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LOWERING UNAFFORDABLE COSTS: LEGISLATIVE SOLUTIONS TO INCREASE TRANSPARENCY AND COMPETITION IN HEALTH CARE

WEDNESDAY, APRIL 26, 2023

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.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, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte,

Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Schrier, Schrier, Trahan, and Pallone (ex officio).

Also present: Representatives Allen; Matsui, and Schakowsky.

Staff Present: Alec Aramanda, Professional Staff Member, Health; Kate Arey, Digital Director; Jolie Brochin, Clerk, Health; Sarah Burke, Deputy Staff Director; Corey Ensslin, Senior Policy Advisor, Health; Seth Gold, Professional Staff Member, Health; Grace Graham, Chief Counsel, Health; Nate Hodson, Staff Director; Tara Hupman, Chief Counsel; Peter Kielty, General Counsel; Chris Krepich, Press Secretary; Carla Rafael, Senior Staff Assistant; Emma Schultheis, Staff Assistant; Michael Taggart, Policy Director; Dray Thorne, Director of Information Technology; Lydia Abma, Minority Policy Analyst; Jacquelyn Bolen, Minority Health Counsel; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Stephen Holland, Minority Senior

Health Counsel; Saha Khaterzai, Minority Professional Staff Member; Una Lee, Minority Chief Health Counsel; Rick Van Buren, Minority Senior Health Counsel; and C.J. Young, Minority Deputy Communications Director.

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

So the chair recognizes himself for five minutes for an opening statement.

We are here today because the health care costs continue to rise, further limiting America's budgets that have already been stretched by the inflation driven by the spending in the last couple of years. We are considering 17 bills and discussion drafts to advance price transparency and improve competition within the health care system to ultimately lower costs.

This legislation hearing builds on our bipartisan work last month. In our educational hearing we heard from experts and witnesses from across the political and policy spectrum who share our goal to lower costs for patients. Republicans and Democrats on this committee are reaching across the aisle to advance solutions, and these bipartisan efforts can be seen in many of the proposals before us today.

Transparency can reveal the true value of each step in the health care supply chain and empower patients and employers to get the best deal on high-quality care. Many of our proposals before the subcommittee today will shine a

light on prescription drug middlemen and further policies to make the health care system more competitive to lower costs. The Transparent Price Act, introduced by the leaders of the full committee, will help build upon the Trump Administration's hospital and insurers' transparency rules to ensure patients and employers are getting the best deal possible.

While transparency is necessary for a functioning market, there must also be competition to lower prices and increase quality. As such, we are reviewing a number of policies designed to reduce incentives to consolidate and require providers to compete with one another on both price and quality, all with the goal of benefiting patients. For example, today we will examine a number of proposals that will ensure patients aren't paying more for the same service in one care setting versus another. I look forward to hearing what the impacts of these policies could be for patients, both in the quality of care they would receive and how these would impact their out-of-pocket spending.

One proposal recommended by MedPAC would save $1.7 billion annually. Similarly, another policy would simply

require CMS to assess the impact that regulatory decisions may have on consolidation in health care to see if Federal regulations may be unintentionally driving consolidation. Improving competition will help ensure seniors maintain access to the highest quality health care services at the best possible prices.

Another theme repeatedly heard during last month's bipartisan educational hearing is the need to address pricing practices by pharmacy middlemen. Patients are facing rising costs at the drug counter resulting from the growing influence of a small number of Pharmacy Benefit Managers. Due consolidation within the PBM industry, 80 percent of all drug claims are adjudicated by 3 PBMs.

It is the subcommittee's duty to ensure this consolidation is driving value and improving outcomes. That is why I strongly support the bipartisan PBM Accountability Act to provide key information to employers about the drug costs and their coverage for their employees. With that information, employers can truly know what benefit their PBM may be providing.

There is also bipartisan legislation from the -- from

Representative Carter that would finally ban spread pricing and Medicaid. In 2019 it was reported that PBMs earned $123 billion in Kentucky alone through spread pricing. Medicaid programs should find a more transparent way to pay PBMs for their services.

Finally, I want to thank Representative Eshoo for working with me on the MVP Act. The innovation coming the next few years is game-changing, including potential one-time cures for rare diseases sickle cell anemia and hemophilia. However, the Medicaid system is not set up to pay for high-cost treatments. Medicaid programs operate on an annual budget, and need more flexibility to help ensure patients gain access to these therapies. This bipartisan legislation builds on a Trump Administration regulation that would give Medicaid programs the flexibility needed over time and enter into contracts that provide patients with access to novel cell and gene therapies. This payment model also ensures states aren't on the hook to pay for treatments that fail patients.

In closing, I look forward to today's hearing to discuss these bipartisan ideas to lower health care costs, and look

forward to working with my subcommittee colleagues to advance these policies.

[The prepared statement of Mr. Guthrie follows:]

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

*Mr. Guthrie. I yield back, and I now recognize the gentlelady from California, Representative Eshoo, for five minutes for an opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, and good morning, colleagues.

Today we are considering 17 legislative proposals to lower costs and increase transparency in our health care system.

Administrator Brooks-LaSure, welcome to the subcommittee. This is your first time, and we are very glad to have you with us.

Our last hearing on this topic showed that the United States spends more on health care than our peer countries, but we have significantly worse health outcomes. Simply put, we are not getting the best value for our health care dollar.

Hospital care is the largest health spending category in the United States, accounting for 31 percent of all health care spending in 2021. Since 2000, hospital prices have increased over 200 percent, and are predicted to continue rising in the coming years. When hospital prices increase, out-of-pocket costs for Medicare beneficiaries, who are often

on fixed incomes, increase, as well.

The proposals before us today raise very interesting and important questions on how to lower costs and improve health outcomes, including how to implement targeted site-neutral policies, while protecting patient access and rural hospitals.

Aligning payment rates across outpatient settings could save Medicare more than 141 billion -- with a B -- dollars over 10 years. But we should heed MedPAC's recommendation to ensure that we prioritize safety and access when advancing our policies: how to bring more transparency to the 340B program without creating unnecessary barriers; how to further competition in the health care industry to better serve patients and to decrease costs.

I am also pleased that we are discussing two bills that I am co-leading. The PBM Accountability Act will finally shed a light on the opaque drug pricing system that PBMs use during their dealings with manufacturers and insurance plans to make enormous profits. It would also save the government, the Federal Government, over $2 billion in the next 10 years.

The Medicaid Value-Based Payments for Patients Act will

codify a CMS rule to help ensure Medicaid enrollees have access to breakthrough gene therapies for dreaded diseases, as the chairman said, for sickle cell anemia and certain cancers. And I am pleased to partner with the chairman on this legislation, and continue -- and I look forward to continuing to carefully craft and tailor it.

Finally, we are considering bipartisan legislation to codify existing price transparency rules for hospitals and insurers, and prevent payment reductions to disproportionate share hospitals under the Medicaid program. I fully support these bills.

[The prepared statement of Ms. Eshoo follows:]

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

*Mr. Guthrie. So thank you, Madam Administrator, for being with us today. We look forward to the -- your answers to our questions. And I know we have a second panel, and I see some of the panelists in the hearing room -- and thank you for being with us.

And with that, Mr. Chairman, I yield back the balance of my time.

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

*The Chair. Good morning, and welcome to Administrator Brooks-LaSure of the Centers for Medicare and Medicaid Services, and a range of stakeholders on proposals to lower the cost of health care for Americans through increased transparency and competition.

This committee has a rich history of plowing the hard ground necessary to legislate and address issues from data privacy to mental health. And I am proud that we are coming together on another top priority for the American people.

Each day it seems we hear a new and more unbelievable story of patients struggling to afford their care and

navigate the system: a four-year-old getting bills his parents can't protest; entire books dedicated to helping people challenge hospital bills and overcome denials of care issued by insurance companies that receive billions in premiums and subsidies each year. Addressing these challenges won't be easy, but I know this committee is up to the task.

Transparency is essential for patients and employers to know and plan for their health care costs. It is foundational to rebuilding the doctor-patient relationship. Seven proposals before us improve transparency in the system, and I am thankful for Ranking Member Pallone for leading H.R. 2691, the Transparent Price Act, with me.

Our bill has been years in the making, and it is a culmination of a lot of bipartisan work and discussions to bring price transparency to the forefront. Our bill builds on regulations released by the Trump Administration and enforced by the Biden Administration, which just had to levy two more fines against hospitals to comply.

Thank you, Ranking Member Pallone, for working with me for years now on this important issue, starting with ensuring

implementation of the rule and now building on it with legislation.

More proposals also help people understand what happens when their insurer owns their doctor, pharmacy, a PBM, and if that is driving value and unaffordable costs for the system. Five bills and proposals look to reduce what patients and employers pay for medicines through transparency and competition.

And lastly, a number address incentives for consolidation in Federal health care programs. At our bipartisan hearing last month we heard a story about a senior from Ohio with painful arthritis. The cost of her annual steroid injection increased from $30 to $1,400 because her office clinic reclassified as a hospital department, even though it was the exact same service with the -- from the exact same provider and the exact same building.

Today patients in Medicare pay more at hospitals than outpatient centers or physician offices for the same services. Several proposals would advance site-neutral payments for certain services that can be routinely done safely in a doctor's office, such as drug administration,

diagnostic tests, imaging procedures, to name a few. For these services Medicare and patients would pay the same amount, regardless of where they are performed.

Ideas for site-neutral payments are bipartisan. Presidents Obama and Trump proposed them in their budgets. Before this committee Secretary Becerra committed to working on these policies. This is the right thing to do for patients. The Committee for a Responsible Federal Budget estimated site-neutral payments would save Medicare patients $94 billion over 10 years.

Let's be clear. Hospitals are integral. They are integral parts of our communities. And we recognize the effects of high labor cost, inflation, and ever-increasing government regulation. But the question before us is this: Should we support hospitals through a complex and opaque network of cross-subsidies with unintended consequences like consolidation that increase costs for patients, or do we separately work on a transparent, accountable way to support hospitals that need it?

I am glad that the American Hospital Association is here today, and I hope we can come together to address these

issues for patients to get the care they need at the cost that they can afford.

And as I close, I want to again thank Ranking Member Pallone and all my colleagues on this committee, the subcommittee chair, the Ranking Member Eshoo, for leading -- all the members that are coming together -- to lead on solutions in a bipartisan way. This is bigger than any one person or political party. It is about people, especially the most vulnerable, who, for way too long, have struggled in a health care system that is too expensive and too complex.

Many are discussion drafts before us today, and we are having this hearing to understand what work needs to be done to move these policies forward. And I invite all the stakeholders to provide constructive feedback to inform our bipartisan work. Patients all over the country are hopeful that this Congress may finally work together to address health care costs and complexity, and I am proud that Energy and Commerce is leading the way.

[The prepared statement of The Chair follows:]

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

*The Chair. I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair now recognizes the ranking member of the full committee, the gentleman from New Jersey, Rep. Pallone, for five minutes for opening statement.

*Mr. Pallone. Thank you, Mr. Chairman. And I want to start out by saying I appreciate Ranking Member Rodger's comments about working with us on various legislation, but I am concerned that we are holding a hearing on legislative efforts to lower health care costs at the same time that the Republican leadership prepares to bring Speaker McCarthy's what I consider irresponsible and extreme Default on America Act to the House floor.

The speaker's bill will raise costs for American families, kick millions of people off their health insurance, and cut $100 billion from the Medicaid program so they can provide huge new giveaways to billionaires and big corporations. Republicans are manufacturing a debt crisis to justify these cruel cuts. They are holding the American economy hostage, and this brinkmanship will be catastrophic to our economy and make it harder for American families to

make ends meet.

Republicans are also rushing the bill to the floor without holding any hearings or a markup. So much for regular order. Last Congress, when Democrats were in charge, we held several days of markups that included robust debates for both the American Rescue Plan and the Inflation Reduction Act. But now they are in charge, and Republicans are moving to Default on America Act without an open or transparent process or any process at all, really. And we haven't had the opportunity to hear from experts about the bill's implications, probably because Republicans know how deeply unpopular these ideas are.

So if Republicans succeed in cutting $100 billion from Medicaid, the consequences will be devastating and will be felt by every beneficiary, provider, and plan that relies on Medicaid. Republicans claim their bill would encourage Medicaid beneficiaries to work, but it is clear that this is just a pretext to cut Medicaid.

As a reminder, the Congressional Budget Office found that Medicaid work requirements do not increase employment. They merely result in individuals losing coverage as a result

of bureaucratic red tape. Two-thirds of adults on Medicaid are already working, and those who are not generally have caregiver responsibilities, are dealing with physical or mental health issues that make work difficult, or are experiencing other barriers to unemployment like lack of education or training. If Republicans actually cared about increasing employment among Medicaid beneficiaries, they would have included policies to address those barriers.

Now, turning to the topic of today's hearing, I do believe we should be working together to bring greater transparency and competition to our health care system. But I have some concerns about the process leading up to today's hearing.

My Republican colleagues shared a vast majority of the discussion drafts we will be discussing a week before the hearing was noticed. Given the broad array of topics and bills, I am disappointed that we did not have adequate time to fully vet some of these policies and provide the minority's input from the beginning.

So I hope my Republican colleagues will commit to work in a bipartisan manner as we consider these policies moving

forward. And I know that the Ranking Member Rodgers has already said that she is committed to that. After all, we have been working together on H.R. 2691, the Transparent Price Act, which I introduced with Chair Rodgers.

Patients deserve greater transparency in the prices they pay for health care. Today consumers are not able to easily obtain price information on health care services. Sometimes the price information that is provided is inaccurate and misleading, making it difficult to compare across providers or determine the true value of the care. And I know that we are going to work on that together. I just heard the chairwoman, Chairwoman Rodgers, say that.

I am also concerned by reports that many hospitals are either acting slowly or not yet complying with the hospital price transparency final rule, making it even more difficult for consumers to access price information. H.R. 2691 codifies the existing requirements for both hospitals and insurers, and it will also improve the accessibility and usability of the price information for consumers.

I am also pleased we are considering two bills that will increase transparency into Pharmacy Benefit Manager practices

by helping employers, consumers, and state Medicaid agencies better understand drug price information which can help lower health care costs.

We will also discuss legislation that I support to cancel the $8 billion in cuts currently scheduled for Federal payments to Medicaid disproportionate share hospitals, and a bill to require hospitals to disclose ownership data. Studies show that health consolidation is leading to higher care prices for consumers, and I am particularly concerned about the role of private equity in hospital consolidation. I look forward to hearing from the witnesses on how these trends may be impacting health care affordability and access to coverage.

[The prepared statement of Mr. Pallone follows:]

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

*Mr. Pallone. So I look forward to the witnesses' testimony. And with that, Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. And I will just say that this is a bipartisan hearing, and we want to work together as we move forward to see if we can get the bipartisan solutions on the bills that you referenced, as the chairman committed to. So thanks.

So this morning we have with us today the administrator for Centers for Medicare and Medicaid Services.

We appreciate you being here. And as you know, you have five minutes for an opening statement, and the yellow light will give you kind of an update. And I know you have a tight timeframe, so we are going to try to keep our questions to the five minutes, as well. So we need to move forward so everybody gets a chance to answer their questions.

So I would like to welcome the administrator here today, Ms. Chiquita Brooks-LaSure, and we appreciate you being here, and you are now recognized for five minutes for your opening statement.

STATEMENT OF THE HON. CHIQUITA BROOKS-LASURE, ADMINISTRATOR, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES

*Ms. Brooks-LaSure. Thank you so much, Chairs McMorris Rodgers and Guthrie, Ranking Member Pallone and Eshoo, and members of the subcommittee. I just really want to thank you for the opportunity to discuss the Centers for Medicare and Medicaid Services' work to lower costs and increase transparency across the health care system.

As the nation's largest payer for health care, CMS plays a key role in incentivizing high-quality care and smarter spending across the health care system. And I would like to highlight some of the work we have been doing.

Drug costs account for a growing portion of overall health care costs, and too often people are forced to choose between paying for their prescriptions or meeting other basic needs. CMS is hard at work implementing the Inflation Reduction Act. And thanks to this law, people with Medicare prescription drug coverage are already beginning to see lower out-of-pocket costs. This includes Medicare beneficiaries that need insulin, which now will no longer pay -- will pay

$35 for a month's supply.

CMS has also taken action to discourage drug companies from increasing their prices faster than the rate of inflation. And we continue to work on the IRA provisions that cap total out-of-pocket drug costs, and allow Medicare to negotiate with drug manufacturers for the first time in the history of the program. Our efforts are lowering costs for people with Medicare and the program overall, while improving access to innovative, lifesaving treatments.

In addition to lowering costs, CMS's efforts to increase transparency across the health care system will incentivize competition, improve consumer experience, and result in additional savings for our health care system and for patients. People should know the cost of their health care services and what they will be required to pay before they seek care. CMS is working hard to get this information into their hands, the CMS hospital price transparency rules providing public access to standard hospital charges, and we will continue to work to ensure that available information is meaningful and useful.

It is important that this information is available to

all Americans, which is why we took action last year to increase the penalty for non-compliance to over $2 million annually. And I am pleased to announce today that we are updating our enforcement process to shorten the time by which hospitals must come into compliance after a deficiency is identified. Further, for hospitals that have not made any good-faith attempt to satisfy the requirements, we will no longer be sending a warning notice, and we will move straight to the corrective action plan phase.

In addition to improving the transparency of hospital prices, we are working to improve transparency from private health plans, so that people know the cost of a covered item or service before receiving care. These data will help people to make informed decisions, and allows third-party developers to create price transparency tools that will help people shop for health plans and for doctors. It is critical to provide Americans with cost information before they receive care.

Additionally, CMS is also working to implement the No Surprises Act to protect patients from surprise medical bills after care has been received.

We are also committed to expanding transparency efforts across health care consolidation and its impacts on prices. In particular, consolidation in health care can leave rural and underserved areas with inadequate or more expensive health care options.

CMS is working to make public information on mergers, acquisitions, consolidations, and changes of ownership for hospitals and nursing homes enrolled in Medicare. Making facility ownership information available supports efforts to identify poor performers, better understand the impacts of consolidation, and help patients and caregivers make more informed decisions about their care.

Thank you for allowing me to highlight some of CMS's efforts to lower costs and increase transparency while continuing to expand access to high-quality, affordable care. We are committed to building on the work that we have done to address rising health care costs in a way that helps us advance health equity, expand access, improve health outcomes, and increase transparency. Thank you.

[The prepared statement of Ms. Brooks-LaSure follows:]

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509 **********COMMITTEE INSERT**********

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*Mr. Guthrie. Thank you, I appreciate that. And I will say that you have a hard stop, we want everybody to have the opportunity to ask questions, so I am going to be enforcing the five-minute rule on questions.

So don't ask a question with 10 seconds left to go. So I will get started. I will -- the chair will now recognize myself for five minutes for questions.

And Administrator Brooks-LaSure, we will start with Alzheimer's disease. It has touched every family. And there has been a lot of attention to a decision to severely -- by CMS -- to severely restrict access to an entire class of FDA-approved Alzheimer's drug treatments. And the Veterans Administration announced it will cover one of these therapies, Lecanemab, which CMS will only coverage in limited circumstances.

And in the case of Lecanemab, what is unnecessary and unreasonable about this FDA-approved drug with the Medicare-age patients?

And would you talk broader, or more of FDA and the Alzheimer treatments that have come forward that are only very limited cover by CMS?

*Ms. Brooks-LaSure. Thank you so much for the question about coverage of Alzheimer's drugs.

As you know, and we all know, Alzheimer's disease is incredibly devastating. And I want to thank all the advocates who are caring for the millions of Americans who suffer from a devastating illness. And it touches so many families, including my own.

I will start by saying it is CMS's responsibility to make sure, when we approach the coverage process, that we evaluate all the evidence and, of course, take in the work of the FDA. When FDA fully approves drugs -- and in this case, for the treatment of Alzheimer's disease -- that means that the FDA has made a determination that it will affect the disease itself. And when FDA fully approves drugs for Alzheimer's disease, CMS will cover it more broadly.

What our requirements are that, once the drug is fully approved by the FDA, we encourage doctors and ask doctors who are prescribing the medication to make sure that information is available through our registry. And we are doing that because we need to continue to develop evidence of and understand the impact on the drug. But we will --

*Mr. Guthrie. Do you believe CMS would benefit from Congress providing greater clarity into the phrase "reasonable and necessary'' in the Medicare program?

*Ms. Brooks-LaSure. I would say that we have very clear guidelines, and we have outlined in our national coverage determinations how we approach our responsibility that we have from Congress, which is to evaluate coverage in Medicare populations. And we absolutely take the work that we get from the FDA as we consider our coverage.

*Mr. Guthrie. Okay. I know there are -- other members are going to address that, as well, so I want to get to one question on the bill before us before we move forward. But that is concerning to all of us. It is bipartisan. I have heard both sides of the aisle talk about the access to this drug for Alzheimer's patients, and we are all concerned about it.

But before leaving office, President Trump finalized a Medicaid rule in place to permit manufacturers to submit multiple best prices, including a bundle sell option as well as value-based best price, to submit to a non-VBP best price opinion -- option, as well. We will have legislation,

bipartisan legislation with myself and Chair -- or Ranking Member Eshoo. H.R. 266, the MVP Act, would codify the rule. Will you commit to working with Ranking Member Eshoo and me to codify this rule?

*Ms. Brooks-LaSure. I will absolutely commit to working with you on outcomes-based options for Medicaid. This is something that we are very interested in in the Administration, and have started to put together a proposal from the Innovation Center, and would love to work with you on that.

*Mr. Guthrie. So could you go further, and just discuss how this rule -- because we have talked about the expensive treatments for sickle cell, for hemophilia that could -- people who suffer from these diseases could greatly benefit from these programs. Could you just go and discuss more how these therapies will help patients by providing flexibility for Medicaid programs to structure them?

*Ms. Brooks-LaSure. Certainly. And while I won't talk about specific proposals, I will say that what we have seen across states is them needing to have more strategies as innovative therapies come to market that affect a limited

number of people, but where these illnesses are incredibly devastating.

And you talked about sickle cell disease. There are others, but sickle cell in particular, where it is so important that people know -- that the doctors know how to treat that disease, and that they -- people get those therapies. It is critical that states are able to cover those in a way that is affordable to them, so that we can ensure access, and I would love to work with you on additional strategies.

*Mr. Guthrie. Yes, I remember talking with Dr. Francis Collins, the previous NIH director, and he said that -- he said, "I never used the word 'cure' for a lot of diseases, but sickle cell can be cured with some of these treatments, and we need to make sure people have access to them.’‘

*Ms. Brooks-LaSure. Absolutely.

*Mr. Guthrie. And so we look forward to -- all of us -- working together with the Administration and from our side of the Capitol, or the -- of D.C. to make sure we work together to move this forward.

My time has expired, and the chair now recognizes the

ranking member for five minutes for questions.

*Ms. Eshoo. Thank you, Mr. Chairman.

I am very glad that the chairman raised the issue of Alzheimer's, the drug. We did not have a conversation with each other coming into this hearing, but I want to take up the same issue. And it is a demonstration that there is a really deep concern on both sides of the aisle on this.

I see, as I expressed to you when we spoke, a disconnect between CMS, the FDA, and the VA on new treatments for mild Alzheimer's. By July 6th, as you know, the FDA will determine whether Lecanemab is -- it is a new treatment for mild Alzheimer's -- whether it -- that it will qualify for full approval. This will be the traditional FDA approval that is the gold standard, not an accelerated approval. That is already in place.

The VA has already said it will cover this drug, as long as patients meet the criteria for use. Currently -- and I am sure you are well aware -- tens of thousands of veterans with mild Alzheimer's can go to their VA neurologist, be assessed, and receive a prescription. But it is unclear whether the estimated one million Medicare patients who could benefit

from the treatment would be able to access the FDA-approved drug in July. And in order to access the drug, they may need to enroll in what you described to me as a CMS-approved prospective comparative study like a registry.

So I have just a few quick questions. They are not long answers, they are really yes-or-no.

Has Medicare ever required participation in a registry for a fully FDA-approved drug before?

*Ms. Brooks-LaSure. Let me start by saying that registries are not a study. So -- just to be clear.

*Ms. Eshoo. But have you ever done this before?

*Ms. Brooks-LaSure. We have. Registries are something that we have done, but I can get back to you on details about that.

*Ms. Eshoo. Has CMS published any details about the required registry for fully-approved Alzheimer's treatments, besides the general description that is in the April 22 memo?

*Ms. Brooks-LaSure. Not beyond that, but we --

*Ms. Eshoo. Okay.

*Ms. Brooks-LaSure. -- intend --

*Ms. Eshoo. Do you know of any doctors' offices or

health systems who are prepared to enroll Medicare Alzheimer's patients in the registry beginning in July?

*Ms. Brooks-LaSure. We welcome doctors to do so.

*Ms. Eshoo. No, but have you -- do you know of any that are prepared to enroll, any doctors' --

*Ms. Brooks-LaSure. We wouldn't know that until --

*Ms. Eshoo. -- or health systems?

*Ms. Brooks-LaSure. We wouldn't know that until FDA fully --

*Ms. Eshoo. Have you published any information to Alzheimer's patients and their families explaining how to get the drug under Medicare?

*Ms. Brooks-LaSure. We will do so.

*Ms. Eshoo. But it is not done.

*Ms. Brooks-LaSure. That is correct.

*Ms. Eshoo. Okay. So here is the thing. If doctors don't know, if patients don't know, and Medicare doesn't really seem to know what this registry entails, how are Medicare patients going to get the drug potentially beginning in July? That is really the $64,000 question in my mind.

Let me describe to you two constituents. One is a

grandfather and a veteran. He has coverage. He has been diagnosed. His wife was also diagnosed. She is not a veteran. How do I, or any of us, explain that to our constituents?

This is, as you said and have said many times, this is a devastating disease, and I don't think this can be treated as 17 months of a little additional hope.

Any -- this drug comes out, families across the country are going to be clamoring for it. Medicare is not prepared, from your answers. You are adding layers to this. The VA is doing something very different. And there is, as I said, there is a huge concern here.

This is a progressive disease. We know that early intervention with progressive diseases is really essential.

So I hope that you will leave this hearing with a new commitment and a new view of how to do this, because you are not prepared. And the beginning of July is, like, two months away, eight, nine weeks away.

So I will give you the opportunity to --

*Mr. Guthrie. We are out of --

*Ms. Eshoo. Well, all right, yes.

*Mr. Guthrie. I am sorry, we are out of time. Hopefully, you will have a chance during the hearing to answer that --

*Ms. Eshoo. I really, really --

*Mr. Guthrie. -- because I want to hear your answer, as well.

*Ms. Eshoo. Well, okay.

*Mr. Guthrie. Absolutely.

*Ms. Eshoo. Thank you, Mr. Chairman.

*Mr. Guthrie. The chair now recognizes Dr. Burgess for five minutes for questions.

*Mr. Burgess. I thank the chairman and the ranking member for bringing this up. I will just stay in the same vein for a moment.

The AMA puts out a -- what is called a Morning Rounds every morning. Yesterday the AMA Morning Rounds was -- talked about how scientists are targeting mild cognitive impairment, the early Alzheimer's stages, with aggressive treatment. And if we don't have these things in our armamentarium because -- not because of the FDA, which is a perennial problem, but it is you, with a coverage

determination that removes a tool from what doctors are able to use.

It actually wasn't what I wanted to talk about. There is a lot of things. I am going to submit some stuff to you in -- for questions for the record.

[The information follows:]

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

*Mr. Burgess. I do have to say, you know, Texas has had an issue with expanding Medicaid coverage to six months, which they did in the last legislative session. It actually was blocked by CMS for reasons that I don't understand. You -- I wrote you a letter, the Texas delegation wrote you a letter, you responded and said you received it last November, but it really wasn't a satisfactory response.

I know the state legislature is working on something now. Yes, time marches on. Things are likely to change, but CMS needs to provide us an answer why they blocked this action by the Texas legislature, which I feel would have helped patients who were falling out of coverage after three months, as used to be standard practice. Granted, 6 months is not as good as 12 months, but it was a start, and Texas should have been allowed to have that state flexibility.

Now, what I really want to talk about is the bill that does away with the prohibition in Medicare physician-owned hospitals. And we have talked about this a lot in this committee. It is just fundamentally wrong that, because of an academic degree that I have, I am not able to engage in a lawful practice in this country. And yet you brought up in

your testimony that consolidation in health care allows hospitals to own doctors. This is nuts. Hospitals can own doctors, but doctors can't own hospitals. Why is that okay?

So I do have a number of statements for the record. I have got a study that I want to submit for the record, Mr. Chairman.

*Mr. Guthrie. Without objection, so ordered.

[The information follows:]

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

*Mr. Burgess. So let me just ask you, are you doing an analysis on -- with this consolidation rulemaking that you are working on or anything in the CMMI model development are you looking at removal of this prohibition on physician-owned hospitals?

*Ms. Brooks-LaSure. Thank you for the question. We need to follow the statute, which sets out what the requirements are and when -- and in terms of physician-owned hospitals, which we are doing so.

And in terms of consolidation, our focus and our authority is around transparency. And that is why we have been working very hard to make it clear where we have ownership in nursing homes, hospitals, hospice, home health. That is where our authority lies.

*Mr. Burgess. Well, look. It was a physician-owned hospital in the Rio Grande Valley that saved a lot of people during the pandemic. Had they not stepped up -- and they had to get a special waiver from the agency in order to just take care of the patient population they had to take care of, all because they were a physician-owned hospital.

So I am just simply going to ask, will you commit to

work with me on this bipartisan issue to ensure CMS examines the considerations in the rulemaking process?

*Ms. Brooks-LaSure. I would be happy to work with you.

*Mr. Burgess. And let me further ask -- CMS, in its recent inpatient prospective payment system proposed rule -- you narrowed the opportunity for physician-owned hospitals to expand, raising barriers to entry and increasing costs. Will you work with me on that?

*Ms. Brooks-LaSure. I would absolutely work with you where -- notice and comment, and happy to work with you on it.

*Mr. Burgess. Are you aware of a working paper co-authored by the Department of Justice and Federal Trade Commission staff addressing hospital competition and restrictions on physician-owned hospitals?

*Ms. Brooks-LaSure. I am definitely aware that DoJ is working on hospital consolidation.

*Mr. Burgess. So the Biden executive order notes the need for improved labor market competition. This working paper notes that repealing the ban on physician-owned hospitals will increase labor market competition. Do you

agree with that?

*Ms. Brooks-LaSure. I would have to review the document, thank you.

*Mr. Burgess. And we will make sure you have it available.

Look, we talk about access and particularly rural access. Physician-owned hospitals is a way to rapidly provide that access. And again, it is just fundamentally wrong that a hospital can own a doctor, but a doctor can't own a hospital.

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

*Mr. Guthrie. Thank you. I thank the gentleman for yielding back. The chair now recognizes my friend from New Hampshire, Ms. Kuster, for five minutes.

*Ms. Kuster. Thank you, Mr. Chairman, and thank you for holding this hearing.

I want to thank all of the guests in the audience and my colleagues for addressing Alzheimer's. This was something that we lived with in our family, and I appreciate your advocacy.

I am going to turn to a different topic. I am glad to

see that my bill, the PBM Accountability Act, was included for discussion. I want to thank the chair. It is great to work with you, Chairman Guthrie, and Ranking Member Eshoo and Congressman Buddy Carter to introduce this legislation that brings transparency to Pharmacy Benefit Manager operations, and lowers costs for patients.

Administrator Brooks-LaSure, thanks so much for your testimony. I would like to focus on the challenges facing the Medicaid program, particularly the unwinding process and the threat from our colleagues on the other side of the aisle of work requirements.

In the past three years, Medicaid enrollment has grown substantially, and the number of uninsured Americans, fortunately, has dropped. Nearly 95 million people had health insurance through Medicaid as of March of 2023. As we move to a new phase of the pandemic with the end of the public health emergency, and states beginning the process of re-determining who is eligible for Medicaid coverage, we must recognize the risk to individuals and their families, and the public health risks that we all became so aware of during the pandemic.

Estimates find that as many as 15 million Americans could lose health insurance coverage because of these re-determinations, including 6.8 million who would still be eligible for coverage and incorrectly lose their Medicaid. These numbers are staggering, but they can hide the true challenge that people in every single district across this country will experience.

Picture a family who loses coverage and is unable to access care, preventative services, behavioral health care, necessary medications because of factors completely outside their control: 6.8 million people will have an experience where logistics lead to them getting kicked off the Medicaid rolls, whether it be agency staffing shortages, low electronic renewal rates, or outreach barriers.

I want to ask you, Administrator, can you detail the efforts that CMS has made in coordination with states to prevent people from unnecessarily losing their Medicaid coverage?

*Ms. Brooks-LaSure. Thank you so much for highlighting how important of an issue it is for us to make sure we hold on to the millions of people who have coverage in the

Medicaid program.

If we have learned anything over the last couple of years, it is how important it is that everyone has access to affordable health care in this country. It is important for the individuals themselves, their families, and for all of us to be safe and secure. We are at record-low levels of uninsured across this country, with over 92 million people who are enrolled in Medicaid and CHIP, many of them caregivers, hard-working individuals who have multiple jobs, who are in school, who are taking care of family and friends.

And so, for -- when we think about the unwinding, what we are doing here at CMS is working very closely with states both on the Medicaid side, as well as the marketplace side, and thinking about healthcare.gov to make sure that people are aware of the need to update their contact information and update their information if they get unwinding letters from states. And we are encouraging states to automatically enroll as much as they can, to automatically rely on data that they have in-house.

We are also wanting to work with partners, community organizations, health plans, providers, everyone who touches

a Medicare -- Medicaid beneficiary. And I have been thrilled with some of the work that the private sector has been interested in doing and already beginning to make sure that people are aware of the importance of staying on their health care coverage.

*Ms. Kuster. Thank you. Medicaid, as we know, is the single largest payer for mental health services in the U.S., and is increasingly playing a larger role in the reimbursement for substance use disorder services.

My time is very short, but I am very concerned that recent analysis shows that the work requirement in a Medicaid program would jeopardize access to care for 21 million people, leaving millions without critical coverage when seeking mental health and recovery. Would you -- would instituting Medicaid work requirements affect how patients and communities respond?

*Ms. Brooks-LaSure. What we have found over time is that whenever we put up red tape barriers to people being able to enroll in coverage --

*Mr. Guthrie. Your time is expired.

*Ms. Brooks-LaSure. -- it affects --

*Mr. Guthrie. -- the five minutes. I apologize. Hopefully, you will have an opportunity to answer as we move forward.

*Ms. Kuster. Thank you very much, and I will --

*Mr. Guthrie. Thank you.

*Ms. Kuster. -- yield back.

*Mr. Guthrie. The gentlelady yields back. The chair recognizes Mr. Latta from Ohio for five minutes for questions.

*Mr. Latta. Well, thanks, Mr. Chairman, and thanks for holding this very important hearing today.

And, you know, there is broad bipartisan consensus that the price of health care is unaffordable, and that government spending is out of control. As has been pointed out a little bit earlier, the United States spent about 4.3 trillion on health care in 2021, which represents about one-fifth of the U.S. gross domestic product. Unfortunately, without congressional action, health care spending is expected to increase to nearly 6.8 trillion by 2030. We all know this is unmanageable, and we need to find some solutions so we can put the patients first.

And, you know, I -- in reading your testimony, when you were talking about the income -- or the Inflation Reduction Act, under the IRA you state that lowers prescription drug spending for millions of people with Medicare, re-designs Part D, and keeps drug premiums stable, and strengthens the Medicare program both now and in the long term.

But let me ask this. You know, we know one thing. The United States leads the world out there in finding drug and new cures. And I know the gentlelady from California was talking about on the Alzheimer's side. But, you know, when we just went through COVID, I remember sitting in those early meetings around the table when COVID was just at its -- we were just starting to deal with it. And sitting around with individuals from companies -- and within a year, you know, we had three different types of medications out there. Nowhere else in the world could -- did that occur but here in the United States. But it is because of -- you know, we have here in this country.

Is there a concern at CMS that with what has been placed in the law right now could inhibit the creation of these new drugs and cures?

Because, again, it is just not one type of a cure out there that we need. In Alzheimer's, a cure that we have got to have -- and I know on both sides of our families, that we have seen the devastating effect of that horrible, horrible disease. But I am really concerned about what is going to happen into the future for companies being able to go out there and find these drugs, and make -- get these drugs to the market.

*Ms. Brooks-LaSure. We share the goal that -- of making sure that drug companies still absolutely have the incentive to be as innovative as they have been. And you are so right, that the drug companies were incredible in making sure that we were safe from COVID-19 with coming -- bringing vaccines to market. And it is our every intention at CMS to make sure that we run the drug negotiation process in a way that continues to foster innovation, but also makes sure that we can provide it to Medicare beneficiaries.

*Mr. Latta. Okay, let me follow up, though. Because when you say that you are going to have that innovation out there, how are you going to provide that?

Because, again, this is something that everybody is

talking about right now. But how is CMS going to make sure that you are going to be able to have -- that the United States leads the world, and everybody sees is the envy of the world, in getting, you know, lifesaving cures to the market that we have to have?

*Ms. Brooks-LaSure. I would answer your question in two ways.

First of all, we are working very closely with drug companies as we work on our guidance, and that is something I have personally done, as well as our staff have met with many, many companies and talked to them through what our process is going to be.

Second of all, the drug negotiation is something drug companies do every day. They do it with companies all across America, as well as, of course, the world. But they do it in our drug benefit right now. And we are building on that work, and taking all of that into account.

The drugs that we will be negotiating are drugs that have been on the market for many, many years. There are drugs that, by law, are going to be drugs that are top spenders where they have been on market for many years. But

we will continue to work with policy-makers and stakeholders to listen to concerns, listen to issues that they raise with their guidance, just like we are right this minute.

*Mr. Latta. Well, in my last 50 seconds -- I know the chairman is being very good on keeping the time -- because, you know, the United States -- and we have had the hearings in here, we have seen the facts that around the -- not only around the -- you know, this hemisphere, but around the globe, when a lot of countries out there say what their costs are, really it is not apples to apples out there. It is really -- because what is happening out there, we are seeing that the United States has a lot more drugs that could be provided, but other countries that are out there, they only have a certain number of drugs, and then those individuals might need a certain type of cancer drug, and the government says, "You can't have it, you are going to have to have this,'' but it might not be the drug that they are going to have to have for -- to get them cured.

So I just want to make sure that CMS always remembers that the United States is going to lead out there, because it is absolutely essential that we do to make sure that we have

the best health care and the cures here, in the United States.

Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Mr. Cardenas from California for five minutes.

*Mr. Cardenas. Thank you very much, Chairman Guthrie, and also Ranking Member Eshoo, for holding this hearing.

And to Administrator Brooks-LaSure, thank you so much for weighing in on these transparency-related issues.

Before discussing proposals we are considering today, I feel like I must mention the threats we are seeing to Medicaid. There is a bill before us this very week that will institute what amounts to a significant cut to Medicaid access under the guise of work requirements. In fact, just yesterday HHS released new analysis showing that around 21 million Americans' coverage and access to care would be threatened under the Medicaid work requirement proposal put forth by my Republican colleagues.

We have seen this before. And not only does it force people out of their insurance, it does nothing to boost

employment. We can look at Arkansas as a case study. The state implemented these work and reporting requirements, and, as a result, thousands of people were disenrolled for failure to comply. For many of these people, they were kicked off not just because they were -- not because they were ineligible, but because it was so difficult to navigate the reporting process. And that is really the point. The proposal is cruel, and a thinly veiled attempt to restrict access to coverage to American citizens, which brings me to my question.

Administrator Brooks-LaSure, why is access to Medicaid so critical, and how do work requirements and the reporting around them further disadvantage already vulnerable populations?

*Ms. Brooks-LaSure. Thank you so much for your question about how important coverage is.

I think we have gotten a lesson, as a country, of how important it is, not only with the COVID-19 pandemic, where it was critical that people could have access to vaccines and treatments, but also when we think about tackling our other crises in this country like maternal health, where we need to

make sure that women are getting health care before they are pregnant, while they are pregnant, and afterwards to address health outcomes, and so on down the list in terms of mental health.

You mentioned the experience that we saw in Arkansas, where people who would have met the requirements where they were working or where they would have been exempted lost coverage. That is what often happens in these situations. I spoke to a family during my time pre-CMS administrator, when work requirements were in discussions. And I remember talking to a woman whose brother was disabled who absolutely would have qualified for an exemption, but she was very overwhelmed by the paperwork that she needed to fill out and the -- and how confusing it was.

That is what happens when we put up barriers to people getting care, and it is critical that we make sure that people in this country are covered, not just for them, but for all of us.

*Mr. Cardenas. Is depression a medical condition?

*Ms. Brooks-LaSure. Depression is a medical condition.

*Mr. Cardenas. Could somebody find themselves diagnosed

with clinical depression and want to work, but for a period of time is having a difficulty being employed?

If that is the case, and the person isn't employed, and they are not able to navigate the system of paperwork, would that be denying somebody access to health care that they obviously critically need?

*Ms. Brooks-LaSure. It is so important that people are healthy so that they are able to work, so that they are able to live their lives. And absolutely, what we have seen is that people have gotten illnesses when they are uninsured, and that has prohibited their ability to be in the workforce. And that is what we don't want, as a country. To make sure our economy continues to grow, to make sure that people are able to achieve the American dream, it is critical that we have that basic protection.

*Mr. Cardenas. Thank you. And I am very concerned about these requirements, and I am grateful for your defense of Medicaid on the record.

Now I also want to be sure to discuss the role of safety net hospitals in providing critical care to medically underserved and low-income communities. I am glad to see

policy proposals that would delay Medicaid DSH cuts, as this funding has been critical to upholding services in safety net settings.

Administrator Brooks-LaSure, if we do not step in, what type of impact would you expect for safety net hospitals, many of which are still struggling in the wake of COVID-19 pandemic, which is still with us?

*Ms. Brooks-LaSure. Yes, hospitals have been on the forefront of the pandemic, and have been keeping so many of us safe and healthy through the last couple of years.

We know that the safety net has -- disproportionately serves the underserved, and DSH payments do go to help support the payments for particularly them supporting the uninsured.

*Mr. Cardenas. Thank you so much. My time having been expired --

*Mr. Guthrie. Okay, the --

*Mr. Cardenas. -- I yield back.

*Mr. Guthrie. The gentleman yields back. I appreciate that. The chair now recognizes the chair of the full committee, Chair McMorris Rodgers, for five minutes.

*The Chair. Thank you, Mr. Chairman.

Just to clarify regarding the proposal that the Republicans have on the floor for work requirements for Medicaid, the Democrats keep talking about millions. CBO just yesterday suggested that it estimated 600,000 may lose their Medicaid if these able-bodied adults with no children choose not to work, volunteer, or get training 20 hours a week. So if you are pregnant, you are not included. If you are a parent with children, not included. If you are mentally or physically unfit, the bill text is very clear, not included.

And I just want to get that on the record, because I don't want people to be concerned, people that -- we all believe it is very important that Medicaid is a very important safety net. What we are trying to do is protect that safety net, and encourage the able-bodied adults without children to work, volunteer, or get some training, come alongside them, and it is their decision.

Administrator, if -- I wanted to ask some questions here. If you could ask Congress -- you know, back to transparency now -- if you could ask Congress for one

specific improvement to price transparency rules, what would they be?

*Ms. Brooks-LaSure. What a question. I think that we have been given authority on price transparency, as we have talked about, with health plans and hospitals.

I will say that some of our transparency -- our guidance on hospitals is probably very limited; there is one sentence in the statute. But I really would love to work with you to increase our authority on price transparency.

*The Chair. Okay, thank you for that. Ranking Member Pallone and I have proposed improvements to these rules, and I am glad that in your testimony you mentioned the importance of needing to standardize hospital price transparency data.

I believe that you are still not doing enough with the authority that you have, and there hasn't been enough enforcement across the board. I am specifically disappointed that you did not mention enforcing the existing requirement that PBMs disclose their drug prices. That is something that is included in the bill. So I just would like to ask, what has kept you from doing more to enforce these requirements?

*Ms. Brooks-LaSure. Certainly, and thank you for your

leadership on price transparency and the push to encourage all of the entities to submit data.

On PBMs in particular, and price transparency on prescription drugs, because our rules interacted with new legislation that passed in No Surprises Act, we took a step and wanted to make sure it was coordinated, but we are committed to continuing to make sure --

*The Chair. So the --

*Ms. Brooks-LaSure. -- that information --

*The Chair. Thank you. I will just take my -- reclaiming my time, there is a lot more to be done. And this hearing is about competition, transparency. Health care businesses like PBMs continue to rapidly consolidate, finding new and innovative ways to add complexity, hide where the money is going. And we are fighting to pass strong transparency laws.

I bring up these key transparency provisions because from the last bipartisan effort to address cost, they are not being implemented. Congress banned gag clauses, but I routinely hear from employers who cannot access their own health claims data. Patients are supposed to get good-faith

estimates on cost when they schedule an appointment, but CMS is not enforcing this for patients with employer-sponsored insurance.

And I do not want this committee's efforts -- we are going through a lot of work, hearings, bills to hopefully get a bill -- you know, many bills signed into law. I don't want it to languish for years, while CMS prioritizes their other agenda. So failure to do the implementation harms the very patients that we are coming together to help in a bipartisan way. So will you commit to work with this committee to get properly implemented and enforced the bipartisan legislation?

*Ms. Brooks-LaSure. We continue to work to enforce the law, and absolutely will work with you on that.

*The Chair. Thank you. We are seeing a dramatic growth in a newer kind of consolidation under payers. In other words, insurance companies purchasing health care providers. And to a patient it means your insurance company might own the doctor you see, the pharmacy where you get your medicine, and the PBM that decides how much you pay for that medicine. And I think we all have questions about what that means for patients, and the costs that they pay, and the quality of

care that they receive.

Administrator, one of the proposals before us contemplates collecting numerous data points to tell us about the health of and the spending on patients who see doctors or pharmacies owned by insurance companies and PBMs, compared to patients that see independent doctors and pharmacies. Have you attempted to collect this data to better understand the effects of vertical integration?

*Ms. Brooks-LaSure. I do not believe we have authority to do so, but I am happy to look in at the issue.

*The Chair. Okay.

*Ms. Brooks-LaSure. But we very much support transparency around ownership and increased transparency.

*The Chair. Okay, lots more to come. Thanks for being here.

I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes the Ranking Member Pallone for five minutes.

*Mr. Pallone. Thank you, Mr. Chairman.

Administrator Brooks-LaSure, thank you for coming here

today. And as I am sure you have seen, last week the Republicans released their bill, what I call Default on America Act. And of course, it includes a provision that would threaten access to care for millions of low-income Americans and cut over $100 billion from Medicaid.

So last Congress, when Democrats were moving through reconciliation, Republicans repeatedly complained about the lack of regular order. And of course, we put those bills through multiple days of markups, considered probably dozens of Republican amendments, and debated for hours. And Republicans are skipping all of that and trying to rush a bill to the floor without so much as a hearing today. So I am going to take this opportunity to ask some of the questions I would have asked if Republicans had been willing to hold themselves to the same standards they held Democrats to last Congress.

And I know you have already been asked about the work requirements, but I want a little more information. Would you expect people to lose access to health insurance if Medicaid were to adopt a work requirement?

*Ms. Brooks-LaSure. I would expect that. And I would

say again that it is not just people who are subject to the requirements that often get caught up in red tape. It is -- can often be people who are exempted.

So, for example, in Arkansas what we found is that there was an individual who had health insurance, who was working, didn't realize that he needed to fill out the paperwork, lost his job, lost his insurance, had a health condition that made him unable to work. That -- those stories replicate across barriers so often.

*Mr. Pallone. Now, this -- thank you. The Centers for Medicare and Medicaid Services have previously said that the administrative burden can make it difficult for beneficiaries to comply with Medicaid work requirements. Is it fair to say that many beneficiaries lose coverage because they get tangled up in red tape? And that is, I guess, your example, but if you want to --

*Ms. Brooks-LaSure. That is an example. I think we have seen it.

It is also -- states are in the process of working on unwinding. If -- we want them focused on making sure they are meeting all the requirements that were established by the

Congress at the end of the year and making sure, again, that we are holding on to coverage so that we are addressing health outcomes like maternal health, like mental health, and making sure we have a strong and healthy workforce.

*Mr. Pallone. So Administrator, CMS has said that research shows that most Medicaid beneficiaries are either already working or subject to an exemption, and that this -- and I quote -- "this makes it challenging for such a work requirement to produce any meaningful impact on employment outcomes.''

In other words, work requirements and Medicaid don't actually increase work. Is that correct?

*Ms. Brooks-LaSure. There has been no link when we have seen work requirements in states to an increase in employment.

*Mr. Pallone. All right. And to summarize, I mean, again, I know you have talked about this quite a bit with some of the previous members asking questions, but to summarize, work requirements, in my opinion, won't increase employment. They will cause people to lose health insurance, and many of these people will still be eligible and just get

caught up in the red tape, and is that correct?

And if you wanted to talk about --

*Ms. Brooks-LaSure. That is certainly our expectation, and based on our experience over the last many, many decades. When we establish new requirements for people, they form barriers to the people who are subject to them, as well as to others.

*Mr. Pallone. Well, thank you. It is clear from your answers that -- you know, why Republicans wanted to skip regular order on this bill. And that is because the Republicans' so-called work requirements is nothing more than another attempt by Republicans to take health insurance away from people and cut over $100 billion from Medicaid. And I am disappointed that my colleagues are choosing to ram this cruel and harmful policy through the House of Representatives without so much as a hearing. And I hope my colleagues will join me in recognizing this bill for what it is: another transparent attempt to take health care away from millions of Americans, unfortunately.

And with that, Mr. Chair, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair now

recognizes Mr. Griffith of Virginia for five minutes for questions.

*Mr. Griffith. Good morning. In CMS's recent notice of benefit and payment parameters rule, CMS finalized a policy that your agency has originally estimated would render more than 60,000 plans illegal to be on the ACA exchange. As many as 2.7 million people may lose their plan or have to scramble to try to find a new plan.

You just finished a whole discussion of people getting caught up in the red tape. Madam Administrator, aren't you the red tape? Aren't you all the ones who are saying you can't do this, you can't do that, particularly when it comes to these ACA exchange programs?

*Ms. Brooks-LaSure. I would say that we are working very hard to make sure that people can enroll in coverage, and that they have good options.

*Mr. Griffith. But you have taken 60,000 options, plans off the table.

*Ms. Brooks-LaSure. So the provision that I think you are referring to is our requirement around making sure that people understand the difference between their plans. People

will have many dozens of choices. What we found in research and what we found from this experience of states --

*Mr. Griffith. And that may be true in some areas, but there have been times in my district, a rural district that is economically stressed, where there has only been one plan available, and now that has changed, there is a couple of plans available, but we are not going to have dozens. And then you have taken 60,000 plans nationwide across the board off the table.

And on top of that, we have seen price increases in the ACA plans. It stands to reason, does it not, that when you limit the number of plans you create an incentive for price increases? Isn't that true?

*Ms. Brooks-LaSure. I would disagree.

*Mr. Griffith. Okay, you disagree. I want to come back to that in a minute.

Where I had originally planned on starting before you talked about getting caught up in red tape, and I am back here going, "But you are the red tape,'' I wanted to talk about Alzheimer's. We have got a bunch of folks here from the Alzheimer's Association, including a former aide of mine

in the Virginia legislature, Josh Myers, who is with us today. If you look around, you will see a lot of purple behind you.

This committee worked hard to change the way the FDA did its work so that we could get things that -- medicines that take a long time to show benefit or to have an impact out there on the marketplace, because Alzheimer's is not something that you cure in a day or a week or two weeks. You have got to have years of using these medicines, particularly the -- if I am saying it right -- the amyloid plaque medications. And we changed those rules. We worked hard in this committee, this subcommittee, so that the FDA could approve it.

My question to you is then, the FDA has approved it; when did CMS decide or get authority to operate like a scientific regulatory body, when that is the FDA's job? And isn't that what you are doing? You have turned yourself into a regulating body, a scientific regulatory body, by denying paying for the Alzheimer's medication that this subcommittee, and this committee on a bipartisan basis, worked hard to make sure was available to the patients of Alzheimer's.

*Ms. Brooks-LaSure. Thank you for your question. And as we have all been talking about, Alzheimer's disease is incredibly devastating, both to the individuals who have it, and the families.

What we -- our requirement by law is to do a determination of whether a drug is covered -- whether it is reasonable and necessary for the Medicare population.

For the drugs that have been a -- that have received accelerated approval --

*Mr. Griffith. And the FDA says it is reasonable and necessary. When the physician says it is reasonable and necessary -- isn't it true you are just trying to cost shift?

*Ms. Brooks-LaSure. Our decisions are based on our requirements, the ones that we need to follow.

*Mr. Griffith. So you say we need to change your laws.

*Ms. Brooks-LaSure. Of course, Congress has the authority --

*Mr. Griffith. Has that authority.

*Ms. Brooks-LaSure. -- to change our rules.

*Mr. Griffith. I just don't understand why you are going against what our clear wishes were from this committee,

this subcommittee, and this -- and the Congress of the United States.

I have time maybe to go into one other direction. On those plans that you ruled illegal for the ACA, one of those is a company that has -- is a disrupter. It is trying to try a new model where they get rid of a lot of the middlemen and, therefore, don't have a network. They approve all drugs approved by the FDA. They will pay for them. It is a novel approach coming out of Ohio. You all ruled if you don't have a network, you can't be on an ACA plan. How does that make any sense?

*Ms. Brooks-LaSure. I would say what CMS focuses on is making sure that we know that if someone is enrolled in a health plan, they will have access to their doctors. And so that is our --

*Mr. Griffith. Well, this plan allows them access to any doctor they want, unlike the other ACA plans. It sounds like to me this is exactly what you ought to be moving forward to approving.

I appreciate your time, and I yield back.

*Mr. Guthrie. The time has expired, the gentleman

yields back. The chair now recognizes Dr. Ruiz for five minutes for questions.

*Mr. Ruiz. Thank you. Thank you for holding this important hearing.

Lowering the cost of health care along with increasing access to care are two of my top priorities. So I am especially glad the Supporting Safety Net Hospitals Act, which will eliminate the pending cuts to disproportionate share hospital payments for the next two years, is included in this hearing for consideration.

You see, I grew up, practiced medicine, and now represent a district that is woefully medically underserved and in dire need of better, more equitable access to health care. In my district alone, I have four DSH hospitals: Pioneer, El Centro, Palo Verde, and San Gorgonio hospitals, all of which will be significantly impacted by these cuts. These hospitals that care for our most underserved populations are already operating on razor-thin margins, and any cuts could mean hospital closures, and we certainly cannot risk that. Many of my constituents are already forced to travel a significant distance to get to a hospital, so any

hospital closure will lead to even worse access.

In addition to helping keep the doors open to DSH hospitals or the DSH hospitals' doors open, such as El Centro, Pioneer, Palo Verde, San Gorgonio hospitals, we also need to address the health care provider shortage that is plaguing our country. One of the ways that we can do that is by increasing the utilization of community health workers and promotoras.

Administrator Brooks-LaSure, you say in your testimony that proposals in the President's budget to invest $8 billion to enhance Medicare benefits such as expanding access to diabetes prevention services, behavioral health services, including addiction services, nutrition and obesity counseling, and community health workers. Can you expand on what the Administration wants to do to increase access to community health workers?

And what is your understanding between the difference of community health workers and promotoras, and will those changes also help promotoras?

*Ms. Brooks-LaSure. Thank you so much for your focus on making sure that people, particularly the underserved,

deliver care. And what we know is that there are so many types of organizations that are providing critical needs. And you mentioned safety net hospitals, which are on the forefront in many respects; Community Health Centers, where so many people get their private primary care --

*Mr. Ruiz. Let me just kind of refocus, because I only have a certain amount of time, and my specific question is can you expand on what the Administration wants to do to increase access to community health workers, or promotoras?

*Ms. Brooks-LaSure. So we are very committed to making sure that people who are helping to make sure that folks are connected to health care coverage and health care services, we are using our authority where we can, and welcome the opportunity to continue.

*Mr. Ruiz. Okay, thank you. I am working on legislation on -- to increase access to community health workers and promotoras, and would love to partner with you on those efforts moving forward.

*Ms. Brooks-LaSure. Thanks.

*Mr. Ruiz. Good?

*Ms. Brooks-LaSure. Mm-hmm.

*Mr. Ruiz. Okay. So switching topics to the No Surprises Act, this landmark policy was a huge win for patients who are now left out in the middle of paying -- payment disputes between providers and insurance companies, and are no longer receiving these balance bills, surprise medical bills.

But as you mentioned in your testimony, there is a significant portion of backlog disputes that are pending eligibility determinations. And I am sure you can imagine that I am hearing from a lot of folks about this backlog and the significant amount of time it is taking to get a resolution on their cases. And I think that the unanticipated backlog is indicative of just how important it was that we addressed the issue of surprise billing.

So I am pleased to hear you say that the departments are working to increase staff in order to address the backlog in eligibility determination, so that cases can be decided more quickly by the certified independent dispute resolution entities. So can you give us a status update on staffing, as well as how long you estimate it will take to clear the current backlog?

*Ms. Brooks-LaSure. I think you are very right in saying that the volume that we have gotten shows just how important of an issue No Surprises has been.

*Mr. Ruiz. So can you give us --

*Ms. Brooks-LaSure. But yes, we will --

*Mr. Ruiz. -- a status update on staffing, as well as how long you estimate it will take to clear the current backlog?

*Ms. Brooks-LaSure. We are working very hard on that, and will continue to, and happy to follow up.

*Mr. Ruiz. Okay. So I will follow up with you on that one for a status update. Staffing is going to be very important. I do think that there are a lot of rural hospitals who serve in underserved areas who rely on us making sure that this backlog is cleared as soon as possible.

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

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Mr. Carter from Georgia for five minutes.

*Mr. Carter. Thank you, Mr. Chairman, and thank you very much for this hearing. This is something you know that

I am very passionate about, and I can't tell you how much I appreciate it.

Administrator, thank you for being here. Just for the record, I am a pharmacist. I have practiced pharmacy over 40 years before I became a Member of Congress. I started when I was 10, by the way.

[Laughter.]

*Mr. Carter. But nevertheless, one of the issues that is most important to me is transparency and drug pricing. I was the one behind the counter who had to go and watch the senior citizen make a decision between buying groceries and buying her medicine. I was the one behind the counter who watched the mother in tears as she tried to find the money to pay for her child's antibiotic. And I set as my goal when I got here eight years ago to do something about that.

The first thing I did was to go to the FTC, and to ask them to look at the vertical integration that exists within the drug pricing chain, where the insurance company owns the PBM that owns the pharmacy that, in many cases, employs the provider. I asked them to look at that. Finally, after seven-and-a-half years, they undertook a study last summer to

look at the impact that the practices of the PBMs are having on independent retail pharmacies.

You know, this is a bipartisan issue. This is a non-partisan issue. I never went to the counter and asked, "Are you a Republican or a Democrat?'' The price was always the same. High drug prices impact everyone here in America, all Americans. That is why we have to do something about it.

Chair Rodgers asked you a question a little while ago, and I want to get clarification and be fair here. I believe she asked you if you had -- I don't know whether she was talking about transparency or about the vertical integration, and you said you had no authority in that area. Was it about the transparency?

*Ms. Brooks-LaSure. It was about vertical integration.

*Mr. Carter. About the -- okay, fair enough. I do believe that is the responsibility of the FTC, and I think the FTC has failed, has failed Americans in not undertaking that responsibility. And that is why I applaud them for this study that they are doing right now.

And it is not just pharmacy, and it is not just drug pricing. It is consolidation within health care, period.

You know -- we had in this committee we had the CBO, the Congressional Budget Office before us in a meeting. We had the director and we had 20 staff members. I asked them directly to give me one, just one, example of where consolidation in health care has saved money. They could not give me one. One example of where consolidation in health care has saved money, and they could not give me one.

You know, we all want the same things. Republicans and Democrats want the same thing. We want affordability, accessibility. We want quality in health care. That is what we want. And when we talk about accessibility, we have to talk about independent retail pharmacies, because 95 percent of all Americans live within 5 miles of a pharmacy, yet 4 percent of all independent retail pharmacies are going out of business every year as a result of the practices primarily of PBMs.

Now, I have got a bill here. You know what spread pricing is, and you understand it. We have got a bill, Drug Pricing Transparency in Medicaid Act. You understand that the State of Ohio, the attorney general, has just recently undertaken a lawsuit against the PBMs, referring to them as

gangsters. And that is exactly what they are.

I just want to ask you, do you agree that more transparency is needed when PBMs are now vertically integrated, and own the insurance company that owns the PBMs, that owns the pharmacy, that in many cases employs the provider?

*Ms. Brooks-LaSure. I agree that transparency is important.

*Mr. Carter. Well --

*Ms. Brooks-LaSure. I did want to mention one thing that we have done -- and it really did come from talking with pharmacists -- was trying to increase the transparency with fees that are paid, and to make sure that pharmacists would understand what the rules were. And it is something that we will continue to work on.

*Mr. Carter. What do you think you can do in helping us with transparency?

*Ms. Brooks-LaSure. I am happy to -- our staff is happy to work with you on ideas around transparency.

*Mr. Carter. Well, we got plenty of them.

If we eliminated spread pricing, do you think that we

could save money here in America?

*Ms. Brooks-LaSure. I think it is -- as with --

*Mr. Carter. If I could, there was a study done -- and it is a little aged now, it was done a little bit over a year ago -- by the Berkeley Research Group that showed -- and listen, and if you remember one thing, then remember this. It showed that only 37 percent of the price of a drug goes to the pharmaceutical manufacturer, which begs the question, where does the 63 percent go? It goes to the PBM, it goes to the middlemen. That is where the problem is. That is where we can control drug prices at.

I want to ask you to please commit that you will work with us to bring forth more drug transparency. We have got bipartisan legislation that we are working on now.

*Ms. Brooks-LaSure. I commit that we will work with you on --

*Mr. Carter. Thank you, and thank you for being here today, and I yield back.

*Mr. Guthrie. Thank you. The gentleman's time has expired. The chair now recognizes Representative Barragan from California for five minutes for questions.

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

Thank you, Administrator Brooks-LaSure, for being here, for all the work that you do at CMS.

Before I want to start, I want to recognize advocates out here in our purple-colored shirts that are advocating for Alzheimer's. As you know, as many people have heard, my mother has Alzheimer's. She is 82 years old. And the issue of Alzheimer's and access to care, access to drugs, and making sure it is equitable is an issue that is not only near and dear to me, but requires advocacy.

Your testimony highlights that part of the goal that you have is to have equity. And it says effort to cross the agency are based on a foundation of goals that aim to advance health equity, eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved. We know that Alzheimer's impacts all Americans. We know that Latino communities are growing, and they are at huge risk of being those that are going to be impacted by Alzheimer's. And I have seen firsthand -- and a lot of our families have seen firsthand -- the devastation.

You and I have had conversation before, both through letters that I have sent to CMS asking them to reconsider its national coverage determination. We have had a meeting. You were very generous with your time. I appreciate your willingness to do that. I have held a press conference. I am going to continue to hold press conferences, and I have introduced legislation to try to fix -- and what I see as a fix -- to CMS's unprecedented decision to tightly restrict coverage for a whole class of Alzheimer's drugs.

And this is a bipartisan issue. This is something that we have heard from colleagues on both sides of the aisle, and something that is, I think, meaningful and a failure, really, of CMS to provide meaningful coverage for the class of therapies targeting Alzheimer's disease. CMS's decision continues to concern me. And so I want to follow up to a letter I had sent to you and a response that you provided on March 27th, just a couple of weeks ago.

Administrator, you stated in your response letter to me on March 27th, when I urged you to reconsider the coverage policy -- you said that -- and I am quoting from the letter, "If the FDA approves a drug within this class based on a

direct measure of clinical benefit, CMS will provide enhanced access and coverage for people with Medicare participating in CMS-approved studies, such as nationwide, registry-based study.'' And I am ending the quote there.

From my understanding, this means that CMS will continue its policy of only providing coverage for those enrolled in a CMS-approved study, which is concerning to me. Is that is that accurate?

*Ms. Brooks-LaSure. No, in the sense of -- I -- and we will work to clarify what we mean by "registry,'' because it is clear that there is a misunderstanding.

When we say "registry,'' all that we are indicating is that individuals who are taking the drug, their doctors will put that information in a privately-owned registry so that some of the other factors that are prescribed by the drug can be included. But it in no way limits people from getting access to the drug.

*Ms. Barragan. But don't they have to be --

*Ms. Brooks-LaSure. Whatever is on the FDA label --

*Ms. Barragan. Don't they have to be part of a study?

*Ms. Brooks-LaSure. It is not a study in the sense of

it will just be included. The people who will be eligible will be based on the FDA label. So whatever -- when FDA approves the drug, they say it -- whichever populations they say it is appropriate for, that will be the basis of which people will get the drug.

*Ms. Barragan. So you are basically saying that all patients indicated for -- for example, the drug lecanemab -- and any future therapies in the class will have coverage for the drug upon full approval?

*Ms. Brooks-LaSure. That is right.

*Ms. Barragan. Do you know when such registries will be ready for patients to enroll and begin receiving treatment?

*Ms. Brooks-LaSure. We encourage --

*Ms. Barragan. And will the registry be available the day of the FDA's approval, or will there be a delay?

*Ms. Brooks-LaSure. That is certainly our goal. Private-sector entities right now can start setting them up.

*Ms. Barragan. Okay. Administrator, can you tell us what other FDA-approved drug has been denied coverage by CMS?

*Ms. Brooks-LaSure. We have never denied a drug for an FDA-approved drug. We have done coverage with evidence

development, which we are doing here.

*Ms. Barragan. Well, except for this, right, except for this drug?

*Ms. Brooks-LaSure. We are not denying coverage. We have said that for an accelerated approval drug it needs to be covered in the -- under a clinical trial. And when it reaches Federal full approval by FDA, we will cover it more broadly.

*Ms. Barragan. I think that is a little inaccurate, and that is my concern, is it has been FDA approved, say, on an accelerated basis, and this is the first time that the CMS has not covered a drug, is my understanding --

*Mr. Guthrie. I believe we have extended our time.

*Ms. Barragan. -- that was FDA-approved.

*Mr. Guthrie. I agree --

*Ms. Barragan. I am sorry.

*Mr. Guthrie. -- that accelerated approval is full approval, my understanding.

*Ms. Barragan. I yield back.

*Mr. Guthrie. Thank you for that. But I agree with you, 100 percent. The chair recognizes Dr. Bucshon for five

minutes for questions.

*Mr. Bucshon. Thank you, Chairman Guthrie, and thank you, Administrator, for appearing today.

So following up on that, has the FDA told you that accelerated approval is not full approval, and should be treated differently?

*Ms. Brooks-LaSure. We have many conversations with the FDA. We consider accelerated approval in a different category than full.

*Mr. Bucshon. Okay, you do, but the FDA does not. So I want to just make that clear.

I am sure, like all of us here today, that you support lowering drug costs for all Americans, particularly seniors on Medicare who live on a fixed income. So I am curious why CMS chose to increase the taxpayer cost of cancer drugs and other expensive medications for serious diseases by 37 percent recently.

What I am referring to is that CMS traditionally paid 340B hospitals, which acquire drugs at a discount in order to reach more patients and expand care, which -- I support the program -- and provide more comprehensive services to those

folks at around 80 percent of the average sales price. But as of September 2022, CMS reimburses for these drugs at 6 percent above average sales price. Why?

*Ms. Brooks-LaSure. We -- and as you probably are aware, under the previous Administration the policy was changed, and we have gone back to the original policy, as dictated by Congress.

*Mr. Bucshon. Okay. Actually, it was a Supreme Court ruling, probably, that has really --

*Ms. Brooks-LaSure. That is right.

*Mr. Bucshon. -- caused that. But for the record, Justice Kavanaugh, in the ruling, ruled that CMS's first option is to pay for 340B drugs based on hospital survey data. And I understand that CMS has that survey data, which indicates that it should be paying for 340B drugs, that average sales price, minus 28.7 percent. Just saying.

So it is a little disingenuous to say you are -- you know, and try to blame it on the Trump Administration, and say you are going back to previous policy. It is based on a Supreme Court ruling. However, your interpretation of the ruling, I would argue, is inaccurate.

I have one additional question as it relates to this 340B court case. It is my understanding that CMS has not yet announced how it will handle payments for 340B drugs made prior to last September 28th. What is the plan?

*Ms. Brooks-LaSure. We plan -- intend to issue it very soon.

*Mr. Bucshon. So you don't have a plan that you have publicly issued yet?

*Ms. Brooks-LaSure. That is correct. We will publicly do so in the next couple --

*Mr. Bucshon. Okay. Do you have an estimate about what the expense will be, what the cost will be?

*Ms. Brooks-LaSure. We will issue that as part of the rule.

*Mr. Bucshon. Okay. It is going to be in the billions and billions of dollars. I understand that. I mean, I believe in our system, you know, and the court made a ruling, and there we go.

Mr. Chairman, I don't really have any further questions. I just have a comment on the hearing in general. This is a great hearing for the American people. This is about

lowering health care costs for all Americans, regardless of your zip code. It is about making sure Americans have access to FDA-approved drugs. It is about maintaining innovation and -- in the health care marketplace. And at the end of the day, again, it is about access to quality, affordable health care services for the people that we all represent.

So I just want to commend the committee and the chairman of the subcommittee and the staff on the Republican side and both sides of the aisle on Energy and Commerce for this hearing. I have been in Congress for 13 years. I am a health care provider. And I am not using hyperbole here, but I think this is potentially one of the most important health care hearings that I have participated in since I have been on the committee.

*Ms. Eshoo. Would the gentleman yield?

*Mr. Bucshon. I will yield.

*Ms. Eshoo. I thank the gentleman.

I just would like to add something to the record in the exchange between Congresswoman Barragan on it takes over a year, Madam Administrator, up to 17 months for approval on medical devices in terms of what you are referencing, the

system you want to use for this drug. That is not acceptable. It really isn't. And so I just wanted to get that down for the record. And I appreciate --

*Mr. Bucshon. Yes, and I would yield --

*Ms. Eshoo. -- it, and I yield back.

*Mr. Bucshon. I reclaim my time. I want to make a comment on what Ms. Eshoo just said. I had -- I am aware of a device in the past that I was involved in -- many of us were -- that took five years to get a national coverage decision of an FDA-approved medical device, limiting access. So the discussion around Alzheimer's drugs and other medications where CMS is not making quick decisions on drugs that have been through the FDA process needs to be looked at.

I yield.

*Mr. Guthrie. The gentleman yields back. The chair now recognizes Ms. Representative Lisa Blunt Rochester from Delaware for five minutes.

*Ms. Blunt Rochester. Thank you, Mr. Chairman, and thank you, Administrator Brooks-LaSure, for your testimony.

I am grateful that we are considering policies to lower unaffordable health care costs, and I would like to focus on

a few programs that protect the health and economic security of low-income seniors.

I believe one of the most under-discussed provisions of the Inflation Reduction Act is the expansion of the Medicare Part D low-income subsidy program, also called Extra Help. The low-income subsidy program pays Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low incomes who meet certain resource criteria. An estimated 40 percent of low-income Medicare beneficiaries spend 20 percent or more of their very modest income on premiums and other health care costs, which makes programs like the low-income subsidy program a lifeline for some seniors.

The Inflation Reduction Act expanded cost-sharing assistance to enrollees in the low-income subsidy program beginning in 2024. Can you tell us how this provision will lower drug costs for vulnerable Americans, and what CMS will do to ensure that all people who qualify can take advantage of this new benefit?

*Ms. Brooks-LaSure. Thank you, Congresswoman, for highlighting what is one of the most exciting provisions of

the Inflation Reduction Act.

Every year there are new provisions that take effect, and in 2024 we are very excited to expand coverage. We encourage seniors right now to look and see if they are eligible for what we call our Medicare savings programs and our low-income subsidy, because if you are already enrolled, you will automatically have access when next year starts to these additional protections around cost-sharing.

It also expands the number of people who are going to be eligible. And so, as part of our annual open enrollment period, we are very focused on trying to get the word out to everyone to make sure that they enroll in this coverage if they are eligible.

*Ms. Blunt Rochester. And you mentioned Medicare savings programs, and MSPs are also programs that help those with limited income and resources pay for Medicare Part A and B cost-sharing. However, MedPAC has noted that many Medicare beneficiaries and providers do not know about the MSPs, and many beneficiaries who are eligible may be particularly -- may be really difficult to reach them because they live in rural areas, or they are homebound, or have limited English

proficiency, or have vision, hearing, or cognitive difficulties.

Furthermore, conflicting enrollment and eligibility requirements between the MSPs and related Federal programs serving similar low-income individuals like the LIS program have resulted in low-income individuals having -- there are being just inefficiencies in the -- and creating under-enrollment.

The President has proposed several reforms to ease the administrative burdens for states and remove enrollment barriers. Can you describe these proposals, and how they would help low-income seniors afford their health care costs?

*Ms. Brooks-LaSure. We are incredibly focused on Medicare savings programs because so many people who are eligible for them are not enrolled, and that is something that we are very focused on. States administer them, and so we are really trying to make the connections even closer between the Medicare program -- so when someone calls our call center, that they get connected to the state to get enrolled, and trying to limit the paperwork as -- in terms of what people need to fill out.

*Ms. Blunt Rochester. I would also like to associate myself with the comments of many of my colleagues about how important this hearing is.

Also, to the advocates who are here today, the Alzheimer's advocates wearing your purple, I always say, you know, as we said, this has touched so many of us, whether it is my grandmother, my mother, one of my good neighbors, that the reason why you wear purple is because this is not a red issue or a blue issue, it is an American issue. So thank you so much for your advocacy.

And I yield back.

*Mr. Bucshon. [Presiding] The gentlewoman yields back. I now recognize Mr. Johnson from Ohio for five minutes for his questioning.

*Mr. Johnson. Well, good morning, and thank you, Administrator Brooks, for making time in your busy schedule to speak with our committee. As I understand it, this is the first time that you have been in front of Congress, despite being in your role for nearly two years.

I take Congress's oversight role very seriously. And while we are on the topic of transparency in the health care

space, I think it is reasonable to question the Biden Administration's commitment to transparency, given that we haven't heard directly from you before our committee previously. So I appreciate having the opportunity to do that today.

You know, in late 2019 the Trump Administration proposed and later finalized rulemaking to increase price transparency for patients, giving the American people all of the information about their health care as vital to ensuring they receive the care and treatment they deem necessary for their own lives and the lives of their loved ones. Since that rule went into effect, there have been varying reports of price transparency compliance among hospitals. To date, CMS has issued only four penalties for non-compliance. Yet a number of academic and non-governmental studies have concluded that the number is much, much higher.

So my first question. Ms. Brooks, could you explain why there is such disagreement with concern to transparency compliance?

I mean, what metrics is CMS using that would cause such confusion about who is following the rules and who isn't?

*Ms. Brooks-LaSure. Thank you for your questions about transparency and the work of the committee, and we are very committed to implementing the rule.

*Mr. Johnson. No, I want to -- but I need you -- Ms. Brooks, I need you to answer my question.

*Ms. Brooks-LaSure. Certainly.

*Mr. Johnson. What metrics are you using that would cause the confusion about who is and who isn't following the rules?

*Ms. Brooks-LaSure. Some of the differences that people have where -- in the different studies, in terms of whether people are complying, is because people have been looking at different metrics. So we are looking at what our rules require. And I will give you an example, if that is helpful.

So there have been some questions where hospitals, for example, might have "N/A.'' The reason why they may do that is because they don't offer that service. And according to our rules, they don't need to do so.

*Mr. Johnson. Well, when cross-referencing hospital pricing data with insurance company data under transparency in coverage, patient advocate groups are finding real

dollars-and-cents amounts in insurance company price data fields, whereas hospitals have posted N/As, blanks, dashes, and hyphens. So it is not that they are not offering those services, because the insurance companies are saying they are.

How can CMS consider hospitals that enter such data as compliant in good faith, as you did in an interview with NBC Nightly News, without first verifying the accuracy of the data?

*Ms. Brooks-LaSure. So as we have been talking about, we are working to implement the legislation. And when anyone lets us know that they think a hospital is in violation, we undertake a review, and we look to --

*Mr. Johnson. And you have only found that four times out of all of the hospitals?

*Ms. Brooks-LaSure. No, that is not right. What we have done is we send first a warning notice if they have met certain standards, if they -- if -- we send a warning notice, we ask them to do a corrective action plan.

And what we have found is, by -- the vast majority of hospitals, when they find out that they have not been in

compliance, come into compliance, because that is our goal. Our goal is not to impose penalties, although we will absolutely do so, and we have increased our penalties. We are focused on getting hospitals into compliance, and that is why today we are shortening our timeframes.

*Mr. Johnson. Well, then why is CMS blindly accepting hospital files, some of which have been flagged by various outside groups as compliant, without first verifying that the rates are legitimate?

*Ms. Brooks-LaSure. We review when we get a complaint, and happy to follow up on specifics.

*Mr. Johnson. Well, I submit, Mr. Chairman, we are not going to get to transparency -- and we all know what transparent does. Transparency improves competition, it ends up improving quality, and it lowers cost. That is across any industry. Price transparency is essential to lowering health care costs. And when you consider that health care costs are the most -- are the largest part driving America's national debt, it is the most expensive part of what the Federal government spends, this is a really important topic, Mr. Chairman.

I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Dr. Schrier from Washington for her five minutes for questions.

*Ms. Schrier. Thank you, Dr. Bucshon, Mr. Chairman, and thank you, Administrator Brooks-LaSure, for coming to speak with us today. It is great to see you, and welcome.

You know, the last couple of years have been really hard for the medical community. Doctors and nurses and respiratory therapists were overwhelmed by the demands of the pandemic. Many put their health and their family's health at risk in order to care for patients. Some physicians had to pause elective procedures. Many shifted to telemedicine, as you know. And because of some of these financial strains, many small offices needed to close their doors.

At the same time, every year we scramble and panic by the end of the year to prevent cuts to Medicare reimbursement rates. And this is happening at a time of inflation and high wages. And it is hard for small and large practices to keep their doors open. In fact, according to the AMA, the failure of Medicare reimbursement to keep pace with inflation has had

such a big impact on physician payment, it translates to a 26 percent drop in inflation-adjusted Medicare pay for doctors. And that is not a way to keep a system functioning.

Add to that early resignations and retirements, and there is a lot of strain on the system. What happens, then, to these small practices is that the big ones eat them up, and you end up with consolidation, and a lack of competition, and higher prices. And if those large systems can't stay afloat, what they will do is number -- limit the number of Medicaid and Medicare patients that they will see in order to get by, and then patient access is impacted.

And so I am wondering, Administrator Brooks-LaSure, what do you see as the best way to bring down costs, increase transparency, have fair reimbursement, keep competition, and how can we help in Congress?

*Ms. Brooks-LaSure. Well, thank you so much for highlighting what we are hearing across the country, just how much doctors and other clinicians are struggling during -- that is something that has been happening for many years, and certainly over the last couple of years, when the health care system has been incredibly strained. We are happy to work

with you to continue to think about how we can support our workforce, how we can really try to make sure that all offices can continue to be able to thrive in different types of environments.

*Ms. Schrier. Let's work together on physician reimbursement. I know the community, and all of us at some point will really appreciate that.

A quick question about transparency and pricing. I know we have talked a lot today about listing -- list prices for procedures at hospitals, which seems really, really helpful on the surface, but it mostly applies to people who either have high deductibles or who are uninsured. And when I look at my explanation of benefits, there is a negotiated price that is far lower than that list price.

And so I am just wondering, given that many, most Americans are not paying the sticker price or a percentage of that sticker price, how much impact are these listed prices really going to have on the cost of health care in this country?

*Ms. Brooks-LaSure. It is a really important point. So we do have rules and requirements around health plans

providing information about the -- about procedures. And I think, for people who are insured, that can be a more helpful understanding of what their costs are going to be. But yes, if you have health insurance you are going to likely choose the doctors that -- and who are in your network.

The list prices, I would say, are a first step in transparency. They certainly are helpful for the uninsured, but also for third-party developers to use that information, and I know this committee heard from one such entity that can help with making the information more accessible.

*Ms. Schrier. Thank you. I have one other issue, and I don't expect an answer, I just look forward to working with you to ease this problem.

I hear about this issue regularly from my patients, my constituents who are also patients, and it strikes a nerve with me because I have Type 1 diabetes, and have been using a pump for, like, almost 40 years. Patients on insulin pump therapy who have Medicare, even those who, like me, have been on a pump for decades, and are stable, and their doctor only thinks they need to come in once a year, they need to go see their physician every three months to get authorization to

use an insulin pump. This puts them at risk for running out, it is a use of medical dollars that we shouldn't be spending. And I would just say that on these and other inefficiencies in the system, I would love to continue to work with you.

I am out of time, and I yield back.

*Ms. Brooks-LaSure. I am happy to talk.

*Mr. Bucshon. The gentlelady yields back -- I agree with you on the insulin pump issue -- and at this point I yield to Mrs. Harshbarger from Tennessee for her line of questioning.

*Mrs. Harshbarger. Thank you, Mr. Chairman, and thank you for being here today, Madam Administrator.

I was concerned by the about-face that your agency took in the last two weeks reversing decades of policy that has otherwise precluded Federal health care coverage for undocumented immigrants. In that rule your agency wrote, "However, given the broad aim of the ACA to increase access to health coverage, we now assess that this rationale for excluding certain non-citizen groups from such coverage was not only statutorily mandated, it failed to best effectuate congressional intent in the ACA.''

And I find it hard to believe that suddenly this Administration, unlike the prior two Administrations, now knows what congressional intent was and, all of a sudden, somehow you are aware of a statutory mandate that none of us knew about, including the Obama Administration who passed the law.

Now, there is two documents, Mr. Chairman. In fact, I have these documents from the Obama Administration that made it clear that DACA recipients were not eligible for Medicare or Medicaid or ACA coverage. And I would like to submit these for the record, Mr. Chairman.

So I guess my question --

*Mr. Bucshon. Without objection.

[The information follows:]

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

*Mrs. Harshbarger. My question to you, Madam Administrator, is how can you legally justify this sudden departure from the law?

*Ms. Brooks-LaSure. The Biden-Harris Administration is focused on making sure that everyone has access to affordable coverage consistent with the law. We have made a determination that people who are brought to this country when they were children, known as DACA recipients, a closed cohort, so everyone who is a DACA --

*Mrs. Harshbarger. Was that --

*Ms. Brooks-LaSure. -- under --

*Mrs. Harshbarger. -- by executive order, or --

*Ms. Brooks-LaSure. It is under --

*Mrs. Harshbarger. It is not congressional intent.

*Ms. Brooks-LaSure. -- administrative authority.

*Mrs. Harshbarger. All right. I want to change subjects right quick.

In late 2021 CMS published a 9-page FAQ with the last Q&A stating, "It is a Stark violation if medical practices simply mail or otherwise deliver an oral drug to a patient.'' And I have practices in my district and in my state like

Tennessee Oncology, and they are alarmed because they routinely send these oral drugs to patients in rural areas like my area as a convenience, or as a medical necessity when the patient is too sick to pick the drug up.

And as a pharmacist for over 35 years, I cannot understand, when an oral drug has been prescribed by a physician and dispensed for a patient, how in the world that constitutes a Stark violation, when it actually costs that practice money to send it and mail it to a patient?

And I am saying that because a number of my House colleagues and I will be sending a letter urging you to retract that FAQ. And very recently, even HHS Secretary Becerra said at one of our committee hearings he would absolutely work with me and our colleagues on this issue.

So I just need a yes or no. Do you really intend that Medicare seniors who are too sick or without transportation to possibly go without their cancer drugs or any of these critical therapies?

*Ms. Brooks-LaSure. I am happy to work with you on this.

*Mrs. Harshbarger. Fantastic. And as my colleague,

Buddy Carter, mentioned, we have heard a lot about PBMs today, and how they operate in the shadows. There is many, many things we could talk about that, and even Secretary Becerra recently told the Senate Appropriations Committee that, with regard to PBMs, transparency would be helpful to see how they are operating, and the moment we try to do something, we likely find ourselves in court. We are trying to move the dial. That came from the Secretary.

And I have two questions, but I do want to tell you about a bill that I just put out this week. It is bipartisan legislation. It is called the PBM Sunshine Accountability Act. And what this would do would require public reporting of PBM information that the HHS Secretary already gets under current law. And it enhances the reporting to include the rebates and fees that PBMs and its financial affiliates receive from drug manufacturers and health insurers so we better understand the rebates and fees that companies are receiving when they are -- where they are coming from, and what is not passed on to the clients and the patients. Would you be in support of something like that?

*Ms. Brooks-LaSure. I would be happy to work with you

on that.

*Mrs. Harshbarger. Absolutely. And I have got a couple other questions, but I know my time is about up, and it concerns the No Surprises Act. And in 2020, when it was passed into law, it required to make publicly available by June 27th, 2023 a report on drug rebates, drug reimbursements, and pricing trends in commercial health insurance. And are you on track to meet this deadline?

*Ms. Brooks-LaSure. We are working to do this provision, yes.

*Mrs. Harshbarger. Okay. I know my time is up, so I yield back. Thank you.

*Mr. Bucshon. The gentlelady yields back. Is Ms. Kelly ready for her line of questioning?

I yield now to Ms. Kelly for five minutes.

*Ms. Kelly. Hello, Administrator. Good to see you.

*Ms. Brooks-LaSure. Nice to see you.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member Eshoo, for holding today's hearing.

Administrator Brooks-LaSure, thank you for being here today.

When we passed the American Rescue Plan, my legislation was included to extend Medicaid postpartum coverage from 60 days to 1 full year. This extension has been a crucial lifeline for mothers and their infants, and I am proud to say that this is no longer a temporary measure. Currently, 32 states and Washington, D.C. have already made this extension permanent. Even other states like Alabama, Tennessee, Kansas, Oklahoma, and Nebraska have enacted postpartum Medicaid extension legislation.

The expansion of Medicaid postpartum coverage is a critical part of our efforts to address, as you know, the maternal health crisis in this country, as the Medicaid program finances about 4 in 10 births in the U.S.

Sadly, mothers aren't the only victims of our maternity care system: 1 out of every 1,000 babies born in the U.S. -- approximately 6 babies die [sic].

Extending postpartum -- Medicaid postpartum coverage to one year is part of our ongoing efforts to break down barriers to accessing care. I am deeply concerned that work requirements -- I know someone mentioned it before -- in Medicaid will undo our progress. Administrator, are Medicaid

work requirements a benefit or a hindrance to Congress's effort to make Medicaid more accessible to low-income individuals, as well as new moms?

*Ms. Brooks-LaSure. Thank you so much for your work on maternal health, and it is very exciting that every time I talk we have more states that have come in to extend coverage, postpartum.

And I think it is really important, when we think about the maternal health crisis, to remember that part of it is making sure that women have coverage before they are pregnant. That is one of the key pieces, that people have coverage so they can live healthy lives, they can work. And the vast majority of people on the Medicaid program are working. They are caregivers. They are students.

But what we have seen over time is that when there are additional barriers to enrollment, that it creates people getting lost in the red tape. And that can mean people who are subject to the requirements. But very often it also means people who are exempt, but need to make sure that they produce the right documents, and produce the right forms, and that they go through it. And let's remember who these people

are. They are people working multiple jobs, who are juggling a lot of life.

And so I think it is -- as we have seen, it is critical for people to have health insurance coverage, both for themselves, for their families, and for us, as a country, to make sure that we are safe when a pandemic hits.

*Ms. Kelly. Thank you so much for your response.

On August 1st, 2022 CMS finalized the proposed rule, and will award a birthing-friendly hospital designation in the fall of 2023 to hospitals that have participated in a national or statewide quality collaborative, and carried out the recommended intervention. This is the first-ever hospital quality designation by HHS that specifically focuses on maternal health.

How will these hospital programs be evaluated to ensure that the awarded organizations' outcomes are higher than the organizations without the designation?

*Ms. Brooks-LaSure. I am so excited about the work that we have been able to do on the birthing-friendly designation, particularly because the private sector has really partnered with us, and is using it even more broadly. So more than

half of the country will be able to look to see these designations for hospitals.

These are hospitals that will have agreed to have taken the recommendations from their maternal health experts and included those, and we intend to continue to get information from the public commenters about quality measures that we will hold these hospitals accountable for.

*Ms. Kelly. I just want to thank you for all of your hard work, and your staff, and for being accessible, and helping our office so much.

Thank you, and I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Dr. Joyce for his five minutes for his line of questioning.

*Mr. Joyce. Thank you for yielding, Mr. Chairman, and for holding this hearing today.

First, I would like to add my voice to the list of those concerned of what CMS has decided on restricting coverage for anti-amyloid treatment for Alzheimer's disease. The CMS standard is defined in statute as "reasonable and necessary for the diagnosis or treatment of illness or injury, or to

improve functioning of a malformed body member.''

I would like to thank my colleague, Rep. Barragan, for working on legislation with me to mitigate this misguided decision, and would urge that this panel take lifesaving measures to address this issue.

Administrator Brooks-LaSure, I was encouraged to see the President's executive order on competition take on hospital consolidation by noting that this consolidation has left many areas, particularly rural communities, with inadequate or more expensive health care options. Can you please elaborate on actions -- and please be specific -- your agency has taken to address hospital consolidation?

*Ms. Brooks-LaSure. Thanks. Thank you so much, Congressman, for your mentioning of the Administration's real focus on consolidation.

Our authority at CMS on consolidation is really around transparency, and that is what we are focused on, making sure that there is ownership information available to people as they are choosing plans. There are other agencies across the Administration with additional authority, of course. That is our focus.

*Mr. Joyce. Thank you. Building on this work, I am hopeful that you will be encouraged to see these bipartisan bills -- draft as a way to address the President's executive order by removing incentives for greater hospital and provider consolidation. Importantly, they are built on a foundation of work from the presidential administrations from both parties, non-partisan groups like MedPAC, and academics and think tanks across the ideological spectrum.

Will you commit to work with us on these policies to mitigate consolidation and promote competition?

*Ms. Brooks-LaSure. I will absolutely do so.

*Mr. Joyce. This year over eight Humira biosimilars will launch in the U.S., with expectations of producing significant cost savings for patients and the health care systems. Medicare alone, it is estimated, could save over $2 billion if it had access to these biosimilars.

In order for patients and the Medicare program to realize these savings, biosimilars must have immediate access to Part D formularies. What policy actions is CMS taking to ensure that these Humira biosimilars are available to beneficiaries?

*Ms. Brooks-LaSure. We are certainly excited about innovative drugs that come to market in particularly biologics and other generics. I am happy to talk in more depth about what we do to encourage Part D formularies -- Part D plans to cover --

*Mr. Joyce. I personally welcome that discussion. I think it is so important for patients across America.

Earlier this year I sent a bipartisan letter asking CMS to take action about biosimilars and formulary access. One point that I raised was having CMS update guidance to ensure maintenance charge -- maintenance change policies were updated to include a broad array of biosimilars. What is the status of this request?

And will you commit to doing a thorough review to ensure that biosimilar formulary access is not only permitted, but is also done in a way that ensures patients can utilize them?

*Ms. Brooks-LaSure. We will follow up with your request, and --

*Mr. Joyce. Thank you.

*Ms. Brooks-LaSure. -- I will get you a status update.

*Mr. Joyce. I appreciate that commitment.

Finally, I would like to thank you, Mr. Chairman and Ranking Member Eshoo, for the work that you have done on the MVP Act, and echo my support for this important legislation.

One of the things that is so important about the MVP Act is it adequately is flexible for many different disease states. As a physician, I understand how different some outcomes could be across different disease states. For example, the outcomes that you might measure and the length of time you would measure them might look different for a gene therapy for muscular atrophy than outcomes for hemophilia. The multiple best price approach would allow payers and states to establish VBAs that could encompass multiple outcomes, including one for diseases where a pay-over-time arrangement is truly the most appropriate way.

Can you discuss how important it is that the best price approach capture different types of VBAs in order for them to work across all disease states?

*Ms. Brooks-LaSure. I certainly agree, and am excited that the committee is going to focus on outcome-based proposals to make sure that we can -- make sure that states can afford to cover drugs, that people have access to them,

and ones that really support these innovative --

*Mr. Joyce. Thank you for --

*Ms. Brooks-LaSure. -- therapies.

*Mr. Joyce. -- your commitment to access.

My time has expired, and I yield.

*Mr. Bucshon. The gentleman yields. I now recognize Mr. Sarbanes for five minutes.

*Mr. Sarbanes. Thank you very much, Mr. Chairman. I appreciate it.

Administrator, thank you for being with us today and for your testimony about the many efforts that CMS is undertaking to create a more transparent, accessible, and affordable health care system. We certainly appreciate it.

Last year, as you know, Congress finally -- finally, after many, many decades, really -- took the historic step of standing up to Big Pharma, and enacting policies that are already -- we are seeing it -- lowering health care costs for millions of seniors in the Medicare program.

As the Inflation Reduction Act reforms continue to be implemented over the coming years, we must continue to build on this success, and I am glad the subcommittee today is

undertaking what is a bipartisan discussion of some of the issues that contribute to rising health care costs today.

Too often, when asked to identify the driver of the high cost of prescription drugs, the various actors in the supply chain point the finger at others, and the veil of secrecy surrounding so many health care pricing and contracting practices makes it virtually impossible for anyone to fully and accurately -- and certainly, not easily -- follow the money trail. This is, in fact, an intentional design feature that allows Big Pharma to continue to increase its prices, and along with Pharmacy Benefit Managers, its profits.

So, Administrator, how can the Administration's current work to increase transparency help policy-makers better understand these pricing practices, get behind this design, and help patients make more informed decisions about their health care?

*Ms. Brooks-LaSure. Thank you for noting just how monumental the Inflation Reduction Act is.

I get asked a lot of questions as CMS administrator, but I don't know one that I get asked about the most more than prescription drug coverage, and the ability of people to pay

for their prescriptions in this country. And we are really moving forward, and tremendously excited about the opportunity to bring additional benefits to negotiate, and we are committed to transparency as far as our authority allows, and want to continue to work with you on all of the proposals that you are considering.

*Mr. Sarbanes. Let me turn to increasing transparency and better understanding of some of the drivers of health care costs. If we have a better understanding of these factors, we can address them more effectively, which will, in turn, improve patient access and care overall.

In Maryland, as you know, we have been working to improve patient care while lowering system-wide health care costs for decades. Since the 1970s, we have had a hospital all-payer system. It is unique now. And our current total cost of care model uses global hospital budgets to incentivize value-based care, eliminate the need for charity hospitals, and strengthen the quality and comprehensiveness of care provided to all individuals, regardless of their geographic location in the state or their insurance status. It is really a visionary approach.

And Maryland's total cost of care model also allows our state to invest in other health system goals, like lowering the maternal mortality rate and the opioid overdose mortality rate, decreasing the number of children who visit emergency rooms for asthma, reducing adult Marylanders' risk of diabetes, and so on.

So, Administrator, what benefits do patients and providers do value-based approaches like the one that we have done in Maryland offer, and how can we work to incentivize and expand similar approaches across the country in this effort to lower costs and improve access to care for all Americans?

*Ms. Brooks-LaSure. Thank you for raising Maryland's innovative approach to paying for care, and it is one of the models that, through our CMS Innovation Center, we are really focused on trying to create other opportunities for states for other types of programs to really be able to operate and move to much more of a value-based, outcomes-based program.

We have a number of demonstrations that are underway, and ones that we are intending to pursue, and really encourage all stakeholders to reach out to us about ideas.

*Mr. Sarbanes. Thanks very much. I look forward to continuing to engage with CMS and others to further strengthen Maryland's total cost of care model, and apply lessons learned from that success to drive future health care initiatives.

I yield back, Mr. Chairman.

*Mr. Bucshon. The gentleman yields back. I now recognize Mrs. Miller-Meeks for her five minutes.

*Mrs. Miller-Meeks. Thank you, Mr. Chair, and thank you, Ms. LaSure, for being here.

There were those of us who spoke very eloquently during the Affordable Care Act that provisions within the Affordable Care Act would lead to increased consolidation, both hospital ownership of physician practices, larger physician practices, and that consolidation would lead to procedures being done at hospitals at higher cost, and ultimately would lead to increased health care costs.

And in 2019 and in 2020, almost 50,000 physicians left private practice to work for hospitals or other corporate entities. Roughly 70 percent of physicians are now employed by larger systems, meaning just 3 out of 10 doctors practice

independently. Hospitals are motivated to gobble up physician practices because they are able to bill Medicare roughly double the amount that private practices are.

Not only do payment differences in Medicare cost the government and taxpayer more money, but it costs seniors more because they are paying inflated co-insurance amounts for services that would cost significantly less if provided by a non-hospital-owned practice.

For example, a level 2 nerve injection in 2023 done in a physician's office would result in a $226 payment from Medicare. That same injection provided by a hospital outpatient department would result in a $741 payment. Same service, but a $515 payment increase due to it being provided in a different location, putting the patient and the government on the hook to cover the delta.

And I am in a district that has numerous both critical access hospitals, community hospitals, and in-between hospitals. And so I am very sensitive to, you know, the concerns of my rural hospitals, but when we are talking about the entire health care system, and the cost of the health care system, and trying to provide increased access and

increased quality care, I think this is concerning.

A 2020 estimate from the Congressional Budget Office projected $141 billion in savings, and I think that has now been increased to 158 by some more recent studies, $158 billion over the next 10 years, if site-neutral payment reforms were implemented.

And let me also say that I was a physician in academic medicine, and in private practice, and a hospital-employed physician.

MedPAC has also supported site-neutral payment reform, not only because it would reduce cost to beneficiaries, but because it would reduce incentives for vertical integration or consolidation in our health care system, which, as we all know, drives up costs.

Can you detail CMS's plans to implement site-neutral payment reform, and how can Congress help?

*Ms. Brooks-LaSure. Well, thank you so much for talking about how important rural hospitals are, which is something that I have been spending a lot of my time and travels just hearing from rural hospitals, their issues, as well as the issues around consolidation, which I think we all are very

much concerned about.

I would say that, as you know, for the most part, Medicare payment policy is determined by statute. And so we are following the way that we pay according to what Congress has passed. In some limited circumstances we have implemented site-neutral payments, where we feel that we have authority, but happy to work with you in ways that we can continue to make sure that people can get care in the most appropriate setting.

*Mrs. Miller-Meeks. And we are also seeing a concerning trend of physicians being purchased by payers, with one health insurance company now owning seven percent of all physicians in the United States. So another vertical integration that is extraordinarily worrisome.

And do you believe it is better or worse for patient care when physicians leave private practice?

*Ms. Brooks-LaSure. We certainly want to make sure that people have access to care and access to choices, and consolidation can be an issue with that.

*Mrs. Miller-Meeks. Thank you so much for your testimony and for being here.

I want to also echo the sentiments -- my mother had Alzheimer's, so I appreciate all of you here in purple supporting Alzheimer's, and our support for getting drugs that have been approved through the FDA on to the marketplace and covered. So I echo the sentiments of my colleague.

Thank you, Mr. Chair. I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Mrs. Trahan for five minutes.

*Mrs. Trahan. Thank you to the chairman and to Ranking Member for holding this important hearing today. Thank you to our witness, Administrator Brooks-LaSure.

I first want to start my remarks by voicing my strong appreciation for our hospitals and their workers, for the unbelievable job that they do in our communities. Whether it is a global pandemic, a natural disaster, a marathon bombing, a mass shooting, our nation's hospitals are always there, and American patients expect them to be there, capable of meeting their needs in times of crisis.

You know, many of my colleagues on this committee know that, when appropriate, I will take opportunity to talk about a critical safety net hospital in my district: Lawrence

General Hospital. Lawrence General serves a majority of Medicaid patients in a city that is 80 percent Hispanic or Latino. Under extremely challenging circumstances, the nurses, doctors, and administrators at Lawrence General have continued to deliver high-quality, affordable care to the underserved.

Like many safety net hospitals coming out of COVID, Lawrence is struggling financially. Administrator Brooks-LaSure, how important is it to maintain access to care for underserved areas like Lawrence, Massachusetts?

And what is the agency doing to protect the nation's safety net providers?

*Ms. Brooks-LaSure. Thank you so much for mentioning how important our nation's hospitals are in all sorts of situations, but certainly over the last couple of years, as we have been going through the COVID-19 pandemic.

We are absolutely committed to doing everything we can within our own authority, and have been looking at ways that we can support a host of hospitals, certainly including safety net hospitals which care for the most underserved, and would love to continue to work with you all on that.

*Mrs. Trahan. So I fully believe this committee has the responsibility to legislate in a way that allows our hospitals to deliver care while also lowering costs for American patients. Many of the bills in this hearing today are in the discussion draft phase. So I do look forward to working with my Republican colleagues to finalize them in a bipartisan manner.

Administrator Brooks-LaSure, it is my understanding -- and as my colleague from Iowa just mentioned -- that in recent years there have been efforts by CMS to implement site-neutral payment policies for certain services. However, there are exemptions to the statutory requirement for rural sole community hospitals, cancer hospitals, and children's hospitals to maintain access to appropriate care. Has CMS measured how some exemptions to site-neutral payment policies have maintained access to care in underserved areas?

And how would extending similar exemptions to the nation's safety nets help them financially?

*Ms. Brooks-LaSure. I am happy to follow up with you on that question.

*Mrs. Trahan. Thank you. Safety net hospitals often

rely heavily on Medicaid and Medicare reimbursements to provide care to underserved populations. And any reduction in reimbursement rates could potentially impact their financial sustainability and their ability to provide essential services in their communities.

We know that CMS supports the nation's hospitals. Can you share how CMS is thinking about lowering Medicare costs for patients, while balancing the need to protect and defend these critical providers?

*Ms. Brooks-LaSure. We certainly, within our authority, are very focused on pulling all of the levers that we can, and happy to continue our discussions around that.

*Mrs. Trahan. Well, I look forward to following up. I mean, it is worth noting that site-neutral payments can be a complex issue. While I am here to lower health care costs for patients, promote price transparency, and encourage competition among health care providers, I do want to make sure we are keeping in mind any unintended consequences that may limit access to care because of the discussion drafts in the hearings today.

So I look forward to working closely with you, with my

Republican colleagues to continue to work on the policies before us today.

And thank you, Mr. Chair. I yield back.

*Mr. Guthrie. [Presiding] The gentlelady yields back. The chair now recognizes Mr. Crenshaw from Texas for five minutes for questions.

*Mr. Crenshaw. Thank you, Mr. Chair.

Thank you, Administrator, for being here. I think we all share the common ground of lowering health care costs, and especially shoring up hospital safety nets. And without appropriate protections that stem from costs from charity care, access is impaired and everyone's health care costs go up.

I want to talk about the Medicaid Disproportionate Share Hospital program, the DSH program. It is an example where we provide very transparent payment to hospitals that do provide that charity care. Our health care system is complex. It is highly regulated. But the DSH program goes around this by directly giving straightforward payments to hospitals that are doing the good work of serving patients without coverage.

Unfortunately, this is often -- this program has been

cut in favor of other priorities like the Affordable Care Act, and it has been cut as a budget gimmick. Now, we have kicked the can down the road by delaying those cuts for years and years and years. I am proud to partner with Congresswoman Clarke on bipartisan legislation to create a fully paid-for two-year solution to Medicaid DSH funding, which covers the costs of safety net hospitals that treat these at-need, uninsured populations, avoiding these cuts also in a way that is more fiscally responsible.

I just want you to comment on that, and underscore how important the DSH program is. I mean, you know, which hospitals bear the brunt of potential DSH cuts?

*Ms. Brooks-LaSure. As you were mentioning, so many of our safety net hospitals are the ones who would lose payments, according to DSH, because DSH really focuses on people -- on hospitals that serve a disproportionate share of uninsured or Medicaid beneficiaries.

*Mr. Crenshaw. So I am going to assume that you would agree that we should probably --

*Ms. Brooks-LaSure. Yes.

*Mr. Crenshaw. -- not cut those in the future.

*Ms. Brooks-LaSure. I would say that it is very important that we maintain coverage for safety net hospitals.

*Mr. Crenshaw. And do you agree with the assessment?

I mean, the Affordable Care Act's cuts were problematic for these health care safety net programs.

*Ms. Brooks-LaSure. I would say that it is important that, particularly as we still have uninsured in the country, to make sure that hospitals are paid for caring for them.

*Mr. Crenshaw. Yes, I mean, I would point out for the record, I mean, one of the problems here was that the DSH cuts did come from the ACA. There was a miscalculation of how many Medicaid enrollees would be in the program. It doesn't matter if it was an expansion state or a non-expansion state. I mean, I am -- Ms. Clarke is helping me lead this, obviously, and that is New York.

So the last question I have, do you agree DSH payments are an accountable and direct mechanism with which to subsidize hospitals?

And as we rethink incentives in the system, could DSH be a good model for transparency when we do need to support hospitals in need?

*Ms. Brooks-LaSure. I do think that DSH is an incredibly important program, and a way of really understanding who is serving the --

*Mr. Crenshaw. Well, it is an important program. But, I mean, the framework, the way it is actually --

*Ms. Brooks-LaSure. Yes, I would agree with you --

*Mr. Crenshaw. -- administered, do you think --

*Ms. Brooks-LaSure. -- that there is --

*Mr. Crenshaw. -- it is a good model?

*Ms. Brooks-LaSure. I think that there is a lot of wisdom to having some understanding of what the mixed payer mix looks like in terms of payment.

*Mr. Crenshaw. I want to talk about primary care access in the Medicaid program. You know, a simple question: Do you think there is a physician shortage, and where do you see that most pronounced?

*Ms. Brooks-LaSure. I would agree with you that we are seeing workforce challenges, and it is not everywhere, but it is in so many of our rural areas. And you mentioned primary care. We absolutely have a lack of primary care in many parts of the country.

*Mr. Crenshaw. Yes. I am introducing bipartisan legislation that would seek to -- open access to independent primary care physicians in state Medicaid programs, particularly through recurring preset payments. We call that direct primary care. And I am doing this because in too many parts of my state -- and throughout the country, actually -- there is a shortage of primary care physicians to serve this critical population. The patient-to-physician ratio in rural areas is 39 to 100,000 people, compared to 53 to 100,000 in urban areas. And we are looking to have a shortage in the United States of as many as 55,000 primary care doctors.

So I think this is very important legislation. I urge my colleagues to support it for obvious reasons. You know, access to primary care reduces emergency room utilization, improves outcomes, probably reduces overall health care spending. You know, we often talk about getting people access to coverage, but that isn't care. I think this legislation would go far in allowing states to experiment with their own Medicaid programs.

There is no question in there, but if you have any last remarks or positive things to say about that, go ahead.

[Laughter.]

*Ms. Brooks-LaSure. Just to agree with you that it is crucial that we do more to support primary care in this country.

*Mr. Crenshaw. Great. Thank you.

And I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair, seeing none on the minority side, will recognize Mr. Bilirakis from Florida for five minutes for questions.

*Mr. Bilirakis. Thank you. I appreciate it, Mr. Chairman.

Administrator Brooks-LaSure, I have expressed concerns about the practice of large health systems purchasing independent, freestanding physician offices, and then subsequently billing for the same services by the same providers at a significantly higher hospital rate. The Office of Inspector General and others have explained that this dynamic has created adverse incentives for consolidation and inappropriate billing practices that ultimately cost the Medicare program and cost patients who have to pay 20 percent co-pay for hospital outpatient services.

So I wanted to ask you about the process CMS undertakes after a hospital purchases a physician office practice to subsequently bill at the hospital rate as a hospital outpatient department. Can you please tell us what CMS does, and what the process involves to ensure that hospital-acquired freestanding physician offices are compliant with the relevant conditions of participation and other provider-based facility requirements in Medicare in order to bill as a hospital?

And then I have a follow-up, as well.

*Ms. Brooks-LaSure. Certainly. And as I thank the committee for really focusing on hospital consolidation and our concerns around what that is meaning for physician offices, our role is to certainly put out, based on Congress, payment policies. And when hospitals agree to get payment from us, they agree to follow the rules around all of our guidances. And we certainly will investigate if a hospital is billing incorrectly.

*Mr. Bilirakis. Yes, that is my follow-up: Will you commit to work with members of this committee to ensure this process is efficient and effective, and ensuring these

facilities meet the necessary requirements to bill as hospitals?

*Ms. Brooks-LaSure. Yes.

*Mr. Bilirakis. Okay. Very important for our patients, to.

Next, I also wanted to ask you about CMS's transitional coverage of emerging technologies rule. We are almost two years after the agency's repeal of the original MSET rule, which we had expressed was incredibly disappointing at the time. CMS promised to replace it with a new TSET rule to provide Medicare coverage for new medical breakthrough device technologies, but has yet to do so, despite the target date supposedly set for this month. That is why I led bipartisan legislation in this space to provide this pathway into law, since it is clear CMS has little interest in advancing innovation for patients.

Again, Administrator, can you tell us when will CMS release and implement your final TSET rule?

And what is CMS planning to do to ensure this simply isn't another CED process, but instead a meaningful separate pathway for new devices with existing, sound data that does

not require additional evidence generation?

If you could answer that, I would appreciate that very much.

*Ms. Brooks-LaSure. Yes. We are committed to releasing updated guidance this spring, and I will just say that we have been working and talking with stakeholders, device companies to make sure that they have an understanding of our roles, and will -- we will absolutely put that out very soon.

*Mr. Bilirakis. Okay, very good. We are going to stay on you with that.

One of themes on our agenda today is about discouraging additional consolidation in the marketplace. In one of our draft bills, the Provider and Payers Compete Act would require HHS, during its annual rulemaking on Medicare provider payments, to consider the effects these regulatory changes have on further consolidation in the marketplace. I have been concerned about how the physician fee schedule, for example, is contributing to these trends.

How will you ensure your agency is doing what it can, from a regulatory standpoint, to prevent additional consolidation, whether it is through the physician fee

schedule or other rules that affect provider reimbursement?

*Ms. Brooks-LaSure. I would be happy to work with you on any and all ideas that you have for us in terms of our authority.

*Mr. Bilirakis. All right, very good. Thank you. I guess my time has run out.

Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. The gentleman yields back, and that concludes all members present who have asked questions or -- questions. Thank you for being here today.

I think just the one thing I can say both sides have absolutely agreed on, that we need to work on the Alzheimer drug, and make sure that people have access as we move forward.

I appreciate the opportunity for you -- I appreciate you being here, but I did have three letters for the record I forgot to submit for the record. I showed the ranking member. It is for our bill, so it is supporting our bill together. And then Dr. Burgess offered one I am not sure I correctly submitted for the record.

So without objection, so ordered.

[The information follows:]

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

*Mr. Guthrie. Thank you for being here, and we appreciate your time, and we got you -- our agreed-upon time, so we appreciate that. And now we will get ready for panel two.

[Pause.]

*Mr. Guthrie. The second -- the hearing will come back to order, and we will be prepared for the second panel. I will introduce our witnesses, and then we will recognize each other for five minutes for questions.

I think most of you have testified or seen this, that you all have a light. When -- you have a green light. When the light gets yellow, it means to start summarizing, and to be ready to finish. And when it is red, it means time has expired. So you have five minutes for moving forward.

So I am going to introduce the witnesses, and we will begin the questions -- the opening statements.

So first, Ms. Ashley Thompson, senior vice president of public policy analysis and development for the American Hospital Association.

Next we have Karen [sic] Bass, chief policy and external affairs officer for the Pharmaceutical Care Management

Association.

Our next witness will be Brian Connell, executive director of federal affairs for Leukemia and Lymphoma Society.

The next witness is Sean Cavanaugh, chief policy officer for Aledade -- sounded like a Kentucky Derby horse name, so -- that is coming up in a couple of weeks, so watch Kentucky.

Our next witness will be Ilyse Schuman, a senior vice president of health policy for American Benefits Council.

And then Mr. Loren Adler, associate director of the USC-Brookings Schaeffer Initiative for Health Policy.

We appreciate you all being here, taking the time. I know you have -- most of you were able to listen to the first panel, and know what some of us are thinking and what our thoughts are, so we appreciate that. We appreciate you being here. All of us are going to be working together to work on these pieces, specific pieces of legislation before you today.

And so with that I will begin with -- our first witness will be Ashley Thompson, senior vice president of public affairs.

STATEMENT OF MS. ASHLEY THOMPSON, SENIOR VICE PRESIDENT, PUBLIC POLICY ANALYSIS AND DEVELOPMENT, AMERICAN HOSPITAL ASSOCIATION; KRISTIN BASS, CHIEF POLICY AND EXTERNAL AFFAIRS OFFICER, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION; BRIAN CONNELL, EXECUTIVE DIRECTOR, FEDERAL AFFAIRS, THE LEUKEMIA AND LYMPHOMA SOCIETY; SEAN CAVANAUGH, CHIEF POLICY OFFICER, ALEDADE, INC.; ILYSE SCHUMAN, SENIOR VICE PRESIDENT, HEALTH POLICY, AMERICAN BENEFITS COUNCIL; AND LOREN ADLER, FELLOW AND ASSOCIATE DIRECTOR, USC-BROOKINGS INITIATIVE FOR HEALTH POLICY, ECONOMIC STUDIES PROGRAM, BROOKINGS INSTITUTION

STATEMENT OF ASHLEY THOMPSON

*Ms. Thompson. Chair Rodgers, Ranking Member Pallone, Chair Guthrie, and Ranking Member Eshoo, and members of the committee and subcommittee, I appreciate the opportunity to testify on behalf of the American Hospital Association's 5,000 member hospitals and health systems.

Hospitals and health systems are cornerstone of communities across our nation. The more than 6 million people who work there provide care, compassion, and comfort

for the sick and injured 24/7, 365 days a year. Last year they delivered 3.5 million babies, and provided emergency care for 123 million people. They are at the forefront of developing new techniques and technologies to prevent, diagnose, and treat disease, and are responsible for training the next generation of doctors and other clinicians.

While hospitals' commitments to caring never wavers, the reality is right now they are facing many significant challenges. These include historic workforce shortages resulting in a national crisis, soaring costs of providing care, cracks in the supply chain, overwhelming regulatory and administrative burdens, and severe underpayment by Medicare and Medicaid.

These challenges are jeopardizing access to care and services for patients and communities. Some hospitals are being forced to cancel or close critical services, particularly in rural areas. Patients are experiencing longer wait times to receive care. As all of you are hearing, hospitals are boarding patients ready for discharge without any additional reimbursement because post-acute care facilities and nursing homes do not have space. Several

hospitals are struggling to remain open.

The AHA appreciates the subcommittee's dedication to health care affordability, a goal that all of our members fundamentally share. Thus, I appreciate the opportunity to comment on five of the issues addressed by the subcommittee's legislative proposals. Moreover, the AHA looks forward to discussing them further with committee members and staff over the next several weeks.

First, as you know, the hospital price transparency rule went into effect two years ago during one of the most difficult periods of the pandemic. Since then, hospitals have made significant progress complying with these regulations. According to CMS, 70 percent of hospitals have adhered to both components of the rule, despite its complexity and lack of clarity. Hospitals are eager to continue their compliance efforts, and the Transparent Price Act affords an opportunity to continue to work together towards this goal.

Secondly, the AHA strongly opposes legislation that would lead to additional site-neutral payment cuts and threaten access to patient care. There is nothing neutral

about site-neutral policies. Compared to other health care settings, hospital outpatient departments treat patients who are often older, poorer, sicker, and with more complex medical conditions. Hospital outpatient departments also must comply with more comprehensive licensing, accreditation, and regulatory requirements. Additionally, hospitals are required to maintain standby capacity for disasters, public health emergencies, and unexpected traumatic events, as well as deliver emergency care, regardless of insurance status.

Third, the AHA strongly supports the 340B drug discount program, which is crucial to helping hospitals stretch limited Federal resources and expand health services to patients and communities. We appreciate the subcommittee's interest in making sure all stakeholders meet 340B program integrity requirements. Already, 340B hospitals must attest to meeting all program requirements, re-certify their eligibility annually, participate in audits conducted by HRSA and drug manufacturers, and maintain records and inventories of all 340B and non-340B prescription drugs. The AHA would oppose efforts to create significant new reporting requirements for 340B hospitals. In addition, any measures

that increase transparency for 340B providers also should include greater transparency for drug companies.

Fourth, the AHA opposes changes that would either expand the number of physician-owned hospitals or ease restrictions on the growth of existing facilities. Studies show that physician-owned hospitals cherry-pick patients who are less medically complex and more financially lucrative, as well as provide limited or no emergency services.

Finally, I would like to express strong support for the Medicaid DSH legislation. We appreciate that Congress has, on a bipartisan basis, kept the Medicaid DSH cuts from going into effect. Hospitals care for a significant number of low-income, uninsured, and Medicaid patients, and the Medicaid DSH program is critical to maintaining access to essential services for these individuals.

Thank you for the opportunity to testify. I look forward to taking your questions.

[The prepared statement of Ms. Thompson follows:]

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

*Mr. Guthrie. Thank you. Thank you for your statement. The chair now recognizes Ms. Bass.

You are recognized for five minutes for an opening statement.

STATEMENT OF KRISTIN BASS

*Ms. Bass. Good afternoon, Chairman Guthrie, Ranking Member Eshoo, and members of the subcommittee. My name is Kristin Bass, and I am the chief policy and external affairs officer for PCMA, the national association representing America's pharmacy benefit companies. I appreciate the invitation to share our industry's views on the legislation under consideration. We are grateful for the opportunity to work with both majority and minority staff, and your willingness to hear a variety of views.

It is important to understand what pharmacy benefit companies do to best evaluate how legislative change may impact their ability to help secure drug savings and drive affordability for patients. We are proud that pharmacy benefit companies are hired to administer prescription drug plans for more than 275 million Americans who have health coverage through public and private employers, labor unions, Medicare, other Federal programs, and the exchanges, and we are proud of the physicians, pharmacists, and other health professionals who help design the prescription drug coverage

options PBMs offer, and administer the medication quality and safety programs they provide.

To be clear, no employer or plan sponsor has to hire or use a pharmacy benefit company, but virtually all choose to do so to secure savings on drugs and to better serve the patients in their plans. Employers select a PBM through a transparent and highly competitive bidding process. With over 70 full-service pharmacy benefit companies in the market and regular new entrants, plan sponsors can choose to contract with the company that best meets their unique needs. Some may choose based on scale and ability to negotiate deep discounts; others prioritize innovative care management programs and different levels of service.

As part of their bid request, plan sponsors define and appropriately demand what information, transparency, and audit rights they need, and those are memorialized in their contracts. Our companies provide their clients with a broad array of actionable, accurate information on price and quality to make efficient purchasing and plan design decisions. And in recent years, Congress and Federal regulators have added numerous additional requirements for

PBMs to report to Federal agencies and to provide aggregated public reporting.

So why do plan sponsors choose to use a pharmacy benefit company? They rely on our company's expertise to secure savings through price concessions from drug companies; to partner with lower-cost, higher-quality pharmacies; and to prove medication adherence. For small employers who may struggle even to provide health benefits, pharmacy benefit companies offer options for cost predictability, enabling them to stretch their benefit dollars further.

Plan sponsors also choose how best to use the savings that PBMs deliver, whether to lower premiums, lower costs at the pharmacy counter, or make benefits more robust. The pharmacy benefit company delivers the savings, and the employer plan sponsor decides how to use them.

As we evaluate the legislation before the subcommittee today, we have two major concerns that carry through many of the bills proposed to address prescription drug costs.

First, the legislation would limit choice by dictating terms to the market, taking away flexibility that is needed for managing drug costs, keeping health coverage affordable,

and helping patients stay on their meds. We should avoid government mandates that could increase costs and decrease innovation.

Second, none of the legislation being considered today would address the price of prescription drugs, but may instead increase costs not only by limiting choice, but by stacking the deck in favor of drug companies when it comes to negotiations for rebates. We have to be cognizant of what happens when one side in a negotiation gets confidential information about their competitors' negotiated rates. It only leads to higher costs.

Instead, we encourage the subcommittee to address the actual cause of the affordability challenge: the price set by the drug company and the rampant patent abuses that have blocked competition. To that end, we greatly appreciate the leadership of many members of this subcommittee who have supported policies to ensure more competition and choice by getting generics and biosimilars to market without delay.

Thank you for inviting me to appear before the subcommittee today. Our companies exist to secure savings and improve health outcomes for plan sponsor employers,

unions, and government programs, and, most importantly, the patients we serve. I hope that you will keep this important and valued role front of mind as you consider these bills, as well as my written testimony, which details unintended consequences about the specific bills before you.

We look forward to continuing our work with you and the patients and payers we serve to secure affordability, access, and adherence to the medications Americans need. I am happy to answer any questions.

[The prepared statement of Ms. Bass follows:]

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

*Mr. Guthrie. Thank you.

Mr. Connell, you are now recognized for five minutes for your opening statement.

STATEMENT OF BRIAN CONNELL

*Mr. Connell. Thank you, Chairman Guthrie and Ranking Member Eshoo, and members of the committee. My name is Brian Connell, and I serve as the executive director of federal affairs at the Leukemia and Lymphoma Society, where our mission is to cure blood cancer and to improve the quality of life for patients and their families.

We were founded by 2 parents who had suffered the unimaginable loss of their 16-year-old son to leukemia. In the nearly 75 years since our founding, the non-profit started by that one couple has invested $1.6 billion in research aimed at creating a world in which cancer patients survive their blood cancer, and thrive after treatment.

The good news is that we have made incredible progress. Several cancers considered death sentences not long ago, including the leukemia that sparked our founding, are now highly survivable. The bad news is that we have much more work to do, and it goes far beyond medical research. The work ahead includes both ensuring that every patient can access the care that they need, and relieving patients of the

terrible financial burden that comes with that care.

The work is urgent. This year alone, more than 180,000 Americans will receive the life-changing news that they have a blood cancer. Each of these individuals and their families will be thrust into an overwhelming, impersonal maze of provider institutions and insurance rules with potentially ruinous out-of-pocket costs around every corner.

For a patient with private insurance, a diagnosis of acute leukemia will rack up an average of more than $800,000 in treatment costs in the first year alone. The costs that are not borne directly by patients in the form of deductibles and co-pays are often foisted upon consumers and public insurance programs. Too often, those insurance companies and public officials then respond by inventing new ways to shift costs back onto patients. We see higher deductibles, additional non-covered care, increased coinsurance, rising premiums, more red tape, stricter eligibility criteria for insurance. The list goes on.

And this is why patients need bold action to make sure that the system is sustainable for patients today and into the future. We are encouraged that many of the proposals

that the committee is considering today to promote -- will promote health care competition and encourage meaningful transparency. We share these goals because we believe that increased competition and transparency have real potential to realign incentives to achieve the improved outcomes -- health outcomes that we are looking for, while lowering costs for patients, consumers, employers, and taxpayers.

The system is riddled with perverse incentives and a frustrating lack of transparency, so the opportunities are plentiful. I will just give two quick examples.

First, the disparity in Medicare's reimbursement for the same service across provider settings is one of the incentives that has led to a dramatic rise in hospital acquisitions of physician practices. Hospitals acquiring physician offices leads to the result that we have seen in the past few years of the share of cancer drug infusions happening in hospital outpatient facilities has increased nearly 300 percent. And when a hospital purchases a physician practice, the shift in reimbursement increases the patient's out-of-pocket costs without corresponding improvement to the quality of their care. Cancer patients

should not pay more simply because the nameplate on the clinic door says "hospital,'' rather than physician office.

Second, the lack of transparency in the pharmacy supply chain has led to the proliferation of so-called spread pricing. Spread pricing is a practice in which the PBM administering a drug's plan charges the plan far more for a drug than the acquisition cost. One study found that PBMs administering Medicaid pharmacy benefits across the country paid roughly $84 per tablet for a critical cancer drug called Imatinib, while charging the state Medicaid programs as much as $296 per tablet for the same drug. And this difference adds up. The state of Ohio reported that its Medicaid program had lost more than $233 million in potential savings due to spread pricing in a single year.

These are big problems. But we are encouraged by this committee's bipartisan work to take on these tough issues. Reforming these incentives will make a meaningful and lasting impact on the lives of patients with cancer. So we look forward to continuing to partner with you to promote transparency and competition across every area of the health care system. Thank you.

[The prepared statement of Mr. Connell follows:]

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

*Mr. Guthrie. Thank you. The chair now recognizes Mr. Cavanaugh for five minutes for questions.

*Mr. Cavanaugh. Thank you, Mr. Chairman.

*Mr. Guthrie. I mean for -- excuse me -- to -- your opening statement.

STATEMENT OF SEAN CAVANAUGH

*Mr. Cavanaugh. Thank you, Mr. Chairman, and I thank the subcommittee for inviting me today to discuss strategies for increasing transparency and competition in health care.

My name is Sean Cavanaugh. I am the chief policy officer at Alidade. We help independent primary care practices deliver better care to their patients and thrive in value-based care. Previous to Alidade, I was at CMS Innovation Center, and also served as director of the Center for Medicare. I am proud to continue the movement to better care at lower cost in the private sector.

Alidade works with more than 1,500 independent primary care practices, including 200 FQHCs and rural health centers across 45 states to make them successful in value-based care. These practices care for 2.2 million beneficiaries in value-based care contracts. More than half of the practices have fewer than 10 clinicians. Sixty percent of them are in primary care shortage areas. And Alidade is now what is called a public benefit corporation. That means explicitly our mission is to improve health care in a way that is good

for patients, good for practices, and good for society.

And Alidade is producing meaningful results. Our estimates are that in 2022 our Medicare ACOs are projected to save Medicare more than $535 million. Prior-year data from CMS, official data, in 2021 Alidade sponsored 4 of the top 10 performing ACOs in the United States. And one of those four, our Mississippi ACO, was an FQHC-only ACO, was the fourth-highest saver in the United States.

And these savings were generated through real improvements in the care for Medicare beneficiaries: more primary care delivering better diabetes control; more blood pressure screening leading to fewer hospitalizations and emergency room visits. The data clearly show that ACOs grounded in advanced primary care can deliver better care at lower cost. But that approach is under threat from consolidation and anti-competitive forces.

And let's be clear. The evidence is overwhelming. Hospital mergers are steadily increasing. Horizontal consolidation leads to higher prices. Vertical consolidation leads to higher prices. And there is no clear evidence that consolidation leads to higher quality. Provider

concentration increases the bargaining power of large health systems, which allows them to demand higher prices from health plans. And unfortunately, COVID may have accelerated these trends. Small physician practices and safety net hospitals entered the pandemic with vulnerable financial positions, and were less likely to access emergency relief funding.

This committee has an opportunity to take meaningful action to promote competition and transparency in this country. First and foremost, we need to invest more in primary care. That means both Community Health Centers, but also independent practices. And I thank this committee for its work recently in looking at workforce, which is critical.

Second, we need to put an end to unnecessary facility fees and move to site-neutral payments. Facility fees are part of the financial engine that hospitals rely on to acquire independent practices and reduce competition in their markets. Independent practices and Community Health Centers struggle to recruit new physicians because they cannot compete with hospitals that are receiving higher payments. And these facility fees, of course, also raise out-of-pocket

costs to Medicare beneficiaries. Congress and CMS have taken some actions toward site neutrality, but the overwhelming majority of services are still receiving higher payments when they are in the hospital -- provider-based clinics.

I would also note there are other policies not in front of the committee today that the Congress should consider, including prohibiting anti-competitive contracting by health care providers such as gag clauses, anti-tiering, anti-steering clauses, as well as all-or-nothing clauses.

There are -- we could optimize some of the incentives in the Medicare shared savings program. We have been talking to CMS about this, especially for rural providers. We could improve access to capital for independent practices, reform CON rules in states, reinvigorate anti-trust enforcement, and regulate anti-competitive data sharing practices.

Thank you again for the opportunity to testify, and I look forward to working with this committee on this bipartisan work.

[The prepared statement of Mr. Cavanaugh follows:]

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

*Mr. Guthrie. I thank you for your testimony. The chair now recognizes Ms. Schuman for five minutes for your opening statement.

STATEMENT OF ILYSE SCHUMAN

*Ms. Schuman. Thank you. Chair Guthrie, Ranking Member Eshoo, and distinguished subcommittee members, thank you for the opportunity to testify on behalf of the American Benefits Council.

The Council represents over 220 of the world's largest corporations advocating on a full range of employee benefit issues. Employers play a critical role in the health care system, and have a vested interest in securing the health and well-being of their employees.

Employers are also deeply concerned about rising health care costs, and are increasingly frustrated by fundamental failures in the health care marketplace that stifle competition, cloud line of sight into price and quality information, impede innovation, and ultimately increase costs.

The only way to truly make health care more affordable for working families is to understand and address these root causes of rising health care costs by increasing transparency and competition.

Hospital price increases are key drivers of recent spending growth among the privately insured. The most important driver of higher hospital prices is, in turn, the rise of hospital monopolies that use their market power to demand higher and higher prices. And at the same time, many hospital systems are becoming vertically integrated, with physician organizations raising prices. These higher hospital prices are coming without an improvement in the quality of care. In fact, provider consolidation leads to less bang for the buck.

The Council strongly supports legislation to expand site-neutral payment reforms. Often physician offices are being purchased by hospitals and simply rebranded as part of a hospital's outpatient department in order to collect the resulting higher payments. Such legislation, by aligning payment differentials across sites of service, removes a powerful incentive for provider consolidation, and corrects a significant distortion leading patients to higher care settings.

Employers recognize that hospitals are an essential component of the nation's health system, particularly during

the pandemic, and understand that some hospitals are facing financial challenges. A recent Health Affairs article examined the financial performance of large, non-profit hospital systems in the post-COVID era, and revealed a more complex financial picture. Investment losses accounted for approximately 85 percent of overall financial losses. This analysis suggests that investment losses are actually the primary driver of these losses, not increased labor and supply costs. Employers, patients, and taxpayers should not have to foot the bill for a hospital's risky financial position.

Hospitals are also able to use a billing practice which is fueling acquisition of physician practices because they are not required to specify where services are provided. The Council strongly supports legislation that will promote honest billing practices by helping patients -- payers to distinguish between sites of care.

The Council also strongly supports the bipartisan Transparent Price Act. A competitive and value-driven health care market is predicated on transparency. Effective transparency tools in the hands of employers and consumers

can be transformative, making health care both simpler and more affordable. Unfortunately, far too many hospitals across the country remain out of compliance, or meaningful compliance, with the hospital transparency rule. Codifying and strengthening the rule, including through increased maximum penalties, is essential to realizing its objective.

The Council also strongly supports the PBM Accountability Act. The current rebate structure is complex and opaque, and employers continue to encounter barriers to PBM pricing transparency. With the three largest PBMs controlling 80 percent of the market, employers, even very large employers, are not going to have the leverage in contract negotiations that they need. Federal legislation requiring strong transparency and accountability for PBMs to employers, their primary clients, is essential to employer efforts to manage prescription drug costs.

While employers continue innovating and exploring strategies to lower costs, Federal legislative solutions are needed to create a more competitive and transparent health care marketplace. This hearing and the solutions under review today, therefore, represent a critical step towards

making health care more affordable.

I appreciate the opportunity to testify, and look forward to answering any questions.

[The prepared statement of Ms. Schuman follows:]

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

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

The chair now recognizes Mr. Adler for five minutes for your opening statement.

STATEMENT OF LOREN ADLER

*Mr. Adler. Thank you, Chairman Guthrie, and Ranking Member Eshoo, and members of the subcommittee. Thank you for the opportunity to testify today on the crucial topic of increasing transparency and competition in health care.

My name is Loren Adler. I am a fellow and associate director at the USC-Brookings Schaeffer Initiative for Health Policy at the Brookings Institution here in D.C. I study a wide range of topics, including health care market competition, provider payments, and prescription drug policy. And relevant to today's hearing, much of my current research is focused on private equity and health plan acquisitions of physician practices.

The health care industry has experienced significant consolidation over the last decades. Horizontal consolidation, such as the merging of hospitals or physician groups within the same geographic market, unambiguously leads to higher prices for consumers, lower wages for workers, and seemingly actually diminished quality of care. With a greater market power as an employer locally, there is also

evidence that hospital mergers reduce the wages paid to nurses and other hospital staff with industry-specific skills.

And vertical consolidation involving hospitals and physician groups has also accelerated. Today about two in five doctors now work for a hospital or a practice that is at least partially owned by a hospital. And more and more evidence suggests that this vertical consolidation appears to drive up costs for consumers with unclear impacts on the quality of care.

And now we are seeing growing vertical consolidation between health plans and physician groups, PBMs, and specialty pharmacies. And we have strong evidence that insurer-provider integration is being leveraged to accelerate coding of their Medicare Advantage enrollees to generate higher government payments than were intended, costing taxpayers billions.

Fundamentally, I want to leave members of the subcommittee with one key message: We need to stop digging the hole deeper. Even with overwhelming evidence of the harms caused by provider consolidation, too little is done to

just stop digging the hole deeper. We need to cut it out with policies that encourage consolidation, and we need better data to get a full picture of what is going on to better limit anti-competitive conduct.

There are a wide array of policy options that could enhance competition in health care markets, you know, from greater anti-trust oversight to Medicare Advantage reform to changes in Medicare payment policies. Today I will try to narrow my focus on two main points relevant to proposals that are under consideration by this subcommittee today.

One, Medicare rates are intended to reflect the costs of providing services for an efficient provider. As such, Medicare should not be paying more for the same exact service when it is delivered in a hospital outpatient department rather than a physician's office, provided that the physician's office setting is safe and clinically effective for most patients. This policy change has widespread bipartisan support in the policy community, across -- basically, any think tank you talk to supports this policy. Lobbyists are pretty much the only opposition, really, to this policy.

Number two, increased transparency can both facilitate stronger research and oversight and, in certain circumstances, drive price competition by helping patients select lower-cost, higher-quality providers.

With respect to site-neutral payments, to illustrate this issue I want to consider the example of a Medicare patient receiving a level two nerve injection, as I think one of the congressmen brought up earlier, because it is the example in a MedPAC report, so -- right?

Let's take this. If the patient receives this injection at a physician's office, she would owe $51 in co-insurance on a $256 total cost. Now, let's say that a hospital buys that physician's practice and converts it into a hospital outpatient department. The care remains the same. It is the same doctor providing the care, but now that same patient receiving the same service will owe nearly three times as much. They would owe $148 in co-insurance on a total payment of $741. This payment disparity not only increases costs for beneficiaries and taxpayers, but encourages hospitals to buy up physician practices, leading to market consolidation and increased health care costs that spill over to the commercial

market, as well.

Small efforts have been made to move toward site-neutral payments, but more work is needed. Legislative proposals under consideration today to eliminate this payment disparity for low-complexity services would result in substantial savings for beneficiaries and taxpayers, while fostering greater competition in physician markets.

And it is important to note here today that we are focused on lower-complexity services where we are saying to equalize payments. We are primarily here talking about office visits, imaging, and drug administration.

And lastly, for transparency, that is also crucial. Specifically with systematic data about provider ownership arrangements and commercial market prices and volumes, researchers could better identify the effects of various forms of health care consolidation and elucidate solutions. The opacity of payment flows between specific actors in the drug supply chain similarly inhibits quality research, and evidence suggests that patients can make use of transparent pricing information for more shoppable services.

The committee's focus on bipartisan policies to improve

health care, competition, and transparency is a welcome sight. And thank you again for the opportunity to testify today.

[The prepared statement of Mr. Adler follows:]

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

*Mr. Guthrie. Thank you. We thank you for your testimony, all the witnesses' testimony. We will now move into members' questions, and I will recognize myself for five minutes for questions.

So, Ms. Bass, we were talking earlier that we had some of the same professors. You probably studied harder than I, so I appreciate that, and look forward to your responses on some of these questions that I have.

But on the rebate model -- so we are interested in the rebate model -- and the, I guess, concern is that it incentivizes brand manufacturers to deliver higher rebates to ensure their products land on the formularies. And I know there is the opposite side that says the brand manufacturers choose to set up prices high. But the reality is that the rebate model seems, in our research, to incent manufacturers to keep prices high to get rebates to get on the formulary. And that affects somebody's paying out of pocket at the counter.

So if the manufacturers could just lower their prices to get on the formulary, rather than give rebates, why wouldn't they?

*Ms. Bass. Thanks for that -- the talk button helps, doesn't it?

Thank you so much for that question. So you are asking about why manufacturers don't just lower their price. And I think we have seen recently that, in fact, manufacturers do sometimes lower their prices. We know that rebates are not correlated with pricing. Medicare Part B gets no rebates, and prices go up at virtually the same amount that is happening on the Medicare Part D side.

The insulin example shows you that manufacturers will, in fact, lower their prices, and only manufacturers can control how the prices are set. So I think we just fundamentally disagree with the premise that rebates have anything to do with driving up prices.

*Mr. Guthrie. That is kind of the point. You know, we did have some -- we had a hearing, and it the was Oversight Committee, actually, the Oversight Committee that Mr. Griffith now chairs. And we had all the manufacturers, we had the PBMs, we had all the group, and we really kind of focused on insulin prices. And coming out of that hearing is when, all of a sudden, the prices started dropping.

So it just didn't seem like until we exposed the price, that it was -- I mean, this is kind of the concern, is that -- what we want, what kind of came out of this, and kind of the genesis for a lot of this work for everybody -- I am not just talking to you, Ms. Bass -- is that people will react different if they know the price. And if it is inefficient, then the market is going to demand that it change and move forward.

And so, Ms. Schuman, I have a kind of a conglomerate business in my area who have several businesses, but grocery stores, and they have supplier retail pharmacy. And they came to me and says, "Look, we are paying this amount of money for our employees to go to the pharmacy,'' and very few employers have this information because they pay for their employers to go the pharmacy benefit. But since they also own the pharmacy, they don't know what the pharmacy is getting reimbursed. And they sit down, and sit down with their insurance company, and the insurance company, "Well, we will give you a break,'' because they were going to say we are not going to let you negotiate on our behalf anymore, because we don't -- this is -- look at the spread between

what we are paying and what we are receiving. And so it gets back to making sure people have access to prices, and prices information, and how they react to that.

And so my question: Do employers readily have access to information related to the prices that -- so the PBMs will receive for their drug that they are selling it to you differently, do they have access to that information?

*Ms. Schuman. Employers don't know what they don't know. And I think that is the issue.

And I think the definitions keep changing about whether something, a rebate, whether it is another fee. And as I mentioned in my testimony, trying to interject all of this transparency, which is, again, foundational for employer efforts to try to manage drug costs, you know, they don't necessarily have the leverage in those contract negotiations to make sure they have the specificity of definitions. And they are shapeshifting, perhaps, on the part of different revenue streams.

And that is why I think this is a really critical market-based solution to require transparency, to require sunshine and daylight, so employers truly know where that

money trail is so they can make sure that they are spending their resources wisely.

*Mr. Guthrie. So it is just difficult to get information.

And I guess what I am trying to get at, so the other argument would be -- somebody has made this argument to me -- is that, well, employers have the information, and they get to decide do they want to pay a lower monthly premium or do they want higher rebates and -- a lower monthly premium and higher rebates, or they are going to have a higher monthly premium. Are you guys seeing that kind of information and making those kind of negotiations?

*Ms. Schuman. Well, you know, that is -- even large employers, even very large employers have significant challenges, have run up to significant challenges just getting a hold of that information. And that information is so critical to have in hand for employers, so they can decide what is the best way to make health care for their employees more affordable.

*Mr. Guthrie. Okay, thank you.

Well, I wish I had more time to ask questions. I only

have five more seconds, so I will yield back to myself and I will recognize the ranking member for five minutes for questions.

*Ms. Eshoo. Thank you, Mr. Chairman, and thank you to all of the witnesses. I have a few comments to make before I get to my questions.

On PBMs, Ms. Bass, I am pleased to hear that you support getting generics and biosimilars to market, but I find it hypocritical when I hear time and time and time again that plans are often blocked by PBMs from offering the lowest-priced generic. Let me give you an example. The non-profit Civica Rx in California has manufactured a prostate cancer drug for $160, but PBMs are not letting that cheap drug on insurers' formularies. Instead, the $160 drug is being blocked from the market so that PBMs can take a larger cut, and the larger cut is priced at $3,000.

So I hope our committee really stands up to what needs to be done relative to PBMs, because there is a lot of work to do there.

To the hospitals, on the whole issue of site-neutral, we need to get a clear explanation from hospitals on why, after

hospitals acquire physician practices, the prices for the services provided by the acquired physicians increases by 14 percent. It is the same doctor, it is the same service, it is the same site, but 14 percent more really doesn't make sense.

So I think that we are going to need more from the hospitals, and I say that really respectfully. Obviously, I love all the hospitals in my district, i.e. you have to love all the hospitals. Look what they have been through with their teams during the pandemic.

To Ms. Schulman, thank you for the written testimony. I just want to highlight something, because hospitals are telling us about -- so much about their losses that in -- investment losses accounted for approximately 85 percent of overall financial losses.

Now, there is some background in that, but for the large ones to have lost that kind of money because of what they invested in the stock market, I think that the committee needs to take that into consideration.

So to Brian Connell, thank you for the work that you have done, your testimony today, and for working with us on

spreading out the costs which are capped, thank God, for Medicare beneficiaries and out of pocket, being able to spread that. I want to talk to you about the MVP.

Can you explain why this new definition of best price is needed to allow for more value-based payment models?

And in your testimony you recommend that value-based models need to protect patients from undue cost burdens. Do you have suggestions in that area for us, as we really hone the legislation and tailor it really well?

*Mr. Connell. Yes, thank you for the question, and thank you again for your work and many folks on this committee's work on lowering Part D costs. As you are referencing, this is incredibly important progress made last year.

But to your question on Medicaid best price and its impact on value-based purchasing, we think value-based agreements have a lot of potential. In cancer care, where we have, you know, some potentially curative therapies, some therapies that, you know, might add a little bit of benefit, some that people question the benefit, there is no reason to pay the same for all of those different therapies. There

should be rewards for innovation and for making a real impact on patient quality.

And so what we see with the best price rules that we have today is that there is a challenge where, if you have an agreement between a manufacturer and a Medicaid program to pay less for a patient where the drug did not work for them, they didn't respond and it had no clinical benefit, right now that lower price that the -- that would be reimbursed for that patient where there was no benefit, even if it is just five percent of patients did not respond, low -- if you have a reduced cost, that cost could become -- that price for the drug could become the price for all Medicaid patients because it is the lower price being paid by Medicaid.

And so, without the flexibility to make sure that lower price can be allowed without drawing down the price for every patient -- because there could be some patients that are responding perfectly to that, and really need a better price. So --

*Ms. Eshoo. That is --

*Mr. Connell. I think reforms are necessary there.

*Ms. Eshoo. That is helpful. Thank you for everything

that you do.

Mr. Loren, real quickly on the transparency for PBMs, I think it is a critical first step to their practices. It drives up drug prices, allows God knows what. What would you add to that?

*Mr. Adler. Sure. So --

*Ms. Eshoo. How would you address this?

*Mr. Adler. Yes, thank you for the question. So -- sure, so I think you are right, and the Congressional Budget Office has said that they think there are some savings, if sort of temporary, to kind of giving some more information to employers so they know what is going on.

I actually also think there is a lot of value that would be gained from transparency more broadly, and making available all of the various payment flows that go between actors, specific actors in the pharmaceutical supply chain, so we can really get at some basic questions in drug pricing that we just don't have the data for at the moment.

*Ms. Eshoo. Great, thank you.

*Mr. Guthrie. Thank you.

*Ms. Eshoo. Thank you to all the witnesses.

*Mr. Guthrie. The gentlelady --

*Ms. Eshoo. I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair now recognizes Dr. Burgess from Texas for five minutes.

*Mr. Burgess. Thank you, Mr. Chairman, and I do want to thank all of our witnesses for being here today.

You can see how extremely important this is. And for all of the discussion that Congress never works together, I think you see the interest is genuine, and it is bipartisan.

Ms. Thompson, let me start with you. We had a press release in September 2022 by the American Hospital Association that stated that 136 rural hospitals closed from 2010 to 2021. Obviously, we have got the pandemic in there. And a record 19 closed in 2020 alone. We continue to receive requests for expanding payments to these hospitals. Many of those expanded payment requests are granted. And yet the closures continue to be reported or threatened.

So the question I would have, is it possible that permitting a new type of entrepreneurial hospital, such as those built and owned by physicians, could be given a chance

in rural -- other areas, and it would not be risking existing hospitals at all because they are already closing in those areas?

*Ms. Thompson. Thank you very much for that question, Congressman Burgess, and thank you for your support of the Medicaid DSH bill. We really appreciate what that will do for vulnerable patients in vulnerable communities.

Physician-owned hospitals are very different than freestanding community hospitals. Data has shown that physician hospitals can pick and choose the patients that they see, and those patients are typically wealthier and less complex to treat. The OIG, the GAO, MedPAC have had some studies in this space.

And so additionally, some of these physician-owned hospitals don't have emergency rooms or backup services. And that means that patients, if something goes wrong, they rely on their community hospital. I think we would be concerned if physician-owned hospitals, given the workforce shortage, were to grow in rural areas such that they would pull workforce from the freestanding emergency -- from the freestanding community hospital, and thus they might not be

able to fulfill their mission of 24/7 backup services.

*Mr. Burgess. We are talking about areas where the existing hospitals have already closed, and we are trying to provide access for patients.

Again, I do not understand why a fundamentally different model could not be entertained, even as a demonstration project. I have already referenced earlier in the previous panel a hospital down on the Rio Grande Valley was doing an excellent job of providing service to uninsured and under-insured patients. They do that every day of the week down there. I mean, that is their business model.

And I will just tell you, and I have shared with the committee before, a brilliant paper written in Health Affairs -- now it has probably been 10 years ago, I may have even been the one who wrote it -- but look, as a physician, I want to go where my time is going to be maximized. And in a physician-owned hospital, a physician-owned-hospital-run operating room, I will just tell you they are much more efficient. There is the pride of ownership. Doctors care about how their patients are taken care of.

And again, I know you have heard me say it over and over

and over today, and you all have emphasized, as well, the vertical integration that is occurring where hospitals are buying doctors, and yet doctors can't buy hospitals. I mean, it just fundamentally makes no sense.

Do you think that CMS appropriately adjusts payments to hospitals according to the risk of the patient?

And if not, can you suggest how CMS could improve its risk adjustment methodology to prevent hospitals from cherry-picking sicker patients?

*Ms. Thompson. So I think that there is a lot to explore in terms of the risk adjustment. I think that different settings of care have different costs associated with them. The fact that freestanding community hospitals have the 24/7 emergency room and backup and standby services is more expensive. I know that we are held to higher regulatory requirements and conditions of participation, et cetera.

*Mr. Burgess. Well, let me ask you this. When an insurance company acquires a hospital and a hospital acquires a medical practice, do they require the doctors to use that hospital?

*Ms. Thompson. Depending on their insurance, my guess is yes.

*Mr. Burgess. Yes. The answer is yes.

Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair now recognizes Mr. Cardenas from California for five minutes.

*Mr. Cardenas. Thank you very much, Mr. Chairman. I would like to thank the witnesses for joining us and providing your expertise on these important issues, and also providing that not only to us, but to the American people who are watching.

At the last hearing we had on transparency in this committee I asked about the use of non-English languages in both the insurance and hospital transparency rules. I am concerned that these rules do not take into consideration constituencies like the majority of the constituents in my district that primarily speak Spanish as their first language.

Mr. Adler, do you have any idea how many hospitals and insurers post information in Spanish and other non-English

languages?

And how can requiring a greater range of languages improve access to critical care and information?

*Mr. Adler. Sure, thank you for the question, Congressman Cardenas.

So I don't know that I have a concrete answer to exactly what share of hospitals or insurers have posted this information in Spanish or other languages. Certainly, it is some. I have seen, you know, some of these tools on insurer websites, where you can access this information in Spanish.

I think you are kind of really focused on the consumer-facing tools here, right? These sort of data have kind of the researcher side for people like me, and then the -- right? And then the sort of consumer-facing angle here.

I do think, you know, especially on sort of the insurer-facing tools that are under consideration by this subcommittee today, to sort of expand upon, it would be useful to require, right? I mean, it is a very common language in this country to speak Spanish. So I think it is important to require that, right, that these data are available both in English --

*Mr. Cardenas. Would providing this important information in multiple languages, would that help with health care, or would it be not important?

*Mr. Adler. I think it would help. I think transparency can help. Transparent data on prices, particularly for folks who are in their deductible, so they are kind of bearing the full cost of these services -- we have evidence that, on net, it does seem to lead to sort of better shopping, at least for a subset of services here -- you know, imaging, for instance -- and that it can lead to lower prices.

I don't think this is, like, changing the whole health care system here --

*Mr. Cardenas. Sure.

*Mr. Adler. But I think it is -- you know, modest steps in the right direction are important here.

*Mr. Cardenas. I think it would be an added benefit to everyone, and to health care overall. So thank you.

And also, as it relates to access, I am worried about the impact of hospital consolidation on access to care in medically underserved communities. Mr. Cavanaugh, in your

testimony you note that consolidation has accelerated, and smaller providers and safety net hospitals are among the most likely to need the resources that bigger systems can provide. So, Mr. Cavanaugh, can you describe the impact of these consolidations?

And also, would you expect there to be implications for access quality and affordability for patients because of accelerated consolidation?

*Mr. Cavanaugh. Certainly. Thank you for that question. Yes. As I said, we work with independent practices in 45 states. And if a practice is independent today, it is fiercely independent. It has had multiple opportunities to sell to an insurer, to a hospital system. So we have seen the impact of anti-competitive -- when the hospitals do consolidate, and if a practice stays outside of that consolidation, we have seen difficulties in remaining in the hospital's own self-insured network.

So literally, we have had hospital systems say to our practices, "If you want to see our employees, you need to join -- either you sell your practice or join our CIN.'' So I think that impacts access. Certainly, as we have all

documented on the Medicare side and other places, the facility fees raise the costs. Anytime costs go up, you need to be concerned about access, particularly for lower-income communities.

So I think those are all legitimate concerns that flow from consolidation.

*Mr. Cardenas. Thank you.

Ms. Schuman, I want to talk about transparency and PBMs. How would requiring reporting of certain drug pricing information held by the PBMs benefit employers and plan sponsors who provide health insurance coverage?

*Ms. Schuman. Well, first of all, they need to know where the money is going. They need to understand what the true cost of drugs are. They need to understand where these different revenue streams are going. Are they flowing back to the plan sponsor to the employer to share those savings with employees?

And the fact remains that, as I said before, they don't know what they don't know. So having this transparency is really foundational to restoring, I think, competition in -- with respect to drug pricing and, ultimately, enabling

employers to have the tools they need to better manage those costs.

*Mr. Cardenas. Can you give an example of what this committee can do to help with that transparency and pricing issue?

*Ms. Schuman. Well, the PBM transparency legislation, for one, is just so critical to these efforts, again, to enshrine in legislation so there is this certainty that employers have, that they know that they are going to be able to have access to this information, to be able to have --

*Mr. Cardenas. Thank you.

*Ms. Schuman. -- the definitional specificity --

*Mr. Cardenas. Thank you.

*Ms. Schuman. -- about what is going to be covered. So, yes, that is a very important piece of legislation.

*Mr. Cardenas. Thank you.

I yield back, Mr. Chairman.

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

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

Mr. Adler, site-neutral payments, the examples that you gave in your oral testimony, I think it all makes sense. If you are getting, you know, a shot, outpatient, it doesn't matter whether it is in the doctor's office or at the hospital or a facility owned by the hospital.

But on Ms. Thompson's side of the ledger -- and this is what we have to try to sort out -- you have a patient who is in the hospital. It may be the same procedure or the same shot that could, if that patient were in better health, be done outpatient. But they are not outpatient, they are in the hospital.

So I noticed that you talked about outpatient in your oral testimony. You said outpatient comparisons. Is that because you recognize that if the patient has other issues and is already in the hospital, there is going to be more cost with having round-the-clock care?

*Mr. Adler. Sure. So thank you for that question, Congressman Griffith.

So certainly, for -- once the patient is on an inpatient basis -- for instance, this is actually not -- this doesn't apply, so there is a whole different Medicare payment system

for inpatient. For -- you know, if this is a drug administration, you know, billing on the outpatient side, even on the hospital's campus, right, I think it is an important -- the argument that the Ms. Thompson was making here, right, is important for why we might not want to equalize payments for more complex surgeries, like a -- for a complex surgery or an emergency room visit.

But the services that we are talking about today, or that the subcommittee bills are focused on today, are very -- we are talking about low-complexity services, where we have not seen -- the data shows there aren't -- don't seem to be any cost differences between providing that service to a --

*Mr. Griffith. Right.

*Mr. Adler. -- between a sicker patient or a less sick patient.

*Mr. Griffith. My next set of questions will be both to you and to Mr. Cavanaugh. And I don't -- I am uncomfortable with all the consolidations. I agree with that.

On the other side of the coin, in my district, particularly in the historical coal fields of southwest Virginia, is one of the most economically stressed regions in

the country. None of us like the fact that we no longer have any competition. But we had two hospital chains a number of years ago. They looked at it. One of them was looking for a partner from outside the area, so they could keep competition going. We couldn't keep our hospitals open if we didn't do something. And the two chains in east Tennessee, in Mrs. Harshbarger's district and in my district, they merged to form one. Is it ideal? No.

But can you each recognize that sometimes in particularly economically stressed areas we may need that consolidation? I know it is a completely different animal when large hospital chains are buying up doctors' practices, but this is a little bit different animal. If you could each speak to that.

*Mr. Adler. Yes, I will jump in quickly. So, yes, I mean, I think fundamentally you are correct, that this is -- I think you do need to think about it differently when you are talking about an area with lower population, and, you know, especially lower population and lower-income folks there, where there are inevitably going to be some rural areas in America that can just only really support one

hospital.

I want to say what I am sort of focusing on here is the sort of, you know, where a lot of people live, but in the bigger urban markets or suburban markets, where I think that competition --

*Mr. Griffith. And because I have time limitations, would that pretty much be your answer, as well, Mr. Cavanaugh, or do you have a different twist?

*Mr. Connell. Similar, except I would say, yes, rural hospitals, safety net hospitals -- certainly don't want to hurt them financially. So if you wanted to do site-neutral, and then funnel some of that money back to those facilities through some other mechanism that doesn't incentivize consolidation, I think that would be fine.

*Mr. Griffith. All right. I appreciate that.

PBMs, a lot of attention here today on that. My experience talking with constituents is there are occasions, Mr. Adler, where the PBMs, for whatever reasons, actually end up -- if you use your insurance, which buys through the PBM, you are paying more than you would have paid if you just paid cash. Is that still the case?

*Mr. Adler. Yes, that is -- in certain circumstances, yes.

*Mr. Griffith. Ms. Bass, how can that possibly be? I mean, if you all are looking out for the consumers, and you keep talking about how you are trying to save money, how can it possibly be that the consumer has to pay more if they use an insurance company that uses one of your affiliates, one of your corporate PBMs?

*Ms. Bass. Thank you for the question, Congressman. That is an unusual situation. Our companies are cognizant of it. Some of it has to do with the benefit design chosen by the employers. And as we have learned more about that, our companies have developed programs to address it.

*Mr. Griffith. So you wouldn't oppose our bill that says we are not going to let that happen anymore. I have got to move on.

Ms. Schuman, you raised an issue on transparency earlier, and I do support transparency. And if you were -- not that you had to, but if you were listening to my testimony earlier, or my questioning earlier when the witness was in front of us, I talked about a disrupter.

This company allows you to get whatever drugs approved by the FDA, but you, based on transparency, can find where you can get it the cheapest. And if you get it below the median price, you get to put that money on account or hit a button that says send me the check. Do you like that concept, at least in principle?

*Ms. Schuman. Well, what I like the concept of is making sure you know that you are paying for value. And that is, ultimately, what we are talking about. And that is, ultimately, why transparency is so important to make sure employers and also patients and consumers are paying for value. And without transparency, they don't know that.

*Mr. Griffith. I appreciate it. My time is up.

I yield back.

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

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

I am pleased that we are holding this hearing so we can better understand how transparency can lead to lower cost for

patients, particularly with respect to drug prices. And I would like to discuss the role of Pharmacy Benefit Managers, and the role that they play in the drug supply chain.

We know that PBMs play a dual role in managing negotiations with pharmaceutical manufacturers to determine the price a plan will pay for drugs on their formulary, while at the same time working with insurance plans to determine how drugs for their enrollees will be covered.

PBMs also manage relationships with pharmacies. My understanding is that many of these arrangements are opaque and hard to decipher, not only for patients but also for plan sponsors and other participants in the drug supply chain.

Mr. Adler, can you clearly explain the role PBMs play in the drug supply chain, and why the practices utilized by PBMs often lack transparency?

*Mr. Adler. Sure, thank you for the question. So, I mean, I think you described the sort of role well of PBMs, right? The -- fundamentally, the PBM's role is to negotiate lower drug prices on behalf of purchasers. And, certainly -- right -- and plans wouldn't hire them if they weren't getting them lower prices, right? I think that part is fundamental.

Why there is a lack of transparency, fundamentally, because it is not in their competitive interest to have that data be transparent. They think it is in their -- each PBM thinks it is in their interest to have that data be secret. And that is sort of why I think, you know, employers, for instance, very much want to see that data, and I think, from my researcher-biased perspective, I think I would very much like to see that data.

*Ms. Blunt Rochester. I think -- you go right into my next question, which is do PBMs take advantage of misaligned incentives that allow them to retain profit instead of effectively lowering prices for patients at the pharmacy counter?

*Mr. Adler. Sure. So to some degree. But I do want to -- right -- I think it is still worth noting that PBMs are generating lower costs than -- and drug prices than they would be without them.

But yes, I mean, I -- to me, sort of the core issue in the PBM industry is just high levels of consolidation. There are three PBMs that dominate the market, and other insurers have to contract with those PBMs, for instance. Some of them

have their own PBMs, but often still have to use them. And I think one of the fears, from a sort of anti-trust perspective here, is that those big PBMs might not give as good deals to the other insurers, and sort of entrench their market position there.

*Ms. Blunt Rochester. And I think this also goes without saying, because we have talked a lot about transparency, but do you believe increasing transparency related to PBM practices will provide plan sponsors with better tools to leverage power prices for -- lower prices for patients?

*Mr. Adler. Sure. So on the margin, yes. So I do think, again, this is up -- I agree with the Congressional Budget Office here, who has made this sort of point here, that there are some subset of purchasers here where having this information probably gives them information to lower prices. I don't know how long-term of a thing that is going to be, because there will be sort of -- these are private actors, and they will try to renegotiate contracts and stuff like that. But there is always a little bit of a game of whack a mole. But I do think there are benefits.

*Ms. Blunt Rochester. And my last question to you is how might comprehensive pharmacy DIR fee reform or clawbacks be an important element of the strategy to manage the rising drug costs for Americans?

*Mr. Adler. I think it could help. I mean, I will just sort of turn to -- I think, when you are talking about drug prices, you know, the bigger picture issues are, you know, competition in the drug industry on the pharmaceutical, you know, manufacturer side of things, or price regulation in the form of, you know, provisions like in the Inflation Reduction Act.

*Ms. Blunt Rochester. Okay. Thank you, Mr. Adler. I agree that increasing transparency is also an important tool to rein in PBM practices and reduce costs. And while these are important first steps, much more work, as you have said, will need to be done to address the role of PBMs in increasing patient out-of-pocket costs. I am really pleased to be working with my colleague, Congressman Buddy Carter, on additional reforms, and I look forward to more discussions about PBMs, DIR fees, and insurance plan practices that keep patient costs from going higher, and that really deal with

making sure that the quality of care, the value of the care is what is our priority.

Thank you, and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair now recognizes Mr. Latta of Ohio for five minutes for questions.

*Mr. Latta. Well, thanks, Mr. Chairman, and also thanks to our panel.

Ms. Thompson, if I could start my questions with you, currently over 62 percent of hospitals in the State of Ohio are operating in a loss, resulting in cuts to services within maternity wards and behavioral health clinics. And in my district, the 5th, which has many rural areas, tight budgets, staff burnout, and over-regulation, are often cited as the main contributing factors for reduction in care and facility closures. For example, over 50 percent of doctors and nurses say they spend more time in front of a screen fulfilling compliance requirements than they do treating patients.

Would you discuss in detail any regulatory barriers or requirements that are hindering the workforce and provision of care?

And what ideas would you have to fix it? Because I -- the question I ask them every time I met one of our facilities in my district, because I look around and I go, you know, who is practicing medicine sometimes? But --

*Ms. Thompson. Thank you for that question. There are a number of regulatory burdens that are facing our hospitals and, really, our caregivers in those hospitals today.

I think one of the biggest areas is prior authorization delays and denials, where physicians and others are spending more time on the phone, trying to get their patients into a new setting of care. You might be aware that it has been very difficult over the past year-plus for hospitals to discharge patients to the next level of care, whether that is a post-acute care setting, or whether it is a skilled nursing facility, mainly because it is hard to get patients out of the hospital due to workforce issues in other places, but also because of these delays and denials in care. So I think that one of the biggest areas where we might be able to find savings is there.

And there is also just a lot of administrative expenses that I think can be streamlined and processed, so that we can

both save some money in the system, make it more efficient, and then also to free up time for our clinicians so that they can see their patients.

*Mr. Latta. And just out of curiosity, a follow-up on that, because when, you know, you are on the phone and you are trying to get some procedure done, how often is it then that it finally does come through, they say, okay, you can go ahead and do it, you can get that procedure?

*Ms. Thompson. You know, that is interesting. I don't have the exact statistic for you, but I do know that a lot of payment denials are overturned after -- let me see, the OIG report, I think, said that there were 13 percent of payment denials or prior authorization denials, and maybe 18 percent of payment denials that were overturned because they actually adhered to Medicare fee-for-service requirements. So MA plans were putting on greater restrictions under fee-for-service.

But how many times or how long it takes for those denials to get overturned, I don't even know. But it is an interesting statistic that we can try to find for you.

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

Ms. Schuman, you mentioned in your testimony that the national health care costs are expected to grow at an annual rate of 5.1 percent from 2021 to 2030. You know, in your opinion, how can Congress get more employers involved so that the burden of covering this increase does not fall on the Federal Government?

*Ms. Schuman. Yes, so absolutely. I mean, employers are, you know, as I said, deeply concerned about rising health care costs. And I think that is what is so critical for employers who ultimately are looking at ways to offer higher-quality, more affordable care to their employees about addressing the root causes of rising health care costs.

And again, that is why the proposals that we are talking about today around transparency and competition are really handing tools to employers to be able to deliver higher-quality, more equitable care to their employees. And I think, really, you know, taking aim at those payment policies, even in, you know, the Medicare space that really drive the broader market and broader distortions, and certainly Medicare payment policies that drive more consolidations impact not just Medicare patients, but all

patients.

*Mr. Latta. Well, you know, from the -- from what you have heard here today, you know, are there any other proposals that you would have that might not be on the table today that would help?

*Ms. Schuman. Absolutely. I think, just following up on the vein of really taking aim at some of these anti-competitive contracting clauses, for example, and I think that is something that Mr. Cavanaugh mentioned. What are hospitals able to do? Why are they taking advantage of this monopoly power? It is simple market dynamics. When you are a larger hospital system, you bought up the competitors, you bought up the rivals, you have more leverage, and you can charge higher prices.

And you can also, with that leverage, enter into contracts with plans, with health plans that restrict their ability to try to promote higher-value care, to direct through plan design, to incentivize their employees to go to a different hospital, to a different practice that maybe is less expensive and higher quality.

So I think, also, proposals that take aim at those anti-

competitive contracting clauses, that tie the hands of employers from pursuing these value-based designs is also really critical.

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

And Mr. Chair, my time is expired and I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair just wants to make everybody aware there is a vote on the floor. So we are probably going to see where we can go, but probably get at least one more question in, and then we have to break and come back afterwards.

So the chair now recognizes the chair of the full committee, Chair Rodgers, for five minutes.

*The Chair. Thank you, Mr. Chairman. I too have concerns about prior authorization and denials within Medicare. I just want everyone to be aware there is a bill in this package -- it is one that I am leading -- that would address the vertical integration and transparency.

So we have heard in our previous hearings from experts, patients, and employers about how transparent prices can lower health care costs. And this morning Administrator Brooks-LaSure reaffirmed this Administration's belief in

price transparency. I wanted to ask each one of you, yes or no, do you believe that price transparency will put downward pressure on costs?

*Ms. Thompson. Yes.

*Ms. Bass. Price transparency that doesn't expose competitive data to competitors PBMs support.

*The Chair. Thank you.

*Mr. Connell. Yes.

*Mr. Cavanaugh. Yes.

*Ms. Schuman. Yes.

*Mr. Adler. Yes.

*The Chair. Thank you.

Just as a follow-up, then, Ms. Bass, the overwhelming opinion from experts, including CBO, is that price transparency lowers cost. In virtually every other part of our economy, consumers know the price they pay. So just -- I would like to hear some more about why you think PBMs should be treated specially, and not required to be transparent.

*Ms. Bass. Thank you for that question. PBMs fully agree that data that will help lead to lower costs that people can actually use to lower costs should be transparent.

We have no disagreement about that.

But where we have a slight quibble is, for example, in Federal bidding for contracts, you don't have those bidders bid openly so that every competitor knows what the competitor's best price is. You don't do that. You make those sealed bids, so that people will be incented to bid as low as possible to get the business. That is the kind of thing that we are concerned about. We think that if every drug manufacturer knew what the other's best deal was, they wouldn't be as willing to go as deep as they are currently going. That is the one quibble we have.

Beyond that, we -- our companies make tools available so that, at the prescribing point of prescription, doctors can just know what the cost sharing is going to be for a given patient, and that the patients know what is going to be on their formulary. Our companies are very transparent in their contracts with employers, and respond to employers' requests for information, and put that in contracts.

So we respectfully think that, just with respect to competitors knowing what their competition's best bid is, that would be the problem.

*The Chair. Okay, I appreciate that. Would -- could you cite specific examples where price transparency has resulted in increased prices, cost?

*Ms. Bass. There have been cases in the past -- there is a concrete case, and we have promised to get that information to your staff. The Justice Department, in a recent case, went through why it thought it was a bad idea to put competitors' information out. The FTC in the past has said that putting out competitors' information leads to tacit collusion. We strongly believe that this is basic economic theory, and that when competitors know each other's data, prices go up.

*The Chair. Well, I understand that we have heard this before, that we have cited this concrete case. I will just say that this is based upon a study of Danish concrete in the 1990s that CBO's own words said "was based on a small sample of plants over a short period,'' and how that is comparable to 2023 American health care system.

I am not sure really applies, and I just encourage all of the stakeholders to bring constructive feedback to these proposals. Simply saying no to price transparency is

unacceptable. And I think what you are hearing today is that both Republicans and Democrats are -- believe that this is fundamental, that we must address the price transparency, and just -- we are anxious to get your feedback, and want to have future engagements that reflect that.

Mr. Connell, the Leukemia and Lymphoma Society advocates on behalf of over 1.5 million Americans living with or in remission from blood cancers. Between 2015 and 2019, chemotherapy in free-standing provider offices fell by 5.4 percent, while the volume of chemotherapy delivered for outpatients increased by 27.8 percent. What do seniors pay if they get chemotherapy in a provider's office, compared to a hospital outpatient setting?

*Mr. Connell. Significantly more is the short answer. It depends on the drug. But provider or patients who are going to get their chemo at an outpatient facility, whether that is attached to a hospital or off campus, are paying significantly more than they would pay in out-of-pocket costs, which are astronomical, I will say, at the baseline.

So when you start to multiply those, it gets really, really burdensome for patients, and it pays a lot more if you

are at a hospital setting than if you are at the physician office --

*The Chair. So are there any reasons they should get the chemotherapy in a hospital outpatient setting?

*Mr. Connell. You know, there is -- every clinical case is different. There are some patients who do need to get their care closer to a hospital, but there is no need at the baseline to say that a patient with the same risk score should be getting the same drug at a different price at a different setting.

*The Chair. Okay. Thank you very much.

Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. Thank you. The chair yields back. We do have two more that are present we just sent to vote, so they showed up to do their questions, so we are going to have to adjourn and come back.

However, we are going to do one more question. You have one on your side, and then we will return after votes. So we have a vice chair of the committee, Dr. Bucshon, five minutes.

*Mr. Bucshon. Thank you, Mr. Chairman. I thank the

witnesses, and everyone in the audience, and everyone watching.

You know, the ground has shifted on a lot of these issues, and I would encourage all the witnesses to recognize the shifting of the ground in a bipartisan way. I have been working on some of these issues for the 12 years I have been in Congress, talking to stakeholders, trying to find common ground. And by some of the testimony here today, it is pretty clear that that is not going to be possible, maybe, and that disappoints me.

But I want to emphasize the resolve of Congress to address these issues on behalf of the people we represent. We are being -- we are -- every day, when I am in Indiana, people are demanding that we address these issues. And that is where this is coming from. And it is going to happen.

Ms. Thompson, everybody here supports hospitals, but the fact of the matter is hospital expenses from 2019 to 2022 increased by less than overall inflation. So did they go up? Yes, but inflation was higher, overall. And the labor cost surges that many hospitals were experiencing during COVID, those were real. Every hospital had to have traveling

nurses. Things like that are beginning to subside, and contract labor costs were down 20 percent year over year, in one recent report from HCA.

In 2021, operating margins went up to a record high, despite COVID relief going down. And that is according to MedPAC. It is not my opinion.

And in 2022, many hospitals said they have lost money, but -- and that is probably true for the rural hospitals, and some that I represent, but the reality is there are serious questions in the larger hospitals. In fact, one study which has already been quoted a couple of times today of the -- of 10 large non-profits found that 85 percent of the losses were isolated to the hospitals' investment portfolios, and actual patient revenues year over year were slightly positive.

Of course, the S&P 500 grew by nearly 90 percent from 2019 to 2021. So yes, in 2022 we all lost money in the market, including hospitals.

So I guess my question is are non-profit hospitals able to cover their investment losses with the gain, the market gains they achieved prior to the market softening?

I mean, what is the balance, what is on their balance

sheet?

*Ms. Thompson. Well, thank you, Congressman Bucshon, for that question, and thank you for sponsoring the SAVE Act to protect our health care workers.

*Mr. Bucshon. You are welcome.

*Ms. Thompson. We appreciate that.

Hospitals don't rely on -- well, let me take that back. Because investments change every year, plus or minus, we really look at our patient care margins. And yes, MedPAC found a positive patient care margin. But when MedPAC looked at Medicare margins, they were down at negative 8-something percent in 2021, moving to negative 10 percent in 2023.

So right now, Medicare is not covering the cost of its care. Because of that, it is important for hospitals to have financial reserves to cover such things like --

*Mr. Bucshon. Okay, fair enough.

*Ms. Thompson. -- a once-a-year pandemic.

*Mr. Bucshon. Fair enough. I have got other things.

So, I mean, I just want to say Federal Government shouldn't be subsidizing losses in the stock market to some of the largest health systems in the country. And that is

where transparency comes in. Honestly, I didn't even know myself the extent of the investment portfolios of some of the largest health systems in the country. It is in the billions and billions of dollars, as they come out and tell the public they are losing money. That is just not right. I mean, okay, you could be losing money on the patient volume, I understand, and on Medicare. But overall, I mean, come on.

I mean -- and so my goal is to reduce the -- honestly, overall, it is to reduce incentives for hospitals to monopolize health care markets, which can increase costs for everyone. And I feel strongly about this because in 2005 my medical practice, in which I was a partner, was purchased by a hospital system in Evansville, Indiana, Ascension Hospital. And that was based essentially on neutral site building. It was based on the fact that we -- the reimbursement had gone to where we couldn't recruit doctors, we just couldn't afford it because we were getting paid a third of what the hospital three blocks away would be for the same tests. The hospitals acquired the primary care doctors, forced them to send their ancillary services to the hospital. So not only were we getting paid less, but we didn't have the patients.

So, I mean, I have been involved in this for 25 years, and the argument from the hospitals about their cost of care is totally valid. And I think I have told you that, some of the cases you make about complexity of care, and I am empathetic.

But please, again, everybody, including the PBMs, work with this committee to find common-sense solutions to prevent consolidation and get the cost down. That is what I am asking.

I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back, so the committee will stand at recess and just be close by. And all you people here, that -- if you haven't testified before, you know where to be, but just be close by. And as soon as the third -- we have three votes, and as soon as the third vote is conducted, we will --

*Mr. Bucshon. Mr. Chairman?

*Mr. Guthrie. -- come straight back.

*Mr. Bucshon. Can I submit two things for the record real quickly, prior to the recess?

*Mr. Guthrie. Any objection to his submission to the

record?

*Mr. Bucshon. One is a letter that Mr. Adler actually signed on to regarding reforms in neutral site billing, and one is a hot-off-the-presses article about how health system Kaiser Permanente is to combine with hospital operator Geisinger, and Kaiser is creating a new subsidiary called Risant Health, and their aim is to acquire four or five more hospital systems across the country: further evidence of consolidation.

*Mr. Guthrie. Without objection, so ordered.

[The information follows:]

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

*Mr. Guthrie. So the committee will stand at recess until the call of the chair following the third vote.

[Recess.]

*Mr. Bucshon. [Presiding] The committee will come to order.

I now recognize the gentleman from Ohio for five minutes for his questioning.

*Mr. Johnson. Well, thank you, Mr. Chairman, and thank you to our panelists for being here this afternoon for this very important hearing.

As this subcommittee looks at a number of proposed pieces of legislation to address staggering health care costs Americans face every day, it is crucially important to hear from all ends of the spectrum, from patients to hospitals. So thank you all, all of you witnesses here today, for engaging in this conversation.

Like many of my colleagues, I am a believer in the power of the free market. Business will flow to quality and availability, and supply will dictate the demand when you have those. But for that to happen, all involved must have access to the necessary information to make informed

decisions. Consumers must be able to know that they are buying -- what they are buying, and patients must be able to know what the cost of care is to make those informed decisions.

Now, I have heard from many in the health care space that the cost of implementing and complying with some of the proposed transparency legislation at issue today, legislation I believe is critically important, is too much of a burden. So my first question to Ashley Thompson -- I don't -- my glasses -- there you are, way down at the end. Thank you, Ashley. Could you explain the impact of reporting requirements for hospitals, particularly those hospitals participating in the 340B program?

*Ms. Thompson. Yes, thank you for that question. The 340B program is of immense value to the patients and the communities we serve. And right now, hospitals are reporting -- were reporting to CMS on the Medicare cost report, were reporting to the IRS on schedule H, and were reporting to HRSA right now, who audits the program and annually re-certifies the ability for hospitals to participate. So there is a number of reporting requirements going on today.

I understand that the bill that is before this committee would have additional reporting requirements, and I think that we would welcome the opportunity to discuss them. I think that they are metrics that are being gathered, that we have some concerns that they might not show the true value of the program. So collecting the metrics, you might not, for example, understand that hospitals are using the program to purchase or to hire --

*Mr. Johnson. Right.

*Ms. Thompson. -- two new behavioral health nurses for a clinic.

*Mr. Johnson. Right. Well, you know, I am a big fan of 340B. It is something I constantly hear about when I am talking to hospitals in my district. It is a very rural district. It is a lifeline to them. My district, like many other rural areas, relies on the 340B program to help health care -- to make health care more affordable for patients. So I want the program to succeed in the long term, but I am getting increasingly concerned that some non-profit 340B hospitals are abusing the program rules to actually deprive patients of the types of support that 340B was intended to

provide.

For example, many of our largest hospital systems, beneficiaries of the 340B program, complain about the cost of price transparency compliance, yet they have signed an HHS health sector climate pledge to, among other things, designate an executive-level lead for their work on reducing emissions by 2023, and conduct an inventory of scope 3 emissions by the end of next year. Now, I am not sure how this relates to delivering affordable, quality health care, but it sounds awfully expensive to me.

Mr. Chair, I ask to consent to put into the record the HHS list of hospitals that have signed that pledge.

*Mr. Bucshon. Without objection.

[The information follows:]

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

*Mr. Johnson. So, Ms. Thompson, back to you again. I find it hard to believe that some hospitals complain that they are unable to shoulder the burden of transparency -- they say it costs too much -- yet they can afford the not-so-little cost of climate resilient infrastructure. Are hospitals taking advantage of the 340B program, and rather than ensuring the savings are being passed onto patients are instead using these savings to further their liberal ESG agenda?

*Ms. Thompson. No, the hospitals that are participating in 340B use those savings in a number of ways for their communities, whether it is to provide free and discounted drugs to those in need, whether it is mobile --

*Mr. Johnson. Well, that is what they are supposed to use them for. But how can they say that the cost of price transparency is too expensive, when they are spending money -- and they are a 340B hospital, they get money through the 340B program -- price transparency is too expensive, but they have got the money to spend on ESG and climate change. Can you help me deconflict that?

*Ms. Thompson. I know that our hospitals are very

supportive of price transparency. And as you heard earlier this morning, we are at 70 percent compliance with the rule. I know that those hospitals that are having the most problem with --

*Mr. Johnson. Well, compliant with the rule, but a lot of those hospitals are putting N/A, and blanks, and spaces in the data, rather than putting the actual price. And we see that -- we can see that because we are getting the prices from the insurance companies. So though we know that they have got the prices, they are just not putting them in the database.

So I am just not sure there is not abuse here, Mr. Chairman. I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Dr. Schrier for five minutes.

*Ms. Schrier. Thank you, Mr. Chairman, and thank you to all of the witnesses for coming today for this discussion about how we can increase transparency and lower costs and foster more competition and improve care for patients.

Mr. Cavanaugh, I am going to start, and then my first question will be directed to you. I just wanted to talk a

little bit about innovation and competition and creative ideas that we are getting ideas about all around the country on how to improve care and decrease cost, because our country spends a tremendous amount of money on health care with lackluster outcomes.

I am a big supporter of the Innovation Center and CMS, CMMI, and there are lots of pilot projects out there. Not every model deployed is successful, but they are taking a stab at it. And so much work has gone on at the state level and state Medicare and Medicaid systems, thanks to flexibility for states to partner with local entities and just try out new ideas and see what works.

Direct primary care is one example of that, and employers around the country are reporting up to 20 percent savings on the total cost of care for their employees by providing better health care up front, sort of loading more on the primary care provider in that setting, reducing unnecessary ER visits, hospital visits, specialty care, and drastically reducing expenses. So I am excited to be working with my colleague, Dan Crenshaw, on this -- these efforts.

Of course, direct primary care can also incentivize

worse outcomes, right? It could discourage patients from coming in. It could mean that expensive tests just don't happen. And so it is really important to track outcomes. And what I haven't really seen is a larger effort to track what works and what doesn't, and where the successes are, and what we should roll out in other states and around the country.

And so I was just wondering, Mr. Cavanaugh, what has your experience been, even particularly with direct primary care, and what can Congress and industry do together to improve this work being done, and roll it out elsewhere?

*Mr. Cavanaugh. Sure. Thank you for that question. Alidade practices are not direct primary care practices in the way that you mean, but there are some analogies, which is we are -- our practices are going to Medicare, to Medicare Advantage plans, to Blue Cross plans, to -- even to Medicaid plans and saying we will accept accountability for the total cost of care for your line beneficiaries.

And importantly, and this is -- gets to your question about skimping on care -- also taking accountability for the quality of care that is delivered, and the access, because

you are -- there is two ways to save money, a bad way and the right way, which is focusing on prevention, wellness, transitions. And that is what, I think, actually has been proven over and over again through the Medicare shared savings program.

There have been not just -- Alidade is probably the biggest, but there are other organizations that have used this primary care approach, held accountable by Medicare and others on the quality measures, and been very successful in reducing costs. That is one of the reasons I am here today, which is we can't get everybody to do this because, if systems consolidate, there is no impetus for them to do this, right? If they are going to be able to consolidate and negotiate higher fee-for-service rates, why do the hard work of learning population health, preventive care? And trust me, it is hard work, and it is different from the way the health system was oriented in the past.

So I would love to look at the bill you are developing. We are not a primary care -- excuse me, we are not direct primary care. But I do see analogies of focusing on better care at lower cost through, primarily, primary care.

*Ms. Schrier. Thank you for mentioning consolidation, because that is another one of my concerns, and I am hearing a lot of echoes of that today with my colleagues.

And you are right. When employers have a choice in who to contract with, their health insurance companies, they are looking at who can give the best bang for the buck, the best care. And when there is consolidation, there is no competition, prices go up, and care potentially can go down because there is no competition.

Thank you, and I will -- unless anybody else has a comment on direct primary care.

*Ms. Schuman. I just wanted to weigh in from the employer perspective, because you mentioned employers and really looking to get the best bang for their buck for their employees. And that means cost, and it means quality.

And employers are really incubators of innovation, and have really looked to models like primary care as ways to drive a healthier workforce later on, and saving health care costs later on. So we would love to just follow up with you on your efforts. Thank you.

*Ms. Schrier. Thank you. Perfect timing. I yield

back.

*Mr. Bucshon. The gentlelady yields back. I now recognize the gentleman from Florida, Mr. Bilirakis, for five minutes.

*Mr. Bilirakis. Thank you, Doctor, I appreciate it.

Mr. Cavanaugh, the Providers and Payers Compete Act draft would ensure HHS is taking into account the effect of regulatory changes to Medicare payment systems on provider and payer consolidation, both horizontally and vertically. I have been an advocate of ensuring that policies within the Medicare physician fee schedule, for example, work best for patients access -- patient access, and don't adversely cause local providers to close their doors and join a larger health system.

You say in your testimony that both types of consolidation have led to higher prices for patients. Can you provide insight into this trend and perspective on whether HHS should be taking these considerations into account as it conducts annual payment rulemaking under Medicare?

*Mr. Cavanaugh. Certainly anything that gets policy-

makers to think longer and harder about whether public policy is contributing to consolidation is something that deserves support.

I would just say, in the meantime, we know there are specific -- rather than -- I mean, in addition to focusing on future policies, we should look at existing policies that we know are part of the problem.

This committee, to its credit, has site-neutral bills before it. I would encourage you to look there. But I agree that, if there is ways to get policy-makers -- and I was formerly one, myself -- to focus more on this -- because I do think it is the major challenge before us in getting our health system to pivot to one that is focused on value, and not just focused on price and consolidation.

*Mr. Bilirakis. Very good, thank you. As co-chair of the Congressional Rare Disease Caucus, I know the challenges that rare disease patients face in terms of getting treatments to market in the first place.

Despite the FDA regulatory challenges, we have seen some incredible advances in cell and gene therapies. Yet even after approval, unfortunately, the current pricing structure

in place causes additional barriers, unfortunately, to access for these patients. That is why I am grateful for Chairman Guthrie's bill, the Medicaid VBPs for Patients, or the MVP Act, is on the docket.

So, Mr. Connell, can you speak to the potential that reducing payment barriers can have, such as following for more value-based payment arrangements on blood cancer and other rare diseases?

And how can we also ensure the innovation pipeline is strong to give hope to so many patients that currently don't have approved treatments or cures?

If you could answer those questions, I would appreciate it. Elaborate, please.

*Mr. Connell. Yes, I appreciate that. You know, we -- there is a truism that we get what we reward, and so we should be rewarding quality. We should be rewarding improved outcomes. We want patients to have better outcomes. That is what we should be paying for. So we want more value-based agreements.

We want more ways that we can reimburse, whether it is to physicians or for drugs, in ways that actually do promote

what we want, which is more investment in the type of innovation, the type of new therapies that are going to be really life-changing for patients. Because you mentioned it is a challenge on the rare disease space, and blood cancers are largely rare diseases, a whole collection of them. Under the mantles of just, you know, three or four names are hundreds of diseases.

And so the market is not there necessarily for any one disease in a way that really creates market problems now in terms of bringing products to patients. And so we see tremendous potential in trying to come up with value-based agreements that do reward that patient-centered innovation, that really make a difference for patients, and use that as a way forward to really get the type of drugs that are most valuable for cancer patients.

*Mr. Bilirakis. Thank you very much.

And Mr. Chairman, I will go back the rest of my time.

*Mr. Bucshon. The gentleman yields back. I now yield to Dr. Joyce for five minutes.

*Mr. Joyce. Thank you for yielding, Dr. Bucshon. This hearing today is incredibly apropos because of the timing. I

just received notification that Kaiser Permanente is acquiring Geisinger Health System in my home state of Pennsylvania.

Let's start with addressing, first of all, though, H.R. 977. We all know that our society is full of experts, each owning their own workplace. We know that lawyers own law firms. We know that auto mechanics own auto garages. We know that chefs own restaurants. Yet we stop doctors like myself from owning a hospital because they have earned a medical degree. I would like to add my voice to those who are supporting H.R. 977, which would repeal this incredibly misguided restriction.

One of the most disturbing trends that we see in health care that defies logic is the prices that insurers pay for medicines that have been broadly flat or declining. Yet patients continue to pay higher prices. In 2021 the net price for medicines, the price after all rebates are paid to PBMs, grew just 1 percent. Meanwhile, insurers and middlemen continue to increase their profits while pocketing the rebates and pocketing the discounts from patients.

Mr. Connell, do you think it is fair that patients could

pay more for their medicine than the insurer or the PBM paid? Does that not defeat the entire point of what insurance is for?

*Mr. Connell. I don't think it is fair. I think that we should try to make sure that patients pay the lowest amount possible, because we know that for every dollar you increase in someone's cost sharing, that patient is less likely to actually get the care that they need. And so we should be getting those copays as low as possible.

*Mr. Joyce. Thank you.

Ms. Schuman, if prescription drug prices were more transparent, do you think that this would happen?

*Ms. Schuman. I think that prescription drug prices being more transparent is the only way for this to happen. It may not be the last step, but it has to be the first step.

*Mr. Joyce. And I agree that that first step must be taken, and I think that is one of the points of this hearing today.

Currently, PBM compensation is "linked'' to a percentage of the list price of a drug, which incentivizes higher list prices and more rebates that the insurers and PBMs pocket,

rather than passing it on to the patient.

Do you believe, Ms. Schuman, that we should delink this compensation based on list price through the supply chain to encourage lower list price?

*Ms. Schuman. Well, I think we need to look at the entire ecosystem, the drug pricing ecosystem, and have more transparency throughout the entire drug pricing system.

And why transparency is such a critical first step is you are able to see those links, you are able to see whether -- what those incentives are, and what -- and how that is really translating into, ultimately, lower costs for employers and, ultimately, employees, too. So I think that is why I said transparency is, I think, the necessary first step, so employers have line of sight into whether or not they and their employees are actually benefiting from that.

*Mr. Joyce. And I agree, transparency is ultimately important, but the next step has to be de-linking the compensation based on the price list.

On another subject, Mr. Connell, I understand that in 2022 Medicare paid 141 percent more in a hospital outpatient setting than in a freestanding provider office for the first

hour of chemotherapy infusion, including both the professional and the facility fees. Mr. Connell, what does this 141 percent premium for the hospital setting mean for cancer patients and the costs that they face at this incredibly important time of their lives?

*Mr. Connell. Yes, it means that they pay more. Right now, patients pay, essentially, 20 percent in Medicare Part B of whatever the cost, the underlying cost, of the service is. And so, if you have that higher underlying cost, so if you have that markup that happens when someone is getting that chemo at the hospital setting, then you have a patient who is paying more because they are paying a higher amount from their 20 percent.

And there are some ways to help patients deal with that. Medigap is one, but if you are a blood cancer patient you can't get a Medigap plan. If you get diagnosed, they will not sell you a Medigap plan. And so there are patients who are paying that full 20 percent, and they really feel it when the cost goes up like it does if you go to a hospital --

*Mr. Joyce. It certainly seems unfair at such a critical stage of their lives, as they are battling for the

life that they want to lead.

Mr. Adler, according to MedPAC, in 2022 Medicare paid 105 percent more in on-campus hospital outpatient departments than in freestanding offices for a mid-level office visit. Can you please elaborate on the economic incentives such a payment disparity creates for consolidation and the acquisition of physician practices?

And do you feel that there is a way to move to site-neutral payments for these visits without risking patient outcomes?

*Mr. Adler. Sure. So I think that is very important to move in that direction, right?

I think the financial incentive created by this market distortion that you are describing is very large. So for an independent physician in 2016, integrating with a hospital would have increased the total annual Medicare payments for their services by $141,000. This is like, per year, per physician, that is how much money is on the table. And as Mr. Cavanaugh was saying earlier, right, this is just a very big incentive for hospitals to buy out practices, and for physicians to go work for hospitals because they just have a

lot more money to deal with for the exact same set of services.

I think if -- just moving to site-neutral payments, where we are focused here on lower complexity services, right -- it is imaging, drug administration, office visits, as you were just describing -- it is hard to imagine there would be any adverse effects on patients, and we have not seen that from the steps that Congress took in this direction in 2015.

*Mr. Joyce. My time has expired, but I want to reiterate from the onset that any action this committee takes must carefully balance maintaining access to care across all communities, especially in rural settings.

Thank you, Mr. Chairman, and I yield.

*Mr. Bucshon. The gentleman yields back now. I now recognize Mrs. Harshbarger for five minutes for her questions.

*Mrs. Harshbarger. Thank you, Mr. Chairman.

Thank you all for being here. You know, I am glad to be talking about transparency. And, you know, I looked up the definition of "transparency,'' and it says it is the quality of being easy to see through. That makes no sense about

health care.

But Ms. Schuman, this week I introduced a bipartisan bill, along with colleagues Rep. Spanberger and Miller-Meeks and Krishnamoorthi, and it is called the PBM Sunshine and Accountability Act. And what this bill does, it requires public reporting of PBM financial information that the HHS Secretary -- he already gets that, and under current law, but it will enhance the reporting to include other things like the rebates, the fees that PBMs and its financial affiliates receive from drug manufacturers and health insurers.

Would it be helpful to employers if group health plans were able to view publicly-reported data on PBM aggregate rebates, including those captured by GPOs, or Group Purchasing Organizations?

*Ms. Schuman. I do believe that it would indeed be helpful to employers if they were able to view this publicly-reported data on PBM aggregate rebates, including those by these Group Purchasing Organizations. Only with more fulsome transparency around the extent of drug manufacturer rebates received by PBMs can employers begin to understand the value that PBMs are generating from administering their drug

benefit for their employer-sponsored plan.

And with this increased information, employers will be better positioned to negotiate for reduced administrative fees from their PBMs.

*Mrs. Harshbarger. Yes, especially self-funded employers.

Would it be helpful for employers to know the highest and lowest retained rebate percentages across all contracts, so employees could see where they fall?

*Ms. Schuman. Yes, absolutely. That also would be very helpful information for employers. It will help employers understand where their contract falls, relative to other employers, and whether they may have an opportunity to negotiate for additional pass-through rebate revenue.

So again, I think it is really important to have this information to help manage a plan's --

*Mrs. Harshbarger. Yes.

*Ms. Schuman. -- overall drug spend, and also ensure that there is no over-compensation.

*Mrs. Harshbarger. You know, we have -- the biggest employer in Tennessee is in the city I live in, and if I went

to tell their benefits manager about the discrepancy in payment from specific PBMs they had contracted with, do you know it would negate my contract? I could not tell them, because that was a stranglehold on me, and I think that is unacceptable, to try to save somebody's money and they tell you you can't do it.

Mr. Connell, in your view does it make sense that, if hospitals have to post laboratory test prices, that retail labs should be required to, as well?

*Mr. Connell. Yes, yes, it does make sense. I know patients like patients with blood cancer get a lot of lab tests, and they get very frustrated by the lack of transparency we see today.

*Mrs. Harshbarger. Yes, because they are totally different, aren't they?

*Mr. Connell. Yes.

*Mrs. Harshbarger. Do you think patients would be able to compare cash prices, or should be able to compare cash prices for tests at retail labs versus hospital labs?

*Mr. Connell. Yes.

*Mrs. Harshbarger. Do you think competition makes

everything better, Mr. Connell?

[Laughter.]

*Mr. Connell. I think so, yes.

*Mrs. Harshbarger. I believe so.

*Mr. Connell. I think so.

*Mrs. Harshbarger. I think I agree with you.

You know, something interesting, I know that in the health care world NPIs -- if you have two different offices, physicians are required to have two NPIs, just like pharmacies are. And I have been reading some things about, you know, when hospitals buy provider practices, and the same provider practices then change your billing methods, you know, generally to generate higher reimbursement for their services. These providers, when they are purchased by hospitals, they can use that hospital's NPI. And I don't think that is -- you know, there has to be some kind of differentiation. And there were three things that, you know, we have researched that looks like may help with that.

If you require -- do you think that if these -- and this goes to Mr. Adler -- do you think that if these hospitals or these off-campus facilities were required to get a different

NPI, that that would fix a lot of this issue?

*Mr. Adler. Sure. So I think in the commercial market, which is where this would be meaningful -- so I think it would help. I don't think it fixes everything, but certainly you talk to insurers, and sometimes they will say, "We have a contract with the hospital that says we do not pay more for an off-campus outpatient department visit,'' for instance. But they literally cannot figure out whether it is an off-campus facility or an on-campus facility.

*Mrs. Harshbarger. I know. How can you, if you have got the same NPI?

*Mr. Adler. Yes, exactly. And it is hard to do that.

I mean, I think the Medicare policy is still where more of the money is, but I do think that is an important step.

*Mrs. Harshbarger. And Mr. Connell, we had the CMS administrator here earlier talking about how it was a Stark law violation if, like for example, Tennessee Oncology mailed to their patients in rural areas if they were too sick to pick the drug up, or if they didn't have transportation because it was a couple of weeks ago, and they interpreted an FAQ to do that. What do you think about that?

*Mr. Connell. I think there are so many ways in which things like Stark -- and we talked about Medicaid best price -- things that do have an important role also have unintended consequences that definitely need to be addressed.

*Mrs. Harshbarger. I think it was pretty ludicrous, and even the HHS Secretary told us he would work with our committee to change that, and negate that particular FAQ.

And I guess, with that, I have asked the important questions, and so, Mr. Chairman, I yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Dr. Miller-Meeks, five minutes.

*Mrs. Miller-Meeks. Thank you, Mr. Chair, and thank you to all of our witnesses that -- who are here today, testifying.

Mr. Adler and -- or Mr. Loren Adler, excuse me, thank you for testifying before the committee. As you know, we are considering multiple site-neutral payment bills. And I understand that you have written about this topic before.

And let me also state that I am a physician who has done both military medicine, private practice, academic medicine, and then been a hospital employee.

You stated specifically that site-neutral payments should ultimately be applied to a much broader set of clinical services, and then in the 2014 MedPAC recommendations at both off-campus and on-campus HOPDs, as well as ambulatory surgery centers.

Furthermore, you stated that increased hospital ownership of physician practices can also drive up costs for private payers by increasing the prices they pay for physician services and the possible hospital services, as well. Can you detail how not having site-neutral payments harms our health care system, and how vertical integration leads to increased costs for patients?

*Mr. Adler. Sure, and thank you for the question, Congresswoman.

So, yes, I mean, I think fundamentally, not having site-neutral payments creates a very large financial incentive to go -- for a doctor to go work for the hospital, or for the hospital to go out and buy up physician practices. And as you are saying, right, that has effects on commercial markets, as well, right?

We have more and more evidence now that this vertical

consolidation, when the hospital goes and buys up a bunch of physician practices, has -- tends to increase costs. And some of that is -- it is straight arbitrage, right? This is taking advantage of a Medicare policy where -- said earlier, it is basically -- it is $140,000 more per year per physician that you get if you do the same set of services in a hospital outpatient department, rather than an independent office. That is 2016 numbers, so probably multiply that by a bit to get to modern dollars.

*Mrs. Miller-Meeks. It was one of the things that myself and others talked about during the debates on the Affordable Care Act, and we were very concerned about that amount of consolidation. And in 2010 there were 50 percent of physician practices that were independent, and now there is 20 percent. So thank you.

Mr. Connell, Congress has always tried to make health care more affordable for patients, as well as more accessible. But health plans and PBMs continue to increase deductibles, use more co-insurance than copays, and are making patients pay based on the list price of medicine. With ever-increasing insurance costs, millions of hardworking

Americans are having to choose between affording, you know, lifesaving medicines or putting food on the table for their families.

On top of that, PBMs have adopted schemes like accumulators and maximizers that force patients to pay even more out of pocket for their drugs, while PBMs, which lack transparency, pocket the money for their own profits.

As a state senator in 2019, I actually passed PBM transparency in the State of Iowa. I was not able to get the rebates through, but we are still working on getting that transparent data all this time later.

I also worked in a bipartisan manner to introduce Help Copays Act with my colleagues, Representative Carter, DeGette, Clarke, and others. This is a bipartisan bill that would prevent PBMs from enacting these schemes, and I am disappointed that it is not included in the hearing today, but I think that it will in the near future.

Do you agree that PBMs and insurers should let cost-sharing assistance count towards patients' out-of-pocket costs and deductibles?

*Mr. Connell. Yes, it is a great question, and you are

dealing with an enormous challenge that is really, really important for patients.

I mean, we see patients, you know, get caught in the middle of a fight between payers and manufacturers of drugs. And so you have, you know, high costs that are dealt with with high cost-sharing, and then you have manufacturer assistance, which is certainly an imperfect solution, but to a real problem. And then you have copay accumulators, copay maximizers, these solutions that have tried to again continue this fight that happens with, really, industries with patients caught in the middle.

And so we have heard situations where you have patients who have been caught, where their assistance goes away as a result of this back and forth between industries. And that is an enormous problem for patients, because if they are left holding the bag, if they are left with $5,000, $6,000 of out-of-pocket costs, that is prohibitive for a lot of people in this country. A lot of people cannot afford even a cancer medication if it is going to come with a cost so high.

And so we do have patients -- we have data patients will walk away from the pharmacy counter. I think Mr. Carter

mentioned this earlier in his experience, and many people in health care have the same experience of working with folks who have a treatment, the good -- the bad news is you get a cancer diagnosis. The good news is maybe you have a treatment that they think will work. You go to the pharmacy counter. Right now we have data that shows that that cost is over $2,000. Then you have 40 percent of patients walking away from the counter without that therapy.

*Mrs. Miller-Meeks. Thank you.

And Mr. Loren Adler, does the current system ever expose patients to a situation where they might pay more than the net price of the drug?

*Mr. Adler. Sure. So there are certainly situations where that happens.

*Mrs. Miller-Meeks. Thank you.

I yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Mr. Carter from Georgia for five minutes.

*Mr. Carter. Thank you, Mr. Chairman. I am going to jump right into it. You know where I am on this issue, so I don't think anybody needs to be prepped with it. Three

companies controlling eighty percent of the market; the vertical integration that exists where the insurance company that owns the PBM, that owns the pharmacy, and many times employees to provider, you are all aware of the FTC and the study they are doing, something I asked for eight years ago. Finally, seven-and-a-half years later, it happens. Well, I am glad it is happening.

You know, one of the most egregious practices that I ever witnessed in anything was the gag clause that I was able to get passed in legislation to do away with -- where we and -- as the pharmacists weren't able to tell -- and the gentleman just mentioned -- about sometimes the co-pay is more than the actual cost of the medication. But if we were to tell that, we would be kicked out of the network by the PBMs, another egregious practice of the PBMs.

Ms. Bass, how -- let me ask you, and Representative Miller-Meeks just mentioned the Helps co-pay bill, helping ensure lower patient co-pays, and how the accumulators are being used and not being used, and the fact that the patient assistance, the cost-sharing assistance to patients aren't being credited to their co-pay or to their deductible. Why

is that? What is the justification that the PBMs use not to do that? Why am I having to introduce this legislation that would force them to do that?

*Ms. Bass. [Inaudible.]

*Mr. Carter. I can't hear you, I am sorry.

*Ms. Bass. I keep forgetting to push the talk.

*Mr. Carter. That is okay.

*Ms. Bass. I apologize. I appreciate the question.

Coupons are a marketing device by drug manufacturers who set high prices for their products. They are considered an illegal kickback in Medicare, and they are used by manufacturers to get around formularies.

Formularies are designed by independent expert clinicians. And our company's view is that the plan sponsor has chosen a formulary, and that the cost-sharing --

*Mr. Carter. And what do you base that formulary on?

*Ms. Bass. The formulary is based on clinical evidence, independent clinical --

*Mr. Carter. Clinical evidence, and not ever on price. Price never enters into it?

*Ms. Bass. The P&T committees tell the PBM, "These are

the drugs you have to have on the formulary,'' and when there are drugs that are --

*Mr. Carter. They tell them that specific drug, or that class of drug?

*Ms. Bass. Sometimes specific drugs. And when there are drugs that compete with each other, they say, "These are drugs that you can go out into the market and get to compete on'' --

*Mr. Carter. And you base it purely on therapeutics, and not on price at all?

*Ms. Bass. The must-haves are purely on therapeutics, and the must-not-haves, because of safety issues.

*Mr. Carter. So you are saying, yes, you base it all on therapeutics, and never on price.

*Ms. Bass. I am saying --

*Mr. Carter. Mr. Connell, let me ask you. What kind of financial burdens in the -- financial burdens, let's start with that first -- does it create for patients when they are not able to use these cost-sharing cards for their deductible or for their co-pay?

*Mr. Connell. Well, benefit designs really foist a lot

of expense onto patients, so deductibles are getting larger. A lot of times there is no separate deductible for pharmacy. And so, as a result, if you have a $5,000 deductible in your plan, then when you go to that pharmacy for the first time to fill that drug for the first time that year, you are going to pay $5,000 --

*Mr. Carter. So we can really question whether or -- excuse me, what the intent is of that cost sharing. It may be so that the patient can get the drug because they can't afford their copay, or they can't afford their deductible, and not that there is some marketing ploy, as was described.

You know, let me ask you this -- and, you know, never ask a question you don't know the answer to. What about adherence? What does it do to adherence?

*Mr. Connell. It has a tremendous impact on adherence. I think you mentioned the study that talks about $2,000, which is in Medicare Part D, and the same study also has information on commercial claims. And we see patients -- over 30 percent, I think, and Part D, certainly over 40 percent -- where, if they faced $2,000 for that first script -- and you certainly face that with a high deductible -- then

if you face $2,000, you are -- 40 percent of those patients are walking away from the pharmacy counter without it.

*Mr. Carter. Absolutely. And I can tell you, again, from experience as a pharmacist, that they don't it -- that it decreases adherence, because they don't come back. They don't get their medication because they can't afford it. And I have witnessed that firsthand.

Finally, Mr. Connell, let me ask you, do you agree that these cost-sharing plans should go toward the deductible and toward the cost-sharing?

*Mr. Connell. I think we should look at all the solutions. I am excited that you all have a solution out there that would try to, like, apply as much assistance as possible to patients who need it. You know, we have at LLS a copay assistance program. There is lots of non-profits out there. Manufacturers --

*Mr. Carter. Absolutely, absolutely. And that is why we had to introduce this legislation. Again, as Representative Miller-Meeks indicated, it is not on the -- not in the markup right now, but I hope it will be, and I think it will be.

And, Mr. Chairman, I thank you, and I yield back.

*Mr. Bucshon. The gentleman yields back.

Ms. Bass, with all due respect, we know for a fact that PBMs keep drugs off of formularies because of cost.

The gentleman has yielded, and I now yield to Ms. Schakowsky for five minutes.

*Ms. Schakowsky. Thank you so much, and I really appreciate the opportunity to waive on to this wonderful committee.

So, you know, I have throughout my career been so concerned about the cost and accessibility of health care, and we have seen the cost continuing to get higher and higher. The, you know, higher premiums, higher out-of-pocket costs. And we know that right now over 40 percent of Americans face medical debt right now, and half of all Americans have difficulty affording their health care costs. Half of all Americans.

And meanwhile, we have seen hospital mergers, and acquisitions are growing. And there is plenty of evidence that are saying that, when that happens, studies have shown that it can also raise the cost. So Mr. Adler, you said --

where are you? I am sorry, just walked in. There you go.

Mr. Adler, in your testimony you do discuss the significant increase in consolidation, and how it can lead to higher prices. I wonder -- you have probably gone over that already, but I wonder if you could just say something about that, and if you think that there are any things that the Congress can actually do to address this issue.

*Mr. Adler. Sure. Thank you for the question, Congresswoman.

So fundamentally, yes, you are 100 percent correct. The consolidation that we have seen, particularly of hospitals, two hospitals merging, one hospital acquiring another, has been very clear evidence at this point that that increases costs and tends to decrease quality, actually, right?

Those costs then flow through to -- right -- we keep talking about kind of people paying a lot of money in their deductible. Fundamentally, that is because we have high health care prices, drug prices, or hospital prices. That is really kind of the crux of why folks are paying a lot of money here. And now we have a lot of evidence, there is new evidence that has come out that very clearly ties hospital

mergers to reductions in employee wages. That -- right -- when hospitals merge --

*Ms. Schakowsky. Yes.

*Mr. Adler. -- it means workers in the area get paid less.

*Ms. Schakowsky. So the workers have paid a price, as well, you are saying.

*Mr. Adler. Correct.

*Ms. Schakowsky. Private equity has gotten involved. You know, we are talking about reimbursement to these companies, often from the Federal Government, because this is health care costs, and I wonder if you could talk a little bit about the role of private equity.

*Mr. Adler. Sure. So that is a -- very happy to talk, this is where a lot of my research is nowadays.

So, yes, we have seen -- I think private equity has come in, particularly in the last decade or so, and been a very big accelerator of these consolidation trends we have seen, and also sort of picking out some areas where hospitals sort of hadn't done the consolidation already. So they got into dermatology or ophthalmology, where there wasn't a lot of

hospital ownership, and really sort of drove things there such that you see, you know, 10 percent of docs and a lot of specialties work for a private equity company or -- in research we have coming out soon -- that more than 20 percent of emergency physicians work for a private equity company right now.

*Ms. Schakowsky. Oh, no. I have been fighting for lower health care costs and Medicare for All kinds of policies, and it just seems like now the Big Money people are getting in.

Mr. Cavanaugh -- let me see my time -- you have also discussed in your testimony how consolidation is leading to higher costs, and I wonder if you could discuss ways that you think -- if you think -- that Congress can address this.

*Mr. Cavanaugh. Certainly. Thank you for the question. Yes, I think I would summarize it by saying consolidation is sort of the antithesis of value-based care.

So we are all trying to do better care at lower cost. Medicare has programs through the Medicare shared savings program, and there has been success. But consolidation allows providers to avoid the need to move to value-based

care, because it allows them to bargain more aggressively with insurers, and get higher prices, and not engage in the activities that would lead to better care at lower cost. So I think that is the real problem. Some of the bills get at some of the things that are feeding it, but ultimately that is the problem we need to address.

*Ms. Schakowsky. So let me just end with this. You know, I really support efforts to strengthen transparency so that we are even requiring that we get reports on ownership, we know who is owning, including private equity. I am not so sure that everyone is really aware of who is making the decisions, who is owning this maybe on the sidelines. And I really think that we ought to have transparency requirements. What do you think about that?

Either one of you, anyone.

*Mr. Adler. I will just say that it is very difficult, as a researcher who has tried to do this, to nail down what sort of entities own physician practices, for instance. There really is not good data out there. And one of the bills before the subcommittee today would require entity-level reporting. So physician group and hospital-level

reporting on the parent company name, the address, and the ownership structure of those physician practices, and make that data publicly available. I think that would do a huge service to being able to understand the effects of private equity and other corporate forms of ownership.

*Ms. Schakowsky. I really agree, Mr. Adler, and hopefully we can do something about it.

Thank you, I yield back.

*Mr. Bucshon. The gentlelady --

*Ms. Schakowsky. Thank you so much.

*Mr. Bucshon. -- yields back. I now recognize Ms. Matsui for five minutes.

*Ms. Matsui. Thank you, Mr. Chairman and Ranking Member Eshoo, for holding this hearing and allowing us to waive on to -- allowing me to waive on to join this important conversation. I would like to discuss the 340B drug pricing program, which is the subject of one of the transparency bills before the committee today.

For years, I have worked to strengthen this program on a bipartisan basis. This includes transparency and accountability. While some of these bills are ostensibly

about transparency, in reality I think they would disincentivize participation in 340B. I know HRSA has requested the authority to audit how entities use their savings, and I want to support their work. But this bill adds a number of burdensome reporting requirements that are unrelated to how 340B operates.

Ms. Thompson, help us to understand why the reporting requirements in this bill do not actually reflect the true value of the true -- of the 340B program.

*Ms. Thompson. Thank you for this question. As you know, hospitals already report quite a bit on the 340B program to CMS, and its cost report to the IRS in Schedule H, and as well to HRSA, as you mentioned.

The provisions in the bill are metrics, and I think that those metrics, looking at payer mix and looking at every single clinic that receives 340B payment, I think that the metrics will mask all the good work that is being done from the program. It will be very difficult to identify, for example, that a hospital is using the savings to purchase or -- sorry, I should say to hire a couple of behavioral health specialists to work in an opioid clinic, or to provide the

amount of free or discounted drugs to needy patients, or the mobile mammography unit that is out in the community finding breast cancer. I am not sure that those metrics will really be able to show the good works that are being done.

*Ms. Matsui. Right, thank you. You know, I support measures to strengthen program integrity, as we all should.

In addition, I know there is already a movement towards transparency around 340B savings. For example, in your testimony you mentioned the good stewardship principles. Some hospitals in my district have adopted these to help them share how 340B benefits their communities. Ms. Thompson, is it possible to craft reporting requirements that demonstrate the true value of 340B?

*Ms. Thompson. Well, we would be very interested in working with you on that. I think that the good steward principles have been a good step forward, and we have been working with our hospitals to encourage them to share with their communities what they are doing with those savings, as well. So we would be -- welcome the opportunity to work with you here.

*Ms. Matsui. Okay. So what kind of activities could we

support that would not be captured by the requirements in this bill?

*Ms. Thompson. I think that we would really need to reflect on additional reporting requirements, because there are so many already upon hospitals. And I really do feel that HRSA has the authority to make sure that the program is being implemented as intended, and that it audits hospitals to make sure that they are conforming to the program as written. So I am just not sure additional reporting requirements are needed at this time, but happy to speak with you and others on the committee to discuss further.

*Ms. Matsui. Thank you. At the last hearing on transparency, we heard from a witness from Pullman Regional Hospital. He explained how burdensome it already is for entities to participate in 340B. From certifying eligibility every year to preparing for audits to simply administering the program, it is a lot of work. And I am really concerned that some of these new requirements proposed would be near impossible for some entities to comply with.

Ms. Thompson, would these requirements even be workable for hospitals, especially rural hospitals and others with

limited resources?

*Ms. Thompson. I think that you are absolutely right. We have heard from many of our small, rural hospitals that are so grateful for this program, because out of everywhere, I think, the 340B savings in rural communities has really provided a lifeline for these hospitals.

They have limited staff. You know, in many of the critical access hospitals, the CEO is also the COO --

*Ms. Matsui. Right.

*Ms. Thompson. -- and the CFO, and the janitor who changes the light bulb. So any additional requirements that is necessary, you hope that they are not so high a barrier that it decreases the ability of providers to access the funds that might be available. And for 340B we all have to say that these are no additional costs to taxpayers or the government. It is really savings on drugs.

*Ms. Matsui. Thank you very much, Ms. Thompson, and I look forward to working with you. Thank you.

I yield back.

*Mr. Bucshon. The gentlelady yields back.

Mr. Pence is going to -- Mr. Pence, are you ready for

your five minutes?

I now recognize the gentleman from Indiana, Mr. Pence, for his five minutes.

*Mr. Pence. Thank you, Chairs McMorris Rodgers, Guthrie, and Ranking Member Pallone and Eshoo for holding this hearing, and thank you to the witnesses today.

Hoosiers 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, could 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, going bankrupt, lowering access to care for vulnerable communities. Lack of competition has left patients with fewer alternatives to access care, particularly in rural communities across Indiana's 6th district, often an

hour or more drive.

These issues are exasperated by unsustainable workforce shortages and skyrocketing labor costs. There have been recent efforts to improve transparency, such as the Pence-Trump Administration's 2019 HHS rule requiring hospitals to disclose standard charges, as well as the transparency and 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.

Mr. Adler, 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 for certain services. However, many outpatient facilities were grandfathered in by the legislation, making the services covered under the new policy a relatively small portion of outpatient services. If this policy were to be expanded, do you think there are ways to ensure rural hospitals continue to receive sufficient support and provide health care access to rural patients?

*Mr. Adler. Thank you, Congressman. So, yes, I think,

as you say, right, this was a pretty small-step policy that was passed in 2015 that tried to move in this direction. Basically, it grandfathered anyone who was -- even had their outpatient department under construction at the time back then. You know, the data is basically less than one percent of outpatient services were covered by that bill.

I think moving towards getting rid of that grandfathering entirely would, right, save money for taxpayers and patients, reduce incentives to consolidate. And I don't -- do not see that there would be -- right? We are talking about pretty low complexity services here. To think that this would sort of have issues on access seems unlikely. And if you do, if you are concerned about that, this isn't the policy to sort of toy with that, right?

I think Mr. Cavanaugh was saying this earlier, but if that is the issue, one, right, there is another bill that is, for instance, getting rid of the -- or delaying the DSH cuts. Or you could increase the physician fee schedule or, you know, other hospital payment rates, right? Even if you did this without saving a ton of money, you would at least be still reducing the incentive for hospitals to consolidate and

buy up all the physician practices in an area.

I just think there are other policies that, if you want to kind of deal with that issue, that are better uses.

*Mr. Pence. All right, then, kind of from there, do you think it makes more sense to further explore transparent and accountable methods of directly supporting rural and medically underserved hospitals than an opaque and complicated network of cross-subsidies?

*Mr. Adler. Sure, right? I fundamentally think that if the goal is to support rural hospitals, I think directly doing that is the best way. Right now we have all of these policies that kind of do that, kind of, don't do it perfectly. I think sort of directly funding that is a much better sense than having, oh, you get to -- you know, when, you know, the hospital buys up your physician practice, all of a sudden you owe three times more money on the service you were getting a week ago.

*Mr. Pence. Yes, I -- you know, just kind of as we are sitting here and I am wrapping up, you know, I have a number of rural hospitals. I will tell you that two of them are probably in the red right now in a big way. And one of them

went bankrupt about three years ago. And if it hadn't been some of the bailout or relief that was provided during COVID, they -- some of them would be closed today.

So I think we really have to figure out ways to kind of separate rural from some of the other conversations we have, and with that I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Mr. Allen from Georgia for five minutes.

*Mr. Allen. Well, thank you, Mr. Chairman, and thank you for allowing me to waive on to this important hearing.

Well, you know, we are going to repeat it again. What we are here today is to address costs by increasing transparency and competition, rather than price-setting that we have seen happen with some drug prices, or with this Medicare for All business. But -- and that is where I come from, the business world, very competitive, very transparent. Our clients, our contracts provided for audits and things like that so that, you know, we hid nothing from them. And and that is kind of the way the free market works out there. And what we have here is a little different.

Mr. Adler, a bill that I co-introduced that we are

discussing today, the Drug Price Transparency and Medicaid Act, would stop the harmful spread pricing practices some Pharmacy Benefit Managers use, where they under-reimburse pharmacies while over-billing state Medicaid programs.

Last Congress the Congressional Budget Office estimated a version of this legislation would save approximately one billion in Federal dollars. Can you speak to the implications that the practice of spread pricing has on businesses, and the benefit that the health care markets would see if we were to implement a ban on spread pricing across the board?

*Mr. Adler. Sure, thank you for the question, Congressman.

I think it is -- honestly, I think it is hard to perfectly game things out, in part because these are private actors who will just come -- try to come up with other ways to do very similar things. And you have already seen a lot of the big PBMs already kind of move away from spread pricing.

I think an important thing just to keep in mind here is that, right, employers also often want maybe not spread

pricing, but they are -- right? Cost-sharing is part of the thing, right? There are two sides of this negotiation here. So often the employer sort of wants part of the benefit design, as well, here.

I do think transparency is useful here to know exactly what money is flowing where, and I think that can be useful. But I think that is sort of where more of the sort of benefits are.

*Mr. Allen. Ms. Schuman, I have long been concerned with the lack of transparency in the health care industry, particularly as it relates to health care middlemen like Pharmacy Benefit Managers. Can you talk more about PBM transparency, and how we can restructure the current rebate system to be more easily understood by employers, plan participants, and beneficiaries?

*Ms. Schuman. Well, let me just thank you very much for that question, and let me just start off by saying that employers, even very large employers, are frustrated by the complexity and opaqueness of the rebate structure, and they need to have the information. They don't know what they don't know. I have repeatedly said that. But that is the

issue. And that is why it is so critical for them to be able to have reporting from the PBMs about the revenue streams to be able to find out that, really, they are paying for value, that their patients, that their workers are paying for value.

And I think it is so important to enshrine this in legislation because, number one, employers need the certainty of knowing that this is there. They also need to know that there is the clear definitions in statute about what needs to be reported. And I think, most importantly, the transparency needs to be robust enough that it captures the PBM business model not just today, but how it is going to evolve tomorrow, as well.

*Mr. Allen. Well, I served on the Healthy Future Task Force, and I couldn't have any of those experts that we talked to -- could tell me how to peel the onion back and find out where all the money is going.

I recently took a trip to Israel, and pretty much I talked to folks about their health care, and they were pretty happy with it. Currently, Israel spends less than eight percent of their GDP on health care. We are close to 20 percent. Obviously, we are in a worldwide competition here.

We need to be looking where -- at where our health care dollars are being spent.

Many attribute our increased health care prices in part to consolidating by merging hospitals and to -- consolidation by merging hospitals and pharmaceutical groups. Health Subcommittee, can you speak to how the hospital consolidation and acquisition of physician practices impacts employers, and why this is such an important issue to them?

*Ms. Schuman. Yes. Well, thank you. Thank you so much.

And it impacts employers because it impacts employees. It impacts costs. I mean, ultimately, that is what we are here today, is figuring out what those root causes of higher health care costs are, and to address them. And consolidation, overwhelmingly, is fueling higher health care costs.

So if we are going to really tackle lower health care costs at their core, which is what employers want to be able to deliver -- high value, affordable care for their employees -- they care about consolidation, they care about Medicare policies that are fueling consolidation.

*Mr. Allen. Exactly, and the Federal Government. Yes. Thank you.

Mr. Chairman, I am out of time and I yield back.

*Mr. Guthrie. [Presiding] Thank you, the gentleman yields back.

Seeing no other members present for questions, the first thing I will do is ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

Without objection, so ordered.

[The information follows:]

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

*Mr. Guthrie. You want to comment here? You are sitting here, do you have a final comment? You would just like a couple of minutes?

*Ms. Eshoo. I would just like to thank you, Mr. Chairman, all the members of the committee, most especially all of the witnesses. Whether I agree or disagree with you, it is very important that you are here. I think that, you know, to a person -- well, maybe not to a -- well, just -- I am getting myself in a little trouble here.

[Laughter.]

*Ms. Eshoo. You did a great job, and I think that you answered -- with your answers you were highly instructive to all of the members of the committee. So I truly thank you.

You heard members complimenting the panel, and we usually do in a very nice way, but it was effusive today on both sides. So know that you are helping to move the needle, and it is so important for the people of our country. They are so hungry and so in need of these changes.

And I often say to my constituents most people don't know who I am, they don't know what I am doing, but the words that we write walk into people's lives. So, Congress

willing, we will write very good words to walk into people's lives. So thank you.

Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. And I just want to sum up, as well. Thanks for everybody being here. It has been a long day, very informative.

We are going to be working together, because we want to deliver the world-class care that you all deliver at the price that -- Ms. Schuman, representing the employer-based plans and the individuals who buy their own coverage that have the price that we can afford to pay, and then people know what the prices are so they can make decisions for themselves. So we really appreciate you being here.

I will remind members that 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 May the 10th, so you should have questions before May the 10th, and I ask for your prompt consideration and responses.

And without objection -- I see no objection -- the committee is -- subcommittee is adjourned.

[Whereupon, at 3:27 p.m., the subcommittee was adjourned.]