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6 HEALTH CARE SPENDING IN THE UNITED STATES:
7 UNSUSTAINABLE FOR PATIENTS, EMPLOYERS, AND TAXPAYERS
8 WEDNESDAY, JANUARY 31, 2024
9 House of Representatives,
10 Subcommittee on Health,
11 Committee on Energy and Commerce,
12 Washington, D.C.
13
14 The Subcommittee met, pursuant to call, at 10:02 a.m.,
15 in Room 2123 of the Rayburn House Office Building, Hon. Brett
16 Guthrie [Chairman of the Subcommittee] presiding.
17
18
19 Present: Representatives Guthrie, Burgess, Latta,
20 Griffith, Bilirakis, Bucshon, Hudson, Carter, Dunn, Pence,
21 Crenshaw, Joyce, Harshbarger, Miller-Meeks, Rodgers (ex

22 officio); Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster,
23 Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, and
24 Pallone (ex officio).
25 Also present: Representatives Allen, Pfluger; and
26 Schakowsky.
27 Staff Present: Kate Arey, Digital Director; Sarah
28 Burke, Deputy Staff Director; Abigail Carroll, FDA Detailee;
29 Nick Crocker, Senior Advisor and Director of Coalitions;
30 Corey Ensslin, Senior Policy Advisor; Grace Graham, Chief
31 Counsel; Sydney Greene, Director of Operations; Nate Hodson,
32 Staff Director; Tara Hupman, Chief Counsel; Patrick Kelly,
33 Staff Assistant; Alex Khlopin, Staff Assistant; Peter Kielty,
34 General Counsel; Emily King, Member Services Director; Chris
35 Krepich, Press Secretary; Emma Schultheis, Clerk;
36 Lydia Abma, Minority Policy Analyst; Shana Beavin, Minority
37 Professional Staff Member; Waverly Gordon, Minority Deputy
38 Staff Director and General Counsel; Tiffany Guarascio,
39 Minority Staff Director; Saha Khaterzai, Minority
40 Professional Staff Member; Una Lee, Minority Chief Health
41 Counsel; Katarina Morgan, Minority Health Fellow; Avni Patel,
42 Minority Health Fellow; Emma Roehrig, Minority Staff

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43 Assistant; and Andrew Souvall, Minority Director of

44 Communications, Outreach, and Member Services.

45

46 *Mr. Guthrie. The subcommittee will come to order. The
47 chair will recognize himself for five minutes for an opening
48 statement.
49 Today marks our subcommittee's first hearing of 2024.
50 Everybody, welcome back and happy new year to you.
51 The Health Subcommittee is tasked with one of the most
52 important jobs in Congress: overseeing nearly one-fifth of
53 the United States' economy. It is a huge task, and demands
54 serious bipartisan solutions to some of the most pressing
55 challenges, challenges that have a large impact and are
56 deeply personal for patients and families. That is why today
57 we are continuing the bipartisan work we did in 2023 to bring
58 down the high cost of health care.
59 In 2023 we held numerous hearings focused on health care
60 costs. We heard from witnesses representing almost every
61 corner of the health sector, including patient advocates,
62 hospitals, administration witnesses, benefits administrators,
63 life science executives, and academics. Our work culminated
64 in the Lower Costs, More Transparency Act, which passed the
65 House in December with more than 300 bipartisan votes. This
66 legislation includes policies that will bring much-needed

67 transparency to our health care system, and finally put
68 patients in the driver's seat of their own health care
69 decisions. The legislation will empower patients, providers,
70 and payers by advancing price transparency throughout the
71 biggest components of the health care sector.
72 If enacted, this legislation would codify and
73 strengthen price transparency rules for hospitals and
74 insurance companies.
75 Further, it would expand price transparency for clinical
76 labs, imaging services, and ambulatory surgical centers.
77 The 2022 health care expenditure data from HHS gives us
78 another important opportunity to identify drivers of high
79 costs and continue looking for additional solutions. In
80 2022, health care spending reached $4.5 trillion, and is
81 expected to grow faster than GDP over the next decade. This
82 runaway growth is why we are here.
83 Each year Americans, businesses, and state governments
84 are dedicating greater shares of their budgets on health
85 care. When we look under the hood, we can see how health
86 care spending is allocated: hospitals represented over 30
87 percent of the total spend; physician services representing

88 roughly 20 percent of total spending; and retail prescription
89 drugs representing less than 10 percent of total health care
90 spending.
91 To put a finer point on this, in the private marketplace
92 the average growth premium is expected to reach 5 percent per
93 enrollee between 2024 and 2034. This comes after Medicaid
94 spending grew by 31 percent between 2019 and 2022. That
95 means those with employer-sponsored coverage would be left
96 paying more of their health care as a result, or seeing less
97 in take-home pay for choosing more comprehensive health care
98 coverage. Or, in the case of Medicaid spending, it means
99 state legislators will be forced to make tough decisions
100 between cutting certain health care services for vulnerable
101 patients or other core functions like educational services.
102 This should tell policymakers that it is time to take a
103 different approach than what we have employed over the past
104 several decades.
105 Much of the debate about subsidies to health insurance
106 companies, I think _ I think the _ much of the debate is
107 about subsidies to health insurance companies, and I think
108 the verdict is in: well-intentioned policies to expand

109 access to coverage are missing a key piece of the puzzle.
110 Right now in the United States the median household income is
111 74,580. The average deductible for a benchmark ACA plan is
112 _ in 2024 is $5,241. This means a hard-working individual,
113 on average, will have to spend 7.5 percent of their annual
114 income on health care before the coverage provides meaningful
115 financial protection. This is why we have to get costs down
116 across the board.
117 To be clear, I am not pointing blame at any specific
118 part of our system. We need to work across the aisle and
119 with industry stakeholders to better understand the
120 relationship between Federal policies and the cost of care.
121 I look forward to continuing discussing these issues
122 today and over the course of the next several months.
123 [The prepared statement of Mr. Guthrie follows:]
124
125 **********COMMITTEE INSERT**********
126

127 *Mr. Guthrie. I will yield back and recognize my
128 friend, the good ranking member from California, Ms. Eshoo,
129 for five minutes for an opening statement.
130 *Ms. Eshoo. Thank you, Mr. Chairman, and good morning,
131 colleagues, and welcome to the first Health Subcommittee
132 hearing of 2024.
133 As the chairman said, today we are going to be
134 discussing a pressing issue for all Americans: health care
135 spending.
136 In 2022, the United States, as the chairman said, spent
137 $4.5 trillion on health care. This accounts for nearly 20
138 percent of our nation's economy. And per capita, that is
139 almost $14,000 per person. But patients are not seeing
140 better health outcomes. Americans live shorter lives than
141 residents of other developed nations such as Germany, the
142 United Kingdom, Austria, despite spending double on health
143 care.
144 Americans are also in an affordability crisis. Half of
145 Americans say it is difficult to afford the cost of health
146 care, and two-thirds of Americans say that our health care
147 system doesn't meet their needs. Patients fear they can't

148 afford to pay their bills if they get sick, even if they have
149 health insurance.
150 Yet there is a bright spot that bears our attention
151 today. Medicare, one of our nation's most important Federal
152 health care programs, covers more than 65 million people and
153 accounts for 10 percent of our nation's budget. After
154 decades of rapid increases, Medicare spending is defying
155 trends seen in other parts of our health care system.
156 Spending on Medicare patients has slowed to the slowest rate
157 since 2005. Between 2013 and 2019, spending increased just
158 over 2 percent, and is expected to remain relatively flat
159 through 2031. Importantly, costs will continue to decrease
160 as Medicare, for the first time ever, negotiates prescription
161 drug prices.
162 Another policy that will lower health care spending is
163 the Lower Costs, More Transparency Act, which passed the
164 House with overwhelming bipartisan support. The legislation
165 will empower patients to make informed decisions about their
166 care by shining a light on parts of the health care industry
167 that have remained hidden for too long, such as the profits
168 middlemen called Pharmacy Benefit Managers extract at the

169 expense of patients. I hope the Senate passes this bill
170 quickly.
171 Now, "Senate" and "quickly" is an oxymoron, but we can
172 still hope.
173 Congress's job won't be done when the Lower Costs, More
174 Transparency Act is signed into law. There is more Congress
175 can do to lower costs, and we can start by building on the
176 successes of the Inflation Reduction Act, which has lowered
177 health care costs for seniors on insulin, prescription drugs,
178 and vaccines. Premium tax credits from the IRA also fueled
179 record-breaking enrollment in health coverage under the
180 Affordable Care Act this year: 21.3 million people enrolled
181 in marketplace coverage during the open enrollment period,
182 including 5 million new enrollees nationwide; 80 percent of
183 enrollees found a plan for less than $10 a month. Congress
184 should make the premium tax credits permanent to protect and
185 expand health care coverage for all Americans.
186 So together with all of my colleagues here I look
187 forward to the testimony that the witnesses are going to
188 offer today, telling us what they think Congress should do to
189 lower costs while improving the health of our nation.

190 [The prepared statement of Ms. Eshoo follows:]

191

192 **********COMMITTEE INSERT**********

193

194 *Ms. Eshoo. Thank you, Mr. Chairman, and I yield back.
195 *Mr. Guthrie. Thank you. The gentlelady yields back,
196 and I now recognize the chair of the full committee, Chair
197 Rodgers, for five minutes for her opening statement.
198 *The Chair. Thank you all for being here today. We
199 have talked a lot in this committee about addressing the
200 impact high health care costs have on patients, employers,
201 and taxpayers, and the work that we need to do to create a
202 less complicated system.
203 More than 60 percent of Americans are living paycheck to
204 paycheck. It means that they are just one medical bill away
205 from a financial emergency, one doctor visit away from not
206 being able to pay their rent or put food on their table.
207 Let's take, for example, a new mom who has what is
208 considered a good health care plan. All her plan's documents
209 say maternity care is covered. After a few weeks at home,
210 enjoying life with her new, healthy baby, she gets a bill
211 from the hospital for over $18,000. Next, she receives an
212 explanation of benefits from her insurer. A number of items
213 were denied, but it is not clear why. It claims she may
214 still owe over $6,000. A month or so later, another hospital

215 bill finally shows up for $1,800. So for one childbirth,
216 that is three different documents with different amounts for
217 this family to pay. This is just one example of how the
218 current confusing and opaque system plays out for everyday _
219 in millions of lives for Americans.
220 Something needs to change. Improving price transparency
221 in our health care system is a critically important step to
222 begin to address these problems and drive down costs. We
223 ended last year with a very important moment. Our Lower
224 Costs, More Transparency Act passed out of the House by an
225 overwhelming bipartisan vote. But our work is not done. We
226 need to get this legislation on to the President's desk to
227 improve price transparency for patients and employers as soon
228 as possible.
229 Today we are hearing from experts on why addressing
230 health care costs is so important, and what more Congress
231 should do once the Lower Costs, More Transparency Act is
232 signed into law. We will hear about how much we are spending
233 on health care. In 2022 spending on health care in the
234 United States reached nearly $4.5 trillion. That averages
235 out to about $13,500 per person. Take a family of four.

236 That means, on average, it will cost more than $55,000 a year
237 to provide health care for that family.
238 Now, of course, not every person or family is average.
239 Some will require more spending, some less. But we all pay
240 the high cost of health care through ever-increasing
241 insurance premiums, through our tax dollars. And we know
242 that when employers have to spend more on health care, they
243 spend less on wages.
244 One study found that the growth in health care premiums
245 over 3 decades resulted in $125,000 in lost wages per family.
246 In other words, when we lower health care costs without
247 sacrificing access and quality of care, we are helping
248 increase the paychecks of hard-working Americans.
249 Spending on health care is projected to continue to grow
250 faster than the economy over the next decade. This trend is
251 not sustainable, and we have to find a way to reverse it. I
252 believe a foundational first step that is necessary to
253 lowering health care costs is improving price transparency.
254 But our work does not stop there.
255 There are plenty of other examples of things driving up
256 costs for patients and employers. One such example is vision

257 insurance, an area that has seen significant consolidation
258 and vertical integration over the past decade. And this has
259 led to the same companies controlling the production of
260 frames and lenses, owning and operating nearly all the
261 laboratories, employing the doctors, and owning independent
262 practices. The result is less transparency and higher costs
263 for treatment, and that is why Chairman Guthrie and I are
264 requesting that the Government Accountability Office examine
265 this issue and help inform the committee on how we can bring
266 more transparency and lower costs for Americans.
267 There are many examples like this one, which is why we
268 are holding today's hearing to examine how much we are
269 spending on different parts of the health care system, and to
270 discuss potential solutions to lower costs and put money back
271 into the pockets of hard-working Americans.
272 I look forward to hearing from all. Thank you,
273 witnesses, for being here. And to my colleagues, I look
274 forward to hearing your ideas, too.
275 [The prepared statement of The Chair follows:]
276
277 **********COMMITTEE INSERT**********
278

279 *The Chair. I yield back.

280 *Mr. Guthrie. Thank you. The gentlelady yields back,
281 and the chair will now recognize the ranking member of the
282 full committee, the gentleman from New Jersey, Mr. Pallone,
283 for five minutes for an opening statement.

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

285 Today's hearing builds on the committee's critical work
286 to lower health care costs and make coverage more affordable
287 for American families. And there is some good news in this
288 regard. More Americans have health coverage today than ever
289 before, thanks to the Affordable Care Act and the expansion
290 subsidies included in the Inflation Reduction Act.

291 Last week the Biden Administration announced that a
292 record-breaking 21.3 million Americans signed up for health
293 care coverage for this year through the ACA marketplaces, and
294 that is 5 million more people than signed up last year, which
295 was also a record.

296 Millions of families have seen the cost of their monthly
297 insurance premiums go down. In fact, 4 in 5 consumers were
298 able to find health care coverage for $10 or less per month,
299 thanks to enhanced subsidies that Democrats passed as part of

300 the American Rescue Plan, and then extended through the
301 Inflation Reduction Act. And this is a big deal, and it is
302 what is possible when you strengthen a program, rather than
303 spend years trying to eliminate it. And I am proud of this
304 historic achievement, and hope we will act expeditiously to
305 ensure that these subsidies are renewed next year when they
306 are set to expire.
307 But despite all this good news on the ACA front, high
308 health care costs and affordability continue to be a
309 challenge for consumers. This is creating a significant
310 financial burden and preventing some families from getting
311 necessary medical care. More than 40 percent of American
312 adults say they have either delayed or forgone medical care
313 because of the high costs, and half of adults have reportedly
314 _ difficulty affording health insurance, or health care.
315 So our health care system is complex and challenging,
316 and too many patients struggle to navigate and understand the
317 cost of a health care procedure or prescription drug.
318 Patients are not able to easily obtain price information in
319 advance, and sometimes the information is inaccurate and
320 misleading, making it difficult to determine the true value

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321 of a given service.

322 Similarly, employers have difficulty accessing data that
323 could help them negotiate lower prices and design high-value
324 plans. Patients also face wide price variations, and the
325 lack of transparency makes it difficult to compare across
326 providers in advance of receiving care. Prices for health
327 care services vary widely across different geographic areas,
328 but also across providers in the same geographic area.
329 According to an analysis by The New York Times, a single
330 hospital can have a threefold difference in the price of the
331 same service.

332 Prices of health care services also vary substantially
333 in the employer-sponsored insurance market. According to
334 another analysis, the average price of an MRI in large
335 employer plans ranged from $251 to more than $1,400 across
336 different geographical regions, and patients and employers
337 deserve greater transparency in the prices they pay for
338 health care. And that is why our committee, led by Chair
339 Rodgers and myself, worked on a bipartisan basis to pass H.R.
340 5378, our Lower Costs, More Transparency Act, out of the
341 committee and, obviously, in the House.

342 Our bill will deliver lower health care costs for the
343 American people and bring much-needed transparency to our
344 nation's complex health care system. And I am fighting to
345 get H.R. 5378 passed into law, as Chair Rodgers is in the
346 Senate, and we look forward to hearing from our witnesses on
347 how we can further increase transparency and lower costs.
348 Now, one area where we need to focus is on Medicare
349 Advantage. Medicare spending is expected to double over the
350 next 10 years, with payments to Medicare Advantage plans
351 totaling $7 trillion. While the Medicare Advantage program
352 offers seniors flexibility in the way that they receive their
353 medical care, it is important that we ensure Medicare remains
354 financially viable, and that seniors are receiving the high-
355 quality care they deserve.
356 The Medicare Payment Advisory Commission has
357 consistently found that providing care under Medicare
358 Advantage has cost more than under traditional Medicare.
359 Overpayments to Medicare Advantage insurance companies were
360 projected to be $27 billion in 2023 alone.
361 Despite the large costs associated with the Medicare
362 Advantage program, there is limited data to conduct oversight

363 and ensure that the program is providing good value for our
364 Federal dollars. In particular, there has been no meaningful
365 accounting about whether or not seniors are actually using
366 supplemental benefits, and if their usage correlates to the
367 additional money insurance companies are being paid.
368 And as Medicare payments for supplemental benefits
369 continue to increase, we have to better understand if they
370 are helping seniors, and whether they are being delivered at
371 a reasonable cost. H.R. 5380, led by Representative
372 Sarbanes, would require insurance companies to report data on
373 supplemental benefits, and the legislation passed this
374 committee with unanimous bipartisan support, and I look
375 forward to seeing it pass the House and signed into law.
376 So, Mr. Chairman, today's hearing is an important step
377 in our continued effort to make health care more affordable,
378 and I look forward to hearing from our witnesses.
379 [The prepared statement of Mr. Pallone follows:]
380
381 **********COMMITTEE INSERT**********
382

383 *Mr. Pallone. And with that, Mr. Chairman, I yield
384 back.
385 *Mr. Guthrie. Thank you. The gentleman yields back,
386 and that concludes opening statements from the members. I
387 want to have opening statements from our witnesses.
388 I will introduce each of you and then call on you for
389 your five-minute opening statement. I think most of you have
390 testified before. If you haven't, you will have five
391 minutes, there will be _ four minutes in _ you will you will
392 see a green light four minutes in. You will see a yellow
393 light, that means you are approaching your end, and so start
394 summing up. When you get to the red light you have exhausted
395 your five minutes.
396 So we will look forward to hearing from you all. Let me
397 first introduce.
398 First we have Ms. Katie Martin. She is president and
399 CEO of Health Care Cost Institute.
400 We have Dr. Benedic Ippolito. Ippolito?
401 *Dr. Ippolito. Close enough.
402 *Mr. Guthrie. Would you say it so we can say it
403 correctly?

404 *Dr. Ippolito. Ippolito.

405 *Mr. Guthrie. Ippolito. I am sorry, Ippolito, senior

406 fellow, American Enterprise Institute.

407 Mr. Kevin Lyons, the plan administrator for the New

408 Jersey State Policemen Benevolent Association, Incorporated.

409 Ms. Sophia Tripoli, senior director of health policy for

410 Families, USA.

411 And Dr. Chapin _ or Chapin _ Chapin White, director of

412 health analysis of the Congressional Budget Office.

413 So I thank you all for being here, and we will call on

414 _ first, we will have Ms. Martin.

415 You are recognized for five minutes for your opening

416 statement.

417

418 STATEMENT OF KATIE MARTIN, MPA, PRESIDENT AND CEO, HEALTH
419 CARE COST INSTITUTE; BENEDIC IPPOLITO, PH.D., M.S., SENIOR
420 FELLOW, AMERICAN ENTERPRISE INSTITUTE; KEVIN LYONS, PLAN
421 ADMINISTRATOR, NEW JERSEY STATE POLICEMEN'S BENEVOLENT
422 ASSOCIATION, INC.; SOPHIA TRIPOLI, MPH, SENIOR DIRECTOR OF
423 HEALTH POLICY, FAMILIES USA; AND CHAPIN WHITE, PH.D.,
424 DIRECTOR OF HEALTH ANALYSIS, CONGRESSIONAL BUDGET OFFICE
425
426 STATEMENT OF KATIE MARTIN
427
428 *Ms. Martin. Thank you. Good morning, everyone. Chair
429 Guthrie, Chair Rodgers, Ranking Member Eshoo, and Ranking
430 Member Pallone, and members of the Health Subcommittee, it is
431 an honor to join you today to share my understanding of
432 health care spending in the United States. I am Katie
433 Martin, and I am the president and CEO of the Health Care
434 Cost Institute.
435 HCCI is an independent, non-partisan, non-profit
436 organization founded in 2011 to foster greater understanding
437 of health care spending trends and the drivers of health care
438 cost growth among people with employer-sponsored insurance.

439 HCCI houses a unique, multi-payer data set that allows us to
440 conduct original research, license data to leading academic
441 and policy researchers, and to produce consumer-facing price
442 transparency tools.

443 High and rising health care spending challenges the
444 budgets of governments, businesses, and families, and forces
445 each of them to make difficult trade-offs. Using the most
446 recent HCCI data, we find that total spending per person
447 enrolled in employer-sponsored health plans was $6,467 in
448 2021. That amount captures payments by payers for health
449 care goods and services, and out-of-pocket costs paid by
450 enrollees. It does not include insurance premiums or
451 insurers' administrative costs _ $6,467 is 21 percent higher
452 than just 5 years earlier, an increase equal to $1,133.

453 Prices accounted for more than half of the spending
454 increase: 915 of the $1,133. Meanwhile, inflation accounted
455 for $108, and the quantity of services used accounted for
456 $364 of that increase. Since 2019 the change in the mix of
457 services has slightly offset spending increases.

458 While prices are driving spending increases in the
459 employer-sponsored insurance population, there is wide

460 variation in what the price of a health care service is.
461 There is no single price for a given health care service.
462 Prices vary from community to community across the country,
463 within the same geographic area. Prices vary across
464 providers. Within the same providers prices vary across
465 patients. Two people can go to the same hospital for the
466 same service and face two different prices, sometimes
467 substantially so.
468 Moreover, prices paid in employer-sponsored insurance
469 are routinely higher, multiples higher than rates reimbursed
470 by Medicare. Recent HCCI analysis of outpatient services
471 found that employer-sponsored insurance reimbursed rates
472 three times higher than Medicare payments, on average.
473 Prices for services provided in the outpatient setting
474 are also frequently higher than those same services provided
475 in a physician's office. For example, we found that the
476 price of a basic metabolic lab test performed in a hospital
477 outpatient department was five times higher _ the same exact
478 test provided in a physician's office or independent lab.
479 Nearly half of people in the United States get health
480 insurance through an employer, and our data suggests that

481 spending for this population continues to grow and is
482 contributing to unsustainable increases in health spending
483 overall. Public and private decision-makers need information
484 and data to identify and implement changes that can alter the
485 trajectory of health care spending. The lack of
486 comprehensive and definitive information on how the U.S.
487 health care system is performing poses an obstacle to
488 understanding what is driving health care costs and makes it
489 difficult to develop effective solutions.
490 Transparency alone likely is not sufficient to lower
491 health care spending, but more complete data, including data
492 on health care prices, can be used to understand cost drivers
493 and design and implement strategies to lower spending growth,
494 improve value, and increase affordability.
495 HCCI's work is just one example of how bringing data to
496 bear on important policy questions can contribute to
497 meaningful policy decisions that respect and reward
498 innovation in health care within the parameters of a
499 sustainable health care system.
500 Thank you for your time today and the opportunity to
501 discuss these critical issues.

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502 [The prepared statement of Ms. Martin follows:]

503

504 **********COMMITTEE INSERT**********

505

506 *Mr. Guthrie. Thank you for your testimony. I
507 appreciate it.
508 And Dr. Ippolito, you are recognized for five minutes
509 for opening statement.
510

511 STATEMENT OF BENEDIC IPPOLITO

512

513 *Dr. Ippolito. Thanks very much, Chairman Guthrie,
514 ranking member Eshoo, members of the subcommittee. my name
515 is Benedic Ippolito, I am an economist at the American
516 Enterprise Institute.

517 I think it is fair to say that the high cost of health
518 care represents _ I have here a persistent challenge for
519 policymakers, which may be a little bit generous. I thought
520 that was put into context really nicely in a recent report
521 from Paragon Health, where they showed that just Federal
522 spending on Medicare and Medicaid and ACA subsidies was going
523 to exceed the discretionary budget. There was a recent
524 report that showed that Federal spending on Medicare and
525 Medicaid and ACA subsidies was going to exceed the entire
526 discretionary budget in 2024, which is remarkable, given how
527 much attention we spend to the discretionary budget. And
528 that is not all of health care spending, of course.

529 And so, again, regardless of one's priorities, I think
530 that crowds out other valuable resources for _ or other uses
531 for those resources, whether in health care or outside.

532 Meanwhile, on the consumer side, a family plan in an
533 employer-sponsored market is now approaching $24,000 a year
534 in total premiums. We heard earlier the median household
535 income is around $75,000 a year. It is very easy to
536 understand, then, how that starts to eat away at wage growth
537 and affect employment, and that is something that research
538 has borne out.

539 So I think there is broad benefits to lowering health
540 care costs, but that does not justify indiscriminate cuts.
541 Instead, the goal should be to target cases where we think
542 health care spending is divorced from value. I think there
543 is many such options, but I am going to focus on one that was
544 included in the Lower Costs, More Transparency Act.

545 You know, in typical markets you can essentially think
546 of the most efficient producer essentially dictating the
547 price. If there is a coffee shop that opens up next to
548 Starbucks, and they can produce the same cup of coffee for
549 half of the price of Starbucks, Starbucks either needs to
550 find some efficiencies, lower their costs, lower their
551 prices, or change their business model, or everyone is going
552 next door. Health care ought to have those same market

553 forces.
554 If providers are able to offer the same quality service
555 for a lower price, purchasers ought to shift towards those
556 settings. But current Medicare policy interrupts that
557 dynamic by paying hospitals and, to a lesser extent,
558 ambulatory surgery centers more than they would pay a
559 physician's office, even if it is a service that we think
560 could be provided in any of those settings.
561 That policy directly increases cost to Medicare and to
562 beneficiaries. But perhaps more importantly, it has effects
563 outside of the Medicare program by giving hospitals an
564 obvious incentive to acquire physicians offices. That is a
565 good example, I think, of where spending and value are very
566 tenuously related.
567 So in cases where care could be delivered safely outside
568 of a hospital, paying a site-neutral rate based on the
569 physician fee schedule embraces behavior we would typically
570 see in markets. And I do think that is something that is
571 often lost in this discussion. This is sort of normal market
572 behavior. It has to be done in a relatively, you know,
573 prescriptive way because Medicare sets rates, but this is

574 what we would expect in a normal market.

575 So the Lower Costs, More Transparency Act proposes to do
576 this for one subset of services, namely drug administration
577 off campus. I think one can argue for a much more expansive
578 policy, but I will say this is a subset of services for which
579 the arguments for site-neutral payments are particularly
580 compelling.

581 Very briefly, some have argued against this kind of
582 policy because it would threaten the finances of some
583 hospitals. Namely, typically you think about rural or safety
584 net hospitals. Ensuring access and hospital viability,
585 hospital financial viability, are reasonable goals. However,
586 it is not a compelling argument for maintaining the status
587 quo. Even if _ the current policy, I would argue, is pretty
588 modest. But even if it does threaten the finances of some
589 hospitals, that does not justify paying all hospitals more in
590 order to accomplish this goal.

591 Instead, a much better approach is to embrace site-
592 neutral payments as the standard, and then either try to
593 mitigate revenue losses for certain hospitals you care about,
594 maybe phase the policy in, or just limit losses at certain

595 types of hospitals, or I think, even better, just embrace
596 site-neutral payments and decide how much you want to
597 subsidize certain kinds of hospitals that are more
598 financially distressed. I think that lays trade-offs more
599 bare, and it, frankly, gives you more bang for your buck
600 because you are not spreading all this money across every
601 hospital, including those that are in very strong financial
602 positions, you are targeting it to the places where you
603 really think that they need help.
604 So I will conclude by saying that is just one of many
605 ways to chip away at high health care costs. Other options
606 that increase competition and transparency tend to work in
607 the same direction. And so I thank you for having me, and I
608 look forward to your questions.
609
610
611 [The prepared statement of Dr. Ippolito follows:]
612
613 **********COMMITTEE INSERT**********
614

615 *Mr. Guthrie. Thank you for your testimony. It is much
616 appreciated.
617 Mr. Lyons, you are now recognized for five minutes for
618 your opening statement.
619 *Mr. Lyons. Thank you, Chairman.
620

621 STATEMENT OF KEVIN LYONS

622

623 *Mr. Lyons. Honorable Chairman Guthrie, Vice Chairman
624 Bucshon, Ranking Member Eshoo, Committee Chairwoman Rodgers,
625 and Ranking Member and fellow New Jerseyan, Honorable Mr.
626 Frank Pallone, and fellow _ and other committee members, my
627 name is Kevin Lyons, and today I stand before you as a
628 retired law enforcement officer, a member of a school board,
629 a labor representative of the _ responsible for the _ New
630 Jersey's public _ largest public sector health benefits
631 program, and, most importantly, as a husband, father, and
632 grandfather.

633 Throughout my career in law enforcement, first as a cop
634 and then a detective, and now as director of member benefits
635 for the New Jersey State Policemen's Benevolent Association,
636 representing over 30,000 active law enforcement officers in
637 New Jersey, I have come to understand that transparency isn't
638 just a policy, it is the bedrock of trust and integrity. We
639 all know when it is missing, the community suffers.

640 It should be no different in health care. In fact, the
641 stakes may be higher because when people begin to distrust

642 this system, lives are at stake. But sadly, it is one of the
643 least transparent, most shrouded aspects of our society,
644 despite the fact that it compromises one-fifth of our
645 economy.

646 In our policing we have embraced body cameras and
647 rigorous public scrutiny, understanding that transparency is
648 essential to gain and build the public trust. Yet the
649 opposite is true with many hospitals, carriers, third-party
650 administrators, and PBMs. We are forced to belong to
651 networks where we are prevented from knowing the price, we
652 are prescribed drugs from a formulary that is largely driven
653 by money and rebates, not clinical efficacy, and we incur
654 tens of billions in foregone revenue from non-profit
655 hospitals with basically zero oversight or benefit to show
656 for it. This dynamic not only makes it challenging to manage
657 public budgets, as I know all too well, but it also
658 effectively erodes the trust of the people, the people it is
659 supposed to serve.

660 And before I go on, let me be clear. My critique here
661 is not and in no way a reflection on the tireless efforts of
662 our doctors, nurses, and support staffs of hospitals. In

663 fact, these dedicated professionals are often themselves
664 victims of the system's lack of transparency.
665 As a labor representative overseeing the second largest
666 public sector health plan in the nation, I have not only
667 witnessed the direct impact of these costs on individual
668 families, I have also witnessed some of the egregious
669 behavior that has led to this crisis. I regularly see
670 instances where our members' hospital claims are paid in
671 amounts far in excess of the billed amounts. And when
672 questioned, my colleagues and I were dismissed, silenced,
673 told _ and told this is how carriers price claims [sic], and
674 it was proprietary and confidential. The detective in me
675 isn't buying it.
676 Or consider my time _ my colleague, then-director of the
677 program, told the carrier to make it easier for members to
678 submit out-of-network mental health claims, to which the
679 carrier responded, "If you do that, you realize they are
680 going to use the benefit more, right?'' It is nothing short
681 of unconscionable.
682 The financial impact of this broken system that operates
683 in the shadows cannot be understated. For example, in my

684 role on the Southern Regional Board of Education in New
685 Jersey, I have seen health care costs balloon from 16 percent
686 to 18 percent of our budget in just two cycles. These aren't
687 just statistics, these represent unfunded school programs,
688 higher teacher-to-student ratios, and struggling
689 infrastructure.

690 What is more distressing is the fact that I could
691 probably tell you every detail of every line item in the
692 budget, from art supplies to transportation. But what is
693 behind health care cost increases? We fly blind and are
694 expected to accept it. To protect what? The business
695 interests of carriers and hospitals and PBMs.

696 The financial impact on my individual members, those
697 that put their lives on the line every day, they had to work
698 and their families _ is real, and it is a tragedy. Many of
699 our members see a significant portion of their hard-earned
700 salaries, sometimes as much as 15 percent, consumed by health
701 care premiums. And this is before they have accessed one
702 ounce of care. The proliferation and peddling of high-
703 deductible health plans mean that many of these families
704 don't see the full benefit of their health care plans until

705 they have emptied their savings accounts.
706 This brings me to the heart of the matter:
707 accountability and the urgent need for action. In my career
708 as a detective, I have learned that accountability is key to
709 justice. Yet on the issue we speak of today, accountability
710 is missing. Costs continue to rise unchecked, opaque billing
711 practices are the norm, and those tasked with running self-
712 funded health plans for tens of millions of people are
713 regularly blockaded and stonewalled from information that
714 would give them a fighting chance. For those of us serving
715 in uniform, this is more than a financial burden. It is a
716 betrayal of the trust and security we, as officers, strive to
717 provide and uphold.
718 I would be remiss if I didn't mention the countless
719 members of the health care community who have been blazing
720 the path for transparency and accountability far in front of
721 me, and who have brought me along this journey, people like
722 Cynthia Fisher, an advocate for price transparency, Dr. Susan
723 Hayes, who was a pioneer in Pharmacy Benefit Managers reform,
724 and especially my friend and colleague, Christin Deacon, who
725 is here with me. They are both fearless in their endeavors

726 and the most zealous advocates for consumers and payers I
727 have met along this journey.
728 I stand before you today not only as a retired police
729 officer and labor representative, but also as a husband,
730 father, and grandfather, and I implore this committee to
731 recognize the urgency of health care reform. We, the
732 everyday Americans, the officers who serve our communities
733 and the public sector workers who keep our society
734 functioning, don't have the deep pockets to lobby Washington,
735 yet our needs and voices are just as important. This is why
736 I am here today to remind you of the countless families like
737 my own.
738 [The prepared statement of Mr. Lyons follows:]
739
740 **********COMMITTEE INSERT**********
741

742 *Mr. Guthrie. Thank you. Thank you, thank you, thank
743 you for your service, and thank you for your testimony.
744 *Mr. Lyons. Thank you, sir.
745 *Mr. Guthrie. The chair now recognizes Ms. Tripoli for
746 five minutes for her opening statement.
747

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

748 STATEMENT OF SOPHIA TRIPOLI

749

750 *Ms. Tripoli. Good morning. Chairman Guthrie, Ranking
751 Member Eshoo, members of the committee, thank you for the
752 opportunity to testify today. It is an honor to be with you.
753 On behalf of Families USA, a leading, national, non-partisan
754 voice for health care consumers working to ensure the best
755 health and health care are equally accessible and affordable
756 to all, I want to thank you for this critical discussion, as
757 well as, Chair McMorris Rodgers and Ranking Member Pallone,
758 for your collective leadership in advancing bipartisan
759 solutions to improve health care affordability and price
760 transparency.

761 Today's hearing is urgently needed. Our health care
762 system is in crisis, evidenced by a lack of affordability and
763 poor quality. Every person in the United States should have
764 high-quality health care that prevents illness, allows them
765 to see a doctor when needed, and keeps their family healthy
766 at a price they can afford. Yet high and rising health care
767 costs are eroding the economic freedom of American families
768 right before our eyes. We can't afford to retire when we

769 want, send our children to college, or even meet basic needs
770 like paying for rent or heat.
771 Almost half of all Americans forgo medical care due to
772 the cost. A third say that the cost affects their ability to
773 secure basic necessities like buying groceries. And over 40
774 percent of American adults, 100 million people, face medical
775 debt. Rising health care costs are a critical problem for
776 national and state governments, and affect the economic
777 vitality of middle class and working families by crippling
778 the ability of working people to earn a living wage.
779 As a nation we spend more than $4 trillion per year on
780 health care, yet our health is not better. Our moms and
781 babies die at higher rates, and a quarter of a million people
782 are killed by the health care system each year from medical
783 errors, infections, and the like. Every American knows that
784 we pay too much for the quality of health care that we get.
785 This crisis is driven by a misalignment between the
786 business interests of the health care sector and the health
787 and financial security of our nation's families. Our system
788 allows the health care sector to siphon money out of workers'
789 paychecks and taxpayer pockets, and into building C suites of

790 big health care corporations to increase health care prices.
791 We reward building medical monopolies and price gouging
792 instead of ensuring the health and well-being of our nation's
793 families.
794 Health care industry consolidation has eliminated
795 competition and allowed monopolistic pricing to push our
796 families to the brink of financial ruin. Nowhere is this
797 clearer than when looking at the price of hospital care,
798 which accounts for 30 percent of U.S. health care spending.
799 That is $1.4 trillion annually. Since 1990, hospital prices
800 have increased 600 percent, and just since 2015 they have
801 increased 31 percent nationally, growing four times faster
802 than workers' paychecks.
803 These prices are not only high, but they are irrational.
804 An MRI at a single hospital in Boston, Massachusetts costs
805 five times more, just depending on the insurance carrier. Or
806 take the average price of a knee replacement, which costs
807 three times more in Sacramento, California than in Tucson,
808 Arizona. These higher prices are passed on to families as
809 annual increases in insurance premiums, abusive facility
810 fees, and higher cost sharing, and become profit margins for

811 large health care corporations.

812 But it doesn't have to be this way. We know what is
813 driving the crisis and how to fix it. The Patient Act, which
814 this committee advanced in May of 2023, and the Lower Costs,
815 More Transparency Act, which this committee played a leading
816 role in drafting and which passed the House of
817 Representatives in an overwhelming bipartisan vote in
818 December of 2023, would both make crucial progress by
819 codifying and strengthening price transparency rules,
820 expanding site-neutral payments, and advancing billing
821 transparency, among other reforms.

822 Congress has enormous public support to do this. Nearly
823 90 percent of voters want Congress to act to reduce hospital
824 prices, including 95 percent of Biden voters and 85 percent
825 of Trump voters.

826 I would like to finish my remarks with the story of
827 Brittany Tesso and her son Roman from Aurora, Colorado.
828 Roman's pediatrician referred him to a hospital to receive an
829 evaluation for speech therapy. Because it was the height of
830 the COVID-19 pandemic, the Tesso's met with a panel
831 specialists via video conference. The observed Roman

832 speaking, playing, and eating. Later, Ms. Tesso received a
833 $700 bill for the 1-hour video appointment. Then she
834 received another bill for nearly $1,000. Thinking it was a
835 mistake, Ms. Tesso called the hospital. And despite the fact
836 that the Tessos never stepped foot inside the hospital, she
837 was told that the bill was a facility fee designed to cover
838 the cost of being seen in a hospital-based setting. This is
839 a national scandal.
840 We urge this committee to continue working with your
841 colleagues in the House and Senate to stand with the American
842 people and enact legislation to stop pricing abuses driven by
843 big health care corporations.
844 I thank the committee for your time and your dedication
845 to these issues, and look forward to answering any questions.
846
847
848 [The prepared statement of Ms. Tripoli follows:]
849
850 **********COMMITTEE INSERT**********
851

852 *Mr. Guthrie. Thank you for your testimony. I
853 appreciate it.
854 Dr. White, you are now recognized for five minutes.
855

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

856 STATEMENT OF CHAPIN WHITE

857

858 *Dr. White. Chairman Guthrie, Ranking Member Eshoo, and
859 members of the subcommittee, I appreciate the opportunity to
860 appear before you today.

861 In consultation with committee staff, I have focused the
862 statement on Federal subsidies for health insurance coverage,
863 the growth of those subsidies, and policy approaches that
864 could reduce health insurance subsidies and the Federal
865 deficit.

866 The Federal Government subsidizes health insurance for
867 almost all of the U.S. population through some combination of
868 Medicare, Medicaid, and various tax provisions. Those tax
869 provisions include allowing employers and employees to
870 exclude payments for health insurance premiums from income
871 and payroll taxes, and by providing premium tax credits
872 through the ACA marketplaces. The CBO projected that in
873 fiscal year 2023 those subsidies would amount to a net $1.8
874 trillion, equal to 7 percent of GDP. Federal subsidies for
875 health insurance are projected over the next 10 years to
876 total 25 trillion. That includes 11.7 trillion for Medicare,

877 6.3 trillion for Medicaid and CHIP, 5.3 trillion for
878 employment-based coverage, and 1.1 trillion for the ACA
879 marketplaces.

880 Partly because of those subsidies, Federal outlays over
881 the next three decades are projected to grow faster than
882 revenues, leading to ever-larger deficits and debt. CBO
883 projects that under current law, outlays for the major
884 Federal health programs would increase from 5.8 percent of
885 GDP in 2023 to 8.6 percent in 2053. At the same time, rising
886 premiums for employment-based coverage will reduce the share
887 of employees' compensation subject to taxes, thereby
888 decreasing Federal tax revenues.

889 Federal subsidies for Medicare and employment-based
890 coverage are projected to increase as a percentage of GDP
891 from 2023 to 2033. The size of those subsidies depends on
892 two factors: the average subsidy per enrollee and the number
893 of enrollees. In Medicare CBO projects that under current
894 law, the subsidy per enrollee will grow by five percent a
895 year and enrollment will grow by two percent a year. For
896 employment-based insurance, the average Federal subsidy is
897 projected to grow by seven percent a year, and enrollment is

898 projected only to grow by half a percent a year. So in
899 Medicare, it is largely an enrollment story; for employer-
900 sponsored insurance, it is largely a subsidy per enrollee.
901 The prices the commercial health insurers pay providers
902 tend to rise faster than the prices paid by government
903 programs such as Medicare and Medicaid, whose prices are
904 generally set administratively. CBO estimated that between
905 2013 and 2018, the prices paid by commercial insurers grew by
906 an average of 2.7 percent a year, whereas the prices paid by
907 Medicare and the fee-for-service program grew by an average
908 of 1.3 percent a year. That was partly using HCCI data.
909 Besides growing faster, the average prices that
910 commercial insurers pay for hospitals and physician services
911 have historically been higher than the prices paid by the
912 Medicare fee-for-service program. Those higher prices result
913 from several factors, primarily the market power of providers
914 and the limited sensitivity of consumers and employers to the
915 prices that insurers pay.
916 Government policies can reduce the high prices paid by
917 commercial insurers by targeting the factors that contribute
918 to those prices, although many of the underlying causes are

919 not amenable to change by Federal legislative action. In
920 CBO's assessment, a comprehensive set of policies that
921 promoted price transparency would lead to price reductions
922 between 0.1 percent and 1 percent, and a comprehensive set of
923 policies that promoted competition among providers would lead
924 to price reductions of 1 to 3 percent. Price reductions of
925 three to five percent or more would be possible under
926 policies that capped the level or growth of prices paid to
927 providers.

928 CBO expects that reductions in prices paid by commercial
929 plans for hospitals and physician services would reduce
930 premiums for employment-based plans, which in turn increases
931 employees' taxable wages and Federal revenues, and decreases
932 the deficit.

933 CBO analyzed an illustrative policy that would lower
934 prices for hospitals and physician services by 1 percent, and
935 found that in the year 2032 it would shrink the Federal
936 deficit by $4.8 billion, mainly by reducing Federal subsidies
937 for employment-based insurance.

938 I look forward to the conversation.

939 [The prepared statement of Dr. White follows:]

940

941 **********COMMITTEE INSERT**********

942

943 *Mr. Guthrie. Thank you. The gentleman has concluded
944 all the testimony, thank you for your testimony, that has
945 concluded all testimony from our witnesses, and we will now
946 move into members' questions, and we will each have five
947 minutes for questions, and I will recognize myself to start
948 the questioning for five minutes.

949 So, Dr. Ippolito, you talked about _ I got coffee
950 sitting here _ you talked about the coffee shop scenario, and
951 I use that quite a bit. So if you said Starbucks and another
952 _ you just said next door across the street _ Starbucks would
953 have to lower prices or change its _ be more efficient.
954 Well, that assumes the person walking down the street knows
955 how much the coffee is between each store. So if you don't
956 know what the price is, you just walk in, you get a cup of
957 coffee and you walk out, and a month later somebody tells you
958 how much you had to pay for it.

959 I mean, that is kind of the system that we have. That
960 is what we are trying to figure out. And if we can get into
961 that part of it, then we will know because Ms. Tripoli said
962 that some people pay five times more than others. What if
963 you are standing in a coffee shop and you get a coffee cup _

964 coffee for $10, and the guy behind you or the lady behind you
965 pays $2? You are going to look and say, "Wait a minute, you
966 just paid $2 and I just paid $10?" That is what the Lower
967 Cost Transparency Act on both sides of the aisle wants to
968 expose and let people find out and make decisions moving
969 forward, and so thank you for that example.
970 So I know that we have other things trying to control
971 costs, so _ because what I envision if we do this is that the
972 employer _ the labor groups, others who provide this
973 insurance are going to say I am not going to pay that if the
974 other person is not paying it, so it drives the cost. But
975 Congress does try to put in _ I don't know if price controls
976 is the right word, but like _ so the medical loss ratio from
977 the Affordable Care Act would be an example to try to control
978 costs. The idea is you got to pay out more than you _ you
979 can't do this to us, you got to pay out more _ I think they
980 find other ways to move their money around to get around
981 that.
982 Would you talk about the medical loss ratio and what it
983 has done to health care prices?
984 *Dr. Ippolito. Yes. I mean, the problem with the

985 medical loss ratio is there is two ways to meet it. You can
986 either lower your premiums or you can just let your costs
987 rise and not worry about them so much. And I know there is
988 at least one paper out there that suggests that, following
989 the ACA, a bunch of insurers just went ahead and let their
990 claims costs rise, and they didn't actually lower their
991 premiums very much. There is evidence to that point.
992 And to your second point that you raise, this MLR-type
993 regulation gets harder in the current world, where we have
994 more vertically integrated entities. If an insurer owns a
995 PBM and a pharmacy, they have a lot of leeway about how money
996 moves through that chain. And if you have got to meet an MLR
997 threshold, you can decide to move the money in a way that is
998 convenient for you and meet the threshold. And so suddenly,
999 it kind of becomes relatively toothless.
1000 *Mr. Guthrie. Well, if you don't own _ if you are not
1001 vertically integrated, does it incentivize you to become
1002 that?
1003 *Dr. Ippolito. Potentially _
1004 *Mr. Guthrie. So if you are a health insurance company,
1005 and you are having MLR, does they say, well, let's go buy up

1006 or downstream so we can _

1007 *Dr. Ippolito. Well, potentially. And, you know, this
1008 is sort of a second concern, which is that if you are the
1009 vertically integrated entity, you have got an incentive to
1010 really screw over the other guys. So you tell your PBM,
1011 "Charge them more than you charge me to make it harder for
1012 them to meet that threshold," right?

1013 *Mr. Guthrie. Okay.

1014 *Dr. Ippolito. And so it is _

1015 *Mr. Guthrie. Well, thanks. I want to move to Dr.
1016 White on the subsidies.

1017 I know that the idea is to get more people covered.
1018 Health insurance continues to rise, so the more you subsidize
1019 _ I go from the coffee exhibit to college tuition and so
1020 forth. And I just went through three kids going through
1021 college, and it seems like _ I know people have done studies,
1022 and they try to say that college tuition doesn't tie directly
1023 to subsidies.

1024 But I will tell you there are people who I have seen
1025 sitting there _ and I am fortunate to have some assets and
1026 didn't face this _ that are completely priced out of the

1027 college their kid wanted to go to, and sitting there going, I
1028 am not sure if my kid is going to be able to go here, I got
1029 to sit down and crunch the numbers and move forward, and it
1030 seems you are either on the subsidy side, which aren't really
1031 sufficient, or you are able to pay, or you are stuck in the
1032 middle. And it seems we have a lot of people stuck in the
1033 middle, and that is happening with health care, as well.
1034 Would you talk about the relationship between the
1035 subsidies _ do subsidies do anything to lower prices that
1036 sponsor plans pay?
1037 And what impacts do rising health care costs have on
1038 wages?
1039 And your microphone.
1040 *Dr. White. Thank you. So in terms of the subsidies as
1041 they relate to the prices that the plans pay, I think there
1042 are two markets to talk about.
1043 One is the employment-based market, where all of the
1044 premiums paid are excluded from taxable wages. And that is a
1045 sizable subsidy for employment-based insurance. And when
1046 employers are thinking about the breadth of their network,
1047 which providers to include in their network, thinking about

1048 benefit design broadly, that tax subsidy puts a pretty heavy
1049 thumb on the scale to broadening the network, including more
1050 providers. And it eases the pressure to reduce costs for
1051 employment-based plans across the board. And my
1052 understanding of the market and the evidence is that that is
1053 going to have some impact on the prices that employment-based
1054 plans pay.

1055 *Mr. Guthrie. I have about five seconds.

1056 *Dr. White. Okay.

1057 *Mr. Guthrie. And the whole purpose of this hearing is
1058 talking about the rising cost, because we can't subsidize our
1059 way out of it. We have to deal with the rising cost of the
1060 system, but we want more people to be covered and have
1061 access. So that is where we have to focus us moving forward.

1062 Thank you. My time has expired. I will yield back and
1063 recognize the gentlelady from California for five minutes.

1064 *Ms. Eshoo. Thank you, Mr. Chairman, and thank you to
1065 each one of the witnesses. I feel overwhelmed. And I think
1066 I would best describe this as trying to get socks on an
1067 octopus. I mean, this is _ there are so many layers to all
1068 of this.

1069 So I know it is not easy to simplify, but I would ask
1070 each one of you to name _ identify a cost savings that really
1071 puts a dent in the system. I mean, you have done a marvelous
1072 job of telling us all the things that are broken and, you
1073 know, the stories from consumers, all of that, hard-working
1074 law enforcement people.
1075 I mean, this is _ this affects everyone. Everyone. No
1076 one skates away from this. We are human beings, our bodies
1077 need care. Some need more, depending on their age. Some are
1078 afflicted with serious illnesses. Others really don't even
1079 get to pay down their deductible because they don't use that
1080 much in health care, and yet they are paying through the
1081 nose.
1082 So why don't we start with you on the left here?
1083 *Ms. Martin. I would say _
1084 *Ms. Eshoo. One thing, one thing.
1085 *Ms. Martin. Increasing competition, reducing
1086 consolidation.
1087 *Dr. Ippolito. In the short term, site-neutral payments
1088 or reforming Medicare Advantage.
1089 *Ms. Eshoo. What? I am sorry.

1090 *Dr. Ippolito. In the short term, either site-neutral
1091 payments in Medicare or trying to reform Medicare Advantage a
1092 little bit.
1093 *Mr. Lyons. Access to claims data so we can tell what
1094 we are paying for services.
1095 *Ms. Eshoo. And do you think that the legislation that
1096 we have passed in the House addresses that fully?
1097 *Mr. Lyons. Ranking Member, I am cautiously optimistic,
1098 but you talked about an octopus. That is how I would refer
1099 to the hospital association. They will figure a way around
1100 it.
1101 *Ms. Tripoli. I would say, without a doubt, price
1102 transparency in the short term, and enacting site-neutral
1103 payments. Real savings to people right now, and then we work
1104 towards longer-term solutions around building _ reducing
1105 competition _ reducing consolidation and improving
1106 competition in the market.
1107 *Ms. Eshoo. What do you think the site-neutral _
1108 addressing that issue, what is your estimate of reducing
1109 overall costs?
1110 *Ms. Tripoli. My understanding from estimates is there

1111 is a range, but it is about $150 billion over 10 years for a
1112 comprehensive, site-neutral package to what the Medicare
1113 Advisory Payment Commission is recommending. And then that
1114 includes about 94 billion in savings directly to Medicare
1115 beneficiaries.

1116 *Dr. White. And CBO doesn't recommend policy. We don't
1117 advocate for policy. But in the score of the Lower Costs,
1118 More Transparency Act, expanding site-neutral payments in
1119 Medicare is a saver.

1120 Increased transparency is a saver on many dimensions,
1121 and the site-neutral policy that is in Lower Costs, More
1122 Transparency is pretty narrow, but the more expansive version
1123 of site-neutral policy we expect could have some dampening of
1124 the incentives to consolidate, and that could spill over to
1125 what commercial insurers pay and negotiating leverage.

1126 *Ms. Eshoo. Dr. White, I want to thank you and CBO's
1127 Office of Health Analysis for your superb work. You and your
1128 staff have lent a really tremendous expertise to my office,
1129 and I think that you are an invaluable part of the
1130 legislative process. So all of my thanks to you.

1131 Thank you to each one of the witnesses. You know, the

1132 price tags that we have called out in our opening statements,
1133 what you all have referred to in some part of your testimony,
1134 seems so overwhelming. And yet I am struck by, piece by
1135 piece, one percent, two percent, three percent in terms of
1136 projected savings, you know, depending on what it may be.
1137 So it seems to me that there is not one blockbuster
1138 policy that is going to, you know, move us in the direction
1139 that we all want to move to. I think it is a series of them,
1140 but thank you for being here. Thank you for your testimony.
1141 I yield back, Mr. Chairman _
1142 *Mr. Guthrie. Can have your seven seconds?
1143 *Ms. Eshoo. Sure.
1144 *Mr. Guthrie. So we have to also balance as we do with
1145 this _ we do have the best hospital system in the world, so
1146 we _ it is a lot of things we have to factor in as we move
1147 forward.
1148 The gentlelady yields back, the chair recognizes the
1149 chair of the full committee, Mrs. Rodgers, for five minutes.
1150 *The Chair. Thank you, Mr. Chairman.
1151 As we work _ as we have worked on price transparency in
1152 healthcare, I have said that it is foundational to restoring

1153 the doctor-patient relationship in decision-making in our
1154 health care system. It also is foundational to addressing
1155 what the actual costs are for us to know what the actual
1156 prices are, the cost, and then to be able to take action.
1157 And as representatives, you know, 70 percent of the
1158 Federal Government spending now is health care. So if you
1159 think about double-digit increases in health care spending in
1160 the Federal Government and what is driving deficits and debt,
1161 I mean, answering this question, and for us to better
1162 understand what the actual prices are in the cost is _ it is
1163 really _ it is just foundational across the board.
1164 I personally know of someone in my district who has
1165 spoken to me. She is actively putting off a needed health
1166 care _ needed eye health care, because she cannot get anyone
1167 to give her an up-front cost estimate.
1168 Price transparency needs to be the standard throughout
1169 the health care system. This is the way that we are going to
1170 restore doctor-patient relationship and address what is
1171 driving cost.
1172 Ranking Member Pallone and I recently applauded the
1173 Centers for Medicare and Medicaid Services' announcement to

1174 finally implement prescription drug price transparency, which
1175 our bill would improve and make the law of the land.
1176 So Dr. Ippolito _ or Ippolito, Ippolito, sorry about
1177 that _ do you believe that prescription drug price
1178 transparency will help lower drug prices?
1179 *Dr. Ippolito. In general, yes. And in particular with
1180 respect to what is included in the bill that we are talking
1181 about, I tend to agree with CBO's assessment. I should point
1182 there, but I tend to agree with their assessment that if you
1183 give employers, in particular, more information about how
1184 they are spending their money, how their formularies are
1185 made, then they are going to make better decisions on
1186 average.
1187 So yes is the short answer.
1188 *The Chair. Thank you.
1189 Ms. Tripoli, in our Lower Costs, More Transparency Act
1190 we took modest but critical steps towards site-neutral
1191 payments by implementing them for drug administration
1192 services. So in other words, Medicare and patients will pay
1193 the same prices, regardless of whether or not a hospital owns
1194 the outpatient office where the drug is provided to the

1195 patient.

1196 The hospital community has argued vigorously against
1197 site-neutral payments, while there seems to be significant
1198 bipartisan agreement among some experts that site-neutral
1199 reforms are the right thing to do to lower seniors' costs and
1200 address potential incentives for consolidation.

1201 Would you talk about the importance of site-neutral
1202 payments to patients?

1203 *Ms. Tripoli. Absolutely. I think site-neutral
1204 payments essentially address this broken economic incentive
1205 in Medicare reimbursement which reimburses for the same
1206 service at a higher cost in a higher cost care setting than
1207 it does in a physician's office. That incentive not only
1208 creates a financial incentive for big hospital systems to
1209 come in and buy up small and independent physicians offices,
1210 rebrand them as an outpatient department so they can generate
1211 a higher reimbursement, but it also pushes patients into
1212 higher cost care settings. Both of those factors together
1213 have an effect of increasing costs, increasing prices in the
1214 health care system.

1215 So addressing this Medicare payment differential, the

1216 site of service differential, is a _ through site-neutral
1217 payments _ is critical to not only reducing the incentives
1218 for hospitals to buy up local doctors, but also helps keep
1219 patients in a lower cost care setting where the quality of
1220 care is the same or better.
1221 *The Chair. Thank you.
1222 Dr. Ippolito, your testimony discussed some of the
1223 arguments around site-neutral payments, and you noted the
1224 drug administration policy in the Lower Costs, More
1225 Transparency Act is important, but narrow.
1226 And I just would like to make clear that the site-
1227 neutral conversation is not an exercise in cutting hospitals.
1228 It is really about how to more efficiently structure Medicare
1229 so that patients and taxpayers are not overpaying for the
1230 same services to subsidize loss leaders.
1231 So would you talk a little bit more about comprehensive
1232 site-neutral policies, how they could be structured to
1233 preserve our very important hospital safety net while fixing
1234 the very real problem we have identified?
1235 *Dr. Ippolito. Yes, and one of the important things to
1236 remember is that if you fix site-neutral payments you have

1237 this big spillover into markets outside of Medicare. It
1238 reduces the incentive for hospitals to buy up all these
1239 independent physicians, which increases costs for everybody
1240 on commercial insurance. So if you address site-neutral
1241 payments, you have this big spillover effect.

1242 If you do a more comprehensive policy and have more
1243 meaningful concerns about the viability of certain hospitals,
1244 it would be far better to go ahead and do site-neutral
1245 payments and come up with a policy that directly addresses
1246 those hospitals you are concerned about, not keep the current
1247 policy that overpays everybody for these services in an
1248 attempt to help this subset. Try and directly address them,
1249 either subsidize them directly or limit the losses from the
1250 policy for those specific hospitals.

1251 *The Chair. Thank you. Thank you all for being here.

1252 My time has expired, I yield back, Mr. Chairman.

1253 *Mr. Guthrie. The gentlelady yields back. The chair
1254 now recognizes the ranking member of the full committee, Mr.
1255 Pallone, for five minutes for questions.

1256 *Mr. Pallone. Thank you, Mr. Chairman. I heard you say
1257 that we have the best hospitals in the world, but it is not

1258 necessarily meaningful without access, and too many families
1259 have to delay or forgo necessary care due to cost.
1260 And our health care system is complex, and often
1261 patients cannot see in advance the prices they have to pay,
1262 and have to wait until after they receive medical care and
1263 have the bill to fully understand how much they owe. And to
1264 me, that is unacceptable. So let me start with Mr. Lyons.
1265 In your testimony you discuss the need for greater
1266 transparency. Can you briefly discuss the difficulties you
1267 faced in navigating our health system?
1268 *Mr. Lyons. Thank you, and good to see you from the
1269 Jersey shore, too.
1270 *Mr. Pallone. Oh, you, too. Thank you.
1271 He is a New Jersey guy, just so you know.
1272 [Laughter.]
1273 *Mr. Lyons. Within my role at a state health benefits
1274 plan, one of our biggest problems is not only getting the
1275 hospital prices, but being able to match it to the claims
1276 data, right? So we need to be able to see both ends of the
1277 equation, because if you just get one you don't know the
1278 other one to make sure everything is lining up. And we do

1279 have instances where we see things are paid over the
1280 contracted rate to the hospitals.
1281 So I think when we get blocked to get information _ and
1282 I have data requests out from probably three years ago that I
1283 still haven't gotten, I still haven't received the data,
1284 claims data, that we wanted _ because the hospitals and the
1285 insurers come together and say, "That is proprietary, we
1286 can't tell you what we are paying."
1287 Well, I am a special state officer when I sit on that
1288 committee. I should have full access to that so I can make
1289 the right decisions. Just like you do for the people of the
1290 country, I need to do it for the people in my plan. So,
1291 essentially, just open access to claims data for the payors.
1292 You know, I am not saying it has to be _ you know, the
1293 insurers' numbers have to be posted on the Internet, but _
1294 and then what the contracted rate is so we can match that up
1295 and make sure _ you know, Ronald Reagan said it, "Trust, but
1296 verify," right? So that is what we should be able to do.
1297 *Mr. Pallone. And then my second question, if you would
1298 just describe specifically how strengthening transparency can
1299 help lower health care costs for patients. I mean, you sort

1300 of got into that, but _

1301 *Mr. Lyons. Yes _

1302 *Mr. Pallone. _ if you want to, elaborate.

1303 *Mr. Lyons. For us, we are looking at a Centers of

1304 Excellence model right now, right? So there is two sides to

1305 that in my eyes. One is quality and one is cost. So if we

1306 can pair them up, and know what we are paying _ I just talked

1307 to a reporter who said he looked at a hospital's website in

1308 New Jersey. They posted their prices, 300,000 lines of data.

1309 Who is supposed to dig that out? You know, we are still lay

1310 people at the end of the day.

1311 So I think, you know, what you are doing here really

1312 helps us take those first steps. And I think when people see

1313 the prices and the price differentials, it is going to shock

1314 the conscience, and people _ and that will start the tide

1315 rolling the right way.

1316 *Mr. Pallone. And I appreciate all your efforts. I

1317 mean, you know, the hospitals just continue to make it

1318 difficult for consumers to access price information. And,

1319 you know, there is low hospital compliance with the

1320 reporting. But let me go to Ms. Martin.

1321 Can you briefly discuss how employers are currently
1322 using the transparency data to achieve savings, and how
1323 increased transparency can help employers?
1324 *Ms. Martin. I think employers are having a hard time
1325 using the currently available transparency data. To the
1326 point that he just made, it is a lot of information, it is
1327 difficult to parse, it is varying levels. But I think the
1328 opportunity is there so that, with additional data, they can
1329 create strategic networks, strategic negotiations. They
1330 would be empowered to negotiate for health services the way
1331 they do for other input costs.
1332 *Mr. Pallone. All right. Well, thank you.
1333 And you know, I am obviously proud of the committee
1334 having passed the Lower Costs, More Transparency Act because
1335 I think it will deliver lower health care costs for the
1336 American people and bring a lot more transparency to our
1337 complex health care system. So I want to thank all of you.
1338 I have to _ Mr. Chairman, I have _ I was laughing
1339 because when you asked Dr. Ippolito how to pronounce his name
1340 and he told you, you know, we have another hearing going on
1341 about sports upstairs.

1342 And I have no problem pronouncing your name because when
1343 I was in high school Coach Ippolito was the coach of our
1344 champion high school football team. So I am very fond of the
1345 name.

1346 [Laughter.]

1347 *Mr. Pallone. Thank you, Mr. Chairman.

1348 *Mr. Guthrie. He wasn't a tough football coach?

1349 *Mr. Pallone. No.

1350 *Mr. Guthrie. We all loved our coaches, but, boy,
1351 sometimes we didn't.

1352 So thank you very much. So the gentleman yields back.
1353 The chair will now recognize Dr. Burgess for five minutes for
1354 questions.

1355 *Mr. Burgess. Thank you, Mr. Chairman, and thank you
1356 for holding this hearing. It is critically important.

1357 Once again, I will bemoan the fact that we don't have a
1358 physician on the panel. One of these days I am going to walk
1359 into one of these hearings, we are going to have six doctors
1360 tell us how much economists should be paid. But that is a
1361 fantasy that I will save for another day.

1362 I do want to answer quickly Mrs. Eshoo's question about

1363 an answer, and I have brought it up to this committee before.
1364 We have a bill that is ready to be marked up that involves
1365 physician ownership of hospitals, particularly in rural and
1366 underserved areas. There is an answer to consolidation; it
1367 is competition. Physician-owned hospitals would provide
1368 that. There is no reason to allow the PBMs and the private
1369 equity and real estate investment trusts to control all of
1370 the money in health care. We could leave some of it for the
1371 doctors and the patients.
1372 We have heard it several times today. Whenever you talk
1373 _ whether you are talking about the GDP or the percentage of
1374 the Federal budget, it is a big number. And it is clear that
1375 we, as policy-makers, need to do something now to curb those
1376 costs.
1377 Across the campus in the Cannon Building, in the Budget
1378 Committee that I also serve on, the Budget Committee has
1379 created a health care task force to serve as an incubator for
1380 ideas, for some of these ideas to lower costs, working to
1381 examine the causes of excessive spending and propose
1382 solutions without sacrificing patient outcomes. And we have
1383 already seen, really, an overwhelming response to our request

1384 for proposals with 180 submissions to that task force,
1385 demonstrating the pent-up demand that exists.
1386 And on that task force we had a roundtable bringing
1387 relevant stakeholders to the table with the Congressional
1388 Budget Office to discuss the Congressional Budget Office's
1389 scoring of mandatory drug pricing in the Inflation Reduction
1390 Act. There was some discrepancy between the number of new
1391 drugs that CBO said would be produced, and people who lived
1392 in the investment world and the research world had different
1393 ideas to try to bring those together.
1394 And to tell you the truth, it was successful because the
1395 CBO now has opened a portal on their website for stakeholders
1396 to submit research and data they have regarding the cost of
1397 the reality of drug innovation. So it just goes to show that
1398 it is possible to have more than a conversation about these
1399 difficult issues; you can, in fact, affect the way policy is
1400 done.
1401 I do have a letter that I want to introduce to the
1402 record responding to the CBO's call for new research in the
1403 area of drug development.
1404 *Mr. Guthrie. Thank you. We will take care of that at

1405 the end of the hearing, and we will make sure that is
1406 distributed.
1407 *Mr. Burgess. And this response letter is signed by
1408 more than 350 biotech investors and innovators representing
1409 $309 billion in assets under management.
1410 Mr. Lyons, I feel your pain. As a senior Member of
1411 Congress I cannot get claims data from the Centers for
1412 Medicare and Medicaid Services, which is, after all, a
1413 governmental body. And you would think Congress, which
1414 created CMS, could get the claims data. But we can't. And
1415 that has been a frustration of mine, literally, for over a
1416 decade.
1417 The other thing I have to bring up, I was on a very,
1418 very difficult telephone call last night, a Zoom call late
1419 last night with physicians all over the country. And I will
1420 tell you, our physicians are discouraged. They are looking
1421 for the exit ramps from the practice of medicine. We have
1422 caused this in Congress because of _ we have made it more
1423 attractive for the private equity buyouts of hospitals and
1424 doctor practices. We have made that more attractive than
1425 actually paying physicians.

1426 This January, physicians got an almost four percent pay
1427 cut. That is in the face of an eight, nine percent inflation
1428 rate last year. So what I am hearing, and I am sure many on
1429 this committee are hearing, is that doctors just simply
1430 cannot sustain that. The cost of their employees _ none of
1431 their help comes to them and says, you know what? I realize
1432 you took a pay cut, I will take a pay cut, too. The world
1433 doesn't work like that. So the doctors do need relief.
1434 I have got a political article I am going to introduce
1435 that has an unfortunate title: "Doctors Just Want a Pay
1436 Raise,'' but really, the understanding that the issue of
1437 provider reimbursement is important _ if we are going _ you
1438 know, it is one thing to talk about the cost of and the
1439 quality of care we have available, but if we have got no one
1440 to deliver the care, it is still going to be unattainable for
1441 the patient. So we on this committee do need to pay
1442 attention to that.
1443 And again, I am going to ask that the Politico article
1444 also _ I submit that, I would ask unanimous consent that that
1445 be part of the record.
1446 I apologize, I used all my time to pontificate. I have

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1447 a number of questions I am going to be sending to each of you

1448 that I will ask to _ for those responses to be on the record.

1449 [The information follows:]

1450

1451 **********COMMITTEE INSERT**********

1452

1453 *Mr. Burgess. Thank you, Mr. Chairman, I will yield
1454 back.
1455 *Mr. Guthrie. Thank you. Dr. Burgess yields back.
1456 Without objection, we will add this to the documents
1457 list that we will act on at the end of the committee, if they
1458 are not already submitted. So if anybody wants to review
1459 those, please let us know before the end.
1460 [The information follows:]
1461
1462 **********COMMITTEE INSERT**********
1463

1464 *Mr. Guthrie. The chair now recognizes Mr. Cardenas for
1465 five minutes for questions.
1466 *Mr. Cardenas. Thank you, Chairman Guthrie, and also
1467 Ranking Member Eshoo, for holding this very important
1468 hearing, and I want to thank the witnesses for being here to
1469 give us your expert testimony and opinions today. It is very
1470 important that the public know what we are deliberating, and
1471 why we are deliberating it, and hopefully we can do it based
1472 on fact and not on other issues.
1473 And I also want to say I agree with the Dr. Burgess,
1474 Congressman Burgess, about physician-owned hospitals. We
1475 need to visit that. We shouldn't be assuming that physician-
1476 owned hospitals cannot follow the rules. In this country we
1477 allow lawyers to own their own law firms, so it is
1478 unbelievable to me that we will trust lawyers more than
1479 doctors to do the right thing.
1480 This committee has done a good amount of work on
1481 improving transparency in the health ecosystem and lowering
1482 costs for patients. I am proud of that work, and I am glad
1483 that we are getting a chance to continue this conversation
1484 today.

1485 For too long we, as Americans, have gotten completely
1486 unacceptable return on our investment when it comes to our
1487 health care. Hard-working Americans are scraping by, often
1488 delaying or forgoing care because they know they will be
1489 forced to pay untenable prices for their health care
1490 services.
1491 And what do we get back in the end? Dismal health
1492 outcomes and widening health disparities. One study found
1493 that the U.S. has the lowest expectancy at birth, the highest
1494 avoidable death rates, and the highest rates of maternal and
1495 infant mortality compared to other high-income countries
1496 around the world. All of this despite health expenditures
1497 being two to three times higher here in the United States.
1498 I urge my colleagues to think about what this means for
1499 the people in every single one of our districts. Let's say
1500 you are a single parent in Sylmar in my district. You have
1501 no idea how much your care is going to cost, and you are
1502 already struggling to make ends meet. Do you risk it and go
1503 to the doctor, not knowing how much it will cost you, or do
1504 you hope your issue resolves itself?
1505 This is why transparency is so critical: it gives

1506 people the power to choose where, when, and how they seek
1507 their care. This is particularly critical for people seeking
1508 preventative care before a medical issue becomes unavoidable
1509 or untenable, when it will still be less expensive to
1510 address.
1511 But transparency is also only as good as the choices
1512 people have. Transparency is a great start, but I want to
1513 focus my questions on what comes next and ensuring choices
1514 and care settings. Ms. Tripoli, what steps can be taken to
1515 improve patient choice past initial _ the initial step of
1516 improving transparency?
1517 *Ms. Tripoli. Well, I think part of the focus,
1518 obviously, of this hearing is talking about how we can
1519 empower consumers and patients, employers, workers with more
1520 information to make more informed decisions. Price
1521 transparency not only for hospitals and for plans, but across
1522 the entire health care system, transparency of information,
1523 is going to be critical to unveil the curtain of what is
1524 happening underneath the system that is driving unaffordable
1525 care and low quality care, frankly.
1526 So I think price transparency, for sure, for hospitals

1527 and plans. Also, many of these provisions, obviously, in the
1528 Lower Costs, More Transparency Act. Enacting site-neutral
1529 payments, which gets underneath the hood of the health care
1530 system, takes on this broken financial incentive. That
1531 allows consumers to have _ whether you are in Medicare or you
1532 are in the private market _ to have more affordable care
1533 options. Those are probably two of the most important
1534 provisions that this committee has been _ has advanced
1535 through this legislation.

1536 *Mr. Cardenas. How can we ensure we build out care
1537 options in medically underserved communities, where there is
1538 less financial incentive to provide services in that
1539 community?

1540 *Ms. Tripoli. I think it is a balance. We have to make
1541 sure that the community-based providers that are in these
1542 communities are financially sustainable. We have to make
1543 sure that the markets function for them. We have to make
1544 sure that care is affordable and that the people that they
1545 are designed to serve have options, have choice. And that is
1546 _ there are a whole variety of policy solutions that we need
1547 to address to make sure that people in communities have

1548 access to what they need.

1549 *Mr. Cardenas. And how do the "broken financial
1550 incentives" you mentioned in your testimony
1551 disproportionately fall on the backs of poor communities and
1552 communities of color?

1553 *Ms. Tripoli. I think consolidation in the health care
1554 system affects every single community across the country.
1555 And the way that the _ you know, the involvement of private
1556 equity in mergers and acquisitions and the impact that has on
1557 reducing wages, on reducing access, even closing the doors of
1558 certain hospitals has a direct impact on some of the
1559 communities who are most hard hit, who need services the
1560 most.

1561 So we have to have a holistic approach when we are
1562 thinking about making sure we have access for all.

1563 *Mr. Cardenas. Thank you. I look forward to continuing
1564 the effort of trying to improve access to quality, affordable
1565 health care for all Americans through the work that we do in
1566 this committee.

1567 Thank you, Mr. Chairman, I yield back.

1568 *Mr. Guthrie. Thank you. The gentleman yields back,

1569 and the chair recognizes Mr. Griffith for five minutes for
1570 questions.
1571 *Mr. Griffith. Thank you very much, Mr. Chairman. Let
1572 me join Dr. Burgess and Dr. Cardenas as a lawyer who believes
1573 that physician-owned hospitals is probably not a bad idea and
1574 probably a good idea, particularly since in my hometown we
1575 have the LewisGale hospital, now owned by a larger
1576 corporation, but started out many, many years ago by Dr.
1577 Lewis and Dr. Gale, and then revived in my childhood by
1578 doctors that I knew. They were physician-owned hospitals,
1579 and there is a lot of communities in my area that wouldn't
1580 have had _ would not have a hospital today if it hadn't been
1581 for physicians a long time ago. And for many years I owned
1582 my own law practice, and I drove down the cost of various
1583 items, particularly wills and representation in small traffic
1584 cases because I liked helping people, and I think doctors can
1585 do the same kind of stuff.
1586 That being said, let me get you all to put on your
1587 common-sense hats. Take off your professional hats for just
1588 a second, and I am going to start with Ms. Martin, and we are
1589 going to go down in a yes-or-no. Am I correct that it is

1590 probably cheaper to treat a person with cancer if we catch it
1591 in stage 1 or 2 versus stage 3 or 4? Yes or no?
1592 *Ms. Martin. Yes.
1593 *Mr. Griffith. Dr. Ippolito?
1594 *Dr. Ippolito. Potentially, yes.
1595 *Mr. Lyons. Yes _
1596 *Mr. Griffith. Mr. Lyons.
1597 *Ms. Tripoli. Yes.
1598 *Mr. Griffith. Dr. White?
1599 *Dr. White. It depends.
1600 *Mr. Griffith. It depends.
1601 *Dr. White. That is a CBO answer.
1602 *Mr. Griffith. Well, I know, but this is where I was
1603 going, and I didn't want to just pick on you.
1604 *Dr. White. Go for it.
1605 *Mr. Griffith. But I have a problem with the way CBO
1606 scores things. And we have a bill in front of the House
1607 right now. It is in process, H.R. 2407, which was an idea
1608 that Mr. Hudson came up with, and Mr. Arrington and Ms.
1609 Sewell are carrying. It is a bipartisan bill, and it says we
1610 are going to say you are going to pay for the multi-cancer

1611 test that you can get, and it is about $1,000 now. But we
1612 can pick up early stage cancers in 50 different types of
1613 cancers. Now, it doesn't tell you, you know, you have got
1614 cancer A or cancer B, but this test will tell you you have
1615 some kind of cancer, and we can narrow it down for you, but
1616 you better go see somebody to check it out. And to me, this
1617 makes _ this would save us money.
1618 Now, I know it is not the formulas that you all use, Dr.
1619 White, but can't you see there is some advantage?
1620 And what do we need to do, as Congress, to give you the
1621 formula that would allow you to see that there is actually a
1622 cost savings?
1623 Taking the test is going to cost money. But in the long
1624 term, if 10 percent of the people that we paid to have a test
1625 done this year found they had a stage 1 cancer, it is going
1626 to save us every bit of that money in the long term. So, A,
1627 do you agree with me? B, is there some way we can change the
1628 formulas that you all use, or give you the authority to look
1629 at where the cost savings would be?
1630 *Dr. White. Sure, and I appreciate the question.
1631 So first let me say CBO, in late 2020, put out a report

1632 on how we score prevention, and the multi-cancer early
1633 detection is a nice example of the types of prevention
1634 policies that we have written up and analyzed. And one of
1635 the key landmark studies that we cite in that comes from a
1636 group at Tufts that has looked at, literally, hundreds of
1637 studies on prevention _
1638 *Mr. Griffith. So you see some advantages _ because my
1639 time is running out, you see some advantages with that kind
1640 of a preventive tool, and you are willing to work with us to
1641 figure out how we can make that most effective for the people
1642 of the United States, because that will lower costs.
1643 *Dr. White. We are very open to _
1644 *Mr. Griffith. Okay.
1645 *Dr. White. _ hearing from _
1646 *Mr. Griffith. Next question. Not prevention, but just
1647 using practical CBO scoring, I have always had this issue
1648 with ambulance rides.
1649 So I am a big proponent of telemedicine. And while
1650 telemedicine won't solve everything, I represent a very rural
1651 district, and if we have somebody who has to go see the
1652 doctor that could be done by telemedicine, you might have a

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1653 40-mile _ that translates, by the way, because the roads are
1654 windy and mountainous _ that translates into an hour to an
1655 hour-and-a-half ambulance ride to go see the doctor when you
1656 could do it by telemedicine, help me figure out that formula
1657 so that you all can give credit when we know that we are
1658 going to reduce the number of ambulance trips that would
1659 allow us to do telemedicine _ in certain cases, it is not
1660 going to be appropriate in all cases. That too would lower
1661 costs if we were able to calculate that, would it not? Yes
1662 or no?
1663 *Dr. White. We have a team working on telehealth
1664 looking _ and what you are saying about ambulance rides being
1665 avoided, that is the kind of thing that we are looking at.
1666 We are building our own evidence base, and happy to hear any
1667 _
1668 *Mr. Griffith. No, I appreciate that, because _
1669 *Dr. White. _ any evidence you have.
1670 *Mr. Griffith. You know, you can't just look at the
1671 flat land sections of the country and come up with a model,
1672 because it is not going to save as much money in a big city.
1673 It is not going to save as much money in the flatlands. But

1674 when I have _ a mayor of one of my towns has told me that he
1675 will drive to Abingdon instead of going to the town closest
1676 to him for medical stuff, because it is an hour over the
1677 mountain to get to the next _ now, on a map, it looks like it
1678 is, you know, just this far, and Abingdon looks like it is
1679 this far, a lot further. But there is a good road, and it is
1680 flat, or it is less flat _ or less mountains. So he goes the
1681 other direction.

1682 When I have had that happen, and I know that that makes
1683 a difference, those ambulance rides are doing the same thing,
1684 and they are costing us a bunch of money.

1685 *Mr. Guthrie. Thanks, Mr. _

1686 *Mr. Griffith. I appreciate it, I yield back.

1687 *Mr. Guthrie. All right. Thanks, thank you for
1688 yielding. The gentleman yields back. The chair recognizes
1689 Mr. _ Dr. Ruiz from California for five minutes for
1690 questions.

1691 *Mr. Ruiz. Thank you, Mr. Chairman. We need a health
1692 care system that allows everyone to get the care they need
1693 when they need it, regardless of where they live or how much
1694 money they make. That is why I am in Congress, to enact real

1695 change to protect patients and better their access to
1696 affordable care.
1697 As an emergency medicine physician, I have treated
1698 patients who made the difficult decision to delay seeking
1699 medical care because they couldn't afford it until their
1700 condition worsened and came into the emergency department.
1701 Well, we have made progress in recent years in improving
1702 our nation's health care system. There is much work to do to
1703 remove barriers to high quality care. And as this hearing
1704 today underscores, one of the biggest barriers is cost.
1705 Research has shown that consolidation in the health care
1706 system leads to higher costs of care and affects physicians
1707 who want to remain independent. Not only that, but
1708 consolidation has also been shown to lead to worse health
1709 outcomes for patients.
1710 Local independent practices are sometimes a patient's
1711 closest health care option in rural or underserved areas.
1712 Ms. Tripoli, in your written statement you referenced the
1713 fact that the percentage of physician practices that were
1714 hospital-owned rose from 15 percent to 53 percent from 2013
1715 to 2021, and nearly 23,000 physicians left independent

1716 practice to work for a hospital or other corporate entity
1717 after the COVID-19 pandemic. That decrease in competition
1718 drives up health care costs. In your opinion, what factors
1719 are leading more and more physicians to leave their
1720 independent practices?

1721 *Ms. Tripoli. There are probably several, but the two I
1722 will focus on is _ the first is that we vastly significantly
1723 undervalue and, therefore, underpay primary care and
1724 behavioral health providers, which disproportionately make up
1725 a lot of independent physician practices. And the result is
1726 that they are financially vulnerable.

1727 And the second is we have these incredibly broken
1728 financial incentives, where we _ site of service payment
1729 differentials that actually have this incentive for big
1730 systems, hospitals to come in and buy up physician practices,
1731 the independent physician practices, rebrand those practices
1732 as outpatient departments so that the hospital system can
1733 generate a higher reimbursement.

1734 And those two factors _ that has particularly been
1735 accelerated from the COVID-19 pandemic, where the financial
1736 vulnerabilities of these independent practices were hit very

1737 hard. Primary care nearly collapsed. And so I think a
1738 policy like site-neutral payments helps to address some of
1739 those problems at the root.
1740 From site-neutral payments, you can actually take some
1741 of that savings and reinvest it to increase investments in
1742 the very physicians _ primary care, behavioral health _ that
1743 we need on the front lines of the health care system.
1744 *Mr. Ruiz. Thank you. For years, physicians have been
1745 experiencing cuts to their Medicare reimbursements, even
1746 while other Medicare providers have experienced increases for
1747 inflation. From 2001 to 2023, inflation-adjusted payments
1748 for physicians declined by 26 percent, even amid the rising
1749 costs of running a medical practice. On top of that,
1750 physicians are facing a 3.37 percent cut this year unless
1751 Congress takes action.
1752 We can't afford for more independent practices to close
1753 their doors or to take fewer Medicare patients because they
1754 can't afford to treat them. When physicians leave to join
1755 large hospital systems, this can create barriers to care for
1756 our most vulnerable patients, especially in rural areas that
1757 often bear the brunt of health care workforce shortages.

1758 A major way Congress can address rising healthcare costs
1759 stemming from consolidation across the health care system is
1760 updating the Medicare physician fee schedule. Ensuring
1761 appropriate Medicare reimbursements would reduce the strain
1762 and burnout on independent practices, and help reduce the
1763 trend of consolidation. My bill with Congressman Bucshon,
1764 the Strengthening Medicare for Patients and Providers Act,
1765 would do just that.

1766 And we should also be investing in residency programs
1767 like Teaching Health Center Graduate Medical Education to
1768 develop a health care workforce that stays in the area where
1769 they are needed the most. Often times, if a patient is out
1770 of network, insurance companies underpay what the cost of
1771 that care was for that patient. When you have small
1772 practices that can't negotiate at the negotiating table with
1773 large, multi-state national insurance companies, then they
1774 are vulnerable to a take-it-or-leave-it type of negotiating
1775 practices because if they don't take it, it doesn't really
1776 matter for the insurance companies.

1777 So I think that our no surprise billing law that we
1778 passed, which had the independent arbitrator _ baseball star

1779 arbitration from my bill, helped to avoid patients getting
1780 surprise billing, but we still have work to do to help
1781 providers be at an equal negotiating level with insurance
1782 companies so that they can get a fair reimbursement for out-
1783 of-network costs.
1784 What other ideas do you have that could help us improve
1785 patient care and access to care, as we have discussed?
1786 Yes.
1787 *Ms. Tripoli. I completely agree. Protection and
1788 ongoing implementation of the No Surprises Act is critical.
1789 I think, in terms of lowering costs, making sure that we
1790 are not only addressing high hospital prices and many of the
1791 solutions that this committee has advanced in Lower Costs,
1792 More Transparency Act around price transparency, site-neutral
1793 payments, transparency across the health care system around
1794 PE ownership.
1795 And also, continued implementation of the Inflation
1796 Reduction Act. We know that drug prices continue to go up.
1797 That has been a hugely important piece of legislation now
1798 being implemented. And as those _ as Medicare begins
1799 negotiating those drugs, we are going to see drug prices come

1800 down, and that will be _ result in direct affordability for
1801 the American people.
1802 *Mr. Ruiz. Thank you.
1803 *Mr. Guthrie. Thank you. The gentleman yields back.
1804 The chair now recognizes Mr. Bilirakis from Florida for five
1805 minutes for questions.
1806 *Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate
1807 it.
1808 Dr. White, a recent report has discussed higher
1809 incidence of cancer among younger Americans, unfortunately.
1810 To the extent this represents better and earlier detection,
1811 this is a good thing, but I fear that is not necessarily the
1812 case. This shines an important light on the need for better,
1813 earlier, and more efficient detection of cancers and other
1814 deadly diseases.
1815 How can we incentivize better use of preventive services
1816 that ultimately lead to save money in the long run, whether
1817 that _ and I know that my good friend over here, Morgan,
1818 discussed this with you _ whether that be through new
1819 screening technologies or finding ways to prevent
1820 hospitalization? If you could elaborate on that, I would

1821 appreciate it.

1822 *Dr. White. Sure, thank you. So in terms of screening,
1823 and whether it is cost saving or cost increasing, part of it
1824 depends on the cost of the test itself. And if you have to
1825 screen 100 people to detect anything, that is going to tend
1826 to be cost increasing. The cost per test matters a lot.

1827 The other question is, is this going to lead to people
1828 being treated earlier in a lower cost way, or is it going to
1829 lead to a larger pool of people treated when the condition
1830 wouldn't necessarily have advanced, and they might _
1831 especially in the Medicare population, there are a lot of
1832 competing risks. Treating someone early may end up treating
1833 a condition that wouldn't have become clinically symptomatic,
1834 and that may just add to add to treatment costs.

1835 So the cost of the test, how sensitive it is, how
1836 specific it is, and the characteristics of the disease
1837 progression all matter. And I feel bad saying it depends,
1838 but depending on the test and the clinical condition it
1839 really changes the calculation of whether it is cost
1840 increasing or reducing.

1841 *Mr. Bilirakis. Okay, thank you. Again, my friend, Mr.

1842 Morgan, told us that, you know, the one test screening test
1843 costs $1,000. That makes a lot of sense to me for early
1844 detection, so _ and it saves money in the long run. Of
1845 course, it increases the person's quality of care, as well.
1846 Ms. Martin and Mr. Lyons, beyond premiums, both insurers
1847 and employers should have mutual financial incentives to keep
1848 employees healthy, and particularly on the front end through
1849 prevention and screenings. What ways are there collaboration
1850 between these two in a cost effective manner?
1851 And then, Dr. Ippolito, if we can follow up with this:
1852 How does price transparency help them meet this goal?
1853 So let's hear from Ms. Martin first, and then Mr. Lyons,
1854 then Dr. Ippolito.
1855 *Ms. Martin. Unfortunately, I am not familiar with ways
1856 that employers and employees and insurers _ I am sorry,
1857 employers and insurance companies are teaming up. That is
1858 beyond the scope of what we look at at HCCI.
1859 *Mr. Bilirakis. Okay. Mr. Lyons?
1860 *Mr. Lyons. Yes, thank you for that question. In New
1861 Jersey, what we did, we took an aggressive stance on primary
1862 care, and we have opened up several primary care centers, so

1863 _ to make sure people have constant access. Because if you
1864 know right now, primary care is dwindling in the marketplace
1865 because of the reimbursements and doctors fleeing the
1866 profession.
1867 But what we did, we started a series of _ first it was
1868 just for the general population of the state health benefits
1869 plan. And then what we did _ and that price is very
1870 transparent, you know, it is separately contracted _ we
1871 started a first responders primary care health center, which
1872 I was _ I actually moved the resolution to get that done in
1873 New Jersey, and I am very proud of that. So that is _ we
1874 think that is the first way to get it moving.
1875 And then price transparency, in general, is going to
1876 allow people to make decisions. And I think transparency
1877 ultimately drives down price, right, because, you know, like
1878 I said, it will shock the conscience. The best disinfectant
1879 is sunlight, right?
1880 So thank you.
1881 *Mr. Bilirakis. That makes sense, and I know that Dr.
1882 Bucshon will probably elaborate on that, too, because he has
1883 several stories.

1884 Again, Dr. Ippolito, how does price transparency help
1885 them meet this goal?
1886 *Dr. Ippolito. Well, I think we can think of employers
1887 as being one of the few entities in health care markets that
1888 perhaps have a medium-to-long-run view. They care about
1889 their employees over the long term. And so greater
1890 information, particularly along the lines of what is the more
1891 _ all we are talking about, the bill we are talking about,
1892 will help them choose benefits that match their employees
1893 better. It helps them investigate where they are spending
1894 too much money relative to what they want, and so it is a
1895 clear first step.
1896 *Mr. Bilirakis. All right, very good.
1897 Thank you. I yield back, Mr. Chairman.
1898 *Mr. Guthrie. The gentleman yields back.
1899 *Mr. Bilirakis. I appreciate it.
1900 *Mr. Guthrie. The chair recognizes the gentlelady from
1901 Michigan, Mrs. Dingell, for five minutes for questions.
1902 *Mrs. Dingell. Thank you, Mr. Chairman, and thank you
1903 to all the witnesses in attendance today.
1904 Health care spending, both per person and as a share of

1905 GDP, remains higher in the United States than any other
1906 wealthy country. And despite this high spending, the United
1907 States has some of the worst health care outcomes in the
1908 world, which is appalling. It is critical we make
1909 substantive reforms to our health care system that not only
1910 reduce health care expenditures and lower costs for patients,
1911 but improve the quality of care patients receive.
1912 The House recently passed the Lower Costs, More
1913 Transparency Act, which contains many provisions led by
1914 members of this subcommittee that tackle some of the drivers
1915 of rising health care costs. This package takes steps to
1916 address predatory Pharmacy Benefit Manager practices,
1917 something that drives me nuts; strengthening price
1918 transparency; lower out-of-pocket costs for seniors; and
1919 empower patients by ensuring they can access important
1920 information about the cost of their care.
1921 I was proud the Providers and Payers COMPETE Act,
1922 legislation I led alongside Representatives Burgess,
1923 Bilirakis, and Ferguson, was included as part of this
1924 package. The legislation requires the Department of Health
1925 and Human Services to report the impact of Medicare

1926 regulations on provider and payer consolidation.
1927 Ms. Tripoli, can you quickly _ because I want to go to
1928 another subject _ elaborate on the recent trends we are
1929 seeing with consolidation in the health care system?
1930 What are the greatest impacts on patients, and how is it
1931 affecting staffing?
1932 *Ms. Tripoli. Absolutely. I think the two biggest
1933 trends we are seeing are horizontal mergers between hospitals
1934 and other hospitals. We now have a situation where most
1935 markets across the health care system are considered highly
1936 concentrated. I think 90 percent of these metropolitan
1937 statistical areas are considered highly concentrated, heavily
1938 concentrated.
1939 And the other type of trend to point out is vertical
1940 integration. When these bigger systems are coming up and are
1941 buying up the smaller, independent practices and forming
1942 bigger sort of health care corporations, the impact of
1943 consolidation in general is that it, from the data, suggests
1944 that quality goes down in a lot of cases, and we know that
1945 prices are going up.
1946 Those prices come in the forms for consumers in higher

1947 insurance premiums. They are seeing abusive facility fees,
1948 higher cost sharing. And so it has a direct impact on the
1949 affordability care _ of care. And we are seeing, in a lot of
1950 cases, quality going down, workers being laid off, wages
1951 reduced for nurses and other health care workers within the
1952 system. So it is hugely problematic.

1953 *Mrs. Dingell. Thank you. I want to quickly turn my
1954 attention to Home and Community-Based Services, or HCBS. As
1955 many of you know, I believe moving care into the home is one
1956 way we can benefit patients while reducing costs.

1957 Medicaid is the largest single payer of long-term
1958 services and supports in the United States. And while state
1959 Medicaid programs must cover long-term care in nursing homes,
1960 nearly all HCBS are optional, despite several studies
1961 indicating HCBS can result in cost savings over institutional
1962 settings. And we know it is where people want to be.

1963 Likewise, according to a recent study of Medicare fee-
1964 for-service beneficiaries, home care was associated with the
1965 savings of nearly $6,500 per patient. And many of you have
1966 heard me speak about my experiences with home infusion.
1967 Several studies, in fact, have found that home infusion can

1968 lead to significant cost savings when compared to inpatient
1969 costs.
1970 Ms. Tripoli, do you believe transitioning care away from
1971 traditional health care settings like doctors' offices and
1972 hospitals can be an effective way to reduce costs and improve
1973 patient outcomes?
1974 *Ms. Tripoli. I think absolutely. I think, as you just
1975 pointed out, there _ we know that shifting out of
1976 institutionalized care into the home or community-based
1977 setting with appropriate levels of care and support is not
1978 only important for consumers and patients maintaining their
1979 dignity, but also is essential, it is critical for having
1980 emotional and social connectedness, which has a direct impact
1981 on the quality of life. So that cannot be stated enough.
1982 And as we know, as you just beautifully laid out, the
1983 shifting into community-based settings does have a cost
1984 savings effect, and I think, on average, about 30, 35 percent
1985 in reduced savings because of that shift.
1986 *Mrs. Dingell. Thank you. When it comes to reducing
1987 health care expenditures, I believe supporting the transition
1988 to home-based care is a critical part of the discussion.

1989 Thank you for that.

1990 And with that, Mr. Chairman, I yield back.

1991 *Mr. Guthrie. Thank you. The gentlelady yields back.
1992 The chair recognizes the gentleman from Indiana, Dr. Bucshon.

1993 *Mr. Bucshon. Thank you, Mr. Chairman.

1994 I was president of a medical group. I was a heart
1995 surgeon before I was in Congress. Here is how billing works,
1996 and it is not transparent. I do bypass surgery on someone,
1997 we bill every patient $6,000, regardless of their _ what
1998 their coverage is or whether they have coverage at all.
1999 Because you can't bill Medicare patients for what they might
2000 actually pay for that surgery, it might be _ and these are
2001 hypotheticals _ it might be $2,000. But for private
2002 insurance company, they may pay $5,800. So what do you do?
2003 You bill everybody $6,000 to capture all of the agreements
2004 anywhere from there between _ usually it is between Medicare
2005 and the top thing.

2006 These are all confidential agreements that your practice
2007 has to sign with insurance plans and patients. And honestly,
2008 most of the doctors don't even know what is contained in the
2009 agreements. So we have no way of knowing. That is just one

2010 lack of transparency.

2011 So the reality is, if you have no health insurance at
2012 all, you have to _ you owe $6,000, unless the doctor decides
2013 to write that off, which, which 99 percent of the time I did.

2014 The other thing is _ I want to say is, ironically,
2015 government subsidies, whether direct subsidies or tax
2016 advantages, are some of the leading drivers of health care
2017 costs in my opinion. It seems like it should be beneficial
2018 to our society, and in many ways it is, but it also drives
2019 costs. It just does.

2020 We have also tried to control health care costs since
2021 the late 1980s by cutting provider reimbursement. And has
2022 that worked? Does anybody think that has worked? No. So
2023 now we have cut providers so much that we can't get doctors
2024 in rural America and underserved urban America.

2025 So we have to do more. We need competition and
2026 transparency. Basically, every one of you said that. I will
2027 direct my question to Dr. White.

2028 As it relates to physician-owned hospitals, are you
2029 aware of a recent study on physician-owned hospitals from the
2030 University of Connecticut and Loyola University last fall?

2031 *Dr. White. I am not aware of that study, but I _

2032 *Mr. Bucshon. Well, I have it here. I didn't figure
2033 you were, and I didn't _ that wasn't a trick question.

2034 *Dr. White. Okay.

2035 *Mr. Bucshon. I just wanted to make sure you didn't.
2036 It is called a study of the cost of care provided in
2037 physician-owned hospitals, compared to traditional hospitals.
2038 It is an analysis of 20 high-cost diagnostic-related groups
2039 using 2019 Medicare claims data. And what it showed,
2040 ultimately, is that _ this study showed that physician-owned
2041 hospitals _ that payments were 8 to 15 percent lower than
2042 traditional hospitals within the same market.

2043 So I am asking for you to think about whether you would
2044 be _ can commit to having the CBO consider this and other new
2045 research on POHs in a reevaluation of prior policy.

2046 *Dr. White. We would be happy to consider that study.
2047 And honestly, we have been tracking this physician-owned
2048 hospital area for some time, and we would be happy to take on
2049 new information.

2050 *Mr. Bucshon. I appreciate that, because it is critical
2051 to competition in the marketplace in many markets, as Dr.

2052 Burgess and others said.

2053 Mr. Chairman, I want to introduce that study for the

2054 record at the end.

2055 *Mr. Guthrie. Without any objection, we will put it on

2056 the documents list to be reviewed at the end, so if somebody

2057 wants to review it, they have the opportunity to. Thank you.

2058 [The information follows:]

2059

2060 **********COMMITTEE INSERT**********

2061

2062 *Mr. Bucshon. Thank you.

2063 And Dr. White, also, you know, one of the things that I
2064 have never been able to understand is how _ and some people
2065 have already addressed this _ preventive health measures
2066 don't reflect savings under CBO projections. I get it. You
2067 know, if you do things preventative, people live longer, so
2068 it costs Medicare more money, so at the end of the day it
2069 might not save as much as you might think. But what are we
2070 here for? We are here to make people healthy, and to live
2071 longer, more productive lives. So, you know, I have just
2072 never understood that, and I think that the CBO needs to
2073 figure out a way to fix that. And I know it is a difficult
2074 challenge.

2075 So a question I do have, though, is on MA plans. Do you
2076 think traditional Medicare or Medicare Advantage is cheaper
2077 for beneficiaries?

2078 *Dr. White. Cheaper for beneficiaries?

2079 *Mr. Bucshon. Yes.

2080 *Dr. White. Let's see. It depends whether the
2081 beneficiary has Medigap plus fee-for-service, or just fee-
2082 for-service.

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2083 *Mr. Bucshon. Yes, say for example they don't have a
2084 supplement plan.
2085 *Dr. White. Right.
2086 *Mr. Bucshon. So let's _ Medicare traditional MA plan,
2087 Medicare.
2088 *Dr. White. Yes, but my sense is that MA plans are
2089 taking part of the rebates, the payments that they are
2090 getting from the Federal Government, and pushing down cost
2091 sharing. I don't have at my fingertips a _
2092 *Mr. Bucshon. Yes.
2093 *Dr. White. _ a solid comparison, but that is my sense.
2094 *Mr. Bucshon. Yes, because recently there has been
2095 some, you know, allegations that MA plans are overpaid, and I
2096 understand that, but experts, some experts, now are
2097 suggesting that there is a good reason to question MedPAC's
2098 conclusion on this.
2099 Does CBO have plans to undertake a component-by-
2100 component comparison of the two programs?
2101 As you know, Medicare Advantage includes A and B
2102 benefits, prescription drug plan, Medigap coverage, and
2103 supplemental benefits compared to traditional fee-for-

2104 service.

2105 Because this is an issue, right, if you look at _ and

2106 there was a Wall Street Journal article recently about profit

2107 margin for plans on Medicare Advantage versus, you know,

2108 traditional Medicare.

2109 *Dr. White. Yes.

2110 *Mr. Bucshon. So can CBO addressed that?

2111 *Dr. White. Yes. We actually have a team that is

2112 digging into the costs of _

2113 *Mr. Bucshon. Okay.

2114 *Dr. White. _ Medicare Advantage _

2115 *Mr. Bucshon. And I am over time, so _

2116 *Dr. White. _ fee-for-service _

2117 *Mr. Bucshon. _ you will address that.

2118 *Dr. White. Yes.

2119 *Mr. Bucshon. Yes. Thank you.

2120 I yield back.

2121 *Mr. Guthrie. The gentleman yields back. The chair

2122 recognizes the gentlelady from Illinois, Ms. Kelly, for five

2123 minutes for questions.

2124 *Ms. Kelly. Thank you, Chair Guthrie and Ranking Member

2125 Eshoo, for holding this hearing, and thank you to the
2126 witnesses today.
2127 As health care costs continue to rise in the United
2128 States, the Biden Administration and congressional Democrats
2129 have delivered for the American people by lowering the cost
2130 of health care and expanding coverage. More Americans have
2131 health coverage today than ever before, thanks to the
2132 Affordable Care Act and the expansion subsidies included in
2133 the Inflation Reduction Act. Enrollment and coverage of the
2134 ACA is at an all-time high: 21.3 million consumers have
2135 coverage through the ACA marketplace in 2024.
2136 Ms. Tripoli, can you discuss the impact of the enhanced
2137 subsidies in the Inflation Reduction Act on coverage, and how
2138 many new individuals have gained access to coverage?
2139 *Ms. Tripoli. Absolutely. Thank you for the question.
2140 I think, as you just articulated, we have saw record
2141 enrollment in open enrollment this year, over 21 million
2142 people. That is five million more this year than last year's
2143 open enrollment. And I think the enhanced subsidies played a
2144 critical role to lower premiums for the American people so
2145 that when they went in and shopped in the marketplace, they

2146 could actually get a plan for $10, and could afford their
2147 health insurance.
2148 So the premium subsidies have been absolutely critical
2149 in terms of the affordability of people being able to afford
2150 their care and feel like they can actually purchase a plan.
2151 *Ms. Kelly. Thank you so much. The enhanced subsidies
2152 in the IRA have led to historic coverage gains. Because of
2153 the enhanced subsidies, millions of families have affordable
2154 and quality health care. The expanded subsidies are also
2155 driving down costs.
2156 Can you also briefly discuss the impact of the enhanced
2157 subsidies on premiums, and how it is lowering costs for
2158 American families?
2159 *Ms. Tripoli. Absolutely. The enhanced subsidies
2160 essentially helped shield consumers, absorb some of the
2161 growing costs of premiums and shield consumers from that
2162 excess cost. So it brings their actual price that they will
2163 pay for their premiums down.
2164 It does, of course, not address the underlying drivers
2165 of what is driving up health care premiums, which _ as we
2166 know, hospital prices and drug prices are a major factor.

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2167 But the enhanced subsidies are critical for making sure that
2168 the American people can actually afford their premiums and
2169 brings down the premiums for families.
2170 *Ms. Kelly. Now, these enhanced subsidies are set to
2171 expire next year. Can you discuss the importance of making
2172 the ACA enhancements permanent?
2173 *Ms. Tripoli. It is absolutely critical. More than 21
2174 million people afford _ in open enrollment getting health
2175 care coverage. We know that health care coverage is
2176 essential to keep people financially secure, to make sure
2177 that they get the preventive care that they need, that they
2178 are not delaying care and going to higher-cost care centers
2179 down the road, making sure that workers can show up to work
2180 healthy, take care of their families. So the permanent
2181 extension of those subsidies is essential to make sure that
2182 we continue to have affordability for the American people.
2183 *Ms. Kelly. So comments or claims that the ACA has
2184 raised health care costs, can you comment about that, how you
2185 feel about that?
2186 *Ms. Tripoli. Some of my colleagues from CBO and
2187 economists might want to comment, but I think that we have

2188 seen underneath the hood of the health care system costs
2189 increasing. And I think what is important to note here is
2190 that subsidies are critical for the American people to access
2191 premiums, but what is underneath the hood of the health care
2192 system are pricing abuses driven by big health care
2193 corporations that are driving up premiums year after year
2194 because they are allowed to consolidate market power and
2195 increase prices year after year. So those prices have a
2196 direct relationship to rising premiums, and have a direct
2197 impact on the affordability of care and the overall cost
2198 increases in the health care system.

2199 *Ms. Kelly. So do any _ either one of you want to make
2200 a comment, who Ms. Tripoli referred to?

2201 Does anyone else want to make a comment about that? No?

2202 Okay, I yield back.

2203 *Mr. Bucshon. [Presiding] The gentlelady yields back.
2204 I now recognize Dr. Dunn, five minutes.

2205 *Mr. Dunn. Thank you very much, Mr. Chairman. I
2206 appreciate this committee taking a holistic look at an issue
2207 that our constituents talk about to us at every single town
2208 hall meeting, and it is the high cost of health care.

2209 You know, we hear from seniors on fixed income, chronic
2210 disease patients, parents who are just trying to give their
2211 children access to the best care, and, of course, small
2212 businesses that are providing health care to their employees.
2213 The American health care system does not come close to a
2214 free market in which consumers can understand the cost of
2215 goods and services and make informed decisions and then spend
2216 their dollars where they see the best value for themselves.
2217 Perverse incentives, business practices that are shrouded in
2218 secrecy leave consumers in the dark as health care spending
2219 rapidly increases as a proportion of U.S. GDP and faster than
2220 inflation.
2221 Now, when we are thinking about reducing health care
2222 spending but preserving high-quality care that Americans can
2223 access, there are many policies that make sense. But I think
2224 _ some of those are. We must take a thoughtful approach to
2225 site-neutral policies, ensure the proper oversight of the
2226 existing transparency rules, and take a very hard look at how
2227 vertical integration in both the provider side and the
2228 insurance spaces is driving costs.
2229 That said, I think the single area of greatest interest

2230 to virtually every one of my constituents is the cost of
2231 prescription drugs. I also think addressing drug spending is
2232 our biggest opportunity to generate real savings immediately,
2233 fast.
2234 [Slide]
2235 *Mr. Dunn. The poster behind me illustrates the
2236 potential savings that clear and transparent cost information
2237 about generic drug prices could generate. You are looking at
2238 the cost of just three common, generic drugs and their
2239 branded counterpart. As you can clearly see, generic drugs
2240 can be manufactured and sold to the consumers at considerably
2241 lower prices than when the patients go through their
2242 insurance plan.
2243 Another illustration of potential savings is pointed out
2244 in the report of Florida's Agency of Health Care
2245 Administration Commission in 2021. I would like to enter
2246 that into the record, Mr. Chair.
2247 *Mr. Bucshon. Without objection.
2248 *Mr. Dunn. Thank you. The report found that the spread
2249 pricing in Florida's Medicaid system, when a plan pays the
2250 PBM more per claim than what the PBM pays the pharmacy,

2251 benefitted PBMs to the tune of $90 million a year; $70
2252 million of that was generated by the spread pricing of
2253 generic drugs.
2254 Let's be clear. If the prices were transparent, this
2255 would never happen. If patients knew that their insurance
2256 company was often charging them 5 to 20 times the cash price
2257 of the drug, they would question the value of their insurance
2258 plan and the interests of their insurance plan, and they
2259 would surely question why the heck the PBM was pocketing the
2260 difference.
2261 Some patients are tricked into paying thousands of
2262 dollars out of pocket for brand drugs by their insurance plan
2263 due to formulary design, when they could pay a small fraction
2264 of that price for a bioidentical generic simply by paying
2265 cash. A complicated web of markups, rebates, kickbacks, and
2266 ever-changing business models is actually designed to shroud
2267 drug prices in complexity and keep patients in the dark about
2268 the true cost of their medications.
2269 This must stop. A functioning market requires informed
2270 and empowered consumers, and I don't think anyone in this
2271 room would say that keeping patients in the dark about the

2272 true cost of their care is lowering costs. That may be a
2273 good model to generate profits, but I am here serving my
2274 constituents, and I believe the health care system can work
2275 better for them.
2276 So how can we ensure more patients take advantage of
2277 these much lower prices you see here? And the answer is
2278 transparency.
2279 Dr. White, earlier I touched on the savings the Florida
2280 Medicaid program could achieve if spread pricing was
2281 addressed. You have scored this committee's PBM transparency
2282 bill as saving several billion dollars. I understand that
2283 additional reforms such as delinking the PBM compensation
2284 from list price would save additional billions. Can you
2285 confirm that?
2286 Can you turn your mike on?
2287 *Dr. White. Sorry about that. I would have to look at
2288 the specifics, and I am happy to follow up in written _
2289 *Mr. Dunn. All right, I will draw your attention to the
2290 a bill called the Drug Act that is led by Dr. Miller-Meeks.
2291 I have time. Mr. Ippolito, would you agree that
2292 marketplace competition often leads to lower prices and more

2293 choices for consumers?

2294 *Dr. Ippolito. In general, yes.

2295 *Mr. Dunn. Good. That is a sort of market 101, right?
2296 I agree with you, but I fear that banning, simply banning
2297 specific practices such as spread pricing might actually lead
2298 to hiding these abuses in other parts of the system, which is
2299 why I encourage us all to continue to pursue complete
2300 transparency. You can't beat transparency in the end of it.

2301 The prices _ I will put that one more time _ the prices
2302 you see here are prices that I can get at retail prices today
2303 online in a _ for pharmacy.

2304 Thank you, Mr. Chair, I yield back.

2305 *Mr. Guthrie. The gentleman yields back.

2306 Mr. Carter, you are recognized for five minutes.

2307 *Mr. Carter. Thank you, Mr. Chairman, and I appreciate
2308 this hearing, and thank all of you for being here.

2309 You know, health care is a key driver of our debt in
2310 this country. All of you know that, $34 trillion in debt in
2311 health care. Right now we are spending 17.3 percent of GDP
2312 on health care, nearly twice as much as any other developed
2313 country, and yet, despite spending almost $4 trillion a year

2314 on health care, patients and employers are unable to make
2315 informed decisions, unable to make informed decisions about
2316 how and where to spend their money because our health care
2317 system lacks transparency.
2318 And I don't mean to sound like a broken wheel, I know
2319 that is what you have been hearing all day today from this
2320 committee, as it should be.
2321 Ms. Martin, I want to start with you. Can you tell me
2322 why the drug supply chain is such a black box for employers
2323 and for patients?
2324 *Ms. Martin. I am not sure I know why it is the case,
2325 but it is certainly the case that it is. There are elements
2326 throughout the health care system that are similarly black
2327 boxes, and it is why transparency is critically important.
2328 *Mr. Carter. What about the vertical transformation
2329 information that exists in the drug pricing chain, where the
2330 insurance company owns the pharmacy, owns the PBM, owns the
2331 group purchasing organization, owns the doctor, the
2332 physician's practice? Do you think that has something to do
2333 with it?
2334 *Ms. Martin. I don't think I can speak to that. I

2335 think there are, as I said, there are practices across the
2336 health care system where opacity reigns, and transparency _
2337 *Mr. Carter. So essentially, what you are saying is
2338 just transparency throughout health care would be the answer.
2339 *Ms. Martin. Yes.
2340 *Mr. Carter. Thank you for that. Let me ask you this:
2341 How would you describe how the Lower Costs, More Transparency
2342 Act can help employer plan sponsors better understand the
2343 cost of drugs, especially?
2344 *Ms. Martin. I think the provisions of the Act and the
2345 increase in transparency will just empower employers with
2346 information across the board.
2347 *Mr. Carter. Thank you for that.
2348 Dr. _ I am sorry _ whatever. Boy, you all got some
2349 great names here on this panel.
2350 [Laughter.]
2351 *Mr. Carter. Thank you all, and I apologize.
2352 PBM's claim that pass-through discounts from drug
2353 manufacturers are passed from the plan to the patients. You
2354 know, as a pharmacist for over 40 years, I know that not to
2355 be the case. But your research found that in some cases the

2356 average discount on drugs from drug makers is around 50
2357 percent. In fact, there was a study done by the Berkeley
2358 Research Group some years ago _ well, it was about a year and
2359 a half ago _ that showed that only 63 percent of the price of
2360 _ or excuse me, only 37 percent of the price of a drug goes
2361 to the pharmaceutical manufacturer, which begs the question,
2362 where does the other 63 percent go?

2363 Well, it is going to the middleman. That is what we
2364 know. It is going to the PBM, which is the insurance company
2365 that owns the pharmacy, that owns the PBM, that owns the
2366 doctor. The largest employer of doctors in this country is
2367 United Optum Health Services, 9,000 doctors.

2368 So let me ask you, would policies like those that you
2369 see in the Lower Costs, More Transparency Act requiring PBMs
2370 and health insurers to disclose negotiated rebates help level
2371 the playing field, do you think?

2372 *Dr. Ippolito. Yes, potentially. The numbers that you
2373 cite are not even unusual _ 50 percent, 60 percent, 70
2374 percent rebates, discounts are pretty normal, amazingly, in
2375 the current market. And so the provisions that are included
2376 in the bill, I think, at a minimum, make the purchaser, the

2377 employer, much more informed about how they are spending
2378 money and where they are spending money.
2379 *Mr. Carter. Ms. Tripoli _ Mr. Chairman, next time
2380 let's get a panel of Jones and Smith and _ anyway,
2381 nevertheless, Ms. Tripoli, is it your belief that correcting
2382 this misaligned incentive structure for PBMs and to delink
2383 the fees, as Dr. Neal was suggesting earlier, that that would
2384 alleviate some of the problems we have discussed with _ that
2385 we are having?
2386 *Ms. Tripoli. I think transparency across the health
2387 care system is critical, including for PBMs, including for
2388 hospitals, including for plans. That information around
2389 prices, negotiated rebates, all of that, is only going to
2390 help unveil the curtain around some of the abuses that are
2391 happening in the market, empower employers with more
2392 information they need to negotiate a better deal, empower
2393 consumers for the same reason.
2394 *Mr. Carter. Thank you for that. Unveiling the
2395 curtain.
2396 You know, I have got a pamphlet out. It is called,
2397 "Pulling Back the Curtain on PBMs," and I would like to make

2398 a copy of that available. In fact, I will get my staff to
2399 bring each one of you one of those pamphlets down here before
2400 you leave. But it does show the problems with PBMs and the
2401 need for transparency.
2402 Look, I am not opposed to anybody making money, but come
2403 on, this is ridiculous. This is not being passed on to the
2404 patient. It is not going where it is supposed to go. That
2405 is why we need transparency to show the employers, at least,
2406 where they are going, where these discounts are going.
2407 Thank you, Mr. Chairman, and I will yield back.
2408 *Mr. Bucshon. The gentleman yields back. I now
2409 recognize Mr. Pence, five minutes.
2410 *Mr. Pence. Thank you, Chair Guthrie, Ranking Member
2411 Eshoo, for holding this meeting, and thank you for the
2412 witnesses all being here today.
2413 As we have said, health care spending in the United
2414 States is continuing to skyrocket at an unsustainable pace.
2415 We spent an astonishing $4.5 trillion on health care in 2022
2416 alone, an increase of 4.1 percent over the previous year. As
2417 the health care system continues to experience higher costs,
2418 particularly for physicians and providers that get rolled up

2419 into hospitals, as someone mentioned earlier, it is
2420 ultimately patients that suffer the most. According to the
2421 Kaiser Family Foundation, nearly half of American adults in
2422 the United States believe it is too difficult to afford
2423 health care. A real shame, particularly in rural America.
2424 Indiana had a $1 billion shortfall last year due to the
2425 difficulty of estimating the cost of Medicare, as Mr. Lyons
2426 discussed in what you do for your members.
2427 Rather than work to find common-sense solutions to lower
2428 health care spending, the Biden Administration is proposing a
2429 rule that would further exasperate the issue by raising the
2430 delivery costs of health care. Under the direction of the
2431 White House, CMS proposed minimum staffing ratio requirements
2432 for nursing homes. This proposed rule, published in the
2433 Federal Register, estimates that the policy would cost $40
2434 billion over 10 years to fully implement.
2435 I bring this up as we talk about transparency, we talk
2436 about how much health care costs. We are running out of
2437 providers in my rural Indiana 6th district.
2438 Dr. Ippolito _ I have an Italian wife, so I think I
2439 probably got that right, right? Finalizing this HHS proposal

2440 would result in limited access to care for seniors, mandatory
2441 increases in state Medicaid budgets, and could most
2442 consequentially lead to widespread nursing home closures. A
2443 report commissioned by CMS analyzing a minimum nurse staffing
2444 requirement found that the quality and safety thresholds
2445 could, and probably would, increase a modest one percentage
2446 point.

2447 Implementing a staffing mandate for nursing homes would
2448 also put added financial pressure _ as Congressman Carter,
2449 nothing wrong with making a little profits, but it would put
2450 pressure on health care settings to make money. And we have
2451 found _ going around my district I have found it would also
2452 drain staff from other areas.

2453 Dr. Ippolito, do you believe it is fiscally responsible
2454 for the Federal Government to spend billions of dollars on a
2455 policy that could result in a modest improvement in care,
2456 when health care spending is already at historical levels?

2457 And what happens to the price of care as we decrease the
2458 supply of caregivers?

2459 *Dr. Ippolito. Well, assessing the full merits of the
2460 policy will probably be beyond the scope of perhaps my _ what

2461 I can speak to today. But what I will say is two things.

2462 The first is that the context is right. Given where we
2463 are, if a new policy is going to lead to tens of billions of
2464 dollars of additional spending, it should be looked at with a
2465 critical eye. That doesn't mean you shouldn't do it, but it
2466 should be viewed critically.

2467 The second thing is the margin, I think, of relevance
2468 that you bring up is very important. Is this going to affect
2469 the financial viability of some of these institutions? And
2470 if the answer is yes, that is a meaningful trade-off.

2471 I can't right now weigh those things perfectly, but
2472 those are the two things I would focus on.

2473 *Mr. Pence. Well, I wish this Administration would
2474 think about that, what they are going to do to rural health
2475 care as they run out physicians and nurses.

2476 So thank you and, Mr. Chair, I would yield back.

2477 *Mr. Bucshon. The gentleman yields back. I now
2478 recognize Mrs. Trahan, five minutes.

2479 *Mrs. Trahan. Thank you, Mr. Chairman.

2480 As I have previously raised in this committee, community
2481 hospitals across our country have faced significant financial

2482 challenges over the years, challenges that were deepened by
2483 the pandemic and, in some cases, are being made even worse by
2484 a private equity model that puts profits squarely above our
2485 patients and their care.

2486 In 2017, Steward Health Care, the largest private, for-
2487 profit health network in the country, purchased Texas Vista
2488 Medical Center in San Antonio with the help of private
2489 equity. This was a community hospital that served mostly
2490 working-class population. And while it looked like the
2491 acquisition might mean that the hospital would keep its doors
2492 open and all of its services available, the purchase allowed
2493 a separate company, Medical Properties Trust, to purchase the
2494 land and buildings on the hospital's campus so it could
2495 charge Steward $5 million in rent each year.

2496 Fast forward six years, and Steward announced it was
2497 closing Texas Vista because of low Medicaid reimbursement,
2498 but it mentioned nothing about the 30-plus million it had to
2499 pay in rent to Medical Properties Trust, a company, by the
2500 way, whose CEO earned $70 million in salary, bonuses, and
2501 stock in the 4 years following the purchase of Texas Vista's
2502 properties.

2503 Mr. Chairman, this is what the disastrous reality of
2504 private equity in our health care system looks like. And the
2505 thing is, it is happening again, but this time families in my
2506 district are the ones who are being told that they have to
2507 pay the price. Families who receive care at Holy Family
2508 Hospital and Nashoba Valley Medical Center, both owned by
2509 Steward, were recently notified that their care is now in
2510 jeopardy because of the corporation's gross financial
2511 negligence that is seeing the company try to shutter four of
2512 the nine hospitals they own in Massachusetts.
2513 For their reasoning, Steward executives have pointed to,
2514 you guessed it, low Medicaid reimbursement rate as the cause
2515 for their financial distress. But earlier this month it was
2516 revealed that the company has missed rent payments to an
2517 outside landlord that actually owns the property and
2518 buildings their facilities operate in. It is looking more
2519 and more like this is part of a dangerous Steward private
2520 equity playbook.
2521 Ms. Tripoli, hospitals have had a rough go of it post-
2522 COVID, with workforce shortages, supply chain issues, and
2523 inflation. Do you have concerns about the increasing role of

2524 private equity ownership of community hospitals, particularly
2525 this type of purchase structure, where a for-profit system
2526 purchases a community hospital with a separate firm
2527 purchasing land and buildings that it operates?
2528 *Ms. Tripoli. I think, absolutely, I think we have to
2529 be very skeptical of the role of private equity in mergers
2530 and acquisitions in the health care system in general. Their
2531 business model is just incompatible with ensuring the health
2532 and financial security of the American people, particularly
2533 at the community level.
2534 And what we see when private equity comes in, they are
2535 trying to make their _ they are cutting costs, they are
2536 trying to increase prices. We see quality go down. We see
2537 hospital-acquired infections go up. We see increasing in
2538 falls. We see prices go up. And they are trying to look
2539 profitable for resale in three to five years. And in some
2540 instances, as you have just pointed out, we actually see them
2541 closing the doors of those centers because the real estate
2542 underneath is much more profitable than the institution
2543 itself.
2544 So we have to be very, very critical and scrutinize. We

2545 need a lot more transparency around the role of private
2546 equity ownership in the health care system. Right now that
2547 is a giant black box, and we need more data unveiled so that
2548 Federal and state regulators can have greater scrutiny over
2549 the role of private equity in health care.
2550 *Mrs. Trahan. Thank you. I mean, when these hospitals
2551 are forced to close, like in San Antonio and now across
2552 Massachusetts, it is patients who suffer.
2553 Your testimony, Ms. Tripoli, urges our committee to
2554 continue to explore opportunities to improve transparency
2555 around the ownership interest of private equity and health
2556 care corporations. It seems doubtful that greater
2557 transparency rules alone could slow private equity's
2558 penetration of health care markets. Can you please elaborate
2559 on how we should be thinking about legislating beyond what
2560 was included in the House-passed Lower Costs, More
2561 Transparency Act so that our health care system is fully
2562 meeting the needs of Americans?
2563 *Ms. Tripoli. I think certainly in terms of the role of
2564 ownership, the piece about transparency is really, really
2565 important. It is a critical first step.

2566 Because of how often private equity buys and sells
2567 within the time period, often times you see systems changing
2568 hands of ownership multiple times, and we don't have good
2569 insight into how often that is happening. And so that is why
2570 we actually need more transparency around the ownership,
2571 private equity ownership in health care, because that not
2572 only will allow us to have a better sense of what the trends
2573 are happening in the market around mergers and acquisitions
2574 related to private equity, we can identify other types of
2575 anti-competitive practices that are going on, and we can
2576 empower Federal and state regulators with important
2577 information to scrutinize the role of private equity in
2578 health care mergers and acquisitions.
2579 *Mrs. Trahan. That is very helpful. Thank you so much.
2580 I yield back the balance of my time.
2581 *Mr. Guthrie. [Presiding] Yes, thank you for yielding,
2582 but we didn't start the clock on you, so you used your five
2583 minutes, but we gave you the _ so we hadn't started your
2584 clock. So thank you for yielding back, and the chair now
2585 recognizes the lady from Tennessee.
2586 Dr. Harshbarger?

2587 *Mrs. Harshbarger. Yes.

2588 *Mr. Guthrie. Yes, from Tennessee.

2589 *Mrs. Harshbarger. Thank you. Thank you, Mr. Chair.
2590 Thank you to the witnesses for being here today.

2591 As you all know, this committee has driven meaningful
2592 bipartisan legislation that passed the House in December that
2593 would lower health care cost, significantly increase
2594 transparency of the historically opaque PBM sector, and also
2595 ban the use of spread pricing by PBMs operating in the
2596 Medicaid program. These reforms were influenced by the
2597 practices of so-called transparent PBMs like Navitus,
2598 Ventegra, and AffirmedRx, just to name a few, that pass all
2599 rebates through to their clients and do not spread price.

2600 Also, there is companies like Lumicera, a specialty
2601 pharmacy that sells its medications at the acquisition cost
2602 of the drugs plus a clearly displayed dispensing and patient
2603 management fee. There is other models like that, and reforms
2604 to the traditional PBM of specialty drug models exist and can
2605 be replicated.

2606 You know, the Lower Costs, More Transparency Act is a
2607 giant step forward, but there is still work we have to do.

2608 So we will start with Ms. Martin, and this can go to anybody
2609 on the panel.
2610 I am specifically interested in your views about other
2611 segments of the supply chain that would benefit from
2612 additional transparency, such as the role that pharmaceutical
2613 group purchasing organizations or rebate aggregators play in
2614 negotiating rebates for PBMs. Because, as you know, the FTC
2615 extended its study into PBMs last made _ two such
2616 pharmaceutical GPOs to its reviews.
2617 And my question is, are there other aspects of the
2618 pharmaceutical supply chain that you think need to be better
2619 examined?
2620 And if so, how might potential reforms in these areas
2621 help lower or moderate the growth of health care costs and
2622 spending?
2623 *Ms. Martin. I don't think there is any segment of the
2624 health care system that should be protected or shielded from
2625 transparency. I think we need transparency across the board
2626 and at all levels.
2627 *Mrs. Harshbarger. Well that is true.
2628 Dr. Ippolito?

2629 *Dr. Ippolito. Rebate aggregators are pretty close to
2630 the top of the list for me, particularly because rebates have
2631 attracted so much attention. There is a lot of policies that
2632 are either being enacted or proposed that would amend how
2633 those dollars flow. Well, if rebate aggregators suck up
2634 those dollars before they formally become the rebates that
2635 have been regulated, it presents an obvious problem.
2636 *Mrs. Harshbarger. Yes.
2637 *Dr. Ippolito. So that seems at the top of my list.
2638 *Mrs. Harshbarger. It does, doesn't it?
2639 Yes, sir.
2640 *Mr. Lyons. Thanks for the question. One of the things
2641 that is _ really upsets me, like, that really gets me going
2642 on this in digging into it is the oncology drugs at the
2643 hospitals. Hospitals are marking up those oncology drugs
2644 five times.
2645 *Mrs. Harshbarger. Well, yes I used to work at a
2646 hospital as a pharmacist, so I _
2647 *Mr. Lyons. And then they are charging tens of
2648 thousands of dollars to administer them, right? Now, these
2649 are oncology patients. So that is one place that I would

2650 drill down on right away.

2651 And right now the insurers have no interest because of
2652 medical loss ratio to lower that threshold. You know, 20
2653 percent of $100 is a lot less than 20 percent of 1,000,
2654 right?

2655 *Mrs. Harshbarger. Yes, yes.

2656 *Mr. Lyons. So _

2657 *Mrs. Harshbarger. I got you.

2658 Yes, ma'am.

2659 *Ms. Tripoli. I think, I just, you know, just want to
2660 say I think we have to just remember that drug companies are,
2661 in fact, really to blame for the drug cost crisis. But of
2662 course, as you mentioned, PBMs do have a role to play. There
2663 is an incredible amount of opaqueness around the pricing
2664 structures and business practices of PBMs. So I think
2665 increased transparency across the health care system,
2666 including PBMs, the drug supply chain is only going to allow
2667 us to unveil again what is happening underneath the root of
2668 what is driving unaffordable care.

2669 *Mrs. Harshbarger. Yes. Yes, sir.

2670 *Dr. White. And as we scored in the Lower Costs, More

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

2671 Transparency Act, giving employers more information about
2672 where their _
2673 *Mrs. Harshbarger. Yes.
2674 *Dr. White. _ benefit dollars are going, how much is
2675 going to the PBM, allowing them to shop among PBMs will lead
2676 to a more competitive market for PBM services and with state
2677 Medicaid programs.
2678 Similarly, we talk a lot about patients as consumers,
2679 but employers and state Medicaid agencies _
2680 *Mrs. Harshbarger. Yes.
2681 *Dr. White. _ they are buying and making decisions
2682 based on the information they have. And if state Medicaid
2683 agencies have more information about PBM costs, and are
2684 better able to comparison shop among PBMs, that reduces PBM
2685 margins and makes for a more competitive market and benefit
2686 cost.
2687 *Mrs. Harshbarger. No joke. They have to make their
2688 decisions based on the information they receive. And as
2689 somebody who owned pharmacies and had to make those
2690 decisions, we didn't get the whole picture. But, you know,
2691 there is discrepancies, and transparencies are needed, for

2692 sure.

2693 Ms. Tripoli, the Paragon Health Institute recently
2694 issued a policy brief sounding the alarm on how mandatory
2695 spending on major Federal programs for health care, Medicaid,
2696 Medicare, Obamacare now exceeds our entire discretionary
2697 budget, driving up our $34 trillion in national debt and
2698 crowding out spending on other important national priorities.

2699 While we appreciate what _ that Families USA support the
2700 policy in the Lower Costs, More Transparency Act, there are
2701 some issues that we have to agree to disagree on. My
2702 question is, does Families USA's view that health insurance
2703 coverage from expanding Medicaid and ACA subsidies _ should
2704 that be our main objective, regardless of budgetary
2705 affordability, efficiency, or the quality of such coverage?

2706 And what does Families USA's position on a one-payer
2707 system, or Medicare-for-all proposals here in Congress,
2708 recognizing that Medicare under the current law faces
2709 significant near-term and long-term financial solvency
2710 challenges?

2711 *Mr. Guthrie. Okay, so Ms. _ can you just quick answer,
2712 like, quick? I am sorry.

2713 *Mrs. Harshbarger. I didn't see my time was up. I am
2714 on a roll here.
2715 *Mr. Guthrie. I am sorry.
2716 *Ms. Tripoli. I can answer _
2717 *Mr. Guthrie. That is a big question, but can you give
2718 a quick answer?
2719 *Ms. Tripoli. Of course. The short answer is
2720 absolutely, ensuring that the American people have affordable
2721 health care coverage is essential to making sure that people
2722 have health.
2723 We have to look underneath the hood of what is driving
2724 those expenditures and driving the increase in costs, and we
2725 know that there are major drivers, major corporatization of
2726 health care from drug pricing abuses to hospital pricing
2727 abuses to abuses in Medicare Advantage and coding abuses that
2728 is driving up the underlying cost of care that are important
2729 areas for this committee to continue to talk about.
2730 *Mr. Guthrie. Thanks.
2731 *Mrs. Harshbarger. Okay, thank you.
2732 Thanks. Sorry, Mr. Chairman.
2733 *Mr. Guthrie. Thanks again, a quick answer.

2734 No problem. The chair now recognizes _ the gentlelady
2735 yields back, the chair now recognizes the gentleman from
2736 Pennsylvania, Dr. Joyce, for five minutes.
2737 *Mr. Joyce. Thank you, Chairman Guthrie and Ranking
2738 Member Eshoo, for holding this hearing today and for our
2739 panel for your testimony.
2740 Health care costs are something that every American
2741 faces, and even planned costs can represent substantial
2742 hardships for the hard-working constituents that we
2743 represent. Costs continue to keep rising, and we must be
2744 looking closely at this issue and working together to find
2745 solutions such as getting the Lower Costs, More Transparency
2746 bill signed into law.
2747 In 2024, total Federal spending on Medicare, Medicaid,
2748 and inflated ACA subsidies will eclipse the size of the
2749 discretionary budget. This is not sustainable, nor is it
2750 resulting in better outcomes. In fact, life expectancy in
2751 the U.S. has fallen back to levels that we have not seen
2752 since the early 1990s. Over-investment in some areas and
2753 under-investment in others has led to issues such as reduced
2754 access. It has caused misaligned incentives across the

2755 entire health care delivery system, resulting in increased
2756 costs. It has lowered efficiency, and it has only
2757 accelerated declining outcomes.
2758 One such area of under-investment is in the way Medicare
2759 compensates physicians. Even before rampant inflation and
2760 the COVID-19 pandemic, physicians were facing an
2761 unsustainable trend. When adjusted for inflation, Medicare
2762 physician payment already has effectively declined 26 percent
2763 from 2001 to 2023, and that is before additional inflation
2764 and these cuts are factored in.
2765 Also, physicians saw a 2 percent payment reduction for
2766 2023, and then again, since January 1st of this year, a 3.7
2767 percent cut. Ever thinning margins increase pressure for
2768 independent physicians to consolidate with hospitals.
2769 Dr. Ippolito, could a policy that advances site-neutral
2770 payments and reinvested savings into physician fee schedules
2771 lead to less hospital physician consolidation in health care?
2772 *Dr. Ippolito. Yes, and it would also attenuate the
2773 reductions in revenues to the hospitals themselves, because,
2774 of course, that would increase the new payment rate, which is
2775 the fee schedule. So yes.

2776 *Mr. Joyce. Dr. White, seeing how this continued
2777 underpayment has driven consolidation and requires seniors to
2778 receive care in higher-cost settings like hospitals'
2779 outpatient departments, how does the CBO account for these
2780 increased government outlays from consolidation when weighing
2781 the direct budgetary cost of providing necessary relief in
2782 the physician fee schedule?

2783 *Dr. White. Thank you for the question.

2784 So if policy were to shift from the current flat
2785 physician fees to being pegged to the Medicare economic index
2786 with automatic inflation adjustments, that would imply
2787 substantial Federal cost increases for physician fees.

2788 If it were coupled with a substantial site-neutral
2789 policy, we would take into account whether that would dampen
2790 consolidation, and maybe change the site of service. But we
2791 would have to look at that carefully. But the _

2792 *Mr. Joyce. And I think these are issues that we need
2793 to continue to look at very carefully as we drive physicians
2794 away from accepting Medicare patients.

2795 On another topic, driving increased mortality rates,
2796 heart disease is one of the top causes of mortality and

2797 expensive hospitalizations among our Medicare beneficiaries.
2798 During the pandemic flexibility for seniors to perform
2799 cardiac and pulmonary rehabilitation at home through
2800 telehealth waivers led to greater compliance with their care
2801 regimens and, in turn, fewer re-hospitalizations.
2802 Dr. Ippolito, there is data to show that cardiac
2803 rehabilitation can reduce hospitalizations by 30 percent
2804 among eligible beneficiaries. How can we best incentivize
2805 this high-value service and others like it that reduce
2806 patients accessing our health care system through the
2807 emergency room and other high-cost settings?
2808 *Dr. Ippolito. Well, the simple answer would be to make
2809 it financially worthwhile for people to provide. So through
2810 reimbursement, probably.
2811 *Mr. Joyce. And continuing access to those outpatient
2812 rehabilitations through telehealth is an important cost-
2813 cutting measure.
2814 *Dr. Ippolito. I would have to think more about the
2815 specific policy, but it certainly could be.
2816 *Mr. Joyce. Mr. Chairman, I would like to take just a
2817 moment of personal privilege and thank a staff member of mine

2818 who is leaving and moving on to another facet of his career,
2819 Mr. Nick Nastasi, who is present here with us today, a native
2820 son of New Jersey, Wildwood, New Jersey, a graduate of Seton
2821 Hall, he is a proud Pirate of Seton Hall, and I would ask
2822 each of us to join in thanking Nick Nastasi for his service
2823 to our team and to the Energy and Commerce Committee.
2824 Thank you, Nick.
2825 [Applause.]
2826 *Mr. Guthrie. Thank you.
2827 *Mr. Joyce. Thank you, Mr. Chair, and I yield.
2828 *Mr. Guthrie. Thank you for your service. We wouldn't
2829 _ this wouldn't work as well as it does without all the hard
2830 work that goes on from the folks who are behind us on both
2831 sides. So thank you.
2832 The gentleman yields back. The chair recognizes the
2833 gentlelady from California, Ms. Barragan, for five minutes
2834 for questions.
2835 *Ms. Barragan. Thank you, Mr. Chair.
2836 The United States spends twice as much per person on
2837 health compared to other high-income countries, and costs are
2838 projected to grow. As we have heard today, this is not

2839 sustainable, and we need to do more to put patients first.
2840 And with that I want to give a shout out to Power to the
2841 Patients, an advocacy group that has worked on health care
2842 price transparency.

2843 Thank you for the work that you do. I am looking
2844 forward to working with organizations and my colleagues to
2845 build upon the committee's prior work to increase
2846 transparency and accountability, while also investing in
2847 evidence-based programs that will lower cost.

2848 Ms. Tripoli, your testimony about the challenges
2849 consumers have to understand the price of health care
2850 services from hospitals was impactful. I represent a
2851 district where almost 70 percent of households reported
2852 speaking a non-English language at home as their primary
2853 language. This often reduces one's ability to understand
2854 complex paperwork and the consumer protections that may be in
2855 place. How can we address unexpected hospital and medical
2856 bills in a way that is inclusive for people who are not
2857 fluent in English?

2858 *Ms. Tripoli. Thank you very much for the question, it
2859 is a very important one.

2860 I think the _ in addition to making sure we actually get
2861 the pricing information and unveil it, we have to make sure
2862 that it is _ we have it translated in multiple different
2863 languages. And so I think that is probably the most
2864 important step, and that when _ regardless of what language
2865 you speak, that when you go into the website, a hospital
2866 website, and you are actually trying to shop and figure out
2867 what the service is and how much it costs, that it is
2868 readable, that you can understand it, that it is explained,
2869 and there is an explanation, there is an actual price in
2870 dollars and cents.
2871 Simplifying that information so that the American people
2872 can actually use the information as the end users of it is
2873 critical.
2874 *Ms. Barragan. Great, thank you.
2875 We spend nearly $2 billion on dental-related emergency
2876 room visits per year. Almost 80 percent of these cases could
2877 be prevented with access to routine dental health, dental
2878 care. I led several bills that will expand access to routine
2879 dental care in Medicaid, Medicare, and the Children's Health
2880 Insurance Program. How can investments in dental care save

2881 money for patients and taxpayers in the long run?

2882 Yes.

2883 *Ms. Tripoli. I think we know that right now we have a
2884 health care system that treats just the part of our body
2885 [sic]. But oral health care, dental care is part of our
2886 body, and when we have unmet oral health needs that go
2887 without treatment, without seeing a dentist or a dental
2888 provider, that that impacts our overall health in the long
2889 run, and can actually lead to higher-cost care in the long
2890 run.

2891 So ensuring that we have a comprehensive dental benefit
2892 in Medicare and Medicaid and across the commercial market is
2893 critical to ensure that every person has the health that they
2894 deserve.

2895 *Ms. Barragan. Great, thank you. Now, your testimony
2896 mentioned how surprise medical bills can lead to high out-of-
2897 pocket costs for patients, which in turn can contribute to
2898 medical debt. The Biden Administration has released
2899 guidelines on rules against surprise medical bills. As a
2900 result, as many as one million surprise medical bills are
2901 being prevented every month. What additional actions can

2902 Congress and the Administration take to build upon this
2903 success and continue to address surprise medical bills?
2904 *Ms. Tripoli. I think the first and foremost is to
2905 preserve the No Surprises Act, and to keep it whole, to make
2906 sure that it is implemented in its entirety as it was
2907 intended in statute. We know that there are many threats to
2908 the No Surprises Act in implementation, and that directly
2909 threatens the ability of consumers to be protected from
2910 surprise medical bills.
2911 So I think first and foremost is protecting and
2912 continuing the implementation, robust, strong implementation
2913 of the No Surprises Act.
2914 *Ms. Barragan. Great, thank you. Lastly, your
2915 testimony touched on how health outcomes are worse for people
2916 of color who experience higher rates of illness and death
2917 across a range of health conditions compared with their White
2918 counterparts. We know that Black Americans and Hispanic
2919 adults are also more likely to owe money for care. Can you
2920 talk about how the issue of medical debt can exacerbate
2921 health disparities that already exist in low-income
2922 communities and those of color?

2923 *Ms. Tripoli. Absolutely. I think medical debt, by
2924 definition, is forcing people into a very difficult position
2925 where they can't actually afford their care and they are
2926 having to make trade-offs. I think this has a
2927 disproportionate impact on low and middle-income individuals,
2928 which disproportionately make up people of color.

2929 So we have to make sure that, when we are addressing the
2930 affordability of health care, that when we are addressing the
2931 root causes, bringing down the price of health care at the
2932 root, it will help to eliminate people getting to the place
2933 where they have medical debt.

2934 *Ms. Barragan. Oh, thank you. I just want to thank
2935 again the committee for its work on lowering not just health
2936 care costs, but price transparency, which I think is a
2937 bipartisan issue that we have got to continue to move ahead
2938 and forward with.

2939 Thank you. I yield back.

2940 *Mr. Guthrie. Yes, thank you for the comments. The
2941 gentlelady yields back, and the chair recognizes the
2942 gentlelady from Iowa, Dr. Miller-Meeks, for five minutes.

2943 *Mrs. Miller-Meeks. Thank you, Mr. Chair, and I thank

2944 the witnesses for testifying today.

2945 Mr. Lyons, employees place a great deal of value on
2946 their health care benefits, but we know that, as health care
2947 costs continue to rise, employers have less money to spend on
2948 wages. There have been numerous studies linking high health
2949 care costs to lower wage growth, making it critical for
2950 American families that employers do everything that they can
2951 to keep health costs down while maintaining access to higher
2952 care.

2953 Can you discuss what strategies have been most
2954 successful in your plan, how price transparency can help
2955 lower costs, and if it would be of benefit to the United
2956 States to change their tax code that was incorporated after
2957 World War II to have health care costs as a benefit, rather
2958 than wage increases?

2959 *Mr. Lyons. Thank you. Being on both sides of the
2960 collective bargaining table, this is a very important topic.

2961 The plan that most municipal employees are in in New
2962 Jersey is called Direct 10. It is $45,000 for family
2963 coverage now. My members are paying $15,000 of that, but the
2964 taxpayers are paying $30,000 of that. We also have a two

2965 percent wage cap in New Jersey. So when we had a 31 percent
2966 increase over the past 2 years, there was no wage increase
2967 because that had to come out of their checks as a premium.
2968 So where we have been successful, some time ago we
2969 implemented a reverse drug auction and the state _ the
2970 estimate _ and once again, I wish I could give you real
2971 numbers, but they won't give me the data, so _ but the
2972 estimates were $2.53 billion over 5 years that we saved. So
2973 that is one place we have been fairly successful.
2974 We had some abusive practices going on in the state, and
2975 we were able to cap them, I think. Actually, I regret voting
2976 for it right now because it was the insurers' way of forcing
2977 people into their network, and we were used as pawns in that.
2978 So _ but that did save a significant amount of money, and
2979 there were some _ there are articles in ProPublica, there
2980 were some pretty intense abuses going on in PTOT and
2981 chiropractic. But we have got that under control, too.
2982 But that is probably the biggest successes. Quite
2983 frankly, we haven't had any successes in a few years. We are
2984 getting kicked around.
2985 *Mrs. Miller-Meeks. Thank you.

2986 Ms. Tripoli, Families USA has published a number of
2987 articles on rising health care costs and the role of
2988 consolidation and lack of Federal action on policies such as
2989 site-of-service reform. A March 2020 MedPAC report
2990 highlighted a 30-year trend in increasing hospital
2991 consolidation, stating that in 2017 one single hospital
2992 system was responsible for 50 percent of discharges in most
2993 markets, and drew a link between hospital consolidation and
2994 higher prices for patients.
2995 In 2010 I warned about this very thing happening with
2996 the passage of the Affordable Care Act _ actually, before and
2997 after the passage _ that it would lead to increased
2998 consolidation. Families USA has also published studies that
2999 claim hospital prices have increased roughly 31 percent since
3000 2015, and that hospital consolidation costs the average
3001 American family $1,000 annually.
3002 What policy proposals, other than the Lower Costs, More
3003 Transparency Act, should Congress be considering to pump the
3004 brakes on consolidation, and do you expect consolidation
3005 trends to continue absent Federal action?
3006 *Ms. Tripoli. Thank you for the question. I think,

3007 absolutely, we have seen a growing trend of consolidation
3008 dating back to the 1990s, I think, and even maybe before
3009 then. And so I think, without Federal action, without the
3010 oversight from the Federal Government and state regulators, I
3011 think we will, in fact, see the continued consolidation
3012 across the markets, within the markets in the United States
3013 healthcare system.
3014 I think there are a number of solutions that Congress
3015 could be considering outside of price transparency and site-
3016 neutral payment policy. But I think those two solutions, in
3017 particular, are so important for this moment. We have the
3018 Lower Costs, More Transparency Act, which, of course, has a
3019 limited site-neutral provision for drug administration
3020 services. It is a foothold to a broader discussion that we
3021 need to have and we hope that the members of this committee
3022 and your colleagues in the Senate and other members of the
3023 House will have about a more comprehensive, site-neutral
3024 policy.
3025 At the end of the day we need to be thinking about
3026 policies that are going to address the underlying broken
3027 incentives in the health care system that incentivize big

3028 hospital corporations, big health care corporations from
3029 consolidating, buying up more market power.
3030 *Mrs. Miller-Meeks. Thank you.
3031 I have just a few minutes. So Dr. Ippolito, if you
3032 could, briefly address this. You have written recently about
3033 shortcomings in the No Surprises Act, and have stated that
3034 there would be an advantage to eliminating the IDR process
3035 and replacing it with an explicit payment standard, or a
3036 requirement that facility-based clinicians contract with the
3037 same insurance plans as the facility. Who do you believe
3038 should be responsible for determining the explicit payment
3039 standard?
3040 And would there be a reason to believe that requiring
3041 facility-based clinicians to contract with the same insurance
3042 plans as the facility would cause more burden for the
3043 physician?
3044 *Dr. Ippolito. A very brief answer is that my concerns
3045 with the current system is that it is generating tremendous
3046 administrative costs, both to physicians and to insurers
3047 alike.
3048 In terms of who would set up the payment, that would be

3049 Congress. I know that wouldn't be an easy question, but that
3050 would be where it would fall.
3051 And the rest of it perhaps I can answer in a question
3052 for the record in more _
3053 *Mrs. Miller-Meeks. If you would, if you could answer
3054 in more detail in writing, that would be _
3055 *Dr. Ippolito. Absolutely.
3056 *Mrs. Miller-Meeks. _ very beneficial. Thank you.
3057 *Dr. Ippolito. Yes.
3058
3059
3060 [The information follows:]
3061
3062 **********COMMITTEE INSERT**********
3063

3064 *Mrs. Miller-Meeks. With that, I yield back my time.

3065 *Mr. Guthrie. Thank you, the doctor yields back. The
3066 chair now recognizes the gentlelady from Washington, Dr.
3067 Schrier, for five minutes for questions.

3068 *Ms. Schrier. Thank you, Chair Guthrie, and thank you
3069 to all of our witnesses today for joining us with all of your
3070 perspectives, which are very much aligned.

3071 Fifty-seven million seniors rely on Medicare for health
3072 coverage, and more than half of these beneficiaries are
3073 enrolled in Medicare Advantage, which has seen increased
3074 enrollment over the past decades. It is a lot like the
3075 health insurance that people are used to.

3076 In Washington State, 49 percent of Medicare
3077 beneficiaries are on a Medicare Advantage plan. Let me be
3078 clear. This can be a really good option for seniors. I know
3079 that firsthand. Both my parents have Medicare Advantage, and
3080 it provides good coverage, coupled with some benefits from my
3081 mom's union benefits, but Medicare Advantage is projected to
3082 cost CMS $943 billion by 2031. And if this is the growth
3083 that we can expect to be spending on these plans in the
3084 future, we are in trouble, and increased oversight is

3085 necessary.

3086 Now, I recently talked to a rural critical access
3087 hospital in my district, Kittitas Valley Hospital, about the
3088 administrative burden that accompanies Medicare Advantage
3089 plans. And they are hearing from their neighboring hospitals
3090 that up to 80 percent of Medicare Advantage claims are being
3091 rejected on the first pass, and this is after care has been
3092 provided. So rural hospitals are being forced to bear the
3093 administrative brunt of these denials, and patients are
3094 having to eat the cost, and it is just not fair or
3095 sustainable.

3096 And I wish I could point to more official data on this
3097 issue, but unfortunately, Medicare Advantage insurers do not
3098 report complete data on denied claims for services that have
3099 already been delivered. This prevents us from knowing what
3100 types of services are being denied, if denial rates vary
3101 across enrollee demographics, and on what grounds these
3102 claims are being denied. But given the difference between
3103 denied claims from private insurance companies and from
3104 Medicare Advantage, this certainly raises eyebrows for me.

3105 Ms. Tripoli, how does this lack of claims data hinder

3106 necessary oversight over the Medicare Advantage program?
3107 And are there other areas in Medicare Advantage that you
3108 think need more transparency?
3109 *Ms. Tripoli. Thank you for the question, and I think
3110 what you have laid out and what you have described is really
3111 _ is one of several abuses that we are seeing in the Medicare
3112 Advantage program, this aggressive denial of prior
3113 authorizations. We don't have enough data about this, so it
3114 is absolutely critical to have pricing transparency around
3115 the prior authorization denials that we are seeing.
3116 We are also seeing this very aggressive marketing to
3117 consumers around what the supplemental benefits are in
3118 Medicare Advantage, and yet we have very little insight into
3119 what are the supplemental benefits, how are consumers using
3120 them, what is the value to consumers, and yet we have many
3121 complaints coming in, some record number of complaints that
3122 they are saying, "What I was marketed is actually not what I
3123 am getting in the plan."
3124 And then, of course, we have _ it is really systematic
3125 intensity of coding, where MA plans are systematically making
3126 patients appear sicker than they actually are so that they

3127 can generate a higher reimbursement for Medicare. It
3128 resulted in $27 billion in overpayments in 2023 alone. That
3129 is significant.

3130 So we need transparency across the entire Medicare
3131 Advantage program.

3132 *Ms. Schrier. So you mentioned $27 billion in
3133 overpayments. And that is compared to private insurance
3134 companies? What is that compared to?

3135 *Ms. Tripoli. I would have to look exactly what the
3136 comparison is. But when you are looking at the traditional
3137 Medicare program to _ in comparison to Medicare Advantage,
3138 the research suggests that it is an overpayment, that they
3139 are getting _ that they are upcoding and submitting coding
3140 intensity so that they can actually take down more dollars
3141 from the Federal Government.

3142 *Ms. Schrier. So basically, fraudulent coding, a total
3143 boondoggle for insurance companies. And you add that to
3144 vertical integration and you have got just putting patients,
3145 hospitals, and the whole health care system at risk.

3146 I have a quick question to follow up with Dr. White.
3147 This is about how CBO scores. There has been a recent real

3148 demand for a class of drugs called GLP 1 agonists _ like
3149 Ozempic, for example _ that have been approved for adults
3150 with type 2 diabetes. They also have a pretty dramatic
3151 effect: weight loss, decreasing type 2 diabetes, heart
3152 disease, stroke, showing some evidence with addictions. It
3153 seems like, if you look long term, this could be real cost
3154 savings, but I am wondering how CBO evaluates that and if you
3155 can take that into effect as we talk about perhaps
3156 negotiating a deal with those companies.
3157 *Dr. White. So this is going to sound a little like a
3158 broken record. We have a team working on the anti-obesity
3159 medications, GLP 1s. And what they are digging into is what
3160 is the price that Medicare would pay if those drugs were
3161 available outside of diabetes, and we are looking at what are
3162 the health impacts of people who go on the drugs and, in
3163 particular, what are the accumulated impacts if they stay on
3164 the _ on those drugs for years and years. There is a lot of
3165 _
3166 *Ms. Schrier. I am out of time. I want to thank you.
3167 *Dr. White. Sorry about that.
3168 *Ms. Schrier. Please submit in writing.

3169 [The information follows:]

3170

3171 **********COMMITTEE INSERT**********

3172

3173 *Ms. Schrier. And I yield back. Thank you.

3174 *Dr. White. I would be happy to.

3175 *Mr. Guthrie. Thank you. Dr. Schrier yields back. The
3176 chair recognizes the gentleman from Texas, Mr. Pfluger, for
3177 five minutes for questions.

3178 *Mr. Pfluger. Thank you, Chairman, for saving the best
3179 for last, and letting me waive on to this committee. I
3180 appreciate it, and I thank the witnesses. I represent a
3181 district that is rural. We have about 3 or 4 towns that are
3182 about 100,000 people, so _ in west Texas. There is not a
3183 single event or town hall or meeting with constituents that I
3184 don't go to where the cost of health care is not brought up.
3185 It is obviously a concern. So I appreciate you being here.
3186 I will start with Dr. White.

3187 Just looking at the demographics, the expanding
3188 especially elderly demographic that we have, you know, in our
3189 country, and also an expanded demand for health care, what
3190 can you tell us about, you know, the _ your _ the observed
3191 escalation in health care expenditures, and to what extent is
3192 that demographic, you know, going to provide maybe a bubble
3193 of cost to our country?

3194 *Dr. White. Thank you for the question. So in the
3195 Medicare program we are in the middle, maybe getting toward
3196 the flattening point of the Baby Boomers aging into Medicare.
3197 That is a huge driver of increase in Medicare spending.
3198 In terms of growth in _ per enrollee Federal subsidy
3199 costs, Medicare is actually lower than for employer-sponsored
3200 insurance. With employer-sponsored insurance, growth in the
3201 prices paid to providers is driving up the per-person
3202 subsidized cost. So Medicare demographics are a big deal.
3203 Eventually, the Baby Boomers will have aged into the program,
3204 and that will level out.
3205 *Mr. Pfluger. Thank you.
3206 Ms. Martin, for you, in recent years the bipartisan
3207 commitment has been to achieve the substantial transparency
3208 in health care pricing for patients and payers. And can you
3209 kind of clarify how the enhanced price transparency can
3210 contribute to the reduction of cost?
3211 *Ms. Martin. Yes. I think opacity certainly hasn't
3212 served us well over the past few years, so just having _
3213 understanding what is driving costs, how money is flowing
3214 through the system can help public and private decision-

3215 makers understand cost drivers and to design interventions
3216 that can rein in health care spending.
3217 *Mr. Pfluger. Thank you.
3218 And Dr. Ippolito, when employers choose a health
3219 insurance plan for their employees, they sometimes lack the
3220 insight into the payment negotiations between the hospitals
3221 and providers and the insurers. Does this limited
3222 information impede employers from selecting cost-effective
3223 and high-quality care options?
3224 And could making prices more available to the employer
3225 empower them to negotiate lower prices?
3226 *Dr. Ippolito. Yes, the short answer is yes. If you
3227 give the informed consumer _ in this case, the employer _
3228 better information about what they are choosing and they have
3229 better ability to cost shop against competing plans, I think
3230 they are going to make a better choice and save money.
3231 *Mr. Pfluger. I will stick with you for just a second
3232 on hospital costs and how some _ whether it is vertical
3233 integration or mergers and acquisitions or the purchasing of
3234 _ you know, using organizations to maybe purchase physician's
3235 groups and practices, talk to us about how that is

3236 contributing to the escalation in prices.

3237 *Dr. Ippolito. Well, one part of that story is very
3238 easy. Horizontal consolidation, hospital buying hospital,
3239 clearly increases prices, and it doesn't seem to have a major
3240 improvement on quality metrics.

3241 The vertical side, a hospital buys a doctor or an
3242 insurer buys a PBM, is a little bit more complicated, but
3243 there are certain risks _ namely, that you might steer
3244 patients to your own _ other parts of your own entity that
3245 may or may not be in their best interest, for example.

3246 So those are the kind of things we know less about in
3247 the research world, but those are the kinds of things that we
3248 would worry about in those settings.

3249 *Mr. Pfluger. Is there a rural aspect that is maybe
3250 over-exaggerated in that?

3251 *Dr. Ippolito. I think rural areas tend to have a more
3252 fundamental problem, which is, even in the best case scenario
3253 there might not be that many hospitals in the first place,
3254 there might not be that many doctors. And so, yes, these
3255 types of issues tend to be a little bit more exacerbated in
3256 those areas.

3257 *Mr. Pfluger. Okay, and I will finish with Ms. Tripoli.
3258 In your testimony you mentioned that there are few truly
3259 competitive health care markets left. And I think you said
3260 with 95 percent of metropolitan statistical areas having
3261 highly concentrated hospital markets, nearly 80 percent of
3262 MSAs having highly concentrated specialty physician markets,
3263 and 58 percent of MSAs having highly concentrated insurer
3264 markets, what measures are necessary to enhance the
3265 competitiveness?
3266 And then, if you can, also focus on the rural side. I
3267 have got 30 seconds left.
3268 *Ms. Tripoli. Sure. I think, as we have been talking
3269 about price transparency, unveiling prices, forcing the
3270 market to compete on fair prices and quality of care is
3271 critical. Reducing some of the broken incentives that
3272 incentivize higher-cost care and are incentives to
3273 consolidate. Addressing the markets and the condition around
3274 anti-competitive contracting practices, things that _ anti-
3275 steering measures are really important to increase
3276 competition in the market, among other solutions.
3277 *Mr. Pfluger. I thank the witnesses.

3278 Mr. Chairman, thank you for having me.
3279 *Mr. Guthrie. Thank you. The gentleman yields back.
3280 The chair recognizes the gentleman from Maryland, Mr.
3281 Sarbanes, for five minutes.
3282 *Mr. Sarbanes. Thank you very much, Mr. Chairman.
3283 Today's hearing focuses on critical issues that an
3284 overwhelming number of Americans want Congress to take action
3285 on. In particular, this issue, obviously, of lowering the
3286 cost of health care.
3287 One area _ and I know you all know this _ where we have
3288 seen a significant increase in spending in recent years is
3289 Medicare Advantage. Enrollment in MA plans has more than
3290 doubled over the last decade, and per capita spending for
3291 these plans is both higher and faster growing than spending
3292 in traditional Medicare.
3293 According to MedPAC, in 2023 the Federal Government
3294 spent six percent more on MA enrollees than it would have
3295 spent for those same enrollees in traditional Medicare, but
3296 not because these beneficiaries had higher health care
3297 expenditures. In fact, they actually had below-average
3298 health expenditures. There is something wrong with that

3299 picture.

3300 High costs are instead driven by the fact that over-
3301 payments to MA plans last year were expected to total $27
3302 billion, and inflated payments as a result of insurers
3303 intense coding practices will amount to an additional $23
3304 billion on top of that.

3305 Ms. Tripoli, how do the over and inflated payments to MA
3306 plans increase costs for seniors?

3307 *Ms. Tripoli. I think the biggest abuse, as you
3308 outlined, is what we are seeing as sort of this systematic
3309 process where MA plans are actually intensively coding _
3310 upcoding patients, making them appear sicker than they
3311 actually are. That increases the overall cost of care for
3312 the Medicare program. And eventually, that gets absorbed
3313 back into the cost of care for beneficiaries.

3314 *Mr. Sarbanes. And despite this high spending,
3315 taxpayers and the Federal Government have very little data on
3316 the supplemental benefits these plans provide, the
3317 supplemental benefits, which makes it very difficult to
3318 assess their true value. This is especially critical because
3319 in most states individuals who opt to enroll in an MA plan

3320 when they turn 65 may be locked out from Medigap supplemental
3321 coverage with important consumer protections, should they
3322 then choose to switch to traditional Medicare later on.
3323 Ms. Tripoli, would increased transparency from MA plans
3324 promote a better understanding of the value of these plans,
3325 while helping to lower costs for seniors?
3326 *Ms. Tripoli. Absolutely, particularly as we are seeing
3327 such aggressive marketing from MA plans about their
3328 supplemental benefits. So yes, we need much more
3329 transparency around what the value is to consumers and what
3330 they are actually getting.
3331 *Mr. Sarbanes. Mr. Ippolito, would you agree that more
3332 data on the value of MA plans would help policymakers make
3333 better decisions about how to lower spending while
3334 maintaining value?
3335 *Dr. Ippolito. In general, yes.
3336 *Mr. Sarbanes. I have introduced legislation, H.R.
3337 5380, to make data on the scope, utilization, and cost,
3338 including to beneficiaries, more available and consistent
3339 across health plans. Dr. Ippolito and Ms. Tripoli, I would
3340 love to hear your thoughts. Would this type of data be

3341 helpful in controlling overpayments and ensuring tax dollars
3342 are actually being used to promote better care and resulting
3343 in better health outcomes for seniors?
3344 Ms. Tripoli?
3345 *Ms. Tripoli. I think, in general, yes, it would help
3346 _ it would be helpful data.
3347 *Mr. Sarbanes. Do you agree, Mr. Ippolito?
3348 *Dr. Ippolito. In general, yes, I do.
3349 *Mr. Sarbanes. Thank you. I hope the full House will
3350 follow the committee's lead and pass H.R. 5380 to help
3351 continue increasing transparency and lower costs for seniors.
3352 I am also glad that the committee has taken a
3353 significant step in this direction through the Lower Costs,
3354 More Transparency Act, which includes legislation that
3355 Representative Joyce and I introduced that would require
3356 hospital-based providers to use a unique identifier for each
3357 of their facilities when billing Medicare.
3358 And Dr. Ippolito, I would be interested in hearing from
3359 you. Would simple policies like this that ensure providers
3360 are correctly billing under current law, or those that go a
3361 step further to ensure patients are not charged more for a

3362 service simply because of where it is provided, would that
3363 help contain rising health care costs?
3364 *Dr. Ippolito. Yes, I think it should.
3365 *Mr. Sarbanes. Okay. I appreciate very much your
3366 testimony.
3367 And I yield back. Thank you, Mr. Chairman.
3368 *Mr. Guthrie. The gentleman yields back. The chair
3369 recognizes the gentleman from Texas, Mr. Crenshaw, for five
3370 minutes.
3371 *Mr. Crenshaw. Thank you, Mr. Chairman, and thank you
3372 for _ all our witnesses, for being here and on this important
3373 topic.
3374 I think the way we pay for health care is the most
3375 frustrating thing about health care in America, and the way
3376 we finance it, and it is clear as day that it is the primary
3377 driver of our debt. Despite all the hand-wringing and
3378 yelling and screaming about our annual appropriations process
3379 that we do up here, that appropriations process is completely
3380 dwarfed by our health care spending.
3381 New data shows that between Medicare, Medicaid, and
3382 Affordable Care Act spending, it actually is larger, just

3383 those three, larger than all of our discretionary spending.
3384 And I did not say Social Security. Social Security is not
3385 even included in that bucket. So that is really something.
3386 Medicare and Medicaid, ACA all bigger than our entire
3387 appropriations bill that we will eventually pass.
3388 Health care is a difficult issue because we want market
3389 forces to be available within it to create competition, which
3390 is what drives prices lower, and to increase quality. But we
3391 also want it to be available and accessible to all Americans,
3392 so it makes it a difficult problem. But I want to focus on
3393 how it is the biggest driver of our spending. Two-thirds of
3394 our spending is _ it is on autopilot, it is automatic.
3395 So Dr. White, last year the Congressional Budget Office
3396 estimated the Federal deficit would grow over the next 10
3397 years by 4 trillion. But then, 9 months later, that estimate
3398 changed to 20 trillion. That is a pretty big difference.
3399 Can you explain to me the role that mandatory government
3400 programs have in driving that deficit increase? Four
3401 trillion to twenty trillion is a pretty big deal.
3402 *Dr. White. That is a complicated question. So I will
3403 just say that there are a lot of moving parts in the update

3404 to our projections of the deficit, and I know my boss, Dr.
3405 Swagel, has been testifying to the House Budget Oversight
3406 Committee on updates to our deficit estimates for fiscal 2023
3407 and going forward.

3408 In the health care space we have actually been doing a
3409 pretty good job of projecting where those Federal subsidies
3410 are going, and the Federal subsidies for health care actually
3411 aren't a big player in the update of our deficit estimate for
3412 2023. We did underestimate the take-up of the expanded,
3413 enhanced subsidies for the ACA marketplace plans. We
3414 underestimated that. We have boosted our take-up projections
3415 of those plans, but it is not a huge driver of the updates to
3416 our deficit projections.

3417 *Mr. Crenshaw. So can we, you know, as these subsidies
3418 are set to expire, can we expect insurance subsidies to grow
3419 the deficit more if they are extended without reform, or are
3420 you saying they are not a big driver?

3421 *Dr. White. If the enhanced subsidies were extended
3422 past 2025, that would increase Federal costs.

3423 *Mr. Crenshaw. Do you have an estimate on how much?

3424 *Dr. White. I don't have one at my fingertips. I would

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3425 be happy to respond to writing.

3426 *Mr. Crenshaw. Okay.

3427 [The information follows:]

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3429 **********COMMITTEE INSERT**********

3430

3431 *Mr. Crenshaw. Dr. Ippolito, during our last hearing
3432 you had mentioned that direct primary care might be a more
3433 cost-efficient overall type of practice, since it is a form
3434 of capitation. What role do personalized care models like
3435 direct primary care play in creating a marketplace that
3436 lowers costs?
3437 *Dr. Ippolito. Yes, so I stand by that assessment. In
3438 general, health insurance is good at protecting people
3439 against uncertain high-cost events. Things that are routine,
3440 relatively low cost, are relatively bad candidates for
3441 inclusion in health insurance. So to the extent that there
3442 are innovative models that try and take it out of that
3443 relatively high administrative cost setting, I think that is
3444 worth exploring.
3445 *Mr. Crenshaw. Well, I appreciate it.
3446 And Ms. Martin, you focus on patient behavior. What
3447 does the continuity of care approach, especially through
3448 options like direct primary care, do for addressing overall
3449 health care spending?
3450 *Ms. Martin. The impact of direct primary care spending
3451 on continuity of care is beyond the scope of what we would

3452 ordinarily look at. So I would like to think about that some

3453 more and get back to you.

3454 *Mr. Crenshaw. Okay.

3455

3456 [The information follows:]

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3458 **********COMMITTEE INSERT**********

3459

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3460 *Mr. Crenshaw. One comment in my last few seconds is on
3461 the small business insurance costs. In 2021, small business
3462 employee premiums increased by at least 12 percent relative
3463 to the previous year. Based on the Agency for Healthcare
3464 Research and Quality Data, we saw employee contributions rise
3465 by 24 percent in the last 10 years for small employers, and I
3466 think it is clear small businesses are bearing the brunt of
3467 insurance costs.
3468 And, you know, Dr. _ well, I am out of time, so I won't
3469 ask the question, but I think it is important to level the
3470 playing field and allow small businesses to provide
3471 affordable coverage to their employees, and congregate and
3472 associate as such.
3473 Thank you, I yield back.
3474 *Mr. Guthrie. Thank you. The gentleman yields back.
3475 The chair welcomes our member of the full committee to our _
3476 the subcommittee this morning, my good friend from Illinois.
3477 Congresswoman Schakowsky, you are recognized for five
3478 minutes for questions.
3479 *Ms. Schakowsky. Thank you, Mr. Chairman, and I want to
3480 thank you and the ranking member for allowing me to waive on

3481 to the committee which is so important.

3482 Current estimates say that Medicare Advantage are over

3483 _ what is it? Come here. What is it? Oh, have been

3484 overcharging taxpayers by up to $140 billion, and this is a

3485 serious problem, I think.

3486 And to put this in perspective, $140 billion could

3487 actually pay for Medicare Part D, or it actually could be

3488 able to cover dental, and health, and vision care that would

3489 be done by traditional Medicare.

3490 Despite this unconscionable, I think, price gouging that

3491 we are seeing, I think in addition we are now seeing that the

3492 _ we are also seeing that private equity is getting into the

3493 picture here. And I wanted to talk to you about that, also.

3494 So now we see that _ in Medicare Advantage, that there

3495 are now groups that are _ I am sorry, I am having trouble.

3496 That what? Yes, we are seeing vertical integration of

3497 Medicare Advantage.

3498 And what I really _ I wanted to ask, Ms. Tripoli, if you

3499 could talk about what this really means for _ this vertical

3500 integration is doing for Medicare Advantage. And it seems to

3501 me that it is contributing to the higher costs that consumers

3502 are having to pay.

3503 *Ms. Tripoli. Thank you so much for the question.

3504 So the evidence suggests that MA plans that are

3505 vertically integrated are actually more likely to engage in

3506 the upcoding, which is the practice that you are referring to

3507 that is generating these billions of dollars, multiple

3508 billions of dollars of overpayments. And this suggests that

3509 plans could actually be putting pressure on the providers

3510 that are _ that they have vertically integrated, so providers

3511 that they own, to increase the intensity of the coding, so to

3512 upcode their patients, make them appear more sick than they

3513 actually are so that they can actually get a higher

3514 reimbursement, get higher payments from Medicare.

3515 So I would say this is, of course, a hugely problematic

3516 practice, and one that should be scrutinized further.

3517 *Ms. Schakowsky. Thank you. Well, you know, we are

3518 also seeing that health _ that the care is being sacrificed,

3519 as well, that we are seeing a lot of people who aren't

3520 getting the services that they want. I hear it all the time

3521 in my office. Have you seen that?

3522 *Ms. Tripoli. Yes. Well, we are seeing under _ that

3523 many Medicare Advantage plans are aggressively marketing to
3524 seniors about the supplemental benefits that they could get
3525 if they enrolled in their plan. And what we have actually
3526 seen in the last couple of years is a huge spike in
3527 complaints from seniors saying that what was marketed to me
3528 is not actually what I have in this plan.
3529 So I think we don't have enough information, enough
3530 transparency around what the simple benefits are that MA
3531 plans are marketing to seniors and actually offering what the
3532 value is to consumers, how they are using them. And so I
3533 think increased transparency around _ in general, for
3534 Medicare Advantage, but particularly for supplemental
3535 benefits, would be critical.
3536 *Ms. Schakowsky. So I did want to say that private
3537 equity has become a major player when it comes to health care
3538 systems. And we know that a 600 percent increase in private
3539 equity being involved in physician practices. And we also
3540 see that 400 hospitals right now are now private equity.
3541 And so I also wanted to ask you, Ms. Tripoli, on _ in
3542 your testimony, that you talked about transparency is very,
3543 very important. I actually have a bill that would require

3544 these companies to divulge them themselves. And I wanted to
3545 see if you could explain how private equity ownership may
3546 also interfere with health costs and maybe health outcomes.
3547 *Ms. Tripoli. Absolutely. I think we have to generally
3548 be very skeptical of private equity mergers and acquisitions
3549 in health care. The data that we do have suggests that
3550 quality does go down and prices go up, higher fall rates,
3551 more hospital-acquired conditions when private equities come
3552 in and acquire a hospital system.
3553 In general, we have a lot of opaqueness around this
3554 change of ownership among private equity when they are doing
3555 mergers and acquisitions. So having more transparency around
3556 that level of information would be really important to better
3557 understand the trends in the market, and actually would help
3558 to facilitate Federal and state investigators to scrutinize
3559 private equity mergers and acquisitions in health care.
3560 *Ms. Schakowsky. I appreciate that.
3561 I can see my time is up and I yield back.
3562 *Mr. Guthrie. Thank you. Thank you for joining the
3563 committee this morning, and thank you for your questions.
3564 And thank everybody for here _ to be here to answer

3565 questions. I see no other member here present to ask
3566 questions. I know it has been a long morning, but it is
3567 absolutely informative, and I don't think that you see as
3568 much on television that we are _ there are some details that
3569 we have to work through, but we are really committed as a _
3570 bipartisan to get this done, so that people know what they
3571 are paying for health care.
3572 And I think _ I would _ used about a minute, so do you
3573 want to say anything, or _ you can say that, since I did. I
3574 just want to be fair.
3575 *Ms. Schrier. I would agree, this is one of the biggest
3576 kitchen table expenses for families, and we want to know how
3577 to fix this in a way that serves patients and our entire
3578 health care system, and does not become a boondoggle for
3579 people who are currently profiting disproportionately.
3580 Thank you.
3581 *Mr. Guthrie. Thank you, I thank you.
3582 And so now we will move to _ I am going to ask unanimous
3583 consent to insert in the record the documents included on the
3584 staff hearing document list, which you have.
3585 Without objection, that will be in order.

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3586 [The information follows:]

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3588 **********COMMITTEE INSERT**********

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3590 *Mr. Guthrie. And then I will remind members that they
3591 have 10 business days to submit questions for the record, and
3592 I ask the witnesses _ I know you commented in your testimony
3593 you are going to answer questions, and you will have them in
3594 writing _ that you will respond promptly to those questions.
3595 And members should submit their questions by the close of
3596 business on February the 14th. So that is the date you
3597 submit your questions.
3598 And again, thank you. It means a lot for you all to
3599 spend the time to be here, and we much appreciate it and have
3600 learned a lot.
3601 And without objection, the subcommittee is adjourned.
3602 [Whereupon, at 12:58 p.m., the subcommittee was
3603 adjourned.]