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LOWERING UNAFFORDABLE COSTS:

EXAMINING TRANSPARENCY AND COMPETITION IN HEALTH CARE

TUESDAY, MARCH 28, 2023

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 1:02 p.m., in Room 2123 of the Rayburn House Office Building, Hon. Brett Guthrie [chairman of the subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Johnson, Bucshon, Hudson, Carter, Dunn, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz,

Dingell, Kuster, Blunt Rochester, Craig, Schrier, Trahan, and Pallone (ex officio).

Also present: Representatives Allen, Balderson; and Matsui.

Staff Present: Alec Aramanda, Professional Staff Member, Health; Jolie Brochin, Clerk, Health; Seth Gold, Professional Staff Member, Health; Grace Graham, Chief Counsel, Health; Jack Heretik, Press Secretary; Nate Hodson, Staff Director; Peter Kielty, General Counsel; Emily King, Member Services Director; Carla Rafael, Staff Assistant; Lydia Abma, Minority Policy Analyst; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Saha Khaterzai, Minority Professional Staff Member; Una Lee, Minority Chief Health Counsel; Greg Pugh, Minority Staff Assistant; and C.J. Young, Minority Deputy Communications Director.

*Mr. Guthrie. The subcommittee will come to order.

The chair recognizes himself for an opening statement.

Today we are holding a bipartisan hearing to examine the rising cost of health care for patients and their families. Rising costs of care for individuals is one of the single greatest threats to the overall economic security of Americans. Over the past 30 years, the cost of health care has steadily risen by almost 5 percent, annually. In 2021 costs eclipse 4 trillion annually, amounting to roughly $13,000 per person.

Rising costs have coincided with a sharp rise in consolidation within the health care industry. 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 an increase over the more than 35,000 acquired in 2012.

The three largest pharmacy benefit managers represent over 80 percent of the marketplace, and many have merged with insurance companies, specialty pharmacies, retail pharmacies, and even drug distribution.

Today we spend 31 percent of all health care expenditures on hospital services, 20 percent on physician services, and 9 percent on prescription medications. It is important to note that these are just recent trends.

The point of today's hearing is to better understand these trends, which I believe can be achieved through greater price transparency in the health care system. Despite having all this aggregate expenditure information widely available to the public, patients and employers are unable to access an upfront price for giving an item or service. They cannot make informed decisions about how and where to spend their money as they can in virtually every other industry. Consequentially, this leads to high, unexpected costs; a lack of trust with the health care system; and a reluctance to seek critical health care services.

Not long ago, a constituent called me. He was frustrated because he could not find the price to get a simple health care procedure done. He had health insurance, but was trying to find high-quality care at the best price within his budget. Unfortunately, this was a -- is a frustration shared by millions of Americans.

I hope today that -- I hope that today can be a start on

finding bipartisan solutions to make health care pricing more transparent, and the health care system easier to navigate for patients. We should start with any improvements necessary to the Centers for Medicare and Medicare Services' Hospital Price Transparency Rule and the multi-department transparency and coverage rule.

These rules require hospitals to publicly post prices of hundreds of common procedures on their website in a user-friendly format, and require private health plans to disclose information about pricing and what patients are obligated to pay. All of this information gives patients and employers that pay for health insurance for their employees more information and some peace of mind to know how much their health care procedures or services would cost ahead of ahead of receiving the care.

It is imperative for the Biden Administration to conduct greater enforcement efforts on these rules to better serve patients with clear and actionable price information.

It is also crucial for Congress to codify and strengthen these important transparency rules to support a more efficient price transparency regulatory environment.

Congress should also consider solutions to make other

parts of the health care system more transparent. We should build on our bipartisan work to make the pharmacy benefit managers more transparent, and ensure patients as well as employers are getting the best possible deal on their prescription drug benefits. This could also lead to greater access to biosimilars and generics when they come to market.

Shining a light on middlemen who are making prescriptions more expensive is one important step to bolster competition and lower prices.

Further, patients, especially seniors, are unnecessarily paying more money for the same service because of the location where it was delivered, which requires further discussion.

It is well past time to carefully examine the root causes of these inefficiencies that are plaguing patients with higher costs and more confusion. By working together across the aisle, I am hoping we can make important strides to make the health care system easier for patients to navigate, so they can get the health care they need. To that end, I look forward to today's discussion.

I really appreciate working with the ranking member and our staffs together to put this wonderful panel together.

Every witness is a bipartisan witness and was -- is brought together, and we really appreciate it.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. I appreciate your hard work, and I yield back, and I will now recognize my good friend, the gentlelady from California, Rep. Eshoo, for five minutes for an opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, for holding this important hearing, and welcome to all the witnesses. We can't wait to start asking you questions.

The late Uwe Reinhardt -- he was a prestigious health economist who often appeared before this subcommittee -- famously said, "It is the prices, stupid,'' when critiquing why the U.S. spends so much on health care. Twenty years since Dr. Reinhardt's seminal analysis, our nation's inflated health care prices are still the primary reason why the U.S. spends significantly more on health care than any other country in the world.

A quick comparison to other large, wealthy nations shows the U.S. is an outlier. We spend two to three times more on prescription drugs and medical devices. We spend $10,000 more, on average, per hospital discharge. We spend seven times more per capita on health insurance administrative costs. Despite spending nearly 18 percent of GDP on health care, we have fewer practicing doctors and nurses, fewer

hospital beds per capita, and a lower life expectancy than other wealthy nations. We also have the highest avoidable death rates and maternal and infant mortality, and an obesity rate nearly two times more than the average of our peer nations. None of this, none of these points are bragging rights, for sure.

In other words, we spend more, but we get much less. So that is why I am pleased that we are holding this important hearing on health care transparency today. I am fully supportive of the efforts to shine a light on the fraud and the waste and the abuse percolating in our health care industry. But we need to do more than shine a light. Fortunately, over the past two years, we have made some major strides.

First, we finally gave Medicare the ability to directly negotiate prescription drug prices, which will save taxpayers more than $300 billion over 10 years. The Biden Administration has implemented price transparency regulations, which require hospitals to publicly post prices for all their services on their websites in a user-friendly format.

Now, the hospitals, I would say, have been slow to

comply. But CMS recently found that 70 -- at least 70 percent of hospitals are in compliance with the rules over 2 years after they were finalized. But this has to be 100 percent participation. CMS is now stepping up enforcement measures against the 30 percent of hospitals who remain non-compliant. And I would just put out a call today, don't fall into the CMS enforcement lane; do it yourselves. You have had time, do this.

Third, we are finally wrangling the abuses by Medicare Advantage programs. The Administration has taken steps to recover improper payments to private plans, and return this money to the Medicare Trust Fund. This is going to put money back into the pockets of American taxpayers, and protect the long-term solvency of Medicare for future generations.

Looking forward, we have to examine reforms to Pharmacy Benefit Managers, PBMs, the secretive middlemen in the prescription drug industry that drive up prices and keep out affordable drugs. And, Mr. Chairman, I was glad to hear in your opening statement that you view this the same way.

*Mr. Guthrie. Absolutely.

*Ms. Eshoo. Count me in with you to do something about this.

We really have to start spending smart. This means spending money on preventive care, public health, and biosecurity. So again, I am glad that we are having this hearing today.

But I am disappointed that we didn't receive the witness testimony until 1:00 yesterday, even though the hearing was noticed three weeks ago. But let's have a good hearing. I want to acknowledge -- and I saw them out in the hall -- the patients -- the patient rights advocates. They all have patient gowns on. I don't see them in the hearing room; I guess they will come in shortly. But I want to acknowledge their advocacy, because advocacy is always highly instructive to Congress.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. So with that, Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. I now recognize the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

*Ms. Eshoo. There they are.

*The Chair. Yes. Thank you, Mr. Chairman. There they are, the patient rights advocates.

Welcome, thank you for being here.

[Applause.]

*The Chair. Yes, welcome to the Energy and Commerce Committee and a very important hearing today. And it is an issue that we are addressing with bipartisan support. I really appreciate the comments of the chairman, the ranking member, as we are focused on driving down the cost of health care.

It is a top concern, as cost of living has surged. More than 60 percent of Americans are living paycheck to paycheck. It means they are just one medical bill away from a financial emergency, one doctor visit away from not being able to pay the rent for their groceries or gas.

A recent poll of Americans with health insurance found more than half ranked reducing health care costs as their top

health care policy priority. For a more secure and healthier future, people need to have certainty and stability.

As the ranking member just mentioned, the United States spends more on health care as a percentage of our economy than any other developed nation, and CBO projects that the Federal health care costs per person are expected to grow faster than the economy, meaning the U.S. will continue to spend more as a percentage of our economy. So I am pleased that we are working together in a bipartisan way to hold this hearing on what the Federal Government can do about the high cost of health care.

Improving price transparency in our health care system is one of the ways that we can drive down costs. It is fundamental to restoring the doctor-patient relationship. Right now it is nearly impossible for patients or their employers to shop for the best and most affordable care they or their employees need. It is nearly impossible for people to plan ahead and budget their health care costs.

Take, for example, Dani Yuengling from South Carolina. She needed a biopsy and had a $6,000 deductible. Her hospital's price tool estimated that she would pay $1,400. After receiving the bill, she found out that the true cost of

the service was nearly 18,000, and she was on the hook for more than $5,000. Patients shouldn't be in the dark until after they receive care and their bills come.

Now, the Trump Administration finalized two rules on price transparency. The first rule requires hospitals to post standard charges and payer-specific rates for all items and services and a consumer-friendly display of at least 300 shoppable services like an MRI. The second rule requires insurers to post comprehensive rate information and provide patients personalized pricing information for 500 items and services. That includes a wide spectrum of services, from routine doctor visits and imaging services to more complex care like knee replacements, or even delivering a baby.

Unfortunately, independent evaluators broadly agree that most hospitals have not complied fully with the rules. We need stronger enforcement at CMS, which to date has only leveled -- levied two penalties against hospitals for not posting accurate information for patients.

We will hear from a hospital in my district that is transparent and in compliance with the rules about their experience, and why we should have reasonable expectations that other hospitals should comply with these rules. Eastern

Washington employers have also been on the forefront of utilizing price transparency for good. Schweitzer Engineering Laboratories in my district, one of the largest private employers in eastern Washington, has been a leader in utilizing price transparency to deliver better quality care at lower prices.

We know from stories like these, if fully implemented, these rules help Americans. A recent economic analysis found that, together, both rules could reduce spending for privately-insured individuals by tens of billions through 2025 alone, with low-income Americans seeing the most significant benefits. Ranking Member Pallone and I have worked together on oversight for these rules for the past two years, and I look forward to continuing that bipartisan work today.

Additionally, we will also examine how more competition can help lower health care costs. Hospital physician and health insurance markets have become increasingly consolidated. Consolidation hasn't just been limited to hospitals buying other hospitals or physician groups buying other physician groups, also known as horizontal integration; we have seen a rise in vertical integration, where purchases

occur across different sectors within the health care system.

For example, this could mean hospitals acquiring physician groups or insurers buying PBMs. For patients, this could mean their insurance company may own their doctor's practice, their pharmacy, and the PBM that decides what they pay for medicine. These -- are these arrangements in the best interests of patients? It remains to be seen, and one of the reasons why we are having this hearing today.

So thank you. Thank you to the witnesses. We are grateful for your expertise and work, and looking forward to having this bipartisan conversation.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. I yield back.

*Mr. Guthrie. Thank you. I thank the chair for yielding. The chair now recognizes the gentleman from New Jersey, the ranking member of the full committee, Mr. -- Rep. Pallone for five minutes for an opening statement.

*Mr. Pallone. Thank you, Chairman Guthrie.

Today's bipartisan hearing builds on this subcommittee's critical efforts to lower health care costs and make coverage more affordable. More Americans have health coverage today than ever before, thanks to the Affordable Care Act and the expansion subsidies included in the American Rescue Plan and the Inflation Reduction Act.

A record-breaking 40 million people have gained coverage, and a record high 16.5 million Americans have coverage through the ACA marketplace. Millions of families have seen the cost of their monthly insurance premiums go down by more than 20 percent. The average family is saving $2,400 in premiums a year, thanks to the ACA enhancements we made over the last 2 years. And the Inflation Reduction Act will also lower prescription drug prices for America's seniors.

We are making significant progress, but high health care

costs and affordability continue to be a challenge and a financial burden for American families. Our health care system is complex and challenging. Too many patients are forced to wait until after they receive care and have the medical bill to fully understand how much they owe.

Patients deserve greater transparency in the prices they pay for health care. Today consumers are not able to easily obtain price information in advance. Sometimes the price information that is provided is inaccurate and misleading, making it difficult to determine the true value of the care. And patients also face wide price variations. The lack of transparency makes it difficult to compare across providers in advance of receiving care.

Prices for health care services also vary widely across different geographic areas, but also across providers in the same geographic area. According to an analysis by the New York Times, a single hospital can have up to a 300 percent price difference for the same service, depending on the insurer. Another analysis by the Peterson Center and the Kaiser Family Foundation found the price of a joint replacement for knee or hip surgery varied widely across the 20 largest metropolitan areas, ranging from less than 20,000

to more than 70,000.

So a lack of transparency into these prices makes it difficult for both consumers and employers to make informed decisions. Employers have difficulty accessing data that could help them negotiate competitive prices and design high-value plans.

The contracts of Pharmacy Benefit Managers are also opaque. This makes it difficult for employers and plan sponsors to understand drivers of cost and negotiate savings. We also need greater oversight and enforcement of Pharmacy Benefit Managers.

We must also build on the Hospital Price Transparency final rule and the transparency and coverage final rule requirements. The Hospital Price Transparency Rule is meant to bring more transparency to health care by requiring hospitals to display charges for the most used services in a consumer friendly way.

However, I am concerned by reports that many hospitals are either acting slowly or not yet complying with the final rule. I am also troubled by reports that some hospitals are making it more difficult for consumers to access the information. I understand that some hospitals are requiring

consumers to input personally identifiable information in order to access information that should be easily available, or burying the information deep in their websites.

All this is inexcusable, so I look forward to hearing from the witnesses on what reforms are necessary, and what more Congress can do to further strengthen those regulations.

While greater price transparency is important, I don't believe it is sufficient in and of itself to expand coverage or to improve affordability. Today 43 percent of U.S. adults are inadequately insured, and half of uninsured or under-insured Americans face problems paying their medical bills. More than 40 percent of adults have delayed or forgone medical care because of the cost. And more than 100 million Americans have medical debt. So transparency alone will not help lower out-of-pocket costs for families.

We need to couple greater transparency with real solutions that will lower costs, and that is why we must continue to build on the historic progress we have made over the last two years. We need to continue to expand coverage and make health care more affordable and accessible for all Americans. It is critical that we make the ACA subsidy expansions permanent, and build on the success of the

Inflation Reduction Act to further lower drug prices for consumers.

So today's hearing is an important bipartisan step in our continued effort to reduce health care costs. I look forward to the witnesses' testimony.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. And with that, Mr. Chairman, I would yield back, Chairman Guthrie.

*Mr. Guthrie. Thank you. I thank the ranking member for yielding back.

The chair reminds members that, pursuant to the committee rules, all members' opening statements will be made part of the record.

Are there any further opening statements? Any opening statements on the Republican side, any on the Democrat? Any further opening statements?

Seeing none, I would like to introduce our witnesses. Our first witness today is Chris Severn, co-founder and CEO of Turquoise Health. Our second witness is Matthew Forge, CEO of Pullman Regional Hospital. Our third witness is Marilyn Bartlett, senior policy fellow with the National Association of State Health Policy. Our fourth witness will -- is -- witness is Sophia Tripoli, director of health care innovation at Families USA. And our final witness today is Ben Ippolito, senior fellow in economic policy studies with the American Enterprise Institute.

I thank you all for being here, and the time that you put into being here today and preparing for -- to be here

today. I thank you.

Some of you -- most of you have testified. If you haven't, you have five minutes. You will see a green button and -- a yellow button means it is getting close to time to -- yellow light, time to wrap up. And then -- that is right, we get to push the buttons on our side -- the lights will wrap up, and then red means that -- to finish up, if possible.

So we will start with our first witness. Our witness will be Mr. Severn.

You are recognized for five minutes for an opening statement.

STATEMENT OF CHRIS SEVERN, CO-FOUNDER & CHIEF EXECUTIVE OFFICER, TURQUOISE HEALTH; MATTHEW FORGE, CHIEF EXECUTIVE OFFICER, PULLMAN REGIONAL HOSPITAL; MARILYN BARTLETT, SENIOR POLICY FELLOW, NATIONAL ASSOCIATION OF STATE HEALTH POLICY; SOPHIA TRIPOLI, DIRECTOR OF HEALTH CARE INNOVATION, FAMILIES USA; AND BENEDIC IPPOLITO, SENIOR FELLOW IN ECONOMIC POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF CHRIS SEVERN

*Mr. Severn. Chairman Guthrie, Ranking Member Eshoo, members of the Health Subcommittee, thank you for the opportunity to testify at today's hearing.

We started Turquoise Health in 2020 as a direct response to the 2019 executive orders on price transparency for hospitals and health insurers. In my 10-year background working with the secret contracts negotiated between providers and insurers, it was clear to me this sudden profusion of price transparency data would both spur health care price competition and reform the patient financial experience.

Prior to January of 2021, there was no accessible market

data for patients to price shop. Perhaps equally important, there was no data to drive regional macroeconomic price competition. In late 2020, as we prepared to launch Turquoise, a platform that would allow patients to browse these new prices for free, bipartisan efforts in Congress passed the No Surprises Act. This new legislation detailed a much-needed workflow for communicating good faith estimates for insured patients. Critically, it also outlined an avenue for patients to dispute inaccurate estimates after the fact.

These three laws each mandate essential data and system changes that will finally permit insured patients and their employers to know the cost of care. Any significant modification to these laws could lead to the overall dilution of the intended dual aims of creating competition and empowering savvy consumers of health care.

There are three main themes I aim to shed light on today: What is the state of compliance with existing transparency mandates? What impacts are we already observing on the economics of health care? And three, in what areas can additional government effort further the impact of these laws?

On the state of compliance, Turquoise is one of the few

data companies that monitors all 6,000 hospital websites on a quarterly basis, and all health insurance websites on a monthly basis. As of March 1st, we have seen over 5,100 hospitals publishing price information, compared to just 1,800 hospitals this time 2 years ago.

Health insurers were required to publish pricing data 18 months after hospitals, starting July 1st of 2022. As of March 1st, we have discovered over 180 insurers with pricing data published, an increase from 69 in July of last year. We estimate these prices to represent 96 percent of covered commercially insured lives in the United States.

Notably, the new insurance disclosed data represents prices for all types of providers, not just hospitals. This creates a compelling new competitive dynamic around the site of care: When is it most cost effective to treat in a hospital or surgery center or at home?

On the impact of the new transparency mandates, the sudden infusion of billions of health care prices into the system requires time for the industry and innovators like Turquoise to adjust. The initial setup time required for data ingestion, software development, and consumer adoption explains much of the gap in perception between the optimism

felt by startups like Turquoise and the skepticism felt by -- in the press, excuse me.

Turquoise has now nearly 50,000 website visitors browsing prices for free every month, a 400 percent increase from a year ago. This data also reaches patients and employers through 20 distribution partners working on care navigation. Critically, we are also beginning to see this data embedded into the clinician workflow at the time of the referral.

Will these new efforts to decrease the cost -- will these new efforts decrease the cost of health care in the U.S.? There is existing literature to support that competition and consumer choice will lead to lower prices.

But these new laws also present a second massive opportunity to reduce the administrative costs of health care, which studies note to exceed 30 percent of every dollar spent in the U.S., health care dollar spent in the U.S. by standardizing the payment of medical claims and the reimbursement methods negotiated between providers and insurers.

That being said, we are still far from seeing the full impact of this new data on the industry. While dozens of

academic researchers now use this data to monitor and publish on economic progress, we need continued government intervention to carry out price transparency's potential. Notably, hospitals and payers should be held accountable to publish transparency data. Enforcement has lagged, and this delays progress for patients.

The No Surprises Act needs enforcement dates for key outstanding critical measures such as the convening of good faith estimates across multiple providers and the provision of the advanced explanation of benefits. These two requirements permit the vast majority of America's commercially insured patients to benefit from the consumer protections of the law.

Finally, hospitals should be required to publish data in a standard format. CMS introduced this format in November of 2022 as a recommendation, and this should be made a requirement as soon as possible in order to create cleaner data sets for patients.

Thank you for your time today and for your continued focus on health care price transparency in the U.S.

[The prepared statement of Mr. Severn follows:]

564 **********COMMITTEE INSERT**********

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*Mr. Guthrie. I thank you for your testimony.

The Chair now recognizes Mr. Forge for five minutes for your opening statement.

STATEMENT OF MATTHEW FORGE

*Mr. Forge. All right, thank you. Good afternoon, Chairs Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and members of the committee. Thanks so much for having me all the way from Pullman out to see you today.

Again, my name is Matt Forge, I am the chief executive officer for Pullman Regional Hospital. I have served as a leader in rural health care in Idaho, Washington, and Wisconsin over the past eight years, and certainly understand the importance of pricing transparency, especially as it relates to supporting effective health care decision-making for individuals and families seeking health care.

You know, we really are here for the communities that we serve, everything that we do. Pullman Regional Hospital is a public hospital district, so everything that we do is in relation to their best interests. Transparency is really, really important to us. I want to give you kind of a -- we have been compliant with the law since 2019, which we are really proud of. And so I want to give you kind of a ground-level observation and look into that.

So first of all, let's talk with -- about the positives

that we have experienced with the transparency in the law. You know, one, it is driving a greater understanding of a really complex environment, down to the ground level. So not just within our communities to patients -- patients are having conversations that they have never had before -- but also within our organization, as we are able to provide more thorough information that our patients can utilize in their decision-making, which is fantastic.

I think the second one, which we are really, really excited about now, is it is creating a table that we can go with people like Schweitzer Engineering and other industries within our community -- it is creating a table where we are looking at data and having conversations about how to lower cost and increase value of health care within our environment. Those are really, really important conversations to have, and I think for one of the -- for the first time we are starting to have those in our community.

Three -- and I think is a big reason why we are here today -- is greater competition. Now, Pullman Regional Hospital is one of five hospitals in our region, so of course we are competing. And I think the important thing is that we are not just talking about cost. I think when we are having

those conversations with our patient financial counselors and our patients about a joint replacement surgery, we are talking about quality, as well. So we are talking about cost, but we are talking about quality. And it is really coming to the table and having those conversations together.

Now, we have been there since 2019. I have personally been working on this my entire career, trying to -- you know, point of care cost reporting is something that people are really interested in. It is a challenging thing to accomplish.

So the first challenge that we face is making it accurate and meaningful. We all know health care is a complicated business. It changes all the time. It is a fingerprint business. That means every individual that comes in has a little bit different experience. They have a different employer. And so making sure that that information is accurate and meaningful is difficult. And especially in rural America, that is something that we are really struggling with. But there is a lot of people putting a lot of time and effort into that.

Managing constant changes. Health insurance plans change every single year. You know, our regulations are

changing consistently. We are spread thin as leaders. So, of course, managing those constant changes, pricing strategies, payer contract tracking, changes in the marketplace are difficult. So managing that here.

And then a big one is competing priorities. We have to recruit physicians. We have to manage health care needs within our community. All these things come up against ensuring that we have great pricing transparency. So while it is one piece, it is a part of a bigger puzzle that will -- that we are working hard to solve.

And then, as we look forward to opportunities and how we can get help from you all today, is continue to align incentives. I mentioned working with industries within our community. We are talking about data. That data is becoming transparent. We are talking about real-life things, real-life problems, and making progress there.

Continue to help us simplify. Our patients are asking for that. Our communities are asking for that. We are asking for that. It is not a simple process, and we need to continue to work with each other to simplify this.

And then how can we minimize distractions? You know, these programs are fantastic. I am a huge believer in all of

them, and I work hard in doing that. Getting them to be operational is extremely challenging. And if we are managing multiple priorities through this, it makes it more and more difficult to handle these things, especially from a rural perspective. So help us minimize distractions.

Again, this is a really important topic, and I really appreciate you guys having me today. Thank you.

[The prepared statement of Mr. Forge follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for being here. I know that you traveled a long way. I know the chair enjoys showing great things that are happening in her home state, so thanks for making the long trip. I appreciate it.

Next, Ms. Bartlett, you are the national policy -- policy fellow for National Association of State Health Plans, but your state health plan was Montana. So please give our regards to your governor. We miss him on the committee, and tell him hello for us. You are now recognized for five minutes for an opening statement.

STATEMENT OF MARILYN BARTLETT

*Mr. Bartlett. Thank you. Chair Rodgers, Ranker Pallone, Chairman Guthrie, and Ranking Member Eshoo, thank you for this opportunity to testify this afternoon. I am a senior policy fellow with the National Academy of State Health Policy, but I am also a health care cost consultant. And today I am speaking as Marilyn Bartlett, a forensic accountant focused on following the money in the health care system to support policy, employer-sponsored health plans, and all with the goal of lowering health care costs.

I hope my testimony today will help the committee not only understand the challenges for health care purchasers, but the opportunities to make systemic and lasting change to benefit all Americans.

Let me begin by sharing a story about the Montana State employee health plan. It has been hailed as something revolutionary, but what we did was nothing more than demanding transparency, analyzing the data, and negotiating for fair prices. The fact that this is remarkable is indicative of a dysfunctional market that is our current model.

I was hired in late 2015 by the State of Montana to save the health plan from insolvency. It had just ended a year losing 28 million. By 2017 we had $112 million in reserves, and had achieved a savings of $121 million.

How did we do it? We negotiated contracts with every Montana hospital to reimburse as a multiple of Medicare Cost Plus. No longer were we going to stand for a secret discount off of an unknown figure.

And we had contracts. There was no balance billing of members. We terminated our traditional PBM, we moved to a transparent passthrough model, and we also removed CVS from our pharmacy network because they would not accept our prices.

We invested strongly in primary care.

So what happened? Employees have had enhanced benefits. They have had no raise to premium -- last time was in 2016. And we were able to return over 50 million taxpayer dollars to Montana General Fund because we were over-funded.

The effort was bipartisan. The Democratic governor and the Republican legislature worked together, and the state employees in the union were engaged throughout the process. We disrupted the status quo.

Since then, other states have successfully launched reference-based pricing. Oregon State employees have seen a savings of 33 percent in the first year. California's state employee plan saw savings between 12 and 18 percent for various surgical procedures. And imagine the tremendous savings you could have if the Federal Employee Health Benefits plan were to take a similar approach with your eight million members.

Other employers and unions have effectuated meaningful change, but it is often against strong headwinds from the industry that profits from the status quo. The State of New Jersey and their unions achieved billions in savings by launching a payment integrity program and a PBM reverse auction. SEIU 32BJ used data to stop egregious billing, and a small Pennsylvania county has identified 4 million in savings by negotiating directly with hospitals.

The Hospital Transparency Rule was passed in order to allow plans and consumers to compare prices of services and supplies across hospitals. Patient rights advocate reports only 25 percent of the hospitals have published complete machine-readable files containing all of the required files which are needed for a consumer, and especially for an

employer, providing benefits.

The Consolidated Appropriations Act mandates employers to have full access to their data, yet carriers are blocking them at every turn, evidenced by a string of lawsuits. Owens and Minor, a large, publicly-traded company headquartered in Virginia, has been forced to sue Anthem to get their plan data after 18 months of demands. A recent survey found that 89 percent of the voters believe Congress should take action to reduce health -- hospital prices, and 72 percent are in agreement that the prices should be limited to two times the Medicare rate.

We can and we must do better. The State of Montana plan did it, other employers are doing it, and the Federal employee health plan can do it. But we have to have price and cost transparency.

Thank you again for your bipartisan leadership.

[The prepared statement of Ms. Bartlett follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. The gentlelady yields back.

Now the chair now recognizes Ms. Tripoli for five minutes for your opening statement.

STATEMENT OF SOPHIA TRIPOLI

*Ms. Tripoli. Chair McMorris Rodgers, Ranking Member Pallone, Chair Guthrie, Ranking Member Eshoo, members of the committee, thank you for the opportunity to testify today. It is an honor to be with you this afternoon.

On behalf of Families USA, a leading national, non-partisan voice for health care consumers working to ensure the best health and health care equally accessible and affordable to all, I want to thank you for this critical discussion on health care affordability, transparency, and competition.

Today's hearing is urgently needed. Our health care system is in a crisis, evidenced by lack of affordability and poor quality. It will take all of us working together across political parties from rural and urban communities alike to fix it.

Every person in the United States should have affordable, high-quality health care that prevents illness, allows them to see a doctor when they need it, and helps to keep their families healthy. Yet almost half of all Americans report forgoing medical care due to the costs. A

third say that the cost affects their ability to secure basic needs like food and housing. And over 40 percent of American adults, 100 million people, face medical debt. Unaffordable health care is a persistent problem for national and state governments, and affects the economic vitality of middle class and working families.

Despite this financial burden, our health is not better. Our moms and babies die at higher rates, and a quarter of a million people a year are killed by the health care system for medical errors, infections, and the like. Make no mistake, America's families are suffering, and swift action is needed.

At its core, this crisis is driven by a misalignment between the business interests of the health care sector and the health and financial security of our nation's families. Health care industry consolidation has eliminated competition and allowed monopolistic pricing to push our nation's families to the brink of financial ruin. Americans of all watched as their local hospitals have become health systems, and those systems were bought by large health care corporations to increase prices year after year. These higher prices are passed on to families as annual increases,

and insurance premiums and cost sharing have become profit margins for large hospital corporations.

Since 2015 hospital prices have increased as much as 31 percent nationally, now accounting for nearly one-third of U.S. health care spending, and growing four times faster than workers' paychecks. And these prices are irrational, with a knee replacement costing three times as much in Sacramento, California than in Tucson, Arizona, and an MRI at Mass General Hospital in Boston, Massachusetts ranging from $800 to $4,200, just depending on the insurance carrier.

Particularly concerning is that health care is one of the only sectors in the U.S. economy where consumers are blinded to health care prices until after they have received a service and a subsequent bill. This lack of transparency is a major barrier to the health care sector competing based on fair prices and high quality care.

But it doesn't have to be this way. We know what is driving the crisis, and we know how to fix it. Solutions can be deployed right away to end these pricing abuses, restore competition, and make health care more affordable.

We urge the committee to consider well-vetted, bipartisan solutions, including strengthening and codifying

price transparency rules, addressing payment differentials that incentivize consolidation and drive up costs, and limiting anti-competitive behavior in provider and health plan contracts.

Ultimately, the health care sector's economics must change to align with the health and financial security of the American people. Congress has overwhelming public support to do this: 93 percent of Americans agree that we pay too much for the quality of care that we get, and 9 in 10 voters believe that Congress should act to reduce hospital prices.

I would like to finish my remarks with the story of Kynghee Lee from Ohio to illustrate just how anti-competitive these prices have become. Ms. Lee has arthritis, and once a year goes to a rheumatologist for a steroid injection in her hand to relieve her pain. Each round of injection costs her $30. But in 2021, when she arrived at her usual office to see her regular rheumatologist, she found they had moved up one floor in the building. She thought nothing of it until she received a bill for nearly $1,400. Ms. Lee's infusion clinic was moved from an office-based practice to a hospital-based setting, resulting in a price increase of more than 4,500 percent for the exact same service from the exact same

provider.

This is a national scandal. This committee has the power and responsibility to stand up for our nation's families, and stop pricing abuses driven by big healthcare corporations.

I thank the Committee for your time, and look forward to answering any questions you might have.

[The prepared statement of Ms. Tripoli follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. I thank you for your testimony. I appreciate it.

I will note there is a vote on the floor. We still have 318 left to vote, so I know we are going to have time for the next -- to finish our opening statements, and then we will -- probably one or two people may be able to ask questions. We will see how it moves forward.

But now, Dr. Ippolito, I will recognize you for five minutes for an opening statement.

STATEMENT OF BENEDIC IPPOLITO, SENIOR FELLOW IN ECONOMIC POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE

*Dr. Ippolito. Well, thanks very much, Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee. My name is Benedic Ippolito. I am an economist at the American Enterprise Institute here in Washington, D.C.

You know, the high costs of health care underpin nearly every health policy debate that we have and, frankly, many non-health policy debates. Rising costs in programs like Medicare and Medicaid create budgetary pressures for the government, right? That stresses tax bases, and it crowds out other valuable uses for that fund, those funds. Whether it is lowering taxes, whether it is spending money on other programs you like, you can't do it if health care is taking all the money.

Within the employer-based market, rising insurance costs eat away at the wage growth of workers. And across all of those settings, it becomes more expensive to expand insurance, either to cover more people or to cover more services. Of course, all of that isn't necessarily a

problem, per se, if we think that health care spending reflects the demands of consumers, their preferences, right, be it clinical quality, non-clinical value, convenience, whatever it might be.

However, at this point there is very ample evidence that much of our spending reflects market frictions and inefficiencies, rather than consumer preferences. And I think this hearing today is highlighting two key sources of those frictions.

Markets require informed consumers who have meaningful choice. If purchasers, whether it is individuals, a state health plan, an employer, if they do not have any meaningful choice, then their decision reflects nothing about their preferences, it just reflects the fact that that was the only option they had. And the same goes for a purchaser who doesn't have any information. If you make a choice, but you don't really know the full cost of that PBM, insurance plan, whatever it is, well, that choice doesn't really reflect your underlying preferences. And that really is the fundamental problem here.

So in both of those cases, we have high prices that can persist for reasons that are divorced from value. So

economic theory and empirical evidence are very clear that improving competition within health care markets increases pressures on firms to improve quality and decrease costs. Increasing transparency in conjunction can help market actors make the best use of the choices that are made available to them, and push markets to invest in the things they value by providing clear signals, by moving with their feet, voting with their feet, if you will.

In other words -- and I do think this is the key point here -- more competition and transparency doesn't just lower spending in some indiscriminate manner. Rather, it targets spending that does not reflect value to consumers. And that is the key point, I think, to this hearing.

Beyond this, policies that make progress along these dimensions, particularly transparency, are important for informing the policy-making process. We need an accurate understanding of how markets work and when they do not. That is key to redesigning incentives that, for example, may affect consolidation incentives that were brought up earlier, and understand when more active intervention is justified.

And I will just take a moment to highlight we are probably going to talk about a lot of policies that are

informed by the last 10 or so years. There has been an explosion of understanding of the commercial health care market. We much better understand the prices and the spending in those markets, how important consolidation is, and that is a direct function of the fact that we have much better data today about commercial health care prices than we did, say, 10 or 15 years ago.

In my written testimony I emphasize a host of specific policy options that can help address high health-care costs by increasing competition and transparency with a particular emphasis on those that have attracted bipartisan interest in recent years. And I will just note that that was coauthored with Loren Adler of the Brookings Institution, and was recently co-published by AEI and Brookings.

I am not going to summarize that list now, but I will note that this is an issue that spans just about every part of health care, and so that is a long way of saying that this hearing is keying in not just on health care costs in general, but rather two of the most important underlying sources of inefficient spending in health care markets.

And I thank you for the invitation to be here today, and I look forward to your questions.

[The prepared statement of Mr. Ippolito follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. The gentleman yields back.

Like I said, there is a vote on the floor. There are two votes. And so we are going to recess the committee. And as soon as the second vote is cast, I am going to come straight back. So -- and then I will be the first one recognized. So people, plan to get back accordingly. I appreciate it.

The committee will be in recess.

[Recess.]

*Mr. Guthrie. The committee will come back to order.

It is now time for members' questions, and the chair will recognize himself for the purpose of -- five minutes for the purpose of asking questions.

So, Ms. Bartlett, I know that you were in the Montana health care policy, and so my question is, what I -- we want individuals out shopping for their health care. We want individuals to have access to that, and shop for their health care.

But I think what is going to drive the system more -- I mean, it would be difficult if I was in your situation in Montana, and calling, trying to make a -- negotiate with hospitals, whatever. But when you have 21,000 covered lives

-- I think that is what you had -- it is more bargaining power, I would say, for you to move forward. And I think getting our big employer groups involved in this would be important to really -- to make this work the way that we think it should work.

And so my questions were, what did you find -- where did you find the most excess spending in Montana?

And then what were a couple of the biggest drivers in spending?

And as you spent less, did your employees have less care, or did you spend less and they still had quality care? Because we all want to make sure we have quality, as well.

So I would like to ask you that: What were the big costs; What were the big drivers of your costs; and, As you spent less, did they have less care?

*Mr. Bartlett. Well, thank you, Chairman Guthrie.

Our biggest spend was in hospitals. And being an accountant, and getting my data, I analyzed it, and 43 percent of our plan spend were in the Montana hospitals. So I knew I had to hit that first.

And we didn't have price transparency. I would argue we still don't have it now, totally. But what I did was run my

claims through an independent Medicare repricer to see what I was paying at different hospitals as a multiple of Medicare. And I found the highest was 611 percent. And I found a range that two of the hospitals were at that had high quality. And to me, they became the efficient hospitals, and I definitely negotiated to get them in the range. So we did separate contracts with each hospital to negotiate to get in the range.

I also implemented Health Care Blue Book, which would show prices as red, yellow, green; and quality as red, yellow, green, so that employees could shop right now.

I do believe that at that point employees were looking for a full bit of information to make decisions, but I also feel, as an employer, I was a fiduciary. I had to make sure only reasonable costs were spent, and I was also a steward of taxpayer dollars. So I had to make sure everything was transparent. I knew the Medicare rate, and I could verify whether or not they were [sic].

Now, you raise a really good question about the size of employer. I had a total of 31,000 lives on the plan.

*Mr. Guthrie. Oh, 31,000. I thought it was 21.

*Mr. Bartlett. And yes, that did give me bargaining

power. I have worked with employer forums, employer groups that bring together employee plans to do that. They still are struggling to get their data from their carrier, and they also come up against a wall with the carriers and with the consultants, large brokerage firms, any brokerage firm who has a vested interest to keep them where they are because of commissions.

So transparency of the whole chain of middlemen and payers, I broke a lot of that out. I fired Aon, I did my own data analysis, and I fired our TPA, I fired our PBM, and contracted differently.

*Mr. Guthrie. Well, so I guess my question -- you know, I used to work in the automotive supply business. And I will tell you, if I had a 611 percent markup on a product that I was selling them, the CEO of said automotive company would have fired the buyer buying from me moving forward.

But the question is just how you know the price. So we want to get into transparency, where people know the price they are shopping for. I don't know if it is too high, too low, or whatever, but the market can determine that if people know what the price is.

And so, as we develop transparency, what do you think

are the one or two things that absolutely are musts for us to make sure that you have access to?

Because you said you went to a lot of effort, and lot of people aren't going to have that kind of buying power. So what is an absolute must for you to know what the marketing --

*Mr. Bartlett. I think two things you need. In my world it was -- hospital prices was the big thing, although I did save 23 percent on pharmacy. But you needed to make sure you have the price. And we are starting to see that in a few of the hospital price transparency files that are complete. I can see the prices by every plan, and I can see the cash price. And I have been surprised.

And STAT published an article showing that 55 percent of the charges are -- cash price are lower than the insurance-negotiated rate.

*Mr. Guthrie. Well, thank you. I am sorry I am out of time. I had some more questions. I had some for Mr. Severn, and I will submit those for the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. The chair now yields back to himself, and will recognize the gentlelady from California, my friend, Ms. Eshoo, for five minutes for questions.

*Ms. Eshoo. Thank you, Mr. Chairman, for holding this hearing.

And to each of the witnesses, I think you all are terrific. You are highly instructive, given your experience, where you come from, what you do.

This is about transparency and, like, who can be against transparency, right? Except there are some people that are. So this is an important hearing.

I have to say, though, that I am somewhat skeptical that patients pick hospitals based on price. I think we go to the hospital that our insurance network covers. Because people that -- their out-of-pocket costs are what are foremost in their mind. I think that insurers need to negotiate prices to lower hospital costs. And in some areas, you know, there are health systems that have been bought up -- that have bought up every practice in town, and they can demand insurers pay whatever price they set.

So I think that in this whole examination, Mr. Chairman, we need to bring the insurers in here and the PBMs. We

really want to get at hidden costs and how they operate, and then how we should operate based on how they operate. I think that that would be an important examination for us. Great.

To Dr. Ippolito, it is nice to see you again. Thanks for coming back to the committee. Civica Rx is, as you know, it is a non-profit drug company. They announced in August that it would offer an important generic drug to treat prostate cancer for $160 a month. This is about $3,000 a month less than the average cost for someone on a medicare Part D plan. But many health plans are having trouble getting this lower cost to their members because of obstruction by PBMs.

So I think there is an evident answer to my question. Why do you think PBMs -- what do you think they have to gain by keeping their costs so high for Medicare beneficiaries?

*Dr. Ippolito. Well, I mean, PBMs are certainly at the -- they have long been blamed for the phenomenon of very high-list prices for many brand drugs. And particularly in Medicare Part D --

*Ms. Eshoo. Right.

*Dr. Ippolito. -- that can really --

*Ms. Eshoo. But why do you think they are doing it?

*Dr. Ippolito. It is because they get paid on the rebates, the differential --

*Ms. Eshoo. It is all about money.

*Dr. Ippolito. -- between the list and the net price.

*Ms. Eshoo. Right, it is all about money.

What would you suggest to us that we do to get at how PBMs manipulate costs this way? That is a -- I mean, this is a stunning difference right here.

*Dr. Ippolito. Yes, I --

*Ms. Eshoo. You know, $160 a month versus over 3,000 and over.

*Dr. Ippolito. Yes, it is an enormous difference. And I think the central point, the big difference between list and net prices in the drug market represents one of the most dysfunctional parts of health care, at least in its current form. So anything you can do to try and align lists and net prices in the drug market aligns -- it doesn't just lower the out-of-pocket for the senior taking that drug. What it does is it aligns the incentive. Suddenly, the insurer has the same incentive to negotiate for the same low net price that the consumer gets at the out-of-pocket -- out of pocket.

Right?

So I think, in terms of conceptual approach, that is the key: aligning the list and the net price in the drug market.

*Ms. Eshoo. Thank you.

To Ms. Tripoli, welcome back. I know Families USA has testified at our subcommittee many, many times to the betterment of the hearings and what we do.

Sutter Health has -- is really dominant in my congressional district, and they have a new CEO that came in and met with me maybe a few weeks ago, three weeks ago, something like that, very recently. And before he even asked me what I had on my mind, I told him. And at the top of my list was that they were turning away new patients with traditional Medicare, but accepting patients who have Medicare Advantage and private insurance.

Obviously, I don't support that. I don't support that practice. And these complaints have come from my constituents. When I asked him about it, he said that as they moved to hire more doctors, that that would -- that policy would not remain in place. But when we circled back with them, they had changed their mind about it. Not a good policy.

Is this -- in your view or your understanding, is this a common practice of health systems nationwide?

*Ms. Tripoli. Thank you for the question, and I would agree that is -- it is outrageous. I think it is just another example of how broken the markets have become, where we have large systems like Sutter with dominant power, and they are able to make all kinds of decisions about prices, turning away patients because of the types of rates that they are getting. So it is completely, completely unacceptable, I would agree.

*Ms. Eshoo. But what it is is that the privately-insured are favored over the publicly insured. So how would you address that? What would you recommend this committee on a bipartisan basis to do?

*Mr. Guthrie. You have got to sum up there, when --

*Ms. Eshoo. Mm-hmm.

*Ms. Tripoli. I think it is the very solutions that we are here --

*Ms. Eshoo. Oh, it is way over.

*Ms. Tripoli. -- to talk about today.

*Ms. Eshoo. You can respond in writing to me in length.

[The information follows:]

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1193 **********COMMITTEE INSERT**********

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*Mr. Guthrie. Okay.

*Ms. Eshoo. Thank you.

Thank you, Mr. Chairman.

*Mr. Guthrie. Yes, we want to hear your response.

*Ms. Tripoli. Thank you for the question.

*Ms. Eshoo. Yes, we need the response.

*Mr. Guthrie. So the chair now recognizes Chair Rodgers for five minutes for questions.

*The Chair. Thank you, Mr. Chairman. I have long said that price transparency is foundational to restoring the doctor-patient relationship. And as I mentioned in my opening statement, we have studies that show billions in savings for the health care system.

I wanted to start by asking each one of you if you agree, yes or no, that robust price transparency will empower patients and help with the downward pressure on prices.

I will start --

*Mr. Severn. Yes. Yes.

*The Chair. I will just go across.

*Mr. Severn. I will start real quick. I mean, there is a reason I dropped everything and started a business with a bunch of great people to work on this. It is a really big

event that all these prices are now public.

In the first effort over these past two years, especially for innovators that jumped in, is get all the data and create market forces. I am not an economist, but --

*The Chair. Okay, thank you.

*Mr. Severn. -- before --

*The Chair. I want to keep this going.

*Mr. Severn. Yes, oh, yes.

*The Chair. Okay, Mr. Forge, yes.

Thank you.

*Mr. Forge. Yes, absolutely.

*The Chair. Thank you.

*Mr. Forge. Yes.

*Mr. Bartlett. Yes, absolutely, too.

*The Chair. Thank you.

*Ms. Tripoli. Yes.

*The Chair. Great.

*Dr. Ippolito. Yes.

*The Chair. Great. We are unified.

So coming back to Mr. Forge, I am just personally very proud of the work that you have done at Pullman Memorial Hospital, a critical access hospital in eastern Washington,

leading the charge on price transparency. And it is clear that you also believe that you are doing right by your patients. Hospitals around the nation should look to Pullman as an example.

So do you believe that your experience is one that can be scaled and replicated nationwide?

*Mr. Forge. Well, I think, you know, first of all, I think transparency is always good. You know, we are all really smart people, and we can solve problems. If they are under the table, we are going to have a difficult time doing that. So I think, first and foremost, getting these challenges on the -- you know, pricing and these things -- on the table is how we are going to solve them.

I think it is a big challenge as you are looking across the country. We are going to have to prioritize it as a key strategy, because there are so many priorities in health care.

So absolutely, I think it can be scaled.

*The Chair. Thank you. Would you speak to recommendations that you have for improving hospital transparency experience, while making sure that the data is available to patients and employers?

*Mr. Forge. Well, I think making -- I think data is going to be the key to it. I think right now we are having to fight to get access to data. But once we do have access to data, and we are sitting down with our partners like we are doing with the business community in Pullman, we are able to come up with solutions that make our communities a great place to receive care, a great place to live, and a great place to conduct business.

*The Chair. Great. Thanks again for being here.

*Mr. Forge. Thanks for having me.

*The Chair. Mr. Severn, I -- you know, so we all agree on -- that price transparency is important.

There has been a lot of issues with the hospital requirements. And unlike Pullman, not all the hospitals are in compliance with the CMS standards. And, you know, we need to have data quality completeness and user friendliness.

So I wanted to ask, Turquoise helps hospitals come into compliance with the Federal regulations. If we increase hospital standards for data quality and completeness, do you have advice on the biggest challenges hospitals face?

And are there ways that we can help mitigate those challenges, while increasing the quality of the data and

compliance?

*Mr. Severn. Yes, there was -- it is a great question. There was a big initial setup of publishing this data for hospitals in Pullman and a lot of others, and they had to guess on a format, because there was no standard format. With the payer rule, there was a prescribed format: the table looks like this, the columns are named this. And hospitals would have appreciated that and, you know, innovators and folks using the data would have appreciated that.

And so, you know, we now have a suggested standard that came out, and I would suggest making that enforced. And I think that also helps hospitals know, if we follow this standard, we are in compliance, we are not guessing, and we don't have a question mark when CMS comes and looks at our file.

*The Chair. And I would also like you to speak to how you believe this is going to improve patient care. So increased compliance, better data, how is that going to bolster the patient-facing transparency, and ultimately directly helping patients?

*Mr. Severn. Yes, there was a great point earlier about

will patients shop for care. And, you know, I hope they do, we are banking on it.

But, you know, when my primary care doctor says, "Hey, you need an MRI,'' and there are four health systems in San Diego, I want those prices in front of my primary care to say, "Hey, you could go to any of these four. You could save $1,000 if you go to Sharp instead of UCSD.'' And so, by making a standard, you speed up that data reaching the EHR in front of the doctor, so that they have that data in front of them.

*The Chair. Well, again, it is just -- thank you all for being here. I really appreciate your input on this important issue. And we are -- we have more work to do.

Thank you, I yield back.

*Mr. Guthrie. I thank the gentlelady for yielding back, the chair for yielding back. The gentleman from California, Mr. Cardenas, is recognized for five minutes for questions.

*Mr. Cardenas. Thank you, Chair Guthrie and Ranking Member Eshoo for holding this hearing, and thank you to our witnesses for being here to give us your expertise and your opinions.

Americans are getting crushed by skyrocketing health

care costs. Medical debt is weighing down far too many people, preventing them from spending on basic necessities, and causing deeper financial pain beyond their health care. It is shameful that an individual's health can completely derail them financially. And what is worse, in most cases there is no information about how to make the best decision about their care.

I am glad to see new rules being instituted to increase transparency about cost and coverage and in hospitals and health care settings. But there is still much to be done to make sure these rules are implemented in a way that is usable and easy to understand.

I apologize, I am having a hard time reading my notes because I have allergies. And I was talking to one of my doctor colleagues, and he goes, "Let's go walk outside. It is a beautiful day,'' right? I forgot that I am probably going to get hit with my allergies. By the time I got to this building, I can barely see, and my eyes are watering. And I was walking with a doctor. My point is he couldn't help me in the moment.

So access is real and different for every person. And in America, it appears, in my opinion, in districts like

mine, which are a little bit lower income than average, access and how we communicate with people really can make the difference as to whether or not they are going to get the care that they deserve and need, even though they might have insurance, even though they might have coverage. How to access that coverage is a real issue.

So, Dr. Ippolito, thank you for providing your remarks today, and I hope I said your name right. That is the way I used to call my uncle. His first name was Hipolito. You are the second person in my life I have met with the same name.

Part of having real transparency is ensuring that the information is accessible and understandable to everyone. To your knowledge, what efforts are being made to ensure that cost disclosures and comprehensible and easy, accessible -- that are comprehensible, and easy, accessible for all, including for those with limited health literacy or reduced access to digital platforms?

*Dr. Ippolito. Well, I think the answer to that is there is sort of twofold. The first is that making sure that the submitted forms come in some type of reasonable format that includes both the raw data that is submitted to places like Turquoise that they use, and the stuff that is put in

the user-friendly format. But the second piece of this is places like Turquoise.

I mean, this is how markets work. Sometimes information is put out, and it is complicated. But Consumer Reports exists. You don't need to know everything about a car and everything about an engine to understand which one is better and which one is worse. And so there really is a role for places just like Turquoise, actually.

*Mr. Cardenas. Thank you.

In districts like mine, Spanish is the primary language for many, many families. And to your knowledge, what efforts are being made to ensure that non-English speakers can still have the same tools at their disposal to make informed decisions?

*Dr. Ippolito. You know, I am not sure about the answer to that question right now. I would have to look it up after.

*Mr. Cardenas. Okay, thank you very much. Does anybody have an answer to that question?

Please.

*Ms. Tripoli. I think on the price transparency requirements in particular, my understanding is there is not

a requirement for the information to be in any other language other than English.

*Mr. Cardenas. Okay. Well, thank you for that. I think that in this very diverse country, we should make an effort to at least make sure that it is accessible to people, and that if there is language barriers, we have the technology and the ability to make it more accessible, which, at the end of the day, means better outcomes for individuals, for people. So thank you for that answer.

I also want to acknowledge the impact of the cost of medications on American families, as well. I am thrilled that the Inflation Reduction Act was signed into law, and with it the many provisions to lower drug costs. But there are still several aspects of the drug pricing pipeline that are unclear, at best. As we turn our attention more to the role of Pharmacy Benefit Managers, or PBMs, as they are called, in the cost of drugs, I am left wondering why there is so little transparency in this space.

Dr. Ippolito, how might greater public transparency around rebates and who they go to impact costs? Can you discuss some of the benefits that we could expect?

*Dr. Ippolito. Yes. PBMs are extraordinarily -- have

extraordinarily complicated contractual relationships. And when you say PBMs, I would include things like PBM aggregators that are at a whole different level, but affiliated with those entities, as well.

The problem is it makes it extremely difficult if you are a plan sponsor, if you are an employer, to evaluate that contract and compare two PBMs to each other if the contracts are very complicated, there is 20 different fees, and you may or may not even be getting all the rebates passed through to you.

So the point about simplifying that information, making it clear to the person purchasing the plan how much this costs and what exactly I am getting suddenly makes it much, much easier to compare one PBM versus the other.

*Mr. Cardenas. Thank you very much.

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

*Mr. Guthrie. I thank the gentleman for yielding back. The chair now recognizes Dr. Burgess for five minutes for the purpose of asking questions.

*Mr. Burgess. I thank the chairman. Great panel today. I am glad we are doing it.

Transparency is something that is -- a lot of us talk

about. It has been very, very difficult to achieve. I would be remiss if I did not acknowledge the signing of the executive order in June of 2019. I was down at the White House when that happened, and I could not believe the people in the audience that day, and how genuinely excited they were that someone at some level had finally elevated this to the point where something was actually going to get done.

I -- you know, as a member of the House, and article 1 in the Constitution, I don't think executive orders are the way to go, I think we should do it legislatively. But we had not been able to do it legislatively. So the President did it with an executive order and, to my surprise, it did not disappear two-and-a-half years ago, when the presidency changed.

Well, Mr. Chairman, I would like to ask -- it is a short document, but it is a phenomenal document, so I would ask unanimous consent to introduce into the record President Trump's executive order on price transparency.

*Mr. Guthrie. Any objection?

Seeing none, so ordered.

[The information follows:]

1459 **********COMMITTEE INSERT**********

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*Mr. Burgess. So, Dr. Ippolito, let me ask you. And one of the things I have worked on for a number of years -- I never understood why in the Affordable Care Act they carved out and said physician-owned practices or physician-owned hospitals could not expand after the passage of the Affordable Care Act.

So I have a bill with Henry Cuellar of Laredo. It is a bipartisan bill to repeal the ban on physician-owned hospitals. Personal experience myself, owning an ambulatory surgery center; my dad, who was a general surgeon, actually had a physician-owned hospital when he was in practice -- I think doctors understand what it takes to make a hospital run, and they want the best facility for their patient. They want their patients to go to a facility that meets their needs, and is obviously of top notch in quality.

I have worked with a hospital in McAllen, Texas, Doctors Hospital Renaissance, for many years on these policies. They operate on the Texas-Mexico border, a 530-bed general acute physician-owned hospital. During the pandemic, Doctors Hospital Renaissance converted its rehabilitation hospital -- rehabilitation unit into a 102-bed COVID hospital in a matter of 10 days. They had to get a waiver from CMS to do that,

because they weren't allowed to expand as a physician-owned hospital. But a phenomenal service they provided in a part of the world that really wasn't receiving much in the way of services.

And then, in addition to all of that, prior to COVID they received an accreditation for and opened several medical residency programs in primary care to bolster the physician workforce in what is a very under-served area of our state. So I would just like to hear your thoughts on the value of physician-owned hospitals. If we are going to combat consolidation in the health care space, physician-owned hospitals, do they play a role in this?

*Dr. Ippolito. Yes. I mean, I think one of the lessons over the last, say, 20 or 30 years is that we ought to take any competition where we can get it in health care markets. And, you know, the bar ought to be very high for impeding entry of new competitors. And so, yes, there is some concern about, you know, potential cream-skimming with physician-owned hospitals. But to be completely honest, I don't really know that it is more acute in those settings than it is in, say, an environment where an insurer is vertically integrated with physicians. So that is a long way of saying --

*Mr. Burgess. Yes.

*Dr. Ippolito. -- it is a reasonable addition.

*Mr. Burgess. I would refer you to an article in Health Affairs of March of 2007 that I wrote that actually refuted that concept. Brilliant article.

[Laughter.]

*Mr. Burgess. So let me ask you this. Is there anything that -- else we can be doing to support the smaller and independent practice of medicine?

*Dr. Ippolito. Yes, I mean, there is a number of things. I guess there is two buckets. One is getting rid of barriers to entry for new competitors. So whether that is certificate of need laws in some states -- I don't think Texas has one --

*Mr. Burgess. Not any more.

*Dr. Ippolito. -- but I think a number of other states have them still. Whether it is scope of practice, trying to make sure that people can actually practice up until their training. And on the other end, you have got to think about other policies that really do make it difficult for physician practices to compete with hospitals. Getting paid much less to, for example, administer a drug compared to a hospital-

based --

*Mr. Burgess. Right.

*Dr. Ippolito. -- facility suddenly makes it very difficult for that kind of facility to --

*Mr. Burgess. So site neutrality is something this committee should focus on.

Let me just ask you one last question. Mark Cuban came into our Doctors Caucus a few weeks ago and talked about his company, Cost Plus Drugs. They offer generic drugs at a discount, transparent price by removing PBMs altogether. Do you see a future for that type of activity?

You talked about a line list of net prices. It seems like that is what is being accomplished there.

*Dr. Ippolito. Yes, at least for some drugs it seems like there is a reasonable future for that kind of arrangement.

It is going to be challenging in the big-name brand drug market to do that. But on the plus side, it is another sort of effort to chip away at the current standard of very high list prices and low net prices. We have seen that in other places. We have seen insulin makers lower list prices. We have seen by biosimilar makers that are competing with Humira

offer products at lower list price versions. And so I think the totality of evidence suggests there is at least an effort to move in that direction.

So that is a reasonable goal, and I think that is one way to do it.

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

*Mr. Guthrie. I thank the gentleman for yielding back. The chair now recognizes Dr. Ruiz for five minutes for the purpose of asking questions.

*Mr. Ruiz. Thank you all for being here today.

High health care costs continue to be a challenge for American families. About half of Americans have reported difficulty affording health care. Time and time again, my constituents tell me they ration or forgo medication or care because of the cost. In the emergency department, the first question I would get was, "Am I going to be okay?'' And the second question was, "How much is this going to cost? Am I going to be able to afford it?''

So even in non-emergency health care settings, patients cannot see prices in advance, and are forced to wait until after they receive medical care and get the bill to fully

understand how much they owe. Ms. Tripoli, can you discuss some of the challenges patients face in navigating the health system, and how increasing transparency can help patients achieve savings?

*Ms. Tripoli. Absolutely. Thank you for the question. I think there are two.

The big purpose of price transparency is that we have a system where we actually don't know what the prices are until we get a service and we get a bill. Price transparency helps to crack that wide open. The most important pricing information that we need in price transparency is the negotiated rate. That is the rate that is being negotiated behind closed doors between dominant health systems, hospitals, and plans, and then buried in proprietary contracts with no insight or oversight from the public.

Pulling out that information gives patients the ability to say, "I want to get my MRI for $80 at this facility, and not for $3,000 at the one half mile down the road.'' It has direct ability for consumers to be able to shop, and also for policy-makers to be able to intervene where prices have gotten too out of control.

*Mr. Ruiz. Thank you. You know, and I agree, patients

deserve greater transparency in the prices they pay for health care. But right now, despite the transparency rules that went into effect in January 2021, it is still difficult for consumers to access pricing.

So, Ms. Tripoli, in your testimony you discussed how some hospitals are failing to fully comply with the hospital price transparency final rule. Can you briefly discuss how hospitals' failure to fully comply with the provisions of the final rule is making it difficult for consumers to access critical information on pricing?

*Ms. Tripoli. Absolutely. I think that it is just another example of the gaming of keeping pricing -- prices hidden, how broken the markets are, that this pricing information is incredibly valuable for hospitals to keep hidden so they can increase prices year after year with no insight or oversight from the public.

So I think being able to pull down the pricing information is critical. We are seeing hospitals doing everything from not posting any pricing information to posting a price as a percentage of Medicare, for example, 120 percent of Medicare, which is meaningless for most consumers. They are publishing information in various formats that are

not usable or machine readable. They are using a lot of "N/As'' as examples, as well.

*Mr. Ruiz. Yes, so what are some ways Congress can further strengthen the final rule?

*Ms. Tripoli. Congress absolutely should be strengthening and codifying, increasing -- including, as we have heard some of the testimony already today about creating more standards around the format, outright prohibiting hospitals from being able to price -- post anything other than a dollar and cents amount. The actual price is what we need.

More streamlining around the names of services, so we can actually compare and understand what the services are across hospitals.

And I would also say that increasing the fine for hospitals that don't comply. The $2 million max fine is not sufficient to incentivize most hospitals to comply.

*Mr. Ruiz. I would also add the out-of-pocket costs for patients, as well, given the different health insurances that are out there.

I continue to be concerned with reports of low hospital compliance, and I believe Congress needs to further

strengthen the regulation. I believe we also need to couple transparency with policies that will further expand coverage and lower health care costs.

So, Ms. Tripoli, can you discuss how the subsidy expansions included in the Inflation Reduction Act are helping lower costs for families?

*Ms. Tripoli. Absolutely. I mean, the bottom line is that our families are facing a health care affordability crisis. The extensions of the subsidies that were passed through the IRA were critical to be able to support families in a moment when 100 million people are facing medical debt because they can't actually afford the cost of care. So we absolutely should be extending those subsidies to continue to support families.

And we also have to address the root problem of what is driving our affordability crisis. It is prices, it is predominantly driven by prices by hospitals due to unchecked consolidation from the last several decades. And so it is really -- it is critical that we are -- it is both/and. We have to also look at the root causes to address the affordability crisis.

*Mr. Ruiz. Well, thanks to the subsidy expansion in the

Inflation Reduction Act, millions of families have seen the cost of their monthly insurance premiums go down, and the average family is saving $2,400 in premiums a year. More than 40 million Americans are enrolled in the health coverage through the Affordable Care Act, the highest total on record. It is imperative that we make permanent the enhanced premium tax credits.

So I thank you, and I yield back my time.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Mr. Griffith for five minutes for questions.

*Mr. Griffith. Thank you, Mr. Chairman.

Mr. Severn and Mr. Forge, we have been discussing the Hospital Price Transparency Rule, which obligates the hospitals, as you have been testifying about, to post the "discounted cash price'' for services to their website. But it seems like some cash prices are not available at specific hospitals.

Are there any barriers in place prohibiting hospitals from complying and posting these cash prices?

*Mr. Forge. I mean, I think there is a lot of challenges that is associated with posting cash prices. Fundamentally, they are in there. They are -- we are talking

about lists of thousands. I know that we are looking at top 300s, but there is a lot in there. We have mentioned the negotiated prices, you know, that we are talking about.

I think the part that we haven't talked enough about is transparency around payer strategies. You know, a lot of times in health care you are talking -- in hospitals it is a 24-hour business, you know, that we are providing care. And, you know, you are looking at, potentially, three service lines that have a profit margin that helps support, you know, the other ones.

I think that, you know, sometimes hospitals have a, you know, you know, have a difficulty, you know, sharing some of that. It is complicated, and it is difficult to manage. And so that is where we are with that.

*Mr. Griffith. And do you agree with that, Mr. Severn?

*Mr. Severn. Yes, cash prices are interesting for hospitals, because when this law came out you had 6,000 hospitals -- some of them didn't have a cash pricing policy. Some did, some didn't. And this law forced them to think about cash prices maybe for the first time formally.

And when we think about competition, if you have options, and you are uninsured or you have a high deductible

and you want to cash pricing option, Pullman or a hospital can say, "Hey, we have a clear menu of cash prices, come on in.'' And to me, that is competition.

And so, if there is a hospital that hasn't come up with a clear cash pricing strategy, or is late to the game, that is just market competition. And we -- you know, we would hope to display sort of cash pricing certainty on the Turquoise website to reward forward-thinking hospitals doing that.

*Mr. Griffith. And let me continue, Mr. Severn. How can HHS strengthen the price transparency rules and improve compliance so that consumers and tech developers can access all prices systemwide, and more meaningfully shop for the best care?

*Mr. Severn. Is this a question about the hospital rule, or payer rule, or both combined?

*Mr. Griffith. Let's go with both.

*Mr. Severn. Okay. So on the hospital rule, you know, we have had two-and-a-half years with this. It is enforcing the standards. So adopting the standard as required, and enforcing it.

On the payer rule, you know, because it is all items and

services for all providers, the data is just so much bigger. You know, I wish we had a scale replica of the comparison in size. And for that it is more course correction. There is a good process that CMS has going technically for technical specifications with the payer rule. I would say continue that process, continue iterating. It comes down to minor course corrections, adding a few fields, renaming a few fields, being more specific. And we will see more proliferation of these rates on the payer side.

*Mr. Griffith. Well, and having these rates out there is helpful.

I recently met with a company that works in Ohio: Sidecar. I think they have actually worked with you some at Turquoise. And what they do is they figure out -- based on the region that is set up by the ACA, they figure out what the average cost is for various procedures, and they cover you. They don't go through middlemen. They just say, "We are going to give you the money for the average cost. If you spend more, that is your choice. You can spend more, but it is out of your pocket. If you spend less, you can save that savings for future medical care.'' Or you can click a box that says, "Send me the check.'' And I think that is an

interesting, disruptor concept. We will see how it goes as it goes forward.

Last week, ProPublica published a report that found Cigna, which covers or administers health care for 18 million people, built a system to instantly reject claims for not being medically necessary without its doctors even opening or looking at the patient's file to make them go through extra steps.

Mr. Forge, based on your experience as a hospital CEO, what impact does this type of a system do when it automatically rejects medical claims? What does it do to the patients?

And I have got about 39 seconds.

*Mr. Forge. Sure. Well, I talked about it earlier in terms of distraction. You know, we have to train and get our people ready in denials management, you know, making denials management a priority. And so they are working hard, you know, to do that. That keeps us away from strategies to help, you know, support our patients, you know, up to the right speed.

So, you know, we have a lot of distractions out there -- those are one of them -- that is preventing us from helping

our patients.

*Mr. Griffith. And in the last couple of seconds that I have I would just say that is what makes Sidecar -- and I am not fully advocating it, I am just saying it makes it kind of interesting, because they get rid of all those middlemen and you, the consumer, get to help drive what is going to happen. And you can either spend more on a doctor if you particularly want that doctor, or find somebody who has a lower price or a hospital that has a lower price. And I think putting the consumers in charge -- I understand there are some who may never use that, but there is a lot of us out there that would start doing it, and that creates the competition Mr. Severn has been talking about.

My time is up, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Ms. Blunt Rochester for five minutes for questions.

*Ms. Blunt Rochester. Thank you, Mr. Chairman, for the recognition, and thank you to our witnesses for your testimonies. I am grateful that we are having this hearing today that is focused on how the lack of price transparency is making health care unaffordable for countless Americans.

The Federal Government has recently made strides toward increasing transparency in the commercial health care market through two important Federal rules. But it is clear that more must be done to help Americans struggling with the crushing weight of health care costs.

Ms. Tripoli, in your testimony you note that almost half of Americans have reported having to forego medical care due to cost. Almost a third of Americans indicate that the high cost of medical care is interfering with their ability to secure basic needs like food and housing. And although 8.2 million fewer Americans are struggling with medical debt under the Biden-Harris Administration, too many Americans continue to have problems paying their medical bills.

Can you give specific examples of how health care transparency can result in lower health care prices, and also let our constituents know why we should have faith in the policies that we are discussing, that they really will bring down cost?

*Ms. Tripoli. Thank you for the question. I think there are two pieces to the price transparency rule that are really important. One is the negotiated rates and making sure we can actually see how irrational prices have become,

and then we can make informed policy decisions that target where they have gone too far in the price gouging direction. The other part of that, as was also mentioned earlier, is around making sure that you can understand out-of-pocket costs. Those are the two most important pieces of information for consumers.

At the end of the day, price transparency is about disrupting the status quo in the hospital business model, which is keep prices hidden, buy up the local competition, price gouge year after year, all on the backs of the American people. So price transparency both for hospitals and for plans helps to disrupt that market and give policymakers, purchasers, employers the tools and consumers to be able to get a better deal in health care.

*Ms. Blunt Rochester. Thank you.

The Hospital Price Transparency Rule requires that hospitals publish a consumer-friendly online tool that allows people to shop for services and make informed decisions. Yet some patients may not have the medical literacy necessary to navigate and take full advantage of the online tools.

Mr. Forge, it sounds like your hospital has been successful in developing a tool that is simple to navigate,

yet comprehensive. What steps did you take to accomplish this, and how can other hospitals replicate your success?

*Mr. Forge. Well, a couple of things. We have a transparency website that went up in 2019. So we have a place, you know, right on our website that is directing patients right there. And I think that you hit on a good point. That is something that we are really working on that I think benefits everybody, which is medical literacy.

You know, I mean, it is a very complicated system, and difficult for patients to understand. And so we are just trying to give multiple methods: a website, but also in-person, you know, care conferences. Like I told you, the patient financial counselors are really helping to train patients on -- right at the front end of service, to make sure that they are making the right decisions for themselves and their families.

*Ms. Blunt Rochester. Thank you. You know, I am really concerned about this because I looked at a couple of these websites, and they are not equal. And some are still very hard to understand.

And so, Ms. Tripoli, I would also like to hear your perspective on how hospitals can make it easier for consumers

and employers to compare prices for services and make informed decisions.

*Ms. Tripoli. Absolutely. I think, first and foremost, we have got to get all the hospitals complying with the basic rules. And we know we have got a lot of work to do to be able to get there. I think part of that is making sure we have more standardization across what the required services are, so that when you are looking for an MRI in one hospital, that same MRI is showing up in another hospital. There is a little bit of variability right now.

And I think the other piece to point out is we also have to clean up the data files. Like, we have to actually have prices. We have to have the same standard way for how we are describing services, so that consumers can actually understand. You know, most folks don't know what a CPT code is.

*Ms. Blunt Rochester. Right.

*Ms. Tripoli. So we need a description to explain, well, what does that mean?

*Ms. Blunt Rochester. Exactly.

*Ms. Tripoli. And what price am I getting for that service?

*Ms. Blunt Rochester. Thank you. I have, like, 30 seconds left, but Ms. Bartlett, I co-chair the Primary Care Caucus, and so I was really pleased and interested to hear about your work with primary care. Can you tell us how you invested in primary care, and how that specifically helped save the plan from insolvency?

*Mr. Bartlett. Yes, thank you. We implemented five on-site or near-site primary care clinics. Employees and dependents could have an appointment online. They could schedule -- all appointments were 20 minutes. You could do back-to-back appointments. We negotiated radiology, ultrasound lab contracts with independents that were wonderful. We also had health coaches for diabetic care clubs. And so we improved access, because the employees had no cost to go to these.

*Ms. Blunt Rochester. That is so powerful.

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

*Mr. Guthrie. Thank you. Ms. Blunt Rochester yields back. The chair now recognizes Dr. Bucshon for five minutes for the purpose of asking questions.

*Mr. Bucshon. Thank you, Mr. Chairman, and I will start by expressing my appreciation to the members of this

committee and the witnesses here today for what seems to be a shared commitment to lowering the costs of health care by increasing transparency and accountability in our health care system.

Many of you know about my long-time interest in a program known as 340B, named for a section of the Public Health Service Act in which it appears. The 340B drug pricing program was created by Congress in 1992 to enable providers, and I quote, "to stretch scarce Federal resources as far as possible, reaching more eligible patients, and providing more comprehensive services.''

If you take away one thing from my comments today, let it be this: I support the 340B program, and I want to see it succeed. I want Federal resources to be put to good use. I want services to reach more patients, and I want patients to have access to more comprehensive services. 340B operates by allowing certain entities -- theoretically, those that serve our most vulnerable populations -- to purchase prescription drugs from manufacturers at a discount.

They are permitted to pocket that discount, because we expect that they are providing disproportionate amounts of charity care for patients who are uninsured or under-insured.

But because Congress failed in 1992 and in the last 30 years since to set clear guidelines and parameters for the program, we have no way of knowing when the program is being exploited, and we know that it is. And that is not just my opinion. A GAO report and a report from this committee's Oversight Subcommittee a number of years ago said so very clearly.

Although I have heard rumors and have seen smaller-scale examples for the last decade, at least, exploitation of the 340B program was clearly and strikingly demonstrated in a New York Times article published last September. I encourage all of my colleagues to read the article, which I will submit for the record.

I ask unanimous consent to submit that for the record.

*Mr. Guthrie. Hearing no objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. The gist of this is -- and I am quoting again -- "Starting in the mid-2000s, big hospital chains figured out how to supercharge the program.'' I am quoting from the article. The -- "where patients with generous private insurance could receive expensive drugs, but on paper make the clinic's extensions of poor hospitals to take advantage of 340B.''

The article discusses how a large hospital system in Richmond, Virginia -- not far from here, in the former district of our late friend and former committee member, Don McEachin -- did just that. It purchased a 340B-eligible hospital in a poor, predominantly Black neighborhood, used the hospital's 340B status to purchase discounted drugs for use at points of care across the system, decreased services to patients at that 340B hospital, including closing its ICU, and profited to the tune of $100 million per year on the 340B program.

We also know from disclosures of Fortune 500 companies that 340B is seen for -- by profit entities as a revenue generator for shareholders. For example, CVS Health, the fourth largest company in the country, warned investors in its 2022 annual shareholder filing that changes to the 340B

program could, and I quote, "materially and adversely affect the company.'' Information like this informs us exactly where the 340B discounts are likely not going to: the patients.

I hope to eventually work on broad, large-scale reforms to the program. But in the short term, consistent with this hearing, I am calling for Members of Congress to join me in advocating for more transparency on the discounts.

Can we not agree that entities benefiting from the discounts need to show the American people what they are doing with the savings, and for that matter, what the savings are? This wouldn't be difficult, because CMS already requires many types of providers, the grantees, to report similar data.

So Mr. Forge, does Pullman Hospital report its annual amounts of charity care and payer shortfall?

*Mr. Forge. Yes, we are required to share our charity care outlay --

*Mr. Bucshon. To CMS, correct. And if Congress asked Pullman to report how much savings in 340B they receive in the aggregate each year, would that be feasible?

*Mr. Forge. I think anything is feasible. I think we

can share any information that is asked for us -- you know, asked from us. Transparency in the spirit is what we are looking for.

I can say that it is a challenging program to manage. We have to get outside help to help us manage that.

*Mr. Bucshon. Right, a lot of smaller facilities like yours have to have third-party people to do --

*Mr. Forge. Correct.

*Mr. Bucshon. -- that reporting. But it is being done, including in my district. And if a small, critical-access hospital like yours has the ability to collect and submit data, I have no doubt that other entities do, as well.

I don't think there is anything hospitals should be afraid of when it comes to 340B transparency, honestly. If an institution needs this benefit to continue helping patients, let them show us so we can support those efforts and make sure we have a strong program.

With that, Mr. Chairman, I yield back.

*Mr. Guthrie. I thank the gentleman for yielding. The chair now recognizes Mrs. Dingell from Michigan for five minutes for questions.

*Mrs. Dingell. Thank you, Mr. Chairman, and thank you,

Ranking Member Eshoo, for convening this hearing.

Nobody, Democrat, Republican, independent, anybody should be harmed by medical expenses. And as health care continues to rise, it is important that consumers have access to accurate pricing information about their health care.

You know, I think the current health care system is gobbledygook. I am healthy, but for -- I have had an infection, and I have had three CAT scans at three different institutions in the last three months. They have all been between 6 and $8,000. Medicare covers a few hundred. My insurance covers another few hundred, but each of them has a different amount, and the rest of it goes into Never Never Land. And I am one of the lucky ones, because I have Medicare and insurance. People can't understand the system.

And talk to a pharmacist or a patient these days. Pharmacy Benefit Managers? I had a pharmacist ranting at me that a pill that cost them $10 for 30 pills, they were -- the Pharmacy Benefit Manager was charging the customer $700. It is wrong.

So the Hospital Price Transparency Final Rule is a step in the right direction to improve transparency in health care prices. It went into effect in January 2021. But since the

hospital rule went into effect, studies have found that most hospitals are not meeting all the requirements of this final rule.

Ms. Tripoli, one concern we continue to hear is the difficulties with the erratic compliance, with some estimates being as little as 16 percent of hospitals being in full compliance of the regulations. What do you think the obstacles are to preventing this compliance?

*Ms. Tripoli. Thank you for the question. I think, at the end of the day, it is just about the business model of the sector, which is to keep prices hidden so that they can continue to increase prices year after year on the backs of the American people. There is not a strong enough financial incentive or requirement to get prices -- disclose prices, because that pricing information is the most valuable piece of information in the hospital business model.

So price transparency, unveiling prices, requiring the negotiated rate to be disclosed for the public is hugely powerful, disrupts the status quo, and it actually allows policymakers to make targeted decisions about how irrational prices have become, and it allows academics to understand where does high value occur -- value care occurring, where is

low-value care occurring, and then we can make targeted interventions to make sure all people living in this country have high-value care.

*Mrs. Dingell. So some of my colleagues were asking this question, but I am going to ask it again. As -- you know, what can we do to help encourage that compliance?

You said there is no incentives. Do we penalize? There is -- what specifically would you recommend we do to start to increase this compliance number?

*Ms. Tripoli. I think strengthening and codifying the rule into statute is a good step in terms of strengthening on top of the requirements that are already there.

I think specifically prohibiting hospitals from posting prices as a percentage of Medicare or a percentage of gross charges -- so we actually need dollars and cents. Dollars --

*Mrs. Dingell. So talk in English.

*Ms. Tripoli. Exactly, in English. To that point, we actually need to understand beyond a confusing code that most folks don't understand what that is, a description that puts things in layman's terms: What is this?

We need more standardization across the services that we can actually compare apples to apples, and not oranges to

grapefruits.

And I would say the other piece that has not been mentioned yet is we need quality information. The only way to assess high-value care is if we have price and quality together so we can determine is that a value product that -- and are we getting our money's worth for that?

*Mrs. Dingell. Thank you. And I should have said Spanish or French or -- "layman's language'' is a much better word.

*Ms. Tripoli. Absolutely.

*Mrs. Dingell. Mr. Severn, while the rule also requires hospitals to publish the prices of common health services, we have heard about challenging -- the challenges of accessing the data. What kind of data are hospitals currently reporting, and how is a lack of standardization contributing to data inconsistencies?

*Mr. Severn. Yes, thank you for the question. So with about 5,100 hospitals in our database now, which is much better than 2 years ago, we have had to written -- we have had to write over 1,000 unique programs to bring that data in.

If you had a standard, not only is it easier to ingest

all the data and enforce compliance, it also puts some pressure on the gobbledygook of the rates, because there is now a column and a suggested format that -- it is a payment method column. And if the payment method is really simple -- just cash, a full, inclusive rate -- patients and referring physicians and employers will go towards the upfront price. And so, you know, the standard will beget competition on simplicity, as well.

*Mrs. Dingell. I am out of time, so I will yield back, Mr. Chairman.

*Mr. Guthrie. I yield briefly to the gentleman from Texas for a unanimous consent request.

*Mr. Bucshon. Thank you, Mr. Chairman. As a consequence of my excellent staff, they were able to dig up the excellent article that I referenced from Health Affairs from 15 years ago.

[Laughter.]

*Mr. Bucshon. And I ask unanimous consent to put that in the record.

*Mr. Guthrie. Without objection.

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. I now yield to the gentleman from Florida for his five minutes for questioning, Mr. Bilirakis.

*Mr. Bilirakis. Thank you. Thank you, Doctor. I appreciate it, and I want to thank the panel for their testimony.

Dr. Ippolito, as you know, Community Health Centers are required under law to have a sliding fee schedule for low-income, patients based on their needs. One way they do this is by passing through the 340B rebates to their patients to lower their prescription drug costs. This allows health centers to meet the unique needs of their communities, and they do an outstanding job.

However, when they utilize contract pharmacies, we have seen instances where these pharmacies will take these rebates, and not pass them on to patients. Do you think that is fair?

*Dr. Ippolito. Well, I mean, I -- it certainly seems to undermine the goals of that program. And I think it speaks to this broader question about the 340B program, which is, as it increases in size, are we comfortable with how the program is actually targeted? Are the right sort of institutions benefiting?

We heard earlier about -- a question about, well, which hospitals are benefiting? Is it community access hospitals? Is it safety net hospitals? Is it the Johns Hopkins and the elite academic medical centers of the world? I think this is a question that is along those same lines.

*Mr. Bilirakis. Thank you. Should we be concerned by the consolidation incentives you mentioned in your testimony, your written testimony, that also allows for single entities to take 340B rebates that should instead be legally passed on to the patient?

How do we incorporate a policy that ensures consistent compliance and accountability in the program?

And that is the bottom line. So if you could comment on that, I would appreciate it.

*Dr. Ippolito. Yes. I think, if you think about 340B, the two big questions are is it targeted well, and is it functioning just literally the way we think it is supposed to be functioning? Are the discounts going where they are on paper supposed to be going? Are there duplicate discounts between the Medicaid program and the 340B program?

When you talk about -- you mentioned consolidation -- I heard at the beginning of that. You know, one of the

ramifications of this whole program is that it gives this enormous arbitrage opportunity to hospitals that have 340B status that -- suddenly they have a big opportunity to propose to a physician that practices independently: "If you come affiliate with us, we have an enormous advantage on our acquisition costs for these medications, and we can basically share that with you.'' And so it is another contributor to this phenomenon of greater consolidation over time, and it goes back to that question about targeting.

*Mr. Bilirakis. Okay. Again, Dr. Ippolito, can you discuss if the way that Medicare reimburses for physician-administered drugs has contributed to the consolidation trend of hospitals purchasing local physician practice offices?

And how do we fix this problem without further squeezing small independent providers?

*Dr. Ippolito. Well, yes. A Medicare payment policy is like a double whammy on top of a 340B. So 340B gives the hospital a big advantage on the acquisition cost, and then Medicare pays the hospital-affiliated facility more than it would an independent physician to administer that drug. And there certainly have been proposals to address that. I know H.R. 19, I believe, incorporated some site-neutral payments,

even just for administration of drugs.

But that is part of this broader effort that places like MedPAC have highlighted. There are certain services that seem like they are basically the exact same service, and they don't really need access to the hospital. And so we ought to start thinking about whether we should reimburse those things in a way that is both saving Medicare money, but it doesn't disadvantage these independent physician practices quite as much.

*Mr. Bilirakis. Thank you very much.

Finally, I am interested in implementation of the price transparency rules. And I know that my good friend, Mrs. Dingell, here on this [sic].

Mr. Severn and Ms. Bartlett, how can HHS not only boost hospital compliance, but ensure that compliant hospitals have prices that make sense and are easy to understand for the consumer -- that is the bottom line for it to work -- so that patients and websites can access more prices and more -- meaningfully shop for the best care, please.

We will go ahead and start with Mr. Severn. I don't have a lot of time, though.

*Mr. Severn. Thanks for the question. The first -- and

I have said this a few times -- there is a standard that is suggested. And the moment that standard is enforced, and there is an enforcement date, it makes it easier for all of us to see what is in these files. It shouldn't be just Turquoise, a company with the resources, that can go through and process all this data. It should be easier to access this. And so the first step to making compliance and enforcement easier is having a standard to look through these 6,000 files.

*Mr. Bilirakis. Thank you.

Ms. Bartlett?

*Mr. Bartlett. I would agree. I think having a standard, a template, as -- would be the first big step to get those prices out, and standard descriptions and everything. But some standards would be great.

*Mr. Bilirakis. Thank you.

I don't -- I ran out of time, so I will yield back. Thank you, I appreciate it.

*Mr. Guthrie. The gentleman yields back. I now recognize the gentlelady from Washington, Dr. Schrier.

*Ms. Schrier. Thank you, Mr. Chairman. Thank you to all the witnesses for being here today, and a big, special

thank you to Mr. Forge for coming out from Spokane, from Pullman. Thank you for the work that you have done for rural patients.

You have all pointed out how transparency is critical in bringing down costs, and for patients to know what they are paying for.

Dr. Ippolito, I was intrigued by the discussion in your testimony -- and many people have commented on it now -- about different Medicare reimbursement rates, depending on whether -- what procedures take place in a hospital, a hospital-affiliated center, or a freestanding clinic, or an ambulatory center that is not associated. And of course, this sets up all kinds of wrong incentives.

And this is not pointing at the people doing the wrong thing for the wrong reason, it is just that when you have, say, an orthopedic surgeon who has to do a knee replacement, there may be pressure from all kinds of directions for that doctor to do a knee replacement in a hospital, rather than an outpatient surgical center, even though for a low-risk patient doing that is the safer and better thing to do, and even though, you know, in a hospital -- a hospital is a very expensive place to stay for a night, when you can just as

well go home and do your rehab and PT at home.

So, you know, I was just going to ask you to expand a little bit on all of this, what we should do about it, whether you are finding that hospitals are buying up ambulatory surgical centers to kind of run around this issue, and how you suggest fixing it.

*Dr. Ippolito. Well, sure. I mean, the short answer to your last question there is yes. There has certainly been a lot of consolidation of facilities that otherwise would have not been affiliated with a hospital into the hospital sphere, if you will.

I will just emphasize one thing that hasn't really come up is that, especially in the Medicare market, the site of service doesn't just affect, like, aggregate Medicare spend or something like that, which obviously matters for taxpayers, and budgets, and all those things, which are very real. But it matters for the person who is getting the care, because your out of pocket can be a 20 percent coinsurance. Well, if the bill is larger, 20 percent of a larger bill is a larger bill, you know.

*Ms. Schrier. That is right.

*Dr. Ippolito. And so I think we don't want to lose

sight of that. It is one of the examples where consolidation issues sometimes sound abstract. They affect the medium and the long run. That is an example where, yes, you can affect the consolidation incentives in a meaningful way, like you point to, but in the short run it materially affects out-of-pocket spending for people. So it is one of the avenues through which we can really make a big difference in the relatively short term.

*Ms. Schrier. And I think you brought up a really important -- there about whether people feel that if you are paying 20 percent of the bill, then you actually feel -- and you can have some power in making those decisions.

Mr. Severn, you were talking about MRIs costing vastly different amounts at different locations. And I was going to say that, with many insurance companies -- for example, with mine -- there is a co-pay. And so I don't feel it if there is a higher price or a lower price for the MRI, and the insurance company negotiates whatever price they want that has nothing to do with the list price.

I was wondering if you could talk a little bit about transparency there, but also how to give people more agency so that, when there is a higher or a lower price out there,

it serves us to go for the place with the lower price. Give us some, like, good skin in the game, if I am explaining that --

*Mr. Severn. Thanks for the question. So there is a couple ways to summit Transparency Mountain.

You mentioned one of them, which is just copay-based plans. And there is a lot of startups innovating to say, hey, no matter where you go, here is the copay.

You know, giving patients the skin in the game. There is a couple of different mechanisms. High-deductible plans is one; having a percent, co-insurance, is one. And it is back to the issue of, hey, 20 percent of a bigger number is more money, right? And so the problem with saying patients need skin in the game, but without giving them a variable that is necessary to calculate that skin in the game is what was so ludicrous before 2021.

Now we have this key negotiated rate variable, where if you have a high deductible plan or a percent co-insurance, you can do the math as a patient. But I think what I am advocating for is they shouldn't have to do the math. You know, companies like Turquoise should make it as simple as possible, like you are buying a toaster off Amazon, to say

you will pay $50 if you go here.

Hopefully, that answers your question.

*Ms. Schrier. Thank you. Yes, I appreciate it. And I know how much people are suffering from high prices.

I just wanted to lastly touch on PBMs. I use insulin. I have seen the price of insulin go up from about $40 a bottle to north of 300 now. We have talked about that before, and the role of PBMs in those pricing changes. And just want to say to my colleagues I am happy and ready to work on combating some of these perverse incentives for Pharmacy Benefit Managers, where they get compensated more for a higher negotiated medication price.

So thank you. I yield back.

*Mr. Guthrie. The gentlelady yields back. I now yield to the gentleman from Ohio, Mr. Johnson, for his five minutes.

*Mr. Johnson. Thank you, Mr. Chairman, and thank you to our witnesses for being here today.

I think this is a crucial time for discussion on price transparency, and I thank the chairman for having this hearing. It comes as Congress is in the middle of debt limit discussions with the President, and health care costs are a

really big part of what is driving the national deficit. The Medicare Trust Fund will be insolvent in less than 5 years, and our national debt is over $31 trillion, a major reason why health care costs are simply too high.

Runaway health care prices are bankrupting the country, often putting everyday Americans, our constituents, in financial distress. They are having to choose between paying for health care or paying for groceries, energy, and other necessities. Often times, they go without the health care that they need because they can't afford to go to the doctor, and they can't afford the insurance premiums that would get them there.

Health care costs now make up nearly 20 percent of GDP. This is not sustainable. At a time when inflation is crushing families, it is our responsibility to scrutinize the contributors to these skyrocketing costs, and either call for regulatory changes or make statutory changes when appropriate.

So my first question, Dr. Ippolito, how can increased health care price transparency and competition tamp down these costs and start to give families a little more wiggle room?

Will this help change the trajectory for health care costs?

*Dr. Ippolito. Yes. Well, I mean, it is a necessity, to some degree. If an employer or an individual doesn't really have much in the way of choice, well, there is not much way for them to put any downward pressure on prices in their local market. And I think we have certainly heard about specific examples of that today.

You know, in terms of a high-level point, you know, it is easy to lose sight of the direct impact that competition in health care costs have on people. We forget you don't see that if you have employer-based coverage, that costs $20,000 a year. And economic theory and evidence is extremely clear: employees pay for that, every cent of it. Every time we see health care costs go up, even if just for a sliver of workers, we see the wages adjust for that sliver of workers.

And so we really need to hammer home that point. This is not some abstract budgetary issue that affects the government in some sense. It is an issue that directly affects people, both through wages and their tax bill and so many other things.

*Mr. Johnson. Okay. Better price transparency

throughout the health care system will result in greater competition, lower costs, and create a better level of trust between patients, insurers, and providers. Congress has given the Biden Administration the tools necessary to ensure compliance of the hospital price transparency regulations already on the books.

So my next question, Ms. Tripoli, in your opinion, what could be done by CMS or the executive branch to better ensure compliance with the hospital price transparency regulations?

*Ms. Tripoli. I think, at the end of the day, this is about hospitals failing to comply. They have the requirements. We have been -- it is a Federal rule. We have been in implementation for two years. At this point we would expect to see much higher compliance, and not just a -- the -- posting some prices, complete data files.

So I think, at the end of the day, this is about hospitals showing up and doing their part and complying with Federal rules.

*Mr. Johnson. Okay, all right.

Mr. Severn, you work to help patients obtain a good faith estimate of what they will pay for services they need under the No Surprises Act, which mandated that providers

furnish such estimates. It has been a challenge to implement this part of the law in cases where multiple providers or facilities are involved.

Do you have recommendations for Congress or CMS to improve data sharing, to make good faith estimates seamless, and ensure patients have access to accurate cost information?

*Mr. Severn. Thank you for the question. So to answer that question, I will give a couple of stats.

You know, we say there are 5,300 hospitals, it looks like as of today, that have prices posted; 4,600 over that have negotiated rates; 4,500 have cash prices. I think these numbers are important, because those stats are pretty high, and we are in this data every quarter. And so maybe a lot of things that you saw last year and the year before show you that there aren't as many prices. There are quite a few prices out there, what we call coverage in the market.

The next step, as you mentioned, is these prices turn into good faith estimates, and these estimates need to be packaged. And the beautiful thing about No Surprises is that there is teeth to create an estimate that is accurate within $400. And so, to us, that is the next step. That is where this is going next is, great, your prices are out there. We

need to get them to a patient before time of service, and then you need to be -- it needs to be enforced that the estimate is accurate.

*Mr. Johnson. Isn't it amazing how a free enterprise economy actually works to drive down costs when you tell people what they are going to pay for stuff?

Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back, and I recognize Mrs. Trahan from Massachusetts for her five minutes.

*Mrs. Trahan. Thank you, Mr. Chair.

Health care in the United States operates on a free market system, where larger systems command higher rates of reimbursement with their market clout and smaller, often urban or rural systems have limited opportunity to negotiate higher prices. As many of my colleagues have said here today, this contributes to the strong getting stronger and the weak getting weaker, as providers with market clout can demand higher reimbursement from insurers.

During COVID we saw a number of rural hospitals closed because of this trend. And in the district I represent, we are seeing the same threat to access among urban community

hospitals. We are told that hospital mergers and consolidation are supposed to increase efficiencies and lower costs, but community hospitals have not been part of market consolidation, and therefore they lack negotiating power. These hospitals don't have strong operating margins to begin with, and provide care for some of the most under-served communities across the country. So they often aren't invited to join larger systems.

Mr. Ippolito, do larger hospitals and hospital systems charge more than smaller community hospitals for the same services because they cost more at larger facilities, or is it simply because these large hospital systems wield more negotiating power, and can therefore fetch higher reimbursement rates for the services they provide?

*Dr. Ippolito. It is to some degree both, but it is important to remember that the costs are endogenous. The hospital gets to choose how much things cost, and Partners has made different decisions about their underlying cost structure than, for example, a smaller community hospital.

But there is no getting around the second point. They have more negotiating leverage, and that is absolutely correct.

*Mrs. Trahan. Thank you. In Massachusetts, outside of cities like Boston, we have lower-income communities that rely on stand-alone providers. These providers have the lowest prices and operate with the fewest resources. They cannot command prices, and many of them limiting essential services and, in the worst cases, are on the brink of closing entirely.

Ms. Tripoli, where is access to care most threatened due to the limited market clout of smaller community hospitals?

*Ms. Tripoli. I think, at the end of the day, what we know about the markets is that these large, dominant systems are able to buy up independent physician practices. And that is one of the greatest trends we are seeing right now, in terms of vertical integration. And that has a direct impact not only on prices, but also access to care, and particularly primary care for many of the communities around our country.

And so one of the solutions we can do right now to end one of those incentives for big systems buying up smaller doctors' offices is to expand site-neutral payments, and -- which will also result in significant savings for the system and also for the beneficiary.

*Mrs. Trahan. So my follow-up question to that was that

I am exploring policy solutions to address this access to care challenge that is disproportionately hurting low-income communities, especially in the district I represent.

So if you could share some of the challenges facing smaller community hospitals and some of the ways that we can improve reimbursement for these kinds of hospitals, that would be helpful.

*Ms. Tripoli. That was directed for me?

*Mrs. Trahan. Yes.

*Ms. Tripoli. Again, I think one of the things we can do right off the bat, which is what is under discussion for this committee here today, is expanding site-neutral payments, which eliminates this perverse incentive for big systems to buy up independent doctors' offices, which has a direct impact on making sure that we have access to critical care in communities.

The other thing that I would just say is one of the other things we are seeing in terms of dominant market power is a lot of anti-competitive practices, including restricting providers from being able to go to competing systems, which has also a direct impact on access to care in communities. So I think taking a closer look at the different types of

anti-competitive practices that are occurring between plans and providers, and prohibiting some of those practices that we know that lead to burnout, reduced access to care, drive up prices, and result in poorer quality care.

*Mrs. Trahan. Great. Thanks so much.

I yield back.

*Mr. Guthrie. The gentlelady yields back. The chair now recognizes Mr. Carter from Georgia for five minutes for the purpose of asking questions.

*Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. I appreciate it very much.

This is my ninth year in Congress, and I have to tell you -- I am just beginning my ninth year and, you know, when I first got here eight years ago, the first thing I did was to go to the FTC and ask them to look at the vertical integration that exists with the insurance company owning the PBM, owning the pharmacy.

To me, it is a direct conflict of interest. All this could be resolved by just saying the insurance company can't own the PBM, and saying the PBM can't own the pharmacy. If we did away with that, we wouldn't have any problem. We would have what all of you have been calling for today, and

that is competition, and that is what we need.

Obviously, transparency is a big part of it. I am not going to repeat everything that you have heard here. You know that 3 PBMs control 80 percent of the market, 75, 80 percent of the market. That in itself is a big problem. When you have the insurance company that owns the PBM, you have steering going on because they are trying to get them to their pharmacy. All of that you understand.

I want to ask you, Ms. Bartlett, because I was intrigued. I haven't, unfortunately, been able to sit here the whole time to listen. But what was done in Montana with our good friend and former colleague, with -- or who is now the governor -- I guess it may have been done before then, but nevertheless, thank you for what you did. But you mentioned that you all had changed PBMs, I think, at one point. Did you know if the PBM before -- were they engaging in spread pricing?

And all of you know what spread pricing is, I am assuming, and I am sure you do. So --

*Mr. Bartlett. Yes, thank you for the question. The PBM we had previously was engaged in spread pricing.

They also had contracted with CVS to be the rebate

aggregator who would bring all the rebates in. And we were given $20 per drug rebate. And from my previous experience, I knew that that was way, way, way too low.

*Mr. Carter. Right.

*Mr. Bartlett. And then they also had contracted with a specialty pharmacy that was owned by an insurance company. And so --

*Mr. Carter. Go figure.

*Mr. Bartlett. Oh, yes. Going through that contract, you were able to see all the places that needed to be cleaned up. And so I terminated all those contracts, and went for a transparent passthrough.

*Mr. Carter. You know, I mentioned earlier about the FTC. And finally, last summer, they are undertaking a study now, a 6B study looking at the impact that PBMs are having on independent retail pharmacies. Four percent of all independent retail pharmacies are going out of business every year, primarily because of the low reimbursement by the PBMs.

And of course, you know, it is such a problem, particularly when you think about the fact that the independent pharmacies adjudicate their claims through the insurance company. Therefore, the insurance company that

owns the PBM that owns the pharmacy has all that information right there.

We had a case in middle Georgia just here in the last year, where they were cut off by one of the PBMs, and all of their patients were transferred to the mail order pharmacy that was owned by the PBM. That is -- I mean, it is so obvious to me, and thank goodness my colleagues are getting it now, and understanding what is going on. And thank goodness the FTC is undertaking this study.

I know you find it hard to believe -- we get updates from them as to how the study is going, and they are having trouble getting the PBMs to cooperate. I can't imagine. But nevertheless, that is happening.

I want to mention -- and I know it is self-serving, but I do have legislation, and it is bipartisan legislation. It is called the Drug Price Transparency in Medicaid Act of 2023. And it is to improve transparency and eliminate the use of spread pricing. You all know what is going on right now -- it made news yesterday with the attorney general of Ohio, and what he is doing -- that is the kind of thing we need. That is the kind of action that needs to be taken.

Dr. Ippolito -- I am sorry, I know you have been before

us and before the Doctors Caucus, and thank you for your expertise in this field, as well. But what about -- you know, the thing that concerns me is employers don't get it, either. They don't understand. They don't know. What can we do to help employers understand, and see just how rogue this is?

*Dr. Ippolito. Well, I mean, I think what -- you referenced your bill, and I think CBO will tell you -- I am sure they have -- that if you give the employers better information, their expectation is that they are going to change their behavior. If they better understand, really, what the rebate levels are, what the gross spend and what the net spend really is.

*Mr. Carter. Right.

*Dr. Ippolito. The only thing I will add -- it has come up a couple times -- you have got to make sure that those things actually incorporate more than just the PBM, but it has to include the rebate aggregator, the one level higher than the PBM, just to make sure that you get the full picture.

But I think their expectation is my expectation. If you know more, you are going to make a better decision, and you

are going to be -- it is going to make it easier to compare the PBMs against each other if these fees and the costs are much clearer.

*Mr. Carter. You know, I will tell my age here, but I can remember practicing pharmacy and -- when PBMs were nothing more than processors. That is all they did, was process claims. And then they evolved into this now that is causing -- you know, all of us in Congress, and Democrats and Republicans alike, we want accessibility, affordability, and quality in health care. That is what we want.

Well, right now, pharmacists are the most accessible health care professionals in America. Ninety-five percent of all Americans live within five miles of a pharmacy. If you start doing away with independent retail pharmacies, that is going to end. Therefore, it will impact accessibility to health care in America.

I am sorry, Mr. Chairman, I know I am over, and I will yield back. Thank you.

*Mr. Guthrie. The gentleman's time has expired and he yields back. We will complete the members of the committee, and then go to people who are waiving on to the committee. So next would be Dr. Dunn from Florida.

You are recognized for five minutes.

*Mr. Dunn. Thank you very much, Mr. Chairman.

You know, policies to promote transparency in health care pricing are a sure way to address the pressing issue of high health care costs. Empowering consumers with knowledge about the true cost of health care services and products will put more Americans in the driver's seat when it comes to their family's health and spending.

President Trump executed a number of transparency policies across the health care continuum, from drugs to insurers to hospitals to doctors. And this committee must ensure that this compliance with these new rules continues or is enacted. However, policies such as price caps and price setting actually pervert the market and limit access to consumer choices. That is not the path we should follow. Instead, I think we should be promoting the transparency that everybody has talked about so well tonight, and thus competition to ensure health care markets operate in a way that serves the consumers.

Mr. Severn, we have seen greater compliance amongst insurers, rather than hospitals, when it comes to their respective transparency rules. But the size and complexity

of the data files has made this information difficult for consumers to use in a meaningful way. I appreciate what Turquoise has been able to accomplish in the private sector when it comes to distilling these complex data sets to empower patients.

Will this data continue to improve the availability -- the legibility, if you will -- of the data, and continue to improve with time, or should we consider tweaks to the regulation to assist with the processing of data?

*Mr. Severn. Thank you for the question. You know, I will leave it up to others, not myself, to decide where best to tweak this.

But what I would recommend is there is a process right now for the insurance data to be modified through a technical back-and-forth that occurs on GitHub, which CMS runs. And over nine months in the -- since this data has come out, every month it has gotten more accessible, easier to work with. More companies and more third parties are making use of it, distributing it to patients and downstream.

So I would recommend continued tweaks, at least through the GitHub process with CMS, and then I will leave it to regulators to decide if more needs to happen in the text.

*Mr. Dunn. How about enforcement?

*Mr. Severn. Enforcement on the payer side is, you know, a little harder to address. I might not fully speak over that, because it kind of filters out to states and --

*Mr. Dunn. Okay, we haven't been doing it, for the most part. I think there is a couple of isolated instances, but we haven't been doing it.

Mr. Forge, the theme of this hearing is competition. It seems that you have, in fact, created competitive value for your patients in -- by complying with the Hospital Price Transparency Rules as a community-based critical access hospital. How does price transparency enhance your ability to compete with larger competitors?

*Mr. Forge. Well, I think we have kind of addressed it a little bit earlier. I think the -- what it focuses on for us, what we can really compete at is with quality. You know, when you are talking about competing on price, you know, volumes really takes the ticket right now. And so we are kind of, you know, where we are.

But if we can continue to provide a better product, and we can prove it, and a better service, maybe our volumes will continue to grow, we will gain more leverage. The cost has

got to be a part of that equation.

*Mr. Dunn. So I would say -- I am a doctor in my real life. I would say that I have seen, you know, large hospital systems that simply did not compete on cost. They didn't use the benefit of their size to get low cost for themselves, which they would then -- they didn't pass on to the consumer. So I think you have some potential to compete on cost, as well.

Dr. Ippolito, we have seen PBMs become vertically integrated with large health companies and pharmacies. I completely associate myself with the remarks of my colleague, Mr. Carter. You have previously written, however, that the effects of that integration is somewhat unclear. I am fairly confident that such integration drives higher costs for consumers. Do you have recommendations for transparency-oriented policies Congress could enact that would shed some light on the effects of that vertical integration?

*Dr. Ippolito. Yes. So I will maybe clarify my prior writing.

The effects of vertical integration, as a general proposition, are a little bit less certain, just because conceptually there can be things like better adherence or

better communication between various levels of the organization that could provide value.

That said, if you want to think about high level, what is important, you know, what do these contracts look like? Where are the incentives, right? Are there incentives to steer patients or steer volume to things that deliver, you know, revenues for you? If there is a choice between, for example, a pharmacy-dispensed product and a physician administered one, and you run a pharmacy, do you tend to steer people to the pharmacy?

Those are the kinds of questions I would be asking when it comes to vertically integrated firms like you are talking about.

*Mr. Dunn. Thank -- I want to thank the panel for their time today.

And, Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Mr. Latta for five minutes for questions.

*Mr. Latta. Well, thank you, Mr. Chair, and thanks for today's hearing, and also thanks for our panelists.

I am sure the chair has already said we have three different subcommittees that have been running today in the

committee, so we appreciate your indulgence.

Mr. Forge, if I could start my questioning, what can or should the Federal Government do to make price transparency requirements and compliance criteria clearer -- this has always been the tougher one -- and more user friendly for hospitals, while also being useful for the -- our patients out there?

*Mr. Forge. Well, I think, you know, basically, just simplification. You know, how do you simplify the regulations so that, you know, more hospitals can comply with them, you know, with less resources, less, you know, less effort, less work? We need simplification of these things.

The truth is we have to compete in rural America with big hospitals. We have to compete in that area. And so we need a little bit of help to make that easier for us to do so at that level.

*Mr. Latta. Well, you know, you bring up a question when you say "simplification,'' because, again, I know that when I go through my health facilities in the 5th district and around the region, you know, sometimes you look around and also we have had panels here before us of docs and other individuals, and I -- you know, after a while you have to ask

this question: How much time do you get to practice? How much time are you actually doing, really, the medical end of this job, instead of all of the paperwork?

And I know I have been in some doctor's offices that they have invited me in, and as I observed things for a little while, I say, "Who is actually practicing medicine here, instead of filing forms?''

So how do we -- you know, how do we get the simplification in there? Because we all know it needs to be done. But how do we do it?

*Mr. Forge. Good question. I spent most of my days trying to solve that for our teams, as it is.

I think, you know, the volume of change in regulations is a big part of it. You know, we are adopting -- adapting to new concepts, to new programs, to new deals every month, every year. And the volume of that becomes excessive. We need to kind of get back to why we are here.

An example would be simplifying the CPT codes. What do we have, 10,000 codes, you know, that we are working on? I know that is really important for value-based care, and I am all for that, but we have to figure out ways to make it easier for providers just to take care of patients and for us

to get clear bills out to our patients.

*Mr. Latta. Well, thank you very much.

Dr. Ippolito -- I hope I pronounced that -- is it Ippolito?

*Dr. Ippolito. Ippolito, but I have heard --

*Mr. Latta. Ippolito, I am sorry. We have heard much about transparency in the 340B program. And while I believe in the importance of transparency, I want to ensure that steps we take do not deny the resources from the hospitals that need them.

So do you believe we can increase transparency over the 340B program without serious consequences for our hospitals that use the program?

*Dr. Ippolito. Yes, sure. When it comes to 340B, I think the first step is transparency on two elements. Number one, is it just functioning the way that we expect it to function? And then, number two, how are the hospitals actually using that money? And I think the answers to those questions should inform any potential reform efforts that people have in mind. And they certainly would be relevant to your question about if you have a hospital that is genuinely delivering a lot of, say, uncompensated care, and they are

using their funds in that manner, then, you know, maybe we -- even if you want to reform 340B, you want to make sure you protect that kind of institution. And so transparency seems like the first kind of step in that direction.

*Mr. Latta. Well, thank you. Let's see if -- maybe I can do this real quickly in my last minute and nine seconds for the panel: Would you each briefly opine on what you believe to be the most significant driver of high health care costs?

And maybe in one minute for all five of you: What is the driver in high health care costs?

*Mr. Severn. Lack of competition and, particularly, the hospital spend, most likely.

*Mr. Forge. Complexity.

*Mr. Bartlett. The middlemen.

*Ms. Tripoli. Consolidation, particularly in the hospital sector.

*Dr. Ippolito. Yes, I would echo that, consolidation on the provider side.

*Mr. Latta. Well, Mr. Chairman, you know, I think if we can get it down in one word for an answer of what is driving the cost, I think we are doing pretty good.

But I want to thank our witnesses and, Mr. Chairman, I thank you for holding today's hearing, and I yield back the balance of my time.

*Mr. Guthrie. I thank the gentleman for yielding. Next will -- I recognize Mr. Joyce for five minutes for questions.

*Mr. Joyce. Thank you for yielding, Mr. Chairman, and to the committee for having this hearing today on such an important topic.

As this committee looks to address health care costs, we need to make sure that we are addressing misguided incentives that are ballooning those costs. As has been mentioned here today, one of the biggest drivers in increasing spending over the last 10 years has been the 340B drug pricing program. The 340B drug pricing program was created in 1992, and aimed at enabling certain health care providers known as covered entities -- and this is a quote -- "to stretch scarce Federal resources to reach more eligible patients or provide more comprehensive services.''

Between 2000 and 2020, the number of covered sites participated in the program grew from 8,100 to over 50,000. During this period, discounted purchases in the program grew from $4 billion to 38 billion from 2007 to 2020.

Mr. Chairman, I would like to ask unanimous consent to enter into the record an article from December in the Wall Street Journal to join the one entered by my friend and colleague, Dr. Bucshon, earlier today.

*Mr. Guthrie. Any objection?

Seeing none, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. Thank you. Both of these detail a myriad of issues in a program which highlight the need for changes to be made.

I want to also be clear that we must ensure that any reform in this space cannot come at the expense of patient access to medications.

Dr. Ippolito, can you explain in detail how the 340B program is contributing to the overall trend of increased costs for patients that we are seeing in the health care marketplace right now?

*Dr. Ippolito. Well, in terms of the patient effect, I think there is probably two things that would come to mind. The first is that, in theory, the money is supposed to be used to help fund care for patients, typically, that cannot afford to pay. So one of the big questions is, is that actually how the money is being used? And if it is not, that is something that is worth addressing.

And then I think the second point that I would emphasize is that this is another one of these policies that tends towards the direction of more consolidation, because it gives certain entities, hospitals, a big arbitrage opportunity over stand-alone physician practices. And so it pushes in the

direction of more consolidation. That pushes in the direction of higher costs for patients.

*Mr. Joyce. So you brought up a very interesting point. So you addressed is this being utilized for the patients who need that care? Do you think it is? And do you think that that explains the $4 billion increase to $38 billion over 13 years, or is this being abused?

*Dr. Ippolito. I think the perhaps most sort of damning answer is that I have no idea. I have no idea how the money is used, because I don't think there really is any effective oversight. I think it operates through HRSA, and I don't even know that there are standards for how the money is supposed to be spent, let alone how the oversight is supposed to work.

So that seems like an area that, for program integrity and just making sure it is doing what people want it to do, that seems like an area where transparency would be particularly useful.

*Mr. Joyce. So I addressed the district where I serve, Pennsylvania's 13th congressional district, which is rural and under-served, and I see great benefits from 340B programs for several of the rural hospitals. But I share your

concerns if this process is being over-utilized and abused.

Mr. Forge, to follow up on my colleague Dr. Bucshon's questions on reporting HRSA, do you think if Congress were to ask to compare current metrics on charity care with the total amount of savings that Pullman gets in a year from 340B or -- from 340B programs, that the need for the program would outstrip any savings that the hospital will get?

*Mr. Forge. I am not sure that I can speak to that. But what I do know is that, in rural areas, hospitals that should benefit from 340B, in my experience, have had a tough time doing so. I think they are getting to the point where they are figuring it out, and we are starting to feel the benefits. But I don't think that all the places that should be feeling the benefits from 340B are feeling that.

*Mr. Joyce. Do you feel that there might be better metrics that we in Congress should use to fully grasp the value to patients that hospitals can provide with these programs, with these savings?

*Mr. Forge. Sure. I think maintaining viability and sustainability of these, you know, hospitals, these community-based hospitals in rural areas is the priority. So how do we, you know, look at 340B in these areas as an

effective measure to keep these hospitals going, keep 24-hour emergency care services going, and make sure that these people have access to services where they live?

*Mr. Joyce. I thank you for your concise answer, because I don't think there is anything that hospitals should be afraid of when it comes to 340B transparency. If a hospital needs that support, it should be obvious, and it should be transparent. And for -- the hospital that you run and in many districts are exactly who this program is meant to serve, but I do wonder whether this same story would be clear for every hospital. And I look forward to working with my colleagues in a bipartisan way to address this issue.

Thank you, Mr. Chair, and I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Mr. Pence from Indiana.

Oh, I am sorry, excuse me. The gentleman recognizes Mrs. Harshbarger for -- yes, Harshbarger for five minutes for the purpose of questions.

*Mrs. Harshbarger. Hey, thank you, Mr. Chairman, and thank you, witnesses, for being here today. This is informative for me.

I have been a pharmacist 37 years, and PBMs are just

from the devil. Okay?

And Ms. Bartlett, you are my kind of gal, okay? And I do want to ask you one question. You have already heard from Mr. Carter about the PBMs, but you said you used a transparent passthrough PBM. Can you tell me who that is?

*Mr. Bartlett. Yes, that was Navitus.

*Mrs. Harshbarger. Navitus, okay. And there are some transparent PBMs out there.

*Mr. Bartlett. Yes, there are.

*Mrs. Harshbarger. Integra, and --

*Mr. Bartlett. And you have to make sure it is in the contract.

*Mrs. Harshbarger. Yes. I will be talking to you later.

*Mr. Bartlett. Okay.

[Laughter.]

*Mrs. Harshbarger. And I want to follow up on something that Mr. Griffith talked about, and I want to talk about that ProPublica report that was published last week.

And this is for Mr. Severn. You know, I am also concerned about the pricing, what they charge: a blood test, $1,000. And I have looked at these, because people bring

them in to me. Remember, we are the most trusted health care professional. Everybody lives five minutes from a pharmacy. And by gosh, they utilize us. All right? I guess -- are all laboratories that are not hospital-based required to post their prices?

*Mr. Severn. Thanks for the question. The simple answer is yes. And that is what is so great. We had 18 months where we only had hospital prices, and now nine months ago we are mixing non-hospital prices into the fray, which should create more competition.

*Mrs. Harshbarger. So the labs have to report that, as well?

*Mr. Severn. The --

*Mrs. Harshbarger. If they are not hospital-based?

*Mr. Severn. The insurance companies report the negotiated rates with labs on their behalf.

*Mrs. Harshbarger. Okay. Are they doing that?

*Mr. Severn. Yes, we --

*Mrs. Harshbarger. Okay.

*Mr. Severn. Billions of rates now just live on the Internet.

*Mrs. Harshbarger. You know, we had the biggest -- in

the history of the country in my district, so there is no competition. We all know competition makes everything better, and it drives prices down. And there was a hospital -- well, it really wasn't a hospital. They published their prices, their cash prices online on Facebook, compared it to the hospital, and people were angry, very angry. It is just getting the information out there.

And I guess this is for everyone. If suddenly the curtains were pulled back on all health care prices, and consumers could see prices systemwide in health care by the insurance payer and the plan, as well as discounted cash prices, what would happen? What would happen?

And I will start with you, sir.

*Mr. Severn. I think people would get in their cars and start driving to Pullman or somewhere more affordable.

[Laughter.]

*Mr. Forge. I think they would be confused.

*Mrs. Harshbarger. They would.

*Mr. Forge. I think they would be confused.

*Mrs. Harshbarger. They would be saying, "I have been paying too much for a long time.''

*Mr. Forge. Yes, that is for sure.

*Mrs. Harshbarger. Yes, ma'am.

*Mr. Bartlett. And I think employers would be very glad to see that, to see that their plan is paying much more than the cash price --

*Mrs. Harshbarger. Those --

*Mr. Bartlett. -- and compare it to their claims data, and see that there is probably some medical spread pricing going on, too.

*Mrs. Harshbarger. Totally. Self funded, they have no idea. They have no idea.

*Mr. Bartlett. You are right.

*Mrs. Harshbarger. Yes, ma'am.

*Ms. Tripoli. When we get to full transparency, I think it would give policymakers the tools to be able to intervene where prices have become completely irrational, so we can actually bring down the cost of care for the American people.

*Mrs. Harshbarger. Yes.

*Dr. Ippolito. Yes, like the last two, employers and policymakers might be the biggest users of that in the end.

*Mrs. Harshbarger. Yes, where --

*Dr. Ippolito. Where are the prices high, where are they low, and why?

*Mrs. Harshbarger. We compare prices at Walmart versus Amazon, don't we? Well, why can't we do that with health care? We can. They call me for a price on a medication at the pharmacy, and I better be lower.

Though I could talk -- I could ask you a whole lot of other questions, but I do have one for you, Dr. Ippolito, and it is about certificate of need. If you are talking about competition, you don't have competition in that arena, do you?

That is one glaring area where health care system lacks competition. And I hear about it from my constituents all the time. And these certificate of need regulations require hospitals and health care providers to obtain government approval before they can build new facilities, expand existing facilities, or purchase certain types of equipments, even beds.

Making matters worse, the laws allow existing providers to prevent competition by giving them the ability to object to new certificate of need application submitted by their would-be competitors. And many view these certificate of need laws as being the epitome of government interference, suppressing competition.

Do you agree that, as a whole, those certificate of need laws are misguided?

*Dr. Ippolito. Yes. Well, I think at this point we have about 30, 40 years of evidence, and that evidence isn't particularly kind to certificate of need, however well intentioned they were. At this point I think we need as few impediments to competition as possible in the health care market.

*Mrs. Harshbarger. Yes, I guess that is -- my time is up. I will submit some more questions to you in writing, though. Okay?

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Harshbarger. All right. With that, Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair now recognizes Ms. Kuster for five minutes for questions.

*Ms. Kuster. Thank you, Mr. Chairman, and thank you to our witnesses for being with us today.

As my colleagues on both sides of the aisle have stated, health care costs are unaffordable for literally millions of Americans. On top of high costs, patients are also navigating a confusing landscape where they can't realistically plan for how much lifesaving treatment will cost them, or if they will be able to afford it. This uncertainty often leads to decisions that only further harm a patient's health and burden the medical system, such as delaying care and rationing medication.

Patients rely on supports like the 340B program, which provides discounts on essential prescription drugs to vulnerable communities. Without programs like 340B, health care would simply be out of reach for too many. We can and must do better by our constituents.

One tool at our disposal are the efforts by this

Administration to increase transparency by enforcing existing compliance law that require hospitals and health plans to make the costs of services public, as we have been discussing today.

Another tool is increasing transparency about how hospital bills -- patients depending on where the care is provided. I am working to introduce bipartisan legislation to give patients the peace of mind that they will pay the same amount for care, regardless of where the care is provided.

Ms. Tripoli, Families USA has supported these site-neutral payment policies because they will save consumers money. How would changing hospital billing for clinically appropriate services help lower costs for patients?

*Ms. Tripoli. Absolutely. It is really about just reducing -- eliminating an incentive in the payment, the way we reimburse for care, that drives towards higher cost outpatient care, and allows hospitals, when they acquire physician practices, to rebrand them as outpatient facilities, they then tack on a facility fee, which consumers are paying directly, thousands of dollars.

I think we have seen from a variety of different

projections, from MedPAC to CBO to the Committee for Responsible Budget, significant savings, not just for the system -- estimates up to $153 billion over the next decade -- also would include lowering premiums and cost sharing for Medicare beneficiaries by $94 billion. And for those in the commercial market up to $466 billion.

It is a no-brainer in terms of cost savings for the American people.

*Ms. Kuster. Thank you so much. Site-neutral policies are also a tool to help strengthen the Medicare program overall.

Mr. Ippolito, your recent report, "Pro-Competitive Health Care Reform Options for a Divided Congress,'' highlighted that site-neutral payments could reduce Medicare spending. How could expanding this policy save the Federal Government and taxpayers money?

*Dr. Ippolito. Well, I mean, the savings to taxpayers are clear. Right now, Medicare pays substantially more for care if it is delivered in one of these settings that was just discussed, the ones that are owned by hospitals, as opposed to a physician-owned facility.

And so I still want to emphasize, though, there is two

pieces of this. There are direct savings to Medicare. There is direct savings to the government, the taxpayer. Those are very, very important. But there are also direct savings to beneficiaries in the form of out-of-pocket spending. Co-insurance can be a percentage of the price. So if the price, the underlying price, is higher, the co-insurance is going to be higher.

And so that is an important thing to keep in mind here, and that is a near-term benefit of these policies.

*Ms. Kuster. Well, thank you. Another aspect of lowering costs for patients is ensuring they can choose less expensive generic drugs.

I am reintroducing my bipartisan bill, Increasing Transparency in Generic Drug Applications Act of 2022. This legislation would make it easier for lower cost generic drugs to come to market, making lifesaving prescription drugs more affordable for patients across the country. By increasing transparency in the FDA's approval process, manufacturers will be able to bring more generic drug options to pharmacies faster.

We must continue to support a competitive drug market that encourages high-quality, lower-cost drug manufacturing.

With that, I look forward to working with my Energy and Commerce colleagues on these important policies that can increase transparency and lower costs for patients and taxpayers.

And I yield back.

*Mr. Guthrie. The gentlelady yields back. We are trying to figure out who is next in line. And next is Mr. Obernolte.

Mr. Obernolte, you are recognized for five minutes for questions.

*Mr. Obernolte. Thank you very much, Mr. Chairman. Thank you to our witnesses.

Mr. Severn, I would like to start with you. You know, we have been having this robust discussion that is -- we are talking about price transparency. But really, the consequence of our inability to have price transparency is that we don't have functional, free markets for health care in the United States. And we have seen the consequence of that not only in a lower standard of care here, but in much, much higher pricing, which I think we are all kind of incentivized here, both there and here on the dais to try and fix.

Mr. Severn, I admire the work that you have been doing trying to enhance the visibility of price data. But, I mean, if we don't have a functional health care market where consumers are making decisions about where to go for their health care based on that data, then the data doesn't do us any good, because we need those consumers to be using the data to make decisions. And when we have got a market where most, if not all the costs are borne by health insurance companies, then it is not the consumers making the choices.

So I know you have been talking about -- I think your exact words were "getting more skin in the game from consumers,'' and I wanted to tunnel down on that a little bit. So you talked about high-deductible health plans, co-pays. What do you think is the optimal strategy?

I mean, realistically, given where we are with the Federal Government's regulation of health care markets, what are the realistic next steps to getting us to -- more towards a functional health care market?

*Mr. Severn. Thank you for the question. I think we are starting to see a ripple effect, where this data is making its way, you know, to smaller and smaller organizations, and ultimately the consumer. You know,

employers, care navigators, nurse care navigation companies, and then now we are starting to see many more tech companies like Turquoise pop up and put this data right in front of the consumer.

You know, our stats is that we have got -- this time a year ago we had 12,000 people a month on our site, and now we have 50,000. So as you start to see more data filter in, and more companies pop up, you see better consumer experiences.

And there is one piece of the transparency in coverage law that we haven't seen many payers use yet, which is issuing rebates back, and writing off those rebates against the MLR. I think we are just going to keep seeing innovation, and we are only nine months into this data being public.

*Mr. Obernolte. Okay. Mr. Ippolito, kind of a similar line of questioning for you, and I am particularly interested, because I know you have done a lot of thinking about this.

The other countries have done this a lot more thoroughly, and with a lot more innovation than we have. We spend three times as much per capita as countries like Singapore, who have allowed consumers to take a much more

active role in their choices about health care.

So what would you think about doing what Singapore has done, in pairing high-deductible health insurance plans with, essentially, a co-insurance program where the government sets aside 100 percent of the amount for the maximum deductible for a year, and gives it to the consumer in a health savings account and says, "Look, this is your money.'' You know, "This will meet 100 percent of your deductible, spend it on what you want to spend it on. But by the way, it rolls over if you don't use it at the end of the year. And if you don't use it after five years, it rolls over into a retirement account. So it is yours. It has got your name on it.''

Would that kind of a system work here, do you think?

*Dr. Ippolito. Yes, it is sort of like a pre-funded HSA, kind of, it sounds like.

I think -- whenever I think of those kinds of systems, I think there is a lot of promise. And I think one of the most important parameters that I focus on is it is not just that you have liability, it is that you have liability that you understand. And so, if you were to ask me to prioritize things, I would say making sure that people actually understand the incentives they face, not just that they know

they are going to get a percentage of the bill, but making it clear.

So that means using things like reference pricing; using things like networks, which are very salient to people; using things like co-payments, which are very salient to people. Those kinds of things, it is not just that you have the incentive, it is that the incentive is very clear to you. And then I think that kind of arrangement has a little bit more potential, and we are likely to see the benefits.

*Mr. Obernolte. Sure. Well, I mean, and I understand that we are talking about transparency and consumer pricing for health care here. And the panel -- and I know everyone is pivoting back to that.

But, I mean, you said something, Dr. Ippolito, in your testimony that resonated so much I wrote it down. You said, "Ample evidence that'' -- "There is ample evidence that health care spending in the United States reflects economic frictions, rather than consumer choice.'' And my point is consumer choice doesn't matter when it is not consumers making the choices.

So when you hand them an account and you say, look, this is your money, here is a card, you can access it, do with it

what you want, you are in charge of your health care, the health insurance system is there to backstop you if you have costs that are greater than what this account can make, can bear, but this is your money, I mean, if you look at economic studies, it is very clear that kind of consumer buy-in is what is going to be required to make our health care markets in the United States function again.

And let me also point out in my remaining 14 seconds that Singapore, in addition to spending about a third what the U.S. does per capita for health care, has the highest quality health care in the world by any objective measurement. So there is a lot of room for improvement for us.

But thank you very much for your testimony today.

I yield back, Mr. Chairman.

*Mr. Guthrie. The gentleman yields back, and the chair recognizes Mr. Pence for five minutes.

*Mr. Pence. Thank you, Mr. Chairman, and thank the witnesses for being here today.

Hoosiers and, as my congressman -- as Congressman Crenshaw is very aware, and all Americans are facing higher medical costs and fewer options for care, particularly in

rural communities. Complex medical fee structures, surprise billing, and confusing coverage plans have further eroded patient trust in our health care system.

Improving health care price transparency, however, would inject needed competition for health care facilities and ultimately lower costs for patients. This is especially needed in the Hoosier State, which consistently ranks among having some of the highest hospital prices in the country.

Across southern Indiana, rural facilities are closing at an alarming rate, as they are all across the country, lowering access to care for vulnerable communities. Lack of competition has patients with fewer alternatives to access care, particularly in rural communities across Indiana's 6th district, my district. These issues are exasperated by unsustainable workforce shortages and skyrocketing labor costs.

There have been recent efforts to improve transparency, such as the Trump-Pence Administration's 2019 HHS rule requiring hospitals to disclose standard charges, as well as transparency in coverage requirements for health insurers. However, it is clear there is still more that needs to be done so that Hoosiers and all Americans can make the best

medical decisions for themselves and their families.

Dr. Ippolito, several years ago Congress took steps to harmonize Medicare payments between various sites of care for the same services provided through a site-neutral payment model. However, the services covered under the existing policy are relatively small -- are a relatively small portion of outpatient services, since almost all existing facilities are grandfathered in by the legislation.

Do we know what portion of facilities are grandfathered in under this policy, and the scope of outpatient hospital spending the current policy impacts?

*Dr. Ippolito. Well, you are certainly right that it is a very limited policy.

I don't know the number of facilities, but I can tell you that it represents less than a percentage of Medicare's total outpatient spending. I think it is 0.8 percent of Medicare's outpatient spending. So it affects a very small share.

*Mr. Pence. Okay, thanks. How would patients be impacted if the policy were to apply to a greater universe of providers and services?

*Dr. Ippolito. Well, Medicare and commercial market

patients would benefit in the long run, because it reduces the incentive to keep consolidating the provider side in the market. In the immediate term, there is an obvious benefit to Medicare beneficiaries in the form of lower out-of-pocket spending. Their out-of-pocket is often a function of the price of the service. And if that price goes down, their out-of-pocket goes down.

*Mr. Pence. So it might be a good idea?

*Dr. Ippolito. Well, I think so. But, you know, nobody voted for me, so --

*Mr. Pence. All right, thank you.

And Mr. Chair, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Mr. Crenshaw for five minutes for the purpose of asking questions.

*Mr. Crenshaw. Thank you to the chair. Thank you to my friend from Indiana. I counted three mentions of Hoosiers.

[Laughter.]

*Mr. Crenshaw. It is a thing. All right.

So thank you all for being here. I appreciate your patience with us.

You know, I want to start out by saying, you know, let's

frame this problem. So everybody needs health care. We can debate whether or not it is a right, per se, but everybody needs it, and we all agree that it is too expensive, and that our payment system is largely to blame. It is not operating like a proper marketplace.

We have a couple of things that we want in our system. We want to increase quality. We want to maintain our innovative edge. We are one of the few countries that still maintains these promises of quality, but we want it to be cheaper and accessible. Okay.

And now, I would articulate that the only forces that really drive down prices while also maintaining an innovative edge and quality are choice, competition, transparency. And that is what we are here to talk about today.

The complexity of health care makes transparency a really difficult problem. It is not like going to the grocery store. And so I would encourage this committee to focus on the entry point that everybody faces in health care, and that should be our legislative entry point, and that is primary care, and what we can do to make primary care more accessible and easier for the patient because that is your quarterback. That is -- that should be the person you use to

navigate the rest of the immensely complex health care system. You can give me all the spreadsheets in the world on price transparency; I still can't figure it out. And I am a pretty experienced patient, okay? It is just -- it is so complex.

And so I want to talk about primary care, and my favorite type of primary care, direct primary care, with you, Dr. Ippolito, if that is all right. A lot of the conversation today is about the traditional care model, where we have patients interacting with primary care providers, specialty care providers in different clinical settings, all of that. It is complex. It is overwhelming. Can you talk about how personalized care models like direct primary care can play in creating a wider, more competitive health care marketplace?

I guess I should define what I am talking about really quick, which is effectively a monthly fee for a primary care doctor, which is all inclusive. It doesn't matter how many visits you have, it is independent of insurance. It is essentially a subscription service for health care. And in the Houston area we are talking 60 to 70 bucks a month.

*Dr. Ippolito. I mean, yes. So to echo a point I made

earlier, given what we see in the health care market, we ought to be encouraging just about any kind of competition we can get. And so I think that is sort of the baseline.

When I think about direct primary care, you know, honestly, it fits pretty well within what you might think of as a sort of optimal insurance design if you were starting from scratch. That is, you really focus insurance on protecting people in the catastrophic situations, but then you try and have competition under a more normal pricing structure for more regular services. And I think that is -- at least conceptually, that is what a lot of direct primary care seems to be trying to get at.

*Mr. Crenshaw. Do you think it could have a positive effect on overall health care spending?

*Dr. Ippolito. You know, it is always tough with spending. I guess I will say two things.

The first is that, at least as I understand these models, they are often a capitated approach. Capitated payments do have really good incentives, right? So that is a good thing.

The second point, though, is that, when you think about primary care, it is often difficult to evaluate that on pure

cost savings, because part of what you are doing is you are giving people access to care that they might need, right? And a lot of that care is really high value. Getting somebody on an antihypertensive or a statin is a really big ROI.

And so I don't know that I would emphasize pure cost savings. Instead, what I would do is say it is -- there is a potential to really get more efficient spending, right?

*Mr. Crenshaw. Yes.

*Dr. Ippolito. Especially --

*Mr. Crenshaw. Well, certainly because you are keeping people out of the emergency room, and what our goal should be this continuity of care. Our goal should be every American knows who their primary care doctor is. That is definitely not the case right now. You think, like, do I call my -- if you have a problem, do you -- do I call my insurance? Do I just go to the ER? Nobody knows what to do. You need a quarterback.

All right, and I got 54 seconds. So Mr. Severn, could you talk to us about -- you get all this data, you guys have all this experience gathering this data. Can you talk about what we should do to make it more transparent and readable to

the consumer, so we can actually translate it?

*Mr. Severn. We have talked about the hospital standard that, you know, is suggested right now, and I think we have pretty unanimously said we would love that standard to be enforced. And that does make these spreadsheets a little bit more apples to apples comparable.

It also -- you know, I mentioned this a bit earlier -- it has got a column that says "payment method.'' And there is a spectrum of complexity to these payment methods. And what you will find is not just price pressure, but you reward simpler payment methods. So I will go to the doctor that can say, hey, it is $50 up front versus some sliding fee or percent of charge.

*Mr. Crenshaw. Okay. Thank you, and I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now yields to Dr. Miller-Meeks for five minutes for the purpose of asking questions.

*Mrs. Miller-Meeks. Thank you, Mr. Chair, and I thank all our witnesses who are here. It is a fascinating discussion. I could certainly ask questions for more than five minutes.

As an ophthalmologist, I moved our small three

ophthalmology practices to have a cash-based payment and a discount for paying cash because it was simpler for patients than trying to navigate through their insurance company.

And I think it is interesting, as we talk about consolidation and competition and PBMs, that, you know, one of the biggest errors was in the establishment of Medicare, Medicare having different reimbursement for different states rather than a single reimbursement for a single procedure or a single visit, which would -- then would have led to competition and medical tourism throughout the United States.

And in 2010, when the Affordable Care Act was being implemented, myself and many other individuals warned that prices would go up, that premiums would go up with the passage of the Affordable Care Act. We especially were concerned about consolidation, hospital to hospital consolidation, physician practices becoming larger physician practices or being purchased by hospitals, and that -- we warned at that time that those procedures and things being done in doctor's offices would then move to hospital-based clinics, and the prices would go up.

And it is not just the price goes up. As Dr. Ippolito said, the patient's cost share is also much greater. So

their out-of-pocket cost is also greater.

So consolidation increases health care prices and insurance premiums, as well as worsens equal access for care to patients in rural communities and medically under-served communities. And why is that? Because consolidation threatens competition. It doesn't matter if you have price transparency if there is no competition. So as you drive out competition, the value of price transparency in certain areas decreases.

You know, we have seen an increasing number of physician groups get absorbed by health systems such as the recent purchase of Oak Street Health by CVS, and more physicians working in integrated groups, and more Medicare beneficiaries being directly affected by the high cost of integration. For example, the numbers of diagnostic and imaging lab tests being performed in a hospital has increased dramatically. We are pushed as physicians within a hospital to do things within the hospital, and this has led to Medicare incurring tens of millions of dollars of unnecessary costs, as was pointed out.

And one of the things we talked about is the payment reform -- or payment reform that we think Congress should

consider, which is site neutrality. And what other things could we encourage providers to remain -- other things to do to remain -- providers to be independent, which could help with competition, Dr. Ippolito?

*Dr. Ippolito. I am sorry. Could you repeat the last part of that?

*Mrs. Miller-Meeks. What other things can we do, payment reforms can we do, to encourage both, you know, physicians --

*Dr. Ippolito. Sure.

*Mrs. Miller-Meeks. -- to remain independent, site neutrality being one of those.

*Dr. Ippolito. Sure. So, you know, think about any payment policy that pushes in the direction of consolidation. So site-neutral, making sure 340B doesn't push too far in that direction. That is one.

At the state -- while there are state policies the Federal Government could, in principle, have effects on, things like certificate of need, which some states still do have -- we have tons of evidence on that at this point -- we can talk about things like scope of practice.

Especially when you talk about rural areas, the natural

level of competition that is going to be supported is going to be lower. And so you have really got to push everywhere you can. You have got to think about where can we realistically harness telehealth, right? Certain areas, mental health, things like that, you have a lot of opportunity to use that.

But still, you know, at the end of the day, I think about the U.S. health care system in sort of three buckets. There is the really competitive markets, big cities; there is the plausibly competitive markets, a lot of mid-sized cities that may have one big, big provider; and then you have got rural areas. And you just do need to recognize that rural areas are a little bit different, and be open to being a little bit more creative in those settings.

*Mrs. Miller-Meeks. Thank you so much for that answer. And we have talked some about PBMs, and as a state senator in 2019 I put forward a bill in Iowa for transparency within the PBM and for the rebates, half of the rebate to go back to the person paying for the drugs. I got it through the Senate, but not the rebate part, the transparency part. We finally did not get it through the House that year, but we finally did. But three years later, we still don't have the

transparency data coming forward, which we are finally getting to come forward.

And as you all know, the three largest PBMs -- CVS Caremark, Express Scripts, and OptumRx manage about 80 percent of all prescriptions in the United States, up from 48 percent a decade ago. And, you know, this is very pivotal in how we make decisions. We have -- one of the PBM tactics -- and I won't talk about all of them, but it is something that Representative Carter and I have worked on -- is the growing practice of misappropriating patient assistance dollars for the benefit of the PBM's bottom line. A middleman places increasing cost on patients by relying more on co-insurance and deductibles, copay assistance, an important bridge to ensure access to needed medications.

So Ms. Bartlett, what financial burdens do accumulators place on patients when copay assistance maximum is reached?

[No response.]

*Mrs. Miller-Meeks. I may have to use -- have you submit that in writing, because my time is --

*Mr. Bartlett. I definitely will.

*Mrs. Miller-Meeks. -- expired, so --

*Mr. Bartlett. I definitely will. I got the question.

*Mrs. Miller-Meeks. So if you would submit that in writing, I would thank you.

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Miller-Meeks. Thank you, Mr. Chair. I yield back.

*Mr. Guthrie. Thank you. I thank the gentlelady for yielding back. We have now completed -- the members who are of the committee, we have three that waived on, two that are present. So we -- it looks like we have two more witnesses, so thank you all for your patience, and we will now go to our members of the full committee that are meeting here with us today, and the first will be Ms. Matsui from California.

You are recognized for five minutes.

*Ms. Matsui. Thank you very much, Mr. Chairman and Ranking Member Eshoo, for having this very important hearing today and allowing me to waive on. And thank you for the witnesses for being here today. I want to ask Mr. Forge a question.

I would like to briefly discuss the 340B program, which I know has been discussed here. But as many of my colleagues know, I have long been a champion of the 340B program, which is a critical part of the health care safety net that all our constituents depend on.

Unfortunately, there has been a lot of criticisms about this program lately, and I am concerned about some of the

conversation around 340B happening today, which is why I felt compelled to waive on. 340B is, first and foremost, a program to provide discounted drugs to low-income patients. But some of the critics of this program seem to forget that 340B has another critical purpose: to help safety net providers to provide critical services to under-served patients, and to empower them to stay open, especially after the strains of the past few years.

Mr. Forge, can you share some of the programs or services Pullman Regional is able to offer because of your 340B discounts?

And what would happen if the hospital is no longer able to participate in the 340B program?

*Mr. Forge. Well, I want to enter in a couple of different ways.

You know, first of all, it impacts more than just Pullman Regional Hospital. You know, there are local pharmacies who we contract with, which are really lifelines for small communities, you know, that they are serving. Colfax, Washington is one that comes to mind.

You know, we are working in rural areas on two to four-percent margins, you know, really tight margins. And so, you

know, maintaining access to high-quality, board-certified physicians in our emergency room, for example, you know, making sure that, you know, we have 24-hour access to obstetric care, et cetera.

You know, two to four percent is not a lot, you know, it doesn't go a long ways. And so 340B, without that, you know, we would most likely have to cut some critical services to our service area, as well as lose some lifeblood providers to our communities.

*Ms. Matsui. Oh, absolutely. Now, you mentioned pharmacies. One way that Pharma and other 340B critics have attempted to chip away at the program is by restricting entities from using contract pharmacies.

Mr. Forge, I know that Pullman Regional has relationships with several contract pharmacies to help you distribute your discounted drugs. Can you share why it is so important to your hospital and the patients you serve to use contract pharmacies?

*Mr. Forge. Well, you know, I have to say that we have had positive and negative experiences with contract pharmacies, and the most positive ones have been with the community-based, you know, pharmacies. So I kind of want to

stick with that. You know, we haven't always had positive ones, but they are -- and the reason why there is one better than the other, it really comes down to the service and -- the customer service that goes back to the patient, goes back to the people that live in the community.

*Ms. Matsui. Certainly.

*Mr. Forge. You lose that a little bit with some of those bigger ones.

*Ms. Matsui. Certainly, yes. I have another question for you regarding transparency around 340B.

Some of the latest proposals on 340B reform have suggested a need for greater accountability. Mr. Forge, can you briefly describe the requirements your hospital already faces when it comes to submitting data to HRSA and maintaining records documenting compliance with 340B requirements?

*Mr. Forge. Sure. You know, I will talk, you know, back to my experiences. I have worked in multiple rural communities in critical access areas.

Some of the hospitals that I worked with were not able to meet the regulatory standards because of the high bar that they have, you know, within 340B. And therefore, those

communities -- in very rural Idaho, for example -- weren't able to benefit from those.

You know, in other areas we had a little more expertise on our team. We were able to kind of pull that off in Wisconsin. And now, you know, back in Pullman, we are still figuring it out. We have to rely on outside resources to help us manage the 340B thing. That just tells you how complicated that it really is. We have multiple audits per year that really stress our team outside of normal operations -- our finance teams, that is.

And so it is a standard that we are continuing to strive to do. We take it seriously. We want to be accountable to that. But that becomes more and more difficult as we go, and more complexity keeps being added.

*Ms. Matsui. Absolutely. You know, I understand, you know, but I am concerned about proposals that unnecessarily burden you. You have already gone through all of that.

I really appreciate the reminder of the importance of this program. I think we all agree that it is very important, and I don't want this program to be a scapegoat of high drug pricing and other problems that we know exist with our health care system. So I really do appreciate this

committee bringing this up today, and I would really like to strengthen 340B and make sure it is there for the right reasons.

So thank you very much, and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back, and next will be Mr. Allen.

You are recognized for five minutes.

*Mr. Allen. Thank you, Mr. Chairman, and thanks for waiving me on.

To give you a little background about why I am very interested in this is -- and I want to thank the witnesses for staying with us, and talking about this important issue. But back from 1991 to 2000, of course, I was running a construction business back then. And about 80 percent of our work was health care. And in fact, one of my clients asked me to serve as chairman of the hospital board, and I did that for -- from 1991 to 2000.

And it was pretty interesting, how things evolved, because in the construction business you got to know what your costs are or you are not going to be in business very long. And what I learned about hospital accounting is -- and one of the things we worked on -- is we really didn't know

what it cost us to do business. We knew that we charged a dollar, that at that time Medicare was paying about $0.60 on the dollar. And the insurance companies started -- you know, they at one time were at $1. Of course, we had a functional free market health care system back then, and then they dropped below Medicare.

So I said we better figure out what our cost is here, or we are going to be out of business real quick. And unfortunately, that hospital is consolidated now, along with two other hospitals, and we have no locally owned or operated hospitals in my hometown of Augusta, Georgia.

And, you know, the -- I was also asked to, as the ranking member on the Health, Employment, Labor, and Pensions Subcommittee over at Education and Workforce, which covers about 160 million lives all year, ERISA, health care, and I was I was asked to serve on the Healthy Future Task Force Subcommittee.

And again, my question to all the experts -- and we had some great testimony from folks talking to us about where health care is, and what we got to do as far as affordability is concerned, but not one could tell me where our health care dollars are going. Not a single one. In fact, they said it

was impossible. And I think it is because we don't have a functional free market system to compare anything to.

And so I said, "How do we peel the onion back here?'' And -- because we got tax dollars going into this, we got premium dollars going into this. And guess what? You know, we are -- I was in Israel, eight percent of their GDP, health care. Nobody complained about their health care system. And I have a hard time finding folks that are happy with the health care system, you know, with their health care or the providers happy with health care in this country.

But, Mr. Tripoli, your organization advocates for patients. And so what is the most single important thing to make sure that patients know about how their health care dollars are being spent?

*Ms. Tripoli. Well, I think you really nailed it, which is there has been an incredible shift over the last 60 years. Hospitals that used to be these community-based institutions have emerged into these mega-cost centers, and communities have watched their local hospitals disappear. It is a major problem. It is the number-one driver -- it is one of the biggest drivers of unaffordable care in the form of higher prices.

So I think, for consumers, it is knowing that, it is knowing that their local hospital doesn't exist anymore. And so we need to think about the types of solutions that we can implement that are going to bring down the cost of care for the American people. It is the very solutions we are talking about today in terms of strengthening price transparency, codifying that rule --

*Mr. Allen. Exactly, yes.

*Ms. Tripoli. -- expanding site-neutral payments.

*Mr. Allen. Yes, right. Well, good, thank you.

Mr. Severn, we -- as part of the Healthy Future Task Force we had several companies -- and Walmart is involved in what is called direct contracting for health care. Could you -- and of course, obviously, they are doing it and our business community is going to figure this out, but we are going to have to have a functioning free market health care system to do it, because the government is driving everything right now.

But they have been able to use direct contracting to personalize care for their employees. Mr. Severn, can you comment on and tell us about your experience with direct contracting?

*Mr. Severn. Prior to this transparency data being published in 2021, direct contracting was really only possible for large employers that could act as payers. They could pay the consultants, they could buy the data sets. With this new transparency data public, the barrier to direct contracting goes down, and so we will see more companies much smaller than Walmart have the ability to enter into direct contracts with providers, just based off the available --

*Mr. Allen. Yes. And one of the things we wanted to do in our committee was to allow companies to form co-ops to do this, that they could then have the influence of a large contractor.

Listen, you all been great. Thank you so much for your testimony.

And thank you, Mr. Chairman, again.

*Mr. Guthrie. Thank you.

*Mr. Allen. I yield back.

*Mr. Guthrie. I thank the gentleman for yielding, and we do have one more. We have Mr. Balderson from Ohio, who is waiving on for the hearing for five minutes.

You are recognized for five minutes for questions.

*Mr. Balderson. Thank you, Mr. Chairman, I appreciate

the waiver, and thank you all for hanging in there today. I will be brief.

Mr. Severn, from your experience with your patient-facing transparency tool, do you agree that when provided accurate pricing data patients make informed judgments on where they want to receive care?

*Mr. Severn. The short answer is patients are just starting to learn that this data is there. And we are very early in seeing patients use this data. The best way to present the data is something simple, a consumer experience like we see elsewhere on Amazon or other e-commerce sites. Once that is possible on Turquoise and other sites, to say this is the upfront cost, this is the only bill you are going to get, we will see a huge consumer uptake here. But we are just starting to see this at Turquoise.

*Mr. Balderson. I agree. Unfortunately, CMS disagrees with you, since it denied an innovative health plan by claiming it is, and I quote, "not reasonable to expect prospective enrollees to understand'' a new, unique plan.

Last year I wrote a letter, a bipartisan letter, to CMS in support of increasing access to innovative health plans that already are providing price transparency for patients.

These plans are similar, somewhat similar, to the ones used in Montana by Ms. Bartlett, as they offer set reimbursement for anything you can do in the health care system. This allows consumers to shop for care and receive information about their cost obligations at any given provider -- not just any given provider in their network, any given provider, period.

But what Mr. Severn is saying is that the consumers can and do have the ability to shop for value. As we increase the level of price transparency in our health care system, it is important to ensure that the entire system keeps up, and lessons learned in one place are applied to others to maximize their benefits for patients.

Mr. Forge, I myself come from rural Ohio, in Ohio's 12th congressional district, but I also have central Ohio, which has some of the big health care systems. Just like yours, though, the smaller one serves smaller communities. No one wants to be more punitive to the small community hospitals that are already stretched thin and trying to serve their patients, but we all agree that price transparency is important.

How do we work with these hospitals to make sure their

price transparency experience is a positive one for the hospital and patients?

*Mr. Forge. Well, good question. I appreciate it.

*Mr. Balderson. Thank you.

*Mr. Forge. I think, though, the first step is just recognizing that they need the help, right, recognizing that we need -- you know, we need support, and making sure that it is a good experience.

But I think it comes back down to, you know, really thinking about those families and those individuals, and really helping those people with their medical literacy, helping them, you know, access programs like Mr. Severn here, and helping people access, you know, what people and the -- that have bigger resources and bigger health systems have access to.

So it is recognizing it, you know, removing barriers, and continuing to focus on improving.

*Mr. Balderson. Okay. Thank you. My last question, Mr. Severn is for you again, I apologize.

Starting this year, insurers were required to provide personalized pricing information for 500 items and services to their enrollees. Have you tracked insurer compliance with

this aspect of the rule?

*Mr. Severn. We don't track -- ensure compliance with that aspect. We just look at the machine-readable file, the second piece of the requirement. That is what we track.

*Mr. Balderson. How is it working?

*Mr. Severn. You know, the stat we shared is 96 percent of covered lives are represented in the data across 181 payers as of today, which is much quicker than the hospital compliance --

*Mr. Balderson. Yes, it is. Thank you.

Mr. Chairman, I yield back and I thank you all again.

*Mr. Guthrie. Thank you.

The gentleman yields back. Seeing no further witnesses, that concludes witness questions.

Thank you all so much for being here. I know it has been a long afternoon, but I know you are passionate about these issues as bipartisan. We are, as well, and look forward to making this the first of many efforts to get to the point where we are going to have transparency in the health care system, so that people can -- we need health care systems to be -- to exist, so they are going to need to do what they need to do -- exist, but we also need information

so people can make fair choices. So we are looking forward to that, moving forward.

I do have a list that I have shared with the ranking member of documents for the record from the majority and the minority. Any objection?

Without objection.

*Ms. Eshoo. No objection, Mr. Chairman.

*Mr. Guthrie. No objection, so it is so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And then I want to remind the members they have 10 business days to submit questions for the record. And I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on April the 11th.

And without objection, the subcommittee is adjourned.

[Whereupon, at 4:32 p.m., the subcommittee was adjourned.]