MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Hearing entitled "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care."

The Subcommittee on Health will hold a hearing on Tuesday, March 28, 2023, at 1:00 p.m. (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care."

I. Witnesses

- **Mr. Chris Severn,** Co-Founder & Chief Executive Officer, Turquoise Health
- **Mr. Matthew Forge,** Chief Executive Officer, Pullman Regional Hospital
- **Ms. Marilyn Bartlett,** Senior Policy Fellow, National Association of State Health Policy
- **Ms. Sophia Tripoli,** Director of Health Care Innovation, Families USA
- **Dr. Benedic Ippolito,** Senior Fellow in Economic Policy Studies, American Enterprise Institute

II. Background

Health Care Costs

Americans rank the cost of health care as a top concern.[1] The United States spent $4.3 trillion on health care in 2021, which is more s as a percentage of GDP than the rest of the developed world.[2,3] Major categories of spending include hospital care (31 percent), physician and clinical services (20 percent), and retail prescription drugs (9 percent). The federal government accounts for the plurality of health care spending (34 percent) followed by households (27 percent), private employers (17 percent), and state and local governments (15 percent).

From 2013 to 2018, spending by commercial health insurers grew by an average of 3.2 percent per year, driven primarily by growth in the price paid by commercial health insurers for health care services to hospitals and providers.[4] Such prices rose by an average of 2.7 percent per year, one percentage point higher than the GDP price index growth over the same period. Similarly, Medicare costs per beneficiary are growing faster than the economy and, according to the Medicare Trustees, will continue to grow 1.2 percentage points faster than GDP per capita over the next 25 years.[5]

---

[1] PowerPoint Presentation (usrfiles.com)
[2] National Health Expenditures 2021 Highlights (cms.gov)
[3] Health resources - Health spending - OECD Data
[4] The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services (cbo.gov)
[5] Analytical Perspectives, Budget of the U.S. Government, Fiscal Year 2024 (whitehouse.gov)

Price Transparency

On November 15, 2019, the Trump administration proposed, and later finalized, two rules to increase price transparency for patients. The first requires hospitals, effective January 1, 2021, to make public their standard charges public through machine-readable files as well as payer-specific negotiated charges, including for cash-paying patients, for 300 shoppable services.

Since the implementation of the hospital transparency rule has gone into effect, the Biden Administration has increased penalties for non-compliance with the rule.[6] That said, numerous academics and other parties have studied hospital compliance with the rule. Academic and non-governmental studies have indicated varying levels of compliance with the rule. To date, the Centers for Medicare and Medicaid Services (CMS) has issued two civil monetary penalties for hospital noncompliance with the price transparency rule.[7]

The second, known as the "Transparency in Coverage" rule, instituted price transparency requirements on most non-grandfathered group health plans and issuers offering group and individual health insurance coverage. Under the rule, CMS required insurance companies to disclose several machine-readable files.[8] First, one file containing in-network rates for all covered services with in-network providers. Next, a file containing allowed amounts for, and billed charges from, out-of-network providers. Finally, a file that included the historical net price of covered prescription drugs. CMS began enforcement of the disclosure rules for the in-network rate and out-of-network provider files on July 1, 2022. CMS has indefinitely delayed enforcement of the prescription drug price disclosure file.[9]

Beginning on January 1, 2023, the Transparency in Coverage rule also required most health insurance plans to provide personalized pricing information for 500 items and services through a consumer tool that can be accessed online, by phone, or in paper form. In 2024, insurance companies will be required to have an internet-based price comparison tool that allows patients to receive an estimate of cost-sharing for a specific item or service from specific provider or providers.

The Congressional Budget Office (CBO) has found that policies to improve price transparency will have the effect of reducing prices by up to one percent, on average, over ten years.[10] A recent peer-reviewed economy analysis found that the price transparency rules will save privately-insured patients from $17.6 to $80.7 billion by 2025.[11] The analysis found that those with lower incomes had the most significant reduction in relative costs among income cohorts.

---

[6] CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care | CMS
[7] Enforcement Actions | CMS
[8] Plans And Issuers | CMS
[9] CMS insurer price transparency rule has taken effect. Signs are good for compliance | Healthcare Dive
[10] Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (cbo.gov)
[11] Estimating the Impact of New Health Price Transparency Policies - Stephen T. Parente, 2023 (sagepub.com)

In prescription drug markets, there is similarly reason to believe that transparency can reduce spending. Previously, the Congressional Budget Office has opined that providing employers with access to data on the rebates pharmacy benefit managers (PBMs) receive from drug manufacturers can save employers – and the federal government – money on employer-sponsored insurance.[12]

Consolidation

CBO has noted that greater market concentration has been linked to less price competition for both hospitals and physicians.[13] According to CBO, hospital markets have generally become more consolidated from 2010 to 2017, the share of metropolitan statistical areas analyzed by CBO as being highly or very highly concentrated increased from 63 percent to 70percent.

In physician markets analyzed by CBO, from 2010 to 2016, the average Herfindahl-Hirschman Index (a measure of market concentration) across 370 metropolitan statistical areas (MSAs) rose by nearly 29 percent for primary care physicians and 5 percent for specialists. The share of MSAs considered highly or very highly concentrated nearly doubled, rising from 20 percent in 2010 to 39 percent in 2016.

Amongst PBMs, roughly 80 percent of all prescription claims were processed by three companies.[14] PBMs have also come under scrutiny for vertically integrating through the acquisition of pharmacies. The Federal Trade Commission (FTC) is currently undergoing a study into the effects of such vertical integration on access to prescription drugs.[15]

III. Staff Contacts

If you have questions regarding this hearing, please contact Grace Graham, Corey Ensslin, Seth Gold, or Alec Aramanda of the committee staff at 202-225-3641.

---

[12] S. 1895 (cbo.gov)
[13] Ibid.
[14] Drug Channels: The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger
[15] FTC Launches Inquiry Into Prescription Drug Middlemen Industry | Federal Trade Commission