impact pharmacy reimbursement and overall patient access. Policymakers should establish and enforce laws already on the books to regulate harmful PBM reimbursement practices that may harm patients and the healthcare system as we know it, especially at the pharmacy counter, and

empower state regulators to do the same to enforce PBM transparency and fair and adequate pharmacy reimbursements.

Conclusion

Again, NACDS thanks the subcommittee for the opportunity to provide our perspective on PBM reform and our support for your dedicated work to rein in PBMs' egregious practices. All PBM loopholes must be closed to help lower drug costs for patients. Additionally, mechanisms must be put in place to account for PBM compliance and modernization of the entire supply chain to help ensure that PBMs do not continue to inflate drug costs with opaque and suspect schemes. We look forward to continuing to work with Congress to stop the manipulation by PBMs who have commandeered the marketplace and restricted competition at the expense of the patient, taxpayers, employers, pharmacies, and more.

We implore you to act on these principles and ensure proper safeguards are established to protect pharmacies and Americans. For questions or further discussion, please contact NACDS' Christie Boutte, Senior Vice President, Reimbursement, Innovation and Advocacy at CBoutte@NACDS.org or 703-837-4211.

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May 17, 2023

The Honorable Vern Buchanan
Chairman
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Buchanan, Ranking Member Doggett, and Members of the House Ways and Means Subcommittee on Health,

On behalf of the National Federation of Independent Business (NFIB), the nation's leading small business advocacy organization, we welcome the subcommittee's focus on health care affordability and competition.

Small businesses are the backbone of our economy and play a critical role in creating jobs and driving economic growth. For over 40 years, NFIB members have identified the rising cost of health insurance as their top concern.[1] However, Congress has failed to address the causes of rapidly rising health insurance costs.

A recent NFIB survey found that 56% of small employers currently offer health insurance to employees, while 44% do not.[2] The data clearly shows that the most significant reason small employers do not offer health insurance is cost, with 65% of respondents reporting cost as the primary reason.[3] Furthermore, 98% of small employers are concerned that the cost of providing health insurance to their employees will become unsustainable in the next 5-10 years.[4]

Small business owners are forced to make difficult decisions in response to this unaffordability crisis. The percentage of small businesses offering health insurance has dropped dramatically in the last decade. Meanwhile, the businesses that do offer coverage have to pass the costs along to their customers. Nearly half of small employers (46%) report raising their prices to keep up with rising health insurance costs. Moreover, almost half of small employers now earn less due to health

[1] Holly Wade & Andrew Heritage, NFIB Research Center, Small Business Problems and Priorities, 2020, https://assets.nfib.com/nfibcom/NFIB-Problems-and-Priorities-2020.pdf
[2] Holly Wade & Madeleine Oldstone, Small Business Health Insurance Survey, NFIB Research Center, March 2023 https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf
[3] Ibid.
[4] Ibid.

insurance premium increases over the last five years.[5] Since 2014, some counties nationwide have witnessed small business premiums skyrocketing to 130%.[6]

Healthcare unaffordability impacts our entire economy. Sixty-three percent of all employers believe offering health insurance to recruit and retain employees is a very or moderately important factor in their business.[7] As small businesses struggle to rebound from crippling inflation, worker shortages, and looming supply chain disruptions, it is critical that they can compete with larger firms in attracting and retaining talent. Health costs make remaining competitive impossible for small employers as they do not enjoy the same regulatory flexibilities and economies of scale.

NFIB recommends that Congress implement policies that lower healthcare costs for small employers and their employees while increasing consumer transparency and competition.

Promote Price Transparency and Price Certainty:

Small businesses support price transparency. In a recent NFIB member ballot, more than three-quarters (77%) of small business owners support requiring insurers to provide price information for healthcare services. And small businesses can benefit greatly from greater price transparency. When healthcare providers and insurers are required to disclose the costs of their services and treatments, small businesses can make more informed decisions about which plans and providers to choose. This enables them to negotiate better rates with their insurers and avoid overpaying for healthcare services. According to a study by the RAND Corporation, improving hospital price transparency could decrease hospital spending by as much as $26.6 billion a year.[8]

Additionally, small business owners would benefit from moving the commercial market toward site-neutral payment policies, which studies find would reduce health expenditures and result in lower premiums and cost-sharing.[9] Lawmakers should discourage off-campus hospital outpatient departments (HOPDs) from billing add-on hospital fees, leading to lower out-of-pocket costs and disincentivizing consolidation in the hospital market. Requiring hospitals to disclose to insurers the location where care was performed would result in greater transparency and lower costs.

Promote Beneficial Competition:

Small businesses can also benefit from greater competition in the healthcare industry. Consolidation in local healthcare markets can be particularly harmful to small employers, which may already have limited options for providers in their area. According to the Congressional Budget Office (CBO), hospital markets have become more highly concentrated in recent years, with the

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[5] Ibid.
[6] Internal Revenue Service. (2022) Instructions for Form 8941, *Credit for Small Employer Health Insurance Premiums.* pp. 10-30 https://www.irs.gov/pub/irs-pdf/i8941.pdf
[7] Holly Wade & Madeleine Oldstone, Small Business Health Insurance Survey, NFIB Research Center, March 2023 https://strgnfibcom.blob.core.windows.net/nfibcom/Health-Insurance-Survey-2023.pdf
[8] Liu, Jodi L., Zachary M. Levinson, Nabeel Qureshi, and Christopher M. Whaley, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans.* Santa Monica, CA: RAND Corporation, 2021. https://www.rand.org/pubs/research_reports/RRA805-1.html.
[9] Committee for a Responsible Federal Budget. (2018). Moving to Site-Neutrality in Commercial Insurance. Retrieved from https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

share of concentrated systems increasing from 63% to 70%.[10] Consolidation undoubtedly has resulted in higher prices in the commercial market: A 2020 review of published research by the Medicare Payment Advisory Commission (MedPAC) concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices."[11]

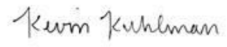
The same is true of Pharmacy Benefit Managers (PBMs), which continue to further consolidate and negatively impact employers and their employees through higher costs. The three largest PBMs control at least 80% of the health plan pharmacy benefit market,[12] and control, through PBM-affiliated pharmacies, more than 65% of total prescription revenues ($122.2 billion in 2021) from pharmacy-dispensed specialty drugs. In contrast to other claims that consolidation would help consumers with greater efficiencies and lower prices, it has only resulted in less transparency and made the system more opaque. PBM reform is necessary to lower prescription drug costs. By increasing transparency, limiting spread pricing, allowing patient choice, and encouraging competition, PBMs can be incentivized to offer higher quality and more affordable services to small businesses and their employees.

Small business owners support increased competition. In a recent NFIB member ballot, more than 80% of small business owners support legislation to rein in healthcare consolidation and anti-competitive business practices.

NFIB remains committed to partnering with you to ensure that small businesses and their employees can access affordable health insurance coverage: When small businesses thrive, our communities thrive.

We greatly appreciate your consideration of these vital policy issues and look forward to working with you to protect and defend the small business community.

Sincerely,



Kevin Kuhlman
Vice President, Federal Government Relations
NFIB

[10] Congressional Budget Office. *S.1895, Lower Health Care Costs Act Cost Estimate.* July 16, 2019
https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.
[11] MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy," March 13, 2020.
[12] 1 Fein, A. (2022). DCI's Top 15 Specialty Pharmacies of 2021—And Three Factors That Will Reshape 2022. Drugchannels.net.

Statement for the Record

Pharmaceutical Care Management Association
325 7th Street, NW
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Submitted to the

United States House of Representatives
Ways and Means Committee
Subcommittee on Health

"Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets"

May 17, 2023

Introduction

On behalf of the Pharmaceutical Care Management Association (PCMA), we appreciate the opportunity to submit this written statement for today's hearing on anticompetitive and consolidated markets in health care. 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, retiree plans, Medicare, Medicaid, the Federal Employees Health Benefits (FEHB) program, and the exchanges established by the Affordable Care Act (ACA). Our members work closely with health plans and health insurance issuers to secure lower costs for prescription drugs and achieve better health outcomes.

Pharmacy benefit managers (PBMs) have always focused on lowering prescription drug costs for patients and a wide range of health plan sponsors – specifically by:

- Negotiating rebates from brand drug companies and discounts from pharmacies to reduce costs for patients, their families, and health plans – saving payers and patients an average of $1,040 per patient per year.[i]
- Encouraging the use of more affordable alternatives to brand drugs, such as generics and biosimilars.
- Offering services that benefit patients, such as home delivery, which saves patients time and money while increasing access and care coordination.
- Managing and helping patients access high-cost specialty medications.
- Reducing waste, preventing potentially harmful drug interactions, and improving adherence.
- Providing clinical support in the form of services to plan enrollees, internal clinical expertise to support business operations, and assembling clinical experts to evaluate drug therapies and make coverage recommendations to plan sponsors.

Pharmacy benefit companies support a competitive market for prescription drugs. In this statement we review the policies PCMA members support to encourage a competitive market for prescription drugs, highlight some of the ways pharmacy benefit companies currently work to lower costs for patients and reduce health benefit costs for health plan sponsors, describe the diversity of the PBM market, and suggest ways to preserve that competitive marketplace.

As an industry, we welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better afford their prescription drugs, and we believe any attempt at understanding the factors driving drug costs must include an examination of the entire supply chain, including drug companies, large pharmacy collectives known as Pharmacy Services Administrative Organizations (PSAOs), wholesale distributors, employer benefit consultants, pharmacies, and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which allows those companies to arbitrarily set and increase prescription drug prices. We encourage the Committee to review all these entities and potential anticompetitive practices as it assesses how to improve the prescription drug market.

Pharmacy Benefit Companies Support Policies to Encourage Competition as the Best Way to Lower Prescription Drug Costs

Pharmacy benefit companies encourage use of the most affordable drugs for patients by providing prescribers with information about less expensive generic alternatives, setting performance standards for pharmacies to encourage generic fills and adherence, and ensuring patients are aware of lower cost 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 the brand and a biosimilar to ensure patients and providers have the incentive to choose lower-cost options and the choice to continue with a drug from which they may be reluctant to switch.

Pharmacy benefit companies offer programs to keep out-of-pocket costs low and work with those providing insurance to encourage patients through formulary design and cost-sharing incentives to use the most affordable drugs, which are usually generics. Generic dispensing has grown over the past decade as more generics have entered the market and patients have responded to health plan designs encouraging their use.[iii] PBMs also employ other tools designed to deliver high-quality drug benefits while bringing down costs.[iv] For many brand drugs, PBMs negotiate directly with drug manufacturers who compete for formulary placement by offering rebates.[v] For drugs on a preferred tier of a plan's formulary, patients typically have lower cost sharing.[vi] As competing products enter the market, PBMs gain the flexibility to leverage competitor products to negotiate deeper drug discounts for patients and employers.[vii]

To enhance competition and enable pharmacy benefit companies to further drive down drug costs, PCMA encourages policymakers to do the following:

1. **Stop patent abuse.** Addressing drug companies' abuses of the patent system that allow them to block competition by extending monopoly pricing well beyond their products' original patent expirations would go a long way toward reducing drug costs for patients and families.
2. **Reserve market exclusivities for true innovation.** Innovation without affordability undermines patient access. Addressing overlong exclusivity periods for biologics and orphan indications will create more competition and lead to lower overall drug costs for patients.
3. **Ensure drugs can compete fairly.** Preventing practices like "shadow pricing" and abuses of the U.S. Food and Drug Administration's citizen petition process will improve the competitive market.
4. **Promote generic and biosimilar competition.** The most effective way to reduce prescription drug costs is to increase competition in the marketplace.
5. **Ensure a competitive Medicare Part D prescription drug market.** Care should be taken to incentivize production of competing products and improve the functionality of the prescription drug market as the drug pricing provisions of the Inflation Reduction Act are implemented.
6. **Support pharmacy networks.** Policies that restrict pharmacy benefit companies' ability to develop pharmacy networks drive costs up, while well managed pharmacy networks offer consumer choice, quality optimization, and savings to both patients and plan sponsors, whether they are Part D plans, employers, or unions.

The PBM Market is Diverse and Competitive

Savings from pharmacy benefit companies benefit health plans, employers, retirees, and patients directly. PBMs save health plans, including Part D plan sponsors and employers, an average of $1,040 per person per year,.[viii] Just like PCMA's members, the PBM market is dynamic, diverse,

and continues to grow. In 2019, there were 64 full-service pharmacy benefit companies active in the market. As of March 2023, there are 73 full-service pharmacy benefit companies in the U.S., with six new ones entering the market since 2021.[ix] In addition to these full-service companies, there are many companies that provide some PBM services to customers with some catering to narrow customer bases, such as workers' compensation.

In 2005, the Federal Trade Commission (FTC) issued a report showing that PBM ownership of pharmacies does not result in higher costs for consumers. The FTC chair at the time noted, "Health insurers manage their drug costs by choosing among a variety of PBM services and service providers," and "Data in the report demonstrate that PBMs' use of owned mail-order pharmacies generally is cost-effective for plan sponsors."[x]

Additionally, in 2012, the FTC completed an investigation to evaluate the potential impact of a proposed merger between two PBMs, Express Scripts and Medco. As a result, the Commission observed that the "market for the provision of full-service PBM services to health care benefit plan sponsors is moderately concentrated and consists of at least ten significant competitors," and further found that "competition for accounts is intense, has driven down prices, and has resulted in declining PBM profit margins—particularly in the large customer segment."[xi] Over the 11 years since that investigation, the market for full-service PBM services has grown, with 73 full-service pharmacy benefit companies of varying size operating across the nation in a variety of markets in 2023. The FTC is currently conducting a 6(b) study on PBMs, which we expect will find, consistent with previous FTC findings, that the PBM market is competitive and diverse.

Preserving the competitiveness of the PBM market is as important as ensuring competitiveness in all other aspects of the prescription drug supply and payment chain. Transparency that helps patients and payers is necessary across the entire prescription drug supply and payment chain. PBMs support and practice actionable transparency that empowers patients, their physicians and pharmacists, those sponsoring health coverage, and policymakers to make informed decisions that can lead to lower prescription drug costs. Our industry supported legislation enacted in 2018 to empower pharmacists to share information with patients about lower out-of-pocket cost alternatives.

Pharmacy benefit companies provide health plans, employer plan sponsors, and consumers with a broad array of accurate, actionable information on price and quality to make efficient purchasing decisions. As part of their requests for proposals (RFPs) when putting their pharmacy benefits out to bid, PBMs' customers lay out the terms of the transparency and information they want to receive, as well as their audit rights, and those terms are memorialized in their contracts. For example, in a May 2022 letter to the FTC, the School Employees Retirement System of Ohio stated: "SERS' PBM contracts are on a transparent pricing basis, with 100% pass-through of rebates and pharmacy pricing. All rebates and pricing discounts are applied directly to SERS members as reduced pharmacy premiums every year. The passthrough contract provision is independently audited bi-annually, confirming that all monies related to the retiree prescription drug benefit are passed back to SERS."[xii]

In recent years, Congress has added more requirements for PBMs to report to federal agencies, as well as public reporting in more aggregated form. In both cases, these laws included appropriate protections for confidential data to avoid encouraging tacit collusion, and PCMA supported that approach. We have also supported legislation that is now law, which provides Congressional support agencies, including Congressional Budget Office (CBO), Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Medicaid

and CHIP Payment and Access Commission (MACPAC), with access to Medicare and Medicaid claims-level data to ensure the Committee is able to perform appropriate oversight.

As the Committee considers how best to preserve the competitiveness of the PBM market, we encourage consideration of the administrative burdens extensive, unharmonized, duplicative reporting requirements create for smaller PBMs. While larger PBMs may be able to adapt, smaller PBMs may find these new regulations overly burdensome or wholly unworkable, forcing them to either close their doors or consolidate; thereby reducing the competitive market for PBMs. It is also important to note that these added reporting burdens on top of the existing requirements could lead to higher costs for consumers.

In addition, while supporting PBM clients' right to request pricing information, we caution the Committee against publicly reporting competitively sensitive pricing information such as manufacturer and pharmacy price concessions, which would lead to lower price concessions and higher costs for both plan sponsors and patients. As the CBO has cautioned this Committee:

> *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.*[xiii]

More recently, in February of this year, the Justice Department's Antitrust Division withdrew three outdated antitrust policy statements related to enforcement in health care markets. As Principal Deputy Assistant Attorney General Doha Mekki remarked:

> *Courts have long recognized that the exchange of competitively-sensitive information can subvert the competitive process and harm competition. …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." …Where competitors adopt the same pricing algorithms, our concern is only heightened. Several studies have shown that these algorithms can lead to tacit or express collusion in the marketplace, potentially resulting in higher prices, or at a minimum, a softening of competition."*[xiv]

Indeed, there are numerous examples of tacit price collusion across multiple markets, from airline tickets and gasoline to credit card interchange fees, to cell phone text messaging and roaming rates, or real estate and travel agent commissions. [xv]

Pharmacy Benefit Companies Support Plan Sponsors' Ability to Choose What Works for Them

Public and private health plan sponsors vary dramatically in size, resources, and function, serving diverse populations. Employers, union and retiree plans, states, and others who provide health care coverage know more about their financial resources and plan participants than any other entity, and they need the ability to design plans tailored to the unique needs of their participants. No Medicare Part D plan sponsor, public or private employer, union, retiree health plan, pension

fund, or other health plan is required to hire or use a pharmacy benefit company, but virtually all do, and the vast majority are pleased with the services their pharmacy benefit companies provide, with employers reporting about 80 percent satisfaction with the cost-saving, health-improving services provided by their PBM. As health plan sponsors strive to create accessible, affordable benefits that meet the needs of the populations they cover, policymakers should avoid mandates that could increase costs and decrease quality.

Health plans, including those serving federal programs, rely on pharmacy benefit company expertise to secure savings through price concessions from pharmaceutical companies, administer medication adherence and health coaching programs, and provide overall guidance and expertise on pharmacy benefit design and coverage. Pharmacy benefit companies' customers choose their PBMs through a transparent and highly competitive bidding process. Some may base selection criteria on pharmacy benefit companies' scale, ability to negotiate deep discounts, or effectiveness managing the risk of price changes. Others may base selection criteria on pharmacy benefit companies' innovative care management programs or different levels of service. For small employers, many of whom may struggle to provide health insurance to employees, PBMs both lower their overall drug costs and provide cost predictability, enabling them to stretch their benefit dollars even further. With 73 full-service pharmacy benefit companies in the market – including new entrants – health plan sponsors have an opportunity to evaluate the differentiated value propositions of multiple companies and select the one that best meets their needs.[xvi]

According to a GAO report from 2019, PBMs provided services to over 600 Part D plan sponsors.[xvii] In addition to the multitude of choices available to plan sponsors, Medicare beneficiaries are presented with options for coverage. For 2023, beneficiaries enrolled in original Medicare could choose from 801 stand-alone prescription drug plans (PDPs),[xviii] while those with Medicare Advantage (MA) typically have their medical benefits and prescription drug benefits (MA-PDs) integrated into one of nearly 4,000 available plans.[xix]

Pharmacy Benefit Companies Support a Robust and Competitive Market for Pharmacies

The structure of a health plan's provider network is one of the most important elements of health benefit design. In working with their pharmacy benefit companies, plans exercise careful judgment to construct pharmacy networks that meet beneficiary needs, balancing breadth of coverage, provider access, provider quality, and cost-efficiency, often on a multi-jurisdictional basis.

Pharmacies large and small are important partners in delivering care to patients, and where a patient acquires a drug can impact its cost significantly. Pharmacy benefit companies negotiate with pharmacies to establish pharmacy networks that support consumer choice while offering high quality pharmacy care at competitive prices. Most pharmacy networks are designed to provide patients with a variety of options allowing them to get the drugs they need where they need them. Policies that restrict pharmacy benefit companies' ability to develop pharmacy networks drive costs up, while well-managed pharmacy networks offer savings to both plan sponsors and enrollees. For instance, some states have passed laws constraining provider networks, to the detriment of employers, Medicare Part D, and union plan sponsors. Such regulation sometimes even seeks to intrude into Medicare Part D despite federal pre-emption, which should prohibit states from acting on exclusive areas of federal regulation. These provider network restrictions could lead to a patchwork of inconsistent state laws, creating administrative burdens for plan sponsors offering benefits across state lines and boosting costs for employer

and Part D sponsors, which can result in higher beneficiary cost sharing and premiums.

Health plan sponsors may select – or in the case of Medicare Part D, prefer – specific networks of pharmacies to provide drugs to their enrollees at competitive prices. Plans with pharmacy networks that include "preferred cost sharing pharmacies" have proven very popular in Medicare Part D, as 98 percent of Part D stand-alone plans (PDPs) and 52 percent of Medicare Advantage plans (MA-PDs) use these networks.[xx] In the private market, nationally, 76 percent of employers report using a tailored pharmacy network, and employees typically save about 38 percent out-of-pocket using in-network vs. out-of-network pharmacies.[xxi]

To preserve the benefits of pharmacy networks, it is important to understand the critical role of pharmacy services administrative organizations (PSAOs) in supporting pharmacies. The largest PSAOs are subsidiaries of the major wholesalers, which also typically operate the equivalent of pharmacy franchises, providing branding, organization support, and back-office support.

Approximately 83 percent of independent pharmacies use PSAOs to negotiate favorable contracts with pharmacy benefit companies. Data shows the independent pharmacy market is stable, growing 0.4 percent over the last year,[xxii] and it is the only sector of retail pharmacy that has experienced growth over the last 10 years. By leveraging the power of large PSAOs to negotiate with pharmacy benefit companies on their behalf, independent pharmacies can secure favorable contract terms and, on average, higher reimbursements than chain drugstores.[xxiii] PSAOs and PBMs also provide pharmacies with software, such as Pharmacy Quality Solutions' Electronic Quality Improvement Platform for Plans and Pharmacies (EQuIPP), which allows pharmacies to access their contracted pharmacy measures, track their own performance against those measures, and compare benchmark measures of their contracts across plans and against other pharmacies.

There are many types of pharmacies – retail, specialty, hospital, clinic, home care, mail-order, compounding, and assisted living or long-term care – to name a few. These pharmacies vary and not all pharmacies can or should do all things because they offer different levels of expertise and services to ensure patients are getting what they need to secure the best health outcomes. In fact, there are more than 60,000 retail pharmacies in the United States, including large chains, mass merchants, grocery stores, and 23,000 independent community pharmacies. Health plans with a variety of sites of care in their pharmacy networks are able to promote access, affordability, and value. For example, the right mix of brick-and-mortar, mail, and specialty pharmacies improves adherence to therapy and patient safety.

The Medicare Program Ensures a Competitive and Robust Pharmacy Market with Beneficiary Protections

Medicare Part D plans are held to rigorous pharmacy network adequacy standards to ensure broad beneficiary access. To meet these standards, Part D plans **need** a robust and competitive retail pharmacy industry. CMS requires that:

- In rural areas, at least 70 percent of beneficiaries live within 15 miles of a retail pharmacy participating in a plan sponsor's network;
- In suburban areas, at least 90 percent of beneficiaries live within 5 miles; and
- In urban areas, at least 90 percent of beneficiaries live within 2 miles.

Medicare Part D Preferred Pharmacy Networks

Medicare Part D plans compete based on pharmacy networks, through a policy that the Centers for Medicare and Medicaid Services (CMS) calls "preferred cost-sharing pharmacies." Under these arrangements, plans incentivize enrollees to choose particular pharmacies with lower cost-sharing for covered drugs. Pharmacies agree to participate and meet certain quality metrics because they are likely to see higher patient volumes.

CMS pays careful attention to these arrangements. The cost-sharing differences cannot be "so significant as to discourage enrollees in certain areas (rural areas or inner cities for example) from enrolling in that Part D plan – even if it otherwise meets the retail access standards." Generally, Part D plan pharmacy networks are very broad and inclusive of nearly all pharmacies in their service area.

Mail-Service Pharmacy

Mail-service pharmacies do not count toward meeting retail pharmacy access requirements. In addition, to the extent that Part D plans offer mail-service pharmacy, they must also ensure enrollees have reasonable access to the same benefits at network retail pharmacies. In addition, "any increase in cost sharing must be limited to the "differential in charge" to the plan in terms of any difference between higher contract rates at a network retail pharmacy as opposed to a network mail-order pharmacy for that benefit." "Enrollee cost-sharing for an extended-day supply at retail must never exceed what the enrollee would have paid at the same retail pharmacy had the enrollee had his or her prescription filled in multiple 1 month supply increments at retail pharmacy rates." Medicare also requires that availability of benefits at retail rather than mail-order pharmacies does not increase government costs.

Specialty Pharmacy

With respect to specialty pharmacies, Part D sponsors may only restrict access to Part D drugs if 1) the FDA has restricted distribution to certain facilities or physicians; or 2) appropriate dispensing of the Part D drug requires extraordinary special handling, provider coordination, or patient education that cannot be met by a network pharmacy. In addition, specialty pharmacy designation cannot be based solely on the placement of a Part D drug in a specialty or high-cost tier. Finally, Part D sponsors may not require network pharmacies to qualify as specialty pharmacies if the network pharmacy is capable of appropriately dispensing the drug in question.

"Any Willing Pharmacy" Requirements

Part D also has an "any willing pharmacy" requirement that permits participation in a Part D plan network by any pharmacy that is willing to accept the sponsor's standard contracting terms and conditions – which also must be "reasonable and relevant".

Conclusion

Pharmacy benefit companies exist to reduce drug costs for plan sponsors and, most importantly, for the patients our companies serve. In doing this work, pharmacy benefit companies generate tremendous value for society, estimated at $145 billion annually,[xxiv] 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.[xxv] Much of this value is generated by the savings pharmacy benefit companies negotiate with pharmaceutical manufacturers and pharmacies. Pharmacy benefit companies also lower prescription drug costs by promoting the

use of generic medications, encouraging better pharmacy quality, and offering things like home delivery of medications. Through their work, pharmacy benefit companies 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 pharmacy benefit company services for their private sector and government partners.[xxvi] As a result, pharmacy benefit companies will lower the cost of health care by $1 trillion over the next ten years.[xxvii]

As we've indicated, PCMA welcomes the opportunity to further engage with the Committee and 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.

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