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6 EXAMINING STATE EFFORTS TO IMPROVE

7 TRANSPARENCY OF HEALTH CARE COSTS FOR

8 CONSUMERS

9 TUESDAY, JULY 17, 2018

10 House of Representatives

11 Subcommittee on Oversight and Investigations

12 Committee on Energy and Commerce

13 Washington, D.C.

14

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17 The subcommittee met, pursuant to call, at 10:15 a.m., in  
18 Room 2322 Rayburn House Office Building, Hon. Gregg Harper  
19 [chairman of the subcommittee] presiding.

20 Members present: Representatives Harper, Griffith, Barton,  
21 Burgess, Brooks, Collins, Walberg, Walters, Costello, Carter,  
22 Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke,

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23 Ruiz, and Pallone (ex officio).

24 Staff present: Jennifer Barblan, Chief Counsel, Oversight  
25 & Investigations; Lamar Echols, Counsel, Oversight &  
26 Investigations; Ali Fulling, Legislative Clerk, Oversight &  
27 Investigations, Digital Commerce and Consumer Protection;  
28 Jennifer Sherman, Press Secretary; Austin Stonebraker, Press  
29 Assistant; Hamlin Wade, Special Advisor, External Affairs; Jeff  
30 Carroll, Minority Staff Director; Chris Knauer, Minority  
31 Oversight Staff Director; Miles Lichtman, Minority Policy  
32 Analyst; Kevin McAloon, Minority Professional Staff Member; C.J.  
33 Young, Minority Press Secretary; and Perry Lusk, Minority GAO  
34 Detailee.

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35 Mr. Harper. Call to order the hearing of the Subcommittee  
36 on Oversight and Investigations.

37 Today, the Subcommittee on Oversight and Investigations is  
38 holding a hearing entitled, "Examining State Efforts to Improve  
39 Transparency of Health Care Costs for Consumers." We are here  
40 today because health care costs continue to rise in the United  
41 States and many Americans are struggling to budget and pay for  
42 their health care expenses.

43 According to the Centers for Medicare and Medicaid Services,  
44 we spent \$3.3 trillion on health care costs in 2016, which means  
45 that nearly 18 percent of the overall share of gross domestic  
46 product was related to health care spending. About 32 percent  
47 of health care spending in 2016 was on hospital care, 20 percent  
48 was on physician and clinical services, and about 10 percent of  
49 the spending was on prescription drugs.

50 The committee has been actively looking at these concerning  
51 trends and has held a number of hearings examining some of the  
52 causes of increased health care costs, and increasing health care  
53 costs. Last year, the Oversight and Investigations Subcommittee  
54 held two hearings on the 340B Drug Pricing Program and issued  
55 a report with the findings from our investigations. In February,  
56 the subcommittee held a hearing examining consolidation in the

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57 health care market, and examined the impact of consolidation on  
58 health care competition and innovation.

59 As health care costs continue to rise, many Americans still  
60 have no idea how much something will cost them before they receive  
61 care. Oftentimes, they only know their out-of-pocket costs once  
62 they have gotten the care and get their bill weeks, sometimes  
63 months later. The purpose of today's hearing is to examine state  
64 laws and policies that have an impact on health care costs and  
65 what can be done to lower costs for all Americans through more  
66 transparency of health care costs.

67 These transparency efforts have generally attempted to  
68 provide consumers information about different types of health  
69 care costs, including information about the cost of health care  
70 services and the cost of prescription drugs. In our work, we  
71 have heard that there are a number of issues that make it difficult  
72 for some of these efforts to be effective.

73 For example, sometimes there may be contractual provisions  
74 that limit the sharing of certain price information or concerns  
75 that the sharing of certain price information may be  
76 anti-competitive. Moreover, health care billing is complex and  
77 it can be difficult to provide the information to consumers in  
78 a meaningful way that is useful to them. Similarly, only a small

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79 percentage of health care services may be "shoppable." I hope  
80 to hear more about some of the barriers to transparency and what,  
81 if anything, Congress can do to help.

82           Unfortunately, early evidence suggests that some price  
83 transparency tools have not helped facilitate price shopping and  
84 lower consumer costs. I, therefore, look forward to hearing more  
85 from the witnesses about why this is the case, and what forms  
86 of transparency might help consumers as they budget for their  
87 care and make better health care decisions. For example, do we  
88 need to pair transparency with some other mechanism for it to  
89 be most effective?

90           The cost of certain health care services can vary  
91 significantly in the same geographic region at different sites  
92 of care. For instance, a 2014 study by the U.S. Government  
93 Accountability Office found that the estimated cost of maternity  
94 care at select, high-quality acute care hospitals in the Boston  
95 area ranged between \$6,834 and \$21,554, over a 200 percent  
96 difference.

97           A more recent 2018 study found that median price of magnetic  
98 resonance imaging, an MRI, of the spine ranges from \$500 to \$1,670  
99 in Massachusetts, also over a 200 percent difference.

100           Empowering consumers with more information about the cost

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101 and quality of their care helps to reduce wasteful spending and  
102 save families money.

103 As we move forward, we have to keep in mind that there is  
104 a delicate balance between beneficial transparency and  
105 transparency that ultimately harms competition and consumers.

106 The Federal Trade Commission has highlighted that it is important  
107 to give consumers the precise information they need to make better  
108 health care decisions. The agency also has cautioned, however,  
109 that it is important to avoid broad disclosures that may chill  
110 competition in the health care market.

111 I welcome and thank the witnesses for being here today.  
112 I look forward to their testimony.

113 And I will now recognize Ms. Castor for purposes of an opening  
114 statement.

115 Ms. Castor. Well, thank you, Mr. Chairman. Thank you for  
116 calling this important hearing. I think it is a worthy topic.

117 But, I wanted to note at the outset it has been almost one  
118 month since the Democrats on this committee have requested an  
119 oversight hearing on the Administration's family separation  
120 policy. The Energy and Commerce Committee has primary  
121 responsibility for oversight of the Department of Health and Human  
122 Services. We have had over the last month a number of hearings

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123 on many varied topics, but none are as important as what is  
124 happening as children who are ripped away from their family.  
125 Now, courts have ordered reunification.

126 It is our responsibility as members of Congress, especially  
127 in the Oversight Committee of Energy and Commerce, to have an  
128 oversight hearing to get to the bottom of this. We hear  
129 horrifying stories every day about the impact on children.

130 And so at this time I am going to renew the request of the  
131 Democrats on Energy and Commerce to schedule an oversight hearing  
132 as soon as possible on the family separation policy.

133 Now, health care costs, also a very worthy topic. And if  
134 we were to schedule another important oversight hearing, it  
135 certainly should be on the impact of the Trump administration's  
136 lawsuit that where they claim that preexisting conditions should  
137 not be a right of American families, especially in their health  
138 care policy. That would be another very worthy oversight  
139 hearing. But, right now we are here on transparency, so let's  
140 talk about that.

141 I understand that every family feels a very significant  
142 impact of rising prices. And part of the, part of the problem  
143 is the fact that health care consumers often have no visibility  
144 into how much services are actually going to cost.

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145           And depending on multiple factors, such as where you live,  
146 your insurance, the type of provider, costs can vary greatly and  
147 are unpredictable. That makes health care unlike virtually any  
148 other purchase, and it makes it more difficult to constrain costs.

149           There are all sorts of reports out there -- many of you all  
150 have experienced this -- of outrageously high bills received by  
151 unsuspecting consumers. Plus, it is darn confusing sometimes.

152           You get a bill and it says this is your responsibility, this  
153 is what is paid, and people simply don't, don't, get it.

154           There was a couple in California recently who were reportedly  
155 charged over \$18,000 for a 3-hour visit to an emergency room where  
156 their baby was examined, took a nap, and drank formula. And  
157 another patient received two CT scans that varied between \$268  
158 and \$9,000.

159           These shockingly high bills are frustrating and can  
160 devastate a family's finances. For that reason, greater  
161 transparency can theoretically provide consumers with more  
162 information to make decisions and to predict the costs that they  
163 are going to incur.

164           To that end, many states have taken some action to bring  
165 more transparency to health care. But it isn't always easy.  
166 My home State of Florida, for example, established a website that

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167 allows consumers to search for health care prices at hospitals  
168 and outpatient surgery centers in 2007, but consumers don't know  
169 about it. And one of the problems is it doesn't even contain  
170 all of the hospitals that are in your market, and it doesn't  
171 contain a lot of the leading health insurers' information in our  
172 state.

173           So there, Florida is currently struggling with trying to  
174 launch another health care transparency website but now the cost  
175 is really escalating. It has been \$4 million to get that up and  
176 running, and we don't have a lot to show for it.

177           Other states now require pharmaceutical companies to  
178 publicize and provide information related to large increases in  
179 prices for certain drugs. And here in the House I am a proud  
180 cosponsor of Congresswoman Schakowsky's Fair Accountability and  
181 Innovative Research Drug Pricing Act, which would require drug  
182 companies to report an increase in certain drug prices by more  
183 than 10 percent in a year to HHS, and submit transparency and  
184 justification reports before they increase the price of certain  
185 drugs by 10 percent.

186           We should move initiatives that can help consumers control  
187 their health care costs. But transparency in our health care  
188 system shouldn't be the only tool in our tool box. It has to

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189 be accompanied with other improvements to have a meaningful impact  
190 on the actual cost of care.

191 So, I am looking forward to hearing the witnesses today.

192 I look forward to hearing from you on how we can use health care  
193 transparency to lower costs for our neighbors back home.

194 Thank you, and I yield back.

195 Mr. Harper. The gentlewoman yields back.

196 The chair will now recognize the chairman of the full  
197 committee, Mr. Walden, for five minutes.

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198           The Chairman. Thank you very much, Mr. Chairman. I  
199 appreciate your holding this hearing on the various transparency  
200 efforts at the state level to engage patients in health care  
201 decision making processes.

202           As Chairman Harper mentioned in his opening statement,  
203 health care costs are increasing and are expected to continue  
204 to rise. In 2016, the U.S. spent approximately \$3.3 trillion  
205 on health care, and the Center for Medicare and Medicaid Services,  
206 CMS, estimates that spending will reach \$5.7 trillion in 2026.

207           Health care costs are having a substantial impact on the  
208 budgets of American families and individuals. In addition to  
209 health insurance premiums increasing, patients are also directly  
210 responsible for more of their health care costs. In 2016, about  
211 11 percent of the \$3.3 trillion spent on health care was paid  
212 for directly by consumers through out-of-pocket costs, which was  
213 about \$352 billion.

214           Unsurprisingly, as health care costs increase, most patients  
215 want to know more about how much different medical services and  
216 products are going to cost them. We all do. That is why we are  
217 having this hearing. I have heard numerous stories about  
218 individuals who were going to have a medical procedure or lab  
219 work performed, found it nearly impossible, and in some instances

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220 literally impossible, to learn how much it was going to cost them  
221 before they got the care. A lot of doctors don't even know how  
222 much different services are going to cost.

223 Many states have adopted policies to prohibit some types  
224 of "gag clauses" and help patients get access to the prices for  
225 prescription drugs. Twenty-two states have passed legislation  
226 prohibiting clauses in contracts that prohibit pharmacists from  
227 telling patients price options for their prescription medicine.

228 In addition to these recent efforts to encourage price  
229 information sharing with patients at the pharmacy counter,  
230 several states have engaged in efforts to provide patients with  
231 more information about the price and quality of different health  
232 care services. Some of these efforts include creating websites  
233 that give patients information about the prices of different  
234 procedures, requiring insurers to provide these tools to their  
235 members, and requiring providers to give patients information  
236 about the estimated prices for their treatment before they get  
237 the treatment. Unfortunately, to date, some of the preliminary  
238 evidence has shown that these some -- that these tools haven't  
239 been very effective in getting patients to price shop.

240 If we are going to successfully reduce health care costs,  
241 we need to empower patients and we need to engage them in the

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242 decision-making process. So there needs to be greater  
243 transparency so patients can have more information about the  
244 prices for different medical products and services, and that  
245 information needs to be given to them in a meaningful way.

246 Given that some of the existing price transparency tools  
247 are still able to be improved, I am eager to hear from our witnesses  
248 today about why there are some of these barriers, and then also  
249 what else we can do to empower patients with the information.

250 I also want to hear about the role the Federal Government can  
251 play in promoting transparency and making patients more informed  
252 about the cost of their care.

253 Patients should be able to learn about how much something  
254 is going to cost before they get it. This includes having  
255 information about different price options for prescription drugs  
256 at the pharmacy counter, and information about different  
257 procedures and lab work, among other things.

258 So, we have got a lot of questions for our witnesses today.  
259 We really appreciate your being here. But one of my main  
260 questions is what is the best way for patients to get health care  
261 price information, and how can we empower the consumer?

262 I am also interested in hearing about any market behaviors  
263 that work against transparency and ultimately harm any attempts

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264 to bring down health care costs.

265 So, thanks for being here. This is a big priority for me  
266 and for the committee to look into all the costs of health care.

267 With that I will just warn you, I have got another hearing  
268 going on downstairs so I have to bounce back and forth. But I  
269 will yield the balance of my time to Dr. Burgess, who chairs our  
270 Health Subcommittee.

271 Mr. Burgess. Well, thank you, Mr. Chairman. And, Mr.  
272 Chairman, it is my fondest wish that one day I will come into  
273 a hearing in the Energy and Commerce Committee and there will  
274 be five doctors at the witness table, and they are going to expound  
275 for us on how much economists should be paid. I am still waiting  
276 for that hearing. We haven't had it yet.

277 Thanks to our witnesses for being here today. And, Mr.  
278 Chairman, to you I have a couple of things that I would just like  
279 to place into the record.

280 This is a copy of H.R. 5547, a bill that was introduced in  
281 the last Congress by Mr. Green and I that dealt with transparency.

282 And, in fact, Mr. Green and I have been working on transparency  
283 for the past several years. And a version of this was actually  
284 included as an amendment in the Affordable Care Act, but I think  
285 it got lost on its way to the Senate.

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Mr. Harper. Without objection.

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[The information follows:]

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\*\*\*\*\* COMMITTEE INSERT 1\*\*\*\*\*

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290 Mr. Burgess. Also, I would like to place for the record,  
291 I printed off some sheets from a website called txpricepoint.org.  
292 Texas PricePoint is a website that is at the least sponsored  
293 by the Texas Hospital Association, and it is useful information  
294 for your county or for your city, for the hospital in your county  
295 or for your city.

296 For example, I printed off a sheet that I will, I will leave  
297 for the record that deals with the cost of an uncomplicated  
298 cesarean section in the hospital where I used to practice. And  
299 I note that although my hospital is a little lower than some of  
300 the other hospitals in the area, it is higher than other hospitals  
301 in the state.

302 And as a physician, I also will submit to you that is useful  
303 information. And if recognizing the decision that a patient  
304 makes to go to a hospital is likely driven by the physician, making  
305 this type of information more available to physicians perhaps  
306 could help with physician behavior as far as directing the course  
307 for hospital care.

308 So, I ask unanimous consent to place this into the record,  
309 and look forward to hearing from our witnesses.

310 Ms. DeGette. Mr. Chairman, I reserve the right to object  
311 till I review the documents, although I am sure they will be fine.

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312 If I could just review the documents.

313 Mr. Harper. Well, as we review that we will come back to  
314 approving the entering that into the record as soon as Ms. DeGette  
315 has had an opportunity to review that.

316 At this time I would ask unanimous consent -- Oh, sorry.

317 I will now recognize Mr. Pallone, the ranking member for purposes  
318 of an opening statement.

319 Mr. Pallone. Thank you, Mr. Chairman.

320 The cost of health care is consistently a top concern for  
321 American families. But all too often, consumers face an initial  
322 problem before they even receive care, knowing how much a certain  
323 health care service is going to cost them. And that is because  
324 there are so many players in the health care industry making it  
325 difficult to bring clear cost transparency to the consumer.

326 Two different patients can receive the same service from  
327 a doctor but end up being charged starkly different prices. And  
328 this makes it difficult for a patient to make an informed decision  
329 about their care.

330 There are multiple factors contributing to this lack of  
331 transparency in health care. For example, a provider may have  
332 a set of rates it changes for private-pay customers, but depending  
333 on a person's insurance and deductible, their price could vary

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334 greatly.

335           This differs from most other markets the consumer has a clear  
336 understanding of how much a product or service will cost, and  
337 can shop around to obtain the best deal. The nature of health  
338 care makes this more complicated. And it is particularly  
339 noticeable in emergency situations where a patient's top concern  
340 is receiving the lifesaving care they need, rather than what the  
341 care will cost. In other expensive specialties such as oncology,  
342 patients trust their doctors to provide them with referrals based  
343 on quality of care.

344           With that being said, consumers can certainly benefit from  
345 more information, and there are opportunities to bring more  
346 transparency to the health care industry. As we will hear from  
347 the witnesses today, just about every state has implemented some  
348 type of transparency initiative. For instance, my home State  
349 of New Jersey recently passed a law requiring providers to notify  
350 patients if they are out-of-network, helping to avoid surprise  
351 bills for patients.

352           Many states have also created websites that post the prices  
353 of common procedures, and allow consumers to browse the prices  
354 of various providers. And this kind of reform can empower  
355 consumers just by giving them greater access to information.

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356           So, I look forward to hearing from the witnesses what the  
357 research says about these efforts, and what other reforms are  
358 being attempted in other states. However, we should be  
359 cautiously optimistic about greater transparency, as we have seen  
360 only modest results in actually bringing down costs. Some  
361 studies have found an increase in prices with more transparency,  
362 so we should be mindful of these results before considering any  
363 reforms.

364           I also think it is important that we keep the big picture  
365 in mind here. It is one thing to bring more transparency to health  
366 care, and give consumers information on what they are being  
367 charged, but we should also encourage meaningful efforts to  
368 actually reduce health care costs for American families.

369           And one of the primary ways to do that is by ensuring access  
370 to affordable health coverage. Whether it be Medicaid, essential  
371 health benefits in private insurance, or a robust marketplace  
372 for individuals who shop for insurance, transparency matters only  
373 if consumers have access to high-quality, affordable health care.

374           And, finally, while I appreciate the efforts of this  
375 subcommittee to explore these issues, I would be remiss if I did  
376 not note that there is an emergency taking place right now within  
377 HHS that this committee should be holding an oversight hearing

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378 on. Today, there are still more than 2,500 children in the  
379 custody of HHS who have yet to be reunited with their families  
380 after being forcibly separated by the Trump administration. This  
381 committee has a responsibility to conduct vigorous oversight of  
382 the Federal Government, and today would have been a perfect day  
383 to have HHS Secretary Azar and Scott Lloyd, the Director of the  
384 Office of Refugee Resettlement to be here.

385 So, I again urge the Republican majority to schedule a  
386 hearing as soon as possible so we can work to fix this crisis,  
387 and so we can finally get some answers.

388 I don't know if anybody wants my time. If not, I will yield  
389 back. Thank you, Mr. Chairman.

390 Mr. Harper. The gentleman yields back.

391 Ms. DeGette. Mr. Chairman, I withdraw my right to object.  
392 I have no objection to these documents from Mr. Burgess.

393 Mr. Harper. The documents are so entered.

394 [The information follows:]

395

396 \*\*\*\*\* COMMITTEE INSERT 2\*\*\*\*\*

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397 Mr. Harper. I ask unanimous consent that the members  
398 written opening, opening statements be made part of the record.

399 Without objection, they will be entered into the record.

400 [The opening statements follow:]

401

402 \*\*\*\*\* COMMITTEE INSERT 3\*\*\*\*\*

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22

403 Mr. Harper. I would now like to introduce our witnesses  
404 for today.

405 Today we have Dr. Jaime King, Professor at UC Hastings  
406 College of Law; and Dr. Michael Chernew, Professor at the  
407 Department of Health Care Policy at Harvard Medical School.

408 Unfortunately, our third witness, Dr. Kavita Patel, was  
409 unable to be here today due to a family emergency. And Dr. Patel  
410 and her family will remain in our thoughts and prayers as we send  
411 them our best wishes.

412 You are both aware that the committee is holding an  
413 investigative hearing, and when doing so has had the practice  
414 of taking testimony under oath. Do either of you have any  
415 objection to testifying under oath?

416 Mr. Chernew. No objection.

417 Ms. King. No objection.

418 Mr. Harper. Both witnesses have stated no.

419 The Chair then advises you that under the rules of the House  
420 and the rules of the committee you are entitled to be accompanied  
421 by counsel. Do you desire to be accompanied by counsel during  
422 your testimony today?

423 Mr. Chernew. No.

424 Ms. King. No.

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425 Mr. Harper. Both witnesses have responded no.

426 In that case, if you would please rise and raise your right  
427 hand and I will swear you in.

428 [Witnesses sworn.]

429 Mr. Harper. You may be seated.

430 You are now under oath and subject to the penalties set forth  
431 in Title 18, Section 1001, of the United States Code. You may  
432 now each give a five-minute summary of your written statement.

433 And Dr. King, we will recognize you for five minutes.

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24

434 STATEMENT OF JAIME KING, PH.D., PROFESSOR, UC HASTINGS COLLEGE  
435 OF LAW; AND MICHAEL CHERNEW, PH.D., PROFESSOR, DEPARTMENT OF  
436 HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

437

438 STATEMENT OF JAIME KING

439 Ms. King. Thank you. Committee Chairman Walden,  
440 Subcommittee Chairman Harper, Committee Ranking Members Pallone  
441 and DeGette, Subcommittee Chairmen Griffith and Castor, and  
442 members of the Subcommittee on Oversight and Investigations, I  
443 very much appreciate the opportunity to testify on price  
444 transparency in the health care market today.

445 As you know, the cost of health care in the United States  
446 currently threatens the economic stability of our citizens, our  
447 businesses, and our nation. A 2018 Gallup poll found that more  
448 Americans worry about the availability and affordability of  
449 health care than any of the 14 other major social issues, like  
450 crime, the economy, and the availability of guns.

451 Economic theory suggests that if consumers had better access  
452 to price information prior to choosing providers and receiving  
453 health care services that they would choose less expensive  
454 options, thereby lowering overall health care spending. As a  
455 result, states have been very active in this endeavor, introducing

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456 163 price transparency bills so far in 2018.

457 Historically, most state price transparency initiatives  
458 have focused on changing consumer behavior to encourage them to  
459 select providers and services that offer the greatest value at  
460 the lowest cost. Yet, health services research examining the  
461 impact of these efforts suggest that most of them have not engaged  
462 patients in a sufficient way to curb health care spending.  
463 Controlling health care spending requires engagement not just  
464 from patients but from all actors in the health care market:  
465 providers, payers, and policy makers.

466 Twenty states, including Oregon, Maryland, Maine, and New  
467 Hampshire, have all developed All Payer Claims Databases which  
468 collect information on both health care services Americans use,  
469 and amounts paid for those services. States can use these health  
470 care claims data to report better reporting to an All Care Claims  
471 Database, to inform patient and provider decisions regarding  
472 care; to allow payers to compare their rates to make sure that  
473 they are getting, you know, close to average or somewhere in there;  
474 and to allow policy makers to examine the drivers of health care  
475 costs over time; evaluate the effectiveness of various reform  
476 efforts; and measure the impact of mergers and acquisitions on  
477 health care price and quality.

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478           However, legal barriers including contractual provisions,  
479 ERISA preemption, and trade secret laws currently hinder the  
480 utility of many existing price transparency initiatives.

481           So, what can Congress do? For transparency initiatives to  
482 receive -- to achieve their full effect at the state level, changes  
483 are needed at the federal level. And, fortunately, Congress has  
484 the ability to address some of the most significant barriers to  
485 price transparency. There are five things Congress can do to  
486 improve health care price transparency:

487           Number one, and most important, address the ERISA preemption  
488 challenges. The main goal of ERISA is to promote uniformity in  
489 state regulations governing employee benefit plans. But over  
490 time, ERISA's preemptive reach has expanded in ways that put this  
491 goal of uniformity for employers over transparency, competition,  
492 and affordability of health care for all Americans.

493           The Supreme Court decision in *Gobeille v. Liberty Mutual*  
494 Insurance held that ERISA preempted state All Payer Claims  
495 Databases, preempted their reporting requirements as applied to  
496 self-insured employer plans. And this decision left state All  
497 Payer Claims Databases without health care claims data for about  
498 a third of their population, which greatly limits their accuracy  
499 and their utility.

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500           Essentially, trying to analyze the health care landscape  
501 using data from an All Payer Claims Database without the  
502 self-insured employer population is kind of akin to Google Maps,  
503 trying to use Google Maps without a third of the road; right?

504           Enabling All Payer Claims Databases to collect the full set  
505 of health care claims data would dramatically increase the utility  
506 and reliability of these initiatives. While addressing ERISA  
507 preemption of state health reform laws is the most important thing  
508 that Congress can do to promote price transparency and bring down  
509 health care costs, additional actions by Congress could also help  
510 illuminate health care prices, which brings me to number two.

511           Congress should seek to encourage price shopping incentives  
512 like reference pricing, rewards, and shared networks, through  
513 demonstration and pilot projects.

514           Number three, Congress should create a public interest  
515 exemption to Defend Trade Secrets Act of 2016. Health care  
516 providers and insurers currently invoke trade secrets protection  
517 to avoid disclosing negotiated health care prices and other  
518 information to consumer, employers, researchers, and state  
519 officials.

520           Trade secrets protections were designed to encourage and  
521 protect innovation, like the Coca-Cola formula, not to permit

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522 Coca-Cola and restaurateurs to hide its price on the menu and  
523 then after you eat your meal give you a bill for a \$25 Coke.  
524 Right?

525           Number four, Congress should require manufacturers of  
526 electronic medical records and insurance companies to establish  
527 uniform standards of interoperability and standard bundles of  
528 care for billing purposes so that providers and patients can  
529 access meaningful and actionable information about the cost to  
530 the patient, who and what is in the patient's network, and the  
531 quality of providers and services being offered to them when the  
532 provider is making referrals during appointments.

533           And, number five, they should develop billing codes for a  
534 physician's time spent in these efforts.

535           Thank you.

536           [The prepared statement of Ms. King follows:]

537

538 \*\*\*\*\* INSERT 4\*\*\*\*\*

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539 Mr. Harper. Thank you very much, Dr. King.

540 And the chair will now recognize Dr. Chernew for five minutes  
541 for purposes of his opening statement.

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542 STATEMENT OF MICHAEL CHERNEW

543

544 Mr. Chernew. Thank you very much, Chairman Harper, Ranking  
545 Member DeGette, members and staff. Thank you for the opportunity  
546 to speak with you today about price transparency in health care.

547 Before I launch into the main thrust of my comments I would  
548 like to emphasize that as an economist I believe strongly in  
549 markets. Well-functioning markets require buyers to effectively  
550 shop for the combination of price and quality that best meets  
551 their needs. And in the market for medical services, buyers,  
552 in this case patients, do not have the necessary information.

553 For that reason, one would think that efforts to promote  
554 price transparency in health care would be able to significantly  
555 lower the cost and perhaps improve the quality of care. In fact,  
556 this logic has spawned the creation of numerous transparency  
557 initiatives and tools, launched several innovative companies.

558 All of the major insurers that I'm aware of have some price  
559 transparency tools -- not all are great -- as do many other vendors  
560 in several states who are pursuing transparency-related programs.

561 Although there are a few studies that suggest transparency  
562 initiatives may be helpful, such as the one in New Hampshire,  
563 they've had a modest impact on the -- only had a modest impact

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564 on the spending for some services, at best. Overall, the  
565 evidence, unfortunately, suggests that the impact of transparency  
566 has been minimal.

567 This reflects several institutional features of health care.  
568 First, health care is complex. Any course of treatment or  
569 diagnostic pathway is comprised of many individual services.  
570 An accurate price quote requires knowing the exact service. This  
571 is complex.

572 For example, there are over 50 codes for CT scans. In some  
573 cases it is even unknowable because the exact service delivered  
574 may change during the course of treatment based on clinical  
575 information that arises during that treatment. Moreover, the  
576 fees to the hospital and the physician are often separate. To  
577 get an accurate price, they have to be combined. This makes it  
578 hard, particularly for providers, to provide the information.

579 Imagine when shopping for a car consumers could only get  
580 the average price of a specific car, and that the actual price  
581 that they would pay depended on who put them together and the  
582 customer's employer. The information would be of limited value.

583 Most transparency tools seek ways around this, but so far  
584 there have not been great successes.

585 Second, physicians are central to almost all consequential

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586 decisions in health care. Physician recommendations about where  
587 to seek care appropriately carry enormous weight. As a result,  
588 few patients shop for care. In our work, we find around 10 to  
589 15 percent of patients use transparency tools when offered. This  
590 result seems pretty standard in the literature. While it's  
591 certainly true that patients can question or even ignore their  
592 physician's referral recommendations, few do.

593 Third, consolidation in health care markets limits choice  
594 and, thus, competition in some markets. Specifically,  
595 competitive forces can only work when there are competing firms.  
596 As markets have consolidated, the potential for transparency  
597 or shopping more broadly diminishes.

598 Finally, insurance distorts choices. Patients  
599 fundamentally care about what they pay out of pocket. The  
600 out-of-pocket price will depend on the details of the patient's  
601 insurance plan and will change over time depending on things like  
602 whether they've met their deductible. As a result, one cannot  
603 accurately quote an out-of-pocket price without knowing details  
604 about the patient's health plan and how much they've often spent  
605 -- already spent, often for specific services. This implies that  
606 insurers are best suited to provide transparency information and,  
607 as noted, many do, although, as we've mentioned, with relatively

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608 little impact.

609 I do not mean to imply that transparency, or more generally  
610 price shopping for medical services, cannot work. Very  
611 simplified indicators such as flagging high-priced providers,  
612 as happened in some tiered insurance projects -- products can  
613 help, particularly when tied to benefit design. Moreover,  
614 transparency can have an impact even if this, even if it does  
615 not alter consumer behavior. The widespread availability of data  
616 may shame high-priced providers to lower their prices,  
617 particularly when journalists have access.

618 There's some evidence that this can be salient in health  
619 care. However, one has to proceed with caution, caution because  
620 it's also possible that widespread availability of information  
621 could alter the negotiation dynamics in other ways, leading to  
622 higher prices for some patients. Because payers negotiate price  
623 discounts with providers, if forced to reveal those discounts  
624 the providers may be more reticent to offer them. And there's  
625 some evidence of that in markets outside of health care.

626 So, where does this leave us? I'm generally supportive of  
627 the initiatives, particularly the private sector ones that  
628 simplify the information and focus on out-of-pocket prices. I'm  
629 more skeptical about public sector initiatives that entail new

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630 mandates on providers to provide data because it's particularly  
631 hard to get that data right. I worry it will not substantially  
632 improve the system, and may impose administrative costs.

633         There is certainly a lot we do not know. And while there  
634 may be deleterious unintended consequences, most evidence is  
635 either neutral or positive, and I think the shaming effect may  
636 be important in the most egregious cases. Moreover, states are  
637 experimenting in many ways, which should be allowed to play out.

638         So, there are a few fundamental things the Federal Government  
639 could support those efforts.

640         The first, as was mentioned, is report the -- support the  
641 ERISA exemption or get rid of the ERISA exemption.

642         Providing financial support for All Payer Claims Databases  
643 could be a wise investment.

644         And providing more funding to AHRQ or other federal agencies  
645 to study what is actually working.

646         We have a lot of problems in health care, and I very much  
647 applaud your efforts to seek a solution. But please do not let  
648 transparency distract you from other strategies such as  
649 supporting alternative payment models or addressing adverse  
650 selection in the individual markets of health care that may be  
651 more impactful.

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35

652

Thank you.

653

[The prepared statement of Mr. Chernew follows:]

654

655

\*\*\*\*\* INSERT 5\*\*\*\*\*

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656 Mr. Harper. Thank you both for your testimony. It is now  
657 the opportunity, the moment that you have waited for, our members  
658 get to ask questions of each of you. That will help us very much  
659 in that process. And I will now recognize myself for five minutes  
660 for the purpose of that. And I will start with you, if I may,  
661 Dr. King.

662 You know, obviously it is clear that, you know, a lot of  
663 Americans struggle greatly with how to pay for their health care  
664 costs. And part of that is they never know how much it is going  
665 to cost until they see a bill sometime later. And as you noted  
666 in your testimony, a lot of transparency initiatives have focused  
667 on changing consumer behavior to encourage them to select lower  
668 price providers and services.

669 But can you elaborate on why these initiatives seem to have  
670 limited usage and have mixed results?

671 Ms. King. Yes.

672 Mr. Harper. Your mike.

673 Ms. King. Okay. So, I think there are largely four reasons  
674 why consumers don't tend to use these as much as we would like  
675 them to. And the first is that insurance often, the structure  
676 of insurance often insulates consumers from feeling the price,  
677 different prices for different providers.

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678           If you pay a \$20 copay every time you go to the doctor, it  
679 doesn't really matter to you what type of doctor you go to; right?  
680       So there is some, some function of that.

681           The second is that the provider relationship is really  
682 important to patients. And it turns out where we have seen price  
683 transparency work is exactly on the thing that you noted before,  
684 Chairman Harper, is on shoppable goods. We have seen some  
685 movement there, where things that people find interchangeable.  
686       Right?

687           So, you might go, you don't care where you go to an MRI,  
688 to have your MRI tested or have your CT scan done. Those seem  
689 likely to go to this lab or that lab, unless this lab or that  
690 lab automatically supplies the results, you know, into your  
691 electronic medical record and it, you know, goes directly to your  
692 provider. That might make a difference to you.

693           But, generally, those are places where people are more  
694 willing to shop.

695           Where they're less willing to shop is on provider; right?  
696       They want a recommendation. Let's say that you, your child,  
697 or your spouse, or your loved one just got diagnosed with cancer.  
698       Are you really going to look at a list of providers and their  
699 charges to decide where you're going to go? You're not. You're

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700 going to go to a trusted primary care physician, or a family member  
701 that's had experience with cancer and ask them who they went to  
702 and who they had a good experience for.

703           So, I think the reality is is that health care is so important  
704 that patients really want to get advice from someone they trust  
705 and not the provider. And that's really why price transparency  
706 initiatives that put pricing information that is relevant to the  
707 patient in terms of their out-of-pocket costs in the hands of  
708 the provider so it's there when they're making that decision,  
709 I think have the most, the most, the greatest possibility of a  
710 shifting choice on the provider side.

711           Mr. Harper. Okay.

712           Ms. King. And the last thing is that there's very, as Dr.  
713 Chernew pointed out, there's very little standardization in  
714 health care pricing; right? So, if you look at one, if you look  
715 at one sheet and it says, well, you can get an MRI for \$300, but  
716 then you don't know if the MRI needs specific, you know, dyes  
717 or other things accompanying it, it's very hard for a patient  
718 to navigate that and to figure out what the overarching price  
719 will be for that.

720           Mr. Harper. All right. Thank you very much.

721           Dr. Chernew, in your testimony you noted that there are

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722 several institutional features of health care that make it  
723 difficult for transparency alone to have a significant impact  
724 on the market. You do highlight, highlight however, that the  
725 transparency initiatives are important as we move to a newer  
726 innovative benefit designs that attempt to help patients shop.

727 Can you please elaborate on that point?

728 Mr. Chernew. Of course. So, let me say for those of you  
729 that don't know or may not care, I chair the Benefits Committee  
730 at Harvard University, which means I advise the provost on what  
731 we, as an employer, should do for the benefits for our workers.

732 And we've been very worried about the variation of prices within  
733 Massachusetts, which was pointed out. And so that was painful,  
734 thank you.

735 So, when we think about what to do we start with how we might  
736 change our benefit designs to incent our workers to make more  
737 informed choices about providers. One cannot do that without  
738 having the relevant information available. So, if you want to  
739 do tiered network, if you want to do reference pricing, if you  
740 want to do any type of benefit design that involves incenting  
741 patients beyond a flat, say, \$20 copay, it's important that you  
742 have the tools to provide information to them. In that way I  
743 think transparency is important. And you should know all of our

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744 vendors will provide such transparency tools should you decide  
745 to do that.

746 Mr. Harper. Are the right to shop laws that also provide  
747 the financial incentives for consumers to choose the lower cost  
748 options perhaps, are they likely to have an impact do you think,  
749 a bigger impact on spending?

750 Mr. Chernew. I'm not familiar enough with all of all the  
751 laws, so I would defer to Dr. King. But I think that the general  
752 sense that allowing patients to shop and supporting their ability  
753 to shop when they want to I think is valuable. But because of  
754 all of the institutional features I think that alone is not really  
755 what's going to be helpful.

756 What we really care a lot about is even if you're not shopping  
757 you just may want to know up front what you're going to have to  
758 pay. And just getting that, which seems incredibly reasonable,  
759 is hard to do. And we're working through that.

760 Mr. Harper. Thank you very much.

761 The chair will now recognize the ranking member of the  
762 subcommittee, Ms. DeGette, for five minutes.

763 Ms. DeGette. Thank you. Mr. Chairman, just to show how  
764 bipartisan this subcommittee can be, you just asked my question.

765 So I am going to follow up on what you were talking about. And

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766 I will start with you, Dr. King.

767 And what I want to ask you is what percentage of health care  
768 costs are these things that would be negotiable to most patients,  
769 the MRI, the lab tests, issues like that? And what percentage  
770 is the things they are less likely to want to negotiate on, like  
771 physician services?

772 Ms. King. I think it's a great question. And I am not,  
773 I am not a health economist. I'm not studying, somebody who  
774 studies all of that percentage, so I don't know exactly.

775 I know that in studies, there was a study done that looked  
776 at Anthem, and United, and some other big health insurers, and  
777 it suggested that if they had, if they used reference pricing  
778 to -- for their shoppable items, for their laboratory tests, that  
779 they would be able to bring down costs. I think it was on the  
780 order of around 10 to 15 percent.

781 So it may not be -- so I don't know the exact number of  
782 laboratories. So maybe Dr. Chernew knows that.

783 Ms. DeGette. Well, he is a health economist.

784 Ms. King. Yes. He may know.

785 Ms. DeGette. So I think I will ask him that.

786 Mr. Chernew. In great humility, there's a lot of things  
787 I don't know.

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788 Ms. DeGette. Even though you are at Harvard?

789 Mr. Chernew. Especially because I'm at Harvard.

790 Ms. DeGette. Good answer.

791 So, so you don't have any idea what the percentage would  
792 be reduced?

793 Mr. Chernew. Advocates of shopping will give you a very  
794 big number, 60, 70 percent.

795 Ms. DeGette. Uh-huh.

796 Mr. Chernew. In for realistic numbers about what really  
797 could be shopped, I think you're probably talking closer to 10  
798 to 15 percent of services.

799 Ms. DeGette. That is the same thing Dr. King just said.

800 Now, now if you, if you did have increased transparency and  
801 if you could encourage patients to actually look at the sources,  
802 with physician costs even though, even though people, I mean I  
803 am not going to pick the cut-rate physician over the, over the,  
804 you know, more expensive one that I might -- that might have gotten  
805 a good reference, or whatever. But, but would there be some  
806 incentive for physicians to, on their own, maybe tamp down some  
807 of their rates?

808 Mr. Chernew. So, the answer is if the markets were working  
809 well there would be an incentive for physicians to change and

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810 facilities to change their prices. And you've seen some of that.

811 I really don't associate that with transparency, I associate  
812 that with benefit design, things like reference pricing.

813 I also think there's evidence, we've done a lot of work on  
814 alternative payment models, which I know is not the specific  
815 subject of this hearing, but when physicians are in payment models  
816 that give them an incentive to shop --

817 Ms. DeGette. Right.

818 Mr. Chernew. -- they are much more active in shopping  
819 because they, they will change their referral patterns if they  
820 get to keep some of the savings if they're more efficient in their  
821 referral patterns.

822 So, really I think transparency should be thought of as a  
823 tool that supports other impactful things as opposed to an end  
824 in and of itself.

825 Ms. DeGette. Dr. King, did you want to add to that?

826 Ms. King. Yes. So, on the, on the reference pricing point,  
827 so the way that reference pricing works is if, you know, that  
828 an insurer will pick, will pick a fee that it decides that it's,  
829 an amount that it's willing to pay for a particular service.  
830 And then any provider that charges above that, the patient has  
831 to pay that out of pocket.

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832           And what the studies have shown with respect to that is that  
833 a number -- there's been a decent amount of savings from patients  
834 saying they don't actually want to go to a higher-priced provider,  
835 but there's been a 30 percent reduction in provider costs overall,  
836 that they have dropped their prices to be under the reference  
837 price to get a broader volume of patients. And so that might  
838 be, that might prove to be helpful.

839           Ms. DeGette. Dr. Chernew, do you want to?

840           Mr. Chernew. I think Dr. King's referring to a study by  
841 Jamie Robinson and colleagues about a program that CalPERS did  
842 in California Anthem. There's a lot of things they did besides  
843 just reference pricing. So it's a very complicated thing. And  
844 they were a very big purchaser, which is helpful.

845           I think we looked at reference pricing for our employees.  
846 And one of the problems we had was if you pick a price and then  
847 the patient's responsible for the amount above that price, you  
848 actually have a lot higher bills that they have to play.

849           Ms. DeGette. Right.

850           Mr. Chernew. Substantially higher bills. And the whole  
851 reason you're here is because you're upset, I'm upset that the  
852 patients are facing very substantial bills.

853           So, we are trying to find ways in our benefit design to

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854 support shopping without going through the full risk that  
855 reference pricing might impose on patients should they not shop.  
856 So, it's a complicated tradeoff.

857 Ms. DeGette. So, what did you do?

858 Mr. Chernew. We decided not to recommend reference pricing.

859 Ms. DeGette. Okay.

860 Mr. Chernew. And you should know, going in I really wanted  
861 to recommend it because as an economist I thought it would be  
862 a victory.

863 Ms. DeGette. Yeah. And so what it is sounding like to me  
864 is that while we can, we can work on some of these transparency  
865 issues -- Dr. King, you mentioned your five items and, don't worry,  
866 they are in your testimony, too, so even though you were kind  
867 of cut short -- but, but we should also look at other ways of  
868 structuring these insurance plans which may make, which may make  
869 incentives for providers versus just the patients.

870 Thank you. Thank you, I yield back.

871 Mr. Harper. The gentlewoman yields back.

872 The chair will now recognize the vice chairman of this  
873 subcommittee, the gentleman from Virginia, Mr. Griffith, for five  
874 minutes.

875 Mr. Griffith. Thank you very much. Appreciate you all

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876 being here today. And obviously this is a very complicated  
877 subject, and I do appreciate it.

878 I wish there was some way people could go in and say I have  
879 got to have this procedure and, like a car, you could say if you  
880 are getting this, you know, the fancy wheels then you pay more,  
881 et cetera. But it seems that that is outside of our realm right  
882 now. Although one would hope that with all these young computer  
883 whizzes coming on that somebody might be able to figure out how  
884 to, how to plug all that in.

885 And I do agree that there are some things, I mean, I am going  
886 to pay more for the doctor that I know. Happy to do that, and  
887 able to do that, fortunately. Some people aren't. And so we  
888 have to try to look at some of the things that you all already  
889 talked about in relationship to insurance and getting, you know,  
890 the ability to say, you know, how much is this going to cost me  
891 out of pocket before you go forward I think is important. And  
892 you all touched on that as well.

893 So, you all are dealing with this huge, complicated matter.  
894 And my questions are much simpler. We, you know, I have just  
895 been really concerned. We had a hearing in the Health  
896 Subcommittee where we had all the providers lined up. And it  
897 was shocking, I had heard rumors but they actually confirmed that

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898 because of the way the system currently works there are cases  
899 where you could go to your pharmacist with your insurance company  
900 and your PBM and say, I want to get this drug, how much will it  
901 cost me if I don't use my insurance? And sometimes it is less  
902 if you don't use your insurance than it is if you do use your  
903 insurance because of the complicated formulas, and so forth.

904 And Todd Pillion, Delegate Todd Pillion in my district out  
905 of Abingdon, Virginia, got a bill through the Virginia legislation  
906 -- I heard there were 22 others this morning -- that said you  
907 can't have those gag orders anymore.

908 Dr. King, do the states eliminating those gag orders, do  
909 we find that that make a whole lot of difference when they go  
910 to the pharmacy? Do they sometimes figure out that they are  
911 better off nothing using their insurance because of the PBMs,  
912 et cetera?

913 Ms. King. Thank you. It's a great question.

914 So, I think a lot of these laws are new and so we haven't  
915 been able to really do the studies on them. But I think in terms  
916 of allowing pharmacists to actually say to the client at the desk,  
917 by the way, if you go outside your insurance or you get this generic  
918 you can save a lot of money, I can't, because pharmaceutical drugs  
919 in a large respect are those kinds of interchangeable drugs, you

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920 know, interchangeable products, and so I think that that will  
921 have, should have some substantial effect. And the idea that  
922 they were prevented from doing so by contract before is  
923 unconscionable to me. So, I think it's great.

924 Mr. Griffith. Mr. Carter has a bill I am glad to be a  
925 cosponsor of to make that a federal policy. And it is really  
926 interesting. I was discussing it back home and lady said, yeah,  
927 that happened to my sister by accident. Her insurance company  
928 initially stated that they wouldn't pay. And so she paid for  
929 the prescription herself. Then when it came time to renew they  
930 said, oh, we changed our minds, we will pay for that particular  
931 prescription, and she found out it was more.

932 She called her pharmacy and said, what is this, it cost me  
933 more when I am using my insurance?

934 Ms. King. Yes.

935 Mr. Griffith. He says, yeah, I can't tell you about that  
936 but, you know, if you will ask me to do it outside of your insurance  
937 you will only have to 17 instead of paying 50.

938 Ms. King. Right.

939 Mr. Griffith. And so, I think it is something we need to  
940 pass. And there are a fair number of patrons on that.

941 But it was clear to me that we need to look at the PBMs along

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942 with all the other things that you all are mentioning as part  
943 of the transparency. I know they serve good purpose.

944 But, again, Virginia on this, and it is my home state, that  
945 is why I keep referencing, but we had Delegate Keith Hodges out  
946 of Gloucester directed the State Bureau of Insurance to report  
947 to the General Assembly about how PBMs charge for their services  
948 and whether they save money or make health care costlier. Among  
949 the findings of the first PBM transparency report as a result  
950 of his work, mandated by that language, last year there were  
951 152,250 payments, with total PBM markups of 3.5 million between  
952 July 1 and September 21.

953 The differential or spread on each claim ranged from 1 penny  
954 to \$4,932.

955 Do you think that having more transparency and more oversight  
956 over PBMs and what they are doing -- I know they work hard in  
957 some cases and save money, but in other cases they are actually  
958 costing the consumer -- do you think that would help?

959 Ms. King. Yes, I do.

960 Mr. Griffith. Dr. King, you do.

961 Dr. Chernew, do you have an opinion?

962 Mr. Chernew. You can call me Michael, please.

963 Mr. Griffith. Michael.

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964 Mr. Chernew. I think as a matter of principle people should  
965 be able to get the information that they need. So, just on the  
966 pure principle of it.

967 In terms of the market demand, that gets much more  
968 complicated. I, I didn't talk about prescription drugs because  
969 a lot of the situation that you're discussing arises because of  
970 the complicated rebate rules that are going on in the prescription  
971 drug market. And those rebates both, they both in some ways they  
972 help markets work, but in other ways, and I think more dominantly,  
973 they make it much more complicated and much more difficult to  
974 have markets work well in health care.

975 And so, I think that while we could debate conceptually what  
976 the ability, you should have the ability to negotiate, I think  
977 the fact though we live in an environment where it's just so  
978 complex for people to get the price and get simple information,  
979 they're told that by contract they're not allowed to tell them,  
980 I think it's just a matter of principle that the situation  
981 shouldn't arise, even though it may well result in some people  
982 paying more because the discount that currently the PBMs can get  
983 might be less because they don't want everybody to know when  
984 they're getting the discount. That's basically what the problem  
985 is.

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986 Mr. Griffith. All right, I appreciate it. And I think that  
987 for a lot of our folks back home, they don't understand all the  
988 big stuff. But they understand when they go to their pharmacist  
989 and they feel like they are being overcharged.

990 I appreciate it, and yield back.

991 Mr. Harper. The gentleman yields back.

992 The chair will now recognize the gentlewoman from Florida,  
993 Ms. Castor, for five minutes.

994 Ms. Castor. Thank you, Mr. Chairman.

995 I want to return to what providers and insurers can do to  
996 help lower the costs through their transparency efforts. Because  
997 I think you correctly stated how folks feel, that if their doctor  
998 recommends something, I mean, it is pretty rare that a patient,  
999 a neighbor is going to go shop and do something else.

1000 So, Dr. Chernew, you, you said, okay, alternative payment  
1001 models can be one way. What else on physicians, because they  
1002 play such a central role on consumer behavior?

1003 Mr. Chernew. So, first let me say I really wish I could  
1004 come here with some silver bullet and solve the problem. And  
1005 I can't. Because anything I'm about to say is going to have  
1006 potential deleterious consequences.

1007 Most of the insurers I know, all of the insurers I actually

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1008 know, are struggling to find ways to address the health care cost  
1009 problem. It is not that insurers want health care spending to  
1010 be high or they're not working on it.

1011           Essentially what matters is the interaction between the  
1012 patient and the physician, the treatment that's given, and the  
1013 price that we pay for that. The way to address that is some  
1014 combination of payment reform and benefit design. And you're  
1015 seeing a ton of private sector initiatives to do that. And where  
1016 we are right now is employers in the market sorting through which  
1017 ones work for them in which particular ways, and we're trying  
1018 to learn what works better than not.

1019           So, alternative payment models honestly is my favorite.  
1020 I'm a big believer in benefit design changes. So the evidence  
1021 on high deductible health plans that are HSA coupled isn't as  
1022 strong as I would like as an economist in general. There's some  
1023 things that I would recommend, like the way chronic care  
1024 medications are treated in the HSAs is something I think are  
1025 probably a good thing to help people being able to shop. Things  
1026 like that.

1027           But there is not a specific federal thing that one can do.  
1028 And the challenge that you will face -- and again I say this  
1029 in a totally non-partisan way -- is where the regulations should

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1030 step in and stop at least the most egregious cases. Because there  
1031 are some really out-of-network billing things, there's some  
1032 really egregious cases that are just unconscionable that should  
1033 probably be stopped by regulation. And I honestly think that  
1034 transparency is not the mechanism to get at those types of things.

1035 To the extent that the private sector can build transparency  
1036 tools, which I am supportive of, and the states can try different  
1037 ways through their All Payer Claims Databases, I think that is  
1038 wonderful. But I think fundamentally my advice would be focus  
1039 on rules to prevent the most egregious situations where people  
1040 in an emergency room are paying some huge out-of-pocket thing.

1041 Ms. Castor. Right.

1042 Mr. Chernew. And telling them that matters. But,  
1043 honestly, I would say just prevent that.

1044 Ms. Castor. So and, Dr. King, your number one  
1045 recommendation was on ERISA. And ERISA was a law passed in the  
1046 1970s that said, you know, across the country you have to have  
1047 certain standards.

1048 Ms. King. Uh-huh.

1049 Ms. Castor. So, why would that be so important for us to  
1050 get into to help lower health care costs? You want to empower  
1051 the states to do additional things I guess?

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1052 Ms. King. So, basically ERISA, the way that it is written  
1053 because it's trying to promote uniformity and place benefit plan  
1054 regulation across all 50 states has a very broad preemption  
1055 scheme. Which means that it will come in and negate any state  
1056 law that relates to an employee benefit plan, including all the  
1057 employer health plans.

1058 Now, there is a savings clause as a part of ERISA which says  
1059 that any state insurance law that directly regulates insurance  
1060 will be saved from ERISA preemption. But there's the next part  
1061 of ERISA says that it doesn't deem self-insured employer plans  
1062 to be insurance, even though that's the way that the vast majority,  
1063 you know, or at least half of our employees get their insurance  
1064 is through self-insured employer plans. Right?

1065 So, any law that's passed by a state to regulate health  
1066 insurance or employer-based insurance is going to be preempted  
1067 by ERISA as it applies to about half of our employees. And --

1068 Ms. Castor. Who would oppose it?

1069 Ms. King. I think, I think industry would oppose it.  
1070 Right? They, they like not having regulations apply to them in  
1071 that way. But it is crippling state All Payer Claims Databases,  
1072 which have demonstrated that they can do a lot.

1073 They're doing a lot with the information they have. But

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1074 if they had all the claims, health care claims in a particular  
1075 state, they could really get a handle on what's driving cost,  
1076 where is competition not working, what thing, what mergers and  
1077 acquisitions should or shouldn't go through.

1078 And it also provides the foundation for every, like, for  
1079 the majority of other, the other solutions we're talking about,  
1080 so, allowing individuals to have better price information for  
1081 what it would cost them, for putting that information into the  
1082 hands of providers, I mean providers and insurers. Like, it would  
1083 just sort of seed a lot of other efforts. Reference pricing would  
1084 be based on that, and other things.

1085 So, I think addressing the ERISA problem -- and I have a  
1086 number of ways, a number of ideas of how you could do that --  
1087 I think is foundational to any sort of transparency initiative  
1088 that you would propose.

1089 Ms. Castor. Thank you very much. I yield back.

1090 Mr. Harper. The gentlewoman yields back.

1091 The chair will now recognize the gentleman from Texas, Mr.  
1092 Barton, for five minutes.

1093 Mr. Barton. Thank you, Mr. Chairman. And it is always good  
1094 to have hearings like this to try to, through bipartisan basis,  
1095 get facts on the table.

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1096           My first question is just kind of a general question. I  
1097 have been on this committee 32 years. I have been involved with  
1098 some of the major health care issues over a number of times.  
1099 One of the most vexing issues we face is pricing drugs. And to  
1100 my mind, except for the long-time over-the-counter drugs like  
1101 aspirin and things of this sort, there is no rational explanation  
1102 for how we price drugs.

1103           I think, I think the over-the-counter drugs that have been  
1104 on the market for decades, in some cases hundreds of years, they  
1105 are pretty much priced like any other commodity and it is  
1106 cost-based, distribution-based, advertising, you know. You pay  
1107 more for Bayer aspirin than you do for the Walmart generic brand,  
1108 but they are basically aspirin.

1109           But I, I would like you, Dr. Chernew, to go back to the Harvard  
1110 Business School and have them come up with a flow chart and  
1111 explanation of how we price Lipitor, or how we price Plavix, or  
1112 how we price the new stem cell-based drugs. Do either one of  
1113 you want to defend the current pricing system for these, these  
1114 new drugs that are coming on the market, or even try to explain  
1115 it?

1116           Mr. Chernew. When you said comment, I thought you were going  
1117 to say comment, I was going to jump in. When you said defend

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1118 I had to back off.

1119 But I, I will do my best. The --

1120 Mr. Barton. Do it in about 30 seconds because I have got  
1121 two or three questions. Give me the executive summary.

1122 Mr. Chernew. New drugs provide great value. I think that  
1123 is undisputable.

1124 Mr. Barton. I agree with that.

1125 Mr. Chernew. We have a patent system that supports them.

1126 And the drug companies charge what the market will bear. And  
1127 that, fundamentally, both gets us really good drugs and creates  
1128 huge amounts of problems.

1129 And that was my 30 seconds. I'm happy to talk more.

1130 Mr. Barton. Well, that is pretty rational. The drug  
1131 manufacturers charge what they think the market will bear. But  
1132 you go through these convoluted, you know, average wholesale  
1133 pricing and 340B discount drug program.

1134 Mr. Chernew. That's all just a distraction. They're  
1135 basically charging what the market would bear. And because of  
1136 a bunch of rules, it's much more complicated than that. And the  
1137 question is how we want to support innovation and pharmaceuticals,  
1138 which we want to support because it --

1139 Mr. Barton. We do.

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1140 Mr. Chernew. And that's where the problem comes in.

1141 Mr. Barton. Dr. King. Then I have got two more questions.

1142 Ms. King. I just want to interject that I think Dr. Chernew  
1143 is totally right that we get, we tend to get good value for new  
1144 drugs, for most of them. Where we're really not getting good  
1145 value is where we've already had a drug that has been on patent,  
1146 expired its patent life, and then they change a tiny little bit  
1147 of this drug, get an entirely new patent, run prices up for 20  
1148 more years. There's a lot of things that we are not getting good  
1149 value for that remain in patent.

1150 And if you want to look strongly at how to fix drug pricing,  
1151 I would look at how drugs are patented and what we allow a whole  
1152 re-upping on the patent.

1153 Mr. Barton. I think that is valid.

1154 All right, I want to go to the very bottom line here. I  
1155 have a constituent in Texas, a real estate agent who is on  
1156 Medicare. And her doctor gave her a coupon for a prescription  
1157 drug covered by Medicare. She took it to her pharmacist and the  
1158 pharmacist said, Great, but I can't, I can't take this coupon  
1159 because you are on Medicare. Medicare doesn't take coupons.

1160 So I got with the Congressional Research Service and some  
1161 other groups and found out that for some reason when we established

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1162 Medicare we don't allow senior citizens -- and we started covering  
1163 prescription drugs -- we don't allow senior citizens to use  
1164 coupons if they are under Medicare.

1165           So, Congressman Doyle and I have got a bill, we are going  
1166 to introduce it either this week or next week, that says if you  
1167 are on Medicare you can -- and you have got a coupon from your  
1168 doctor, you can't use them for generic drugs, but for any other  
1169 drug you can. Good idea, bad idea?

1170           Mr. Chernew. So, I appreciate your constituent's problems.  
1171 I think the challenge is most of the time in the patent system  
1172 what the market will bear is not distorted by insurance. In  
1173 health care it's distorted by insurance. So the problem is if  
1174 you take any consumer incentive away by the coupon, the actual  
1175 price for the drug the market will bear goes up. And that's what  
1176 the tension is, is that if you want the consumers to --

1177           Mr. Barton. Well, then the manufacturer doesn't have to  
1178 give the coupon. If they don't give the coupon to the doctor,  
1179 the doctor doesn't give it to the patient.

1180           Mr. Chernew. No, the manufacturer likes giving coupons  
1181 because then they charge a higher price and the insurer can't  
1182 use the cost function.

1183           Mr. Barton. Then we should just stiff the Medicare

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1184 recipients?

1185 Mr. Chernew. Is my time up? I hope so.

1186 [Laughter.]

1187 Mr. Barton. It is not complicated if you are an elected  
1188 member of Congress and all of a sudden Medicare recipients start  
1189 showing up at their town, town hall.

1190 Mr. Chernew. Yes. I, I totally agree. The challenge at  
1191 the core is you want the market to discipline the providers, which  
1192 requires people having to pay. And when people have to pay, it  
1193 turns out they don't like having to pay. And therein lies the  
1194 problem with coupons and a bunch of other distortionary things.

1195 So, I agree with you. And we'll have to have a longer  
1196 conversation on how to deal with it.

1197 Mr. Barton. I think that is yes, he agrees with me.

1198 Mr. Harper. The gentleman yields back.

1199 The chair will now recognize the gentlewoman from New York,  
1200 Ms. Clarke, for five minutes.

1201 Ms. Clarke. I thank you, Chairman Harper, Ranking Member  
1202 DeGette, for convening this important hearing examining state  
1203 efforts to improve transparency of health care costs for  
1204 consumers. Additionally, I want to thank our witnesses for  
1205 providing your expert testimony here this morning.

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1206           This is a critical issue that is most deserving of Congress'  
1207 attention as we work with industry to ensure consumers have a  
1208 positive experience on their health care journey. In my home  
1209 State of New York, since 2015 we have an out-of-network law that  
1210 protects patents from surprise billing when services are  
1211 performed by non-participating providers. This same law also  
1212 protects New Yorkers from bills for emergency services.

1213           The focus on transparency and consumer protection are needed  
1214 so that consumers will not have to continue paying more than their  
1215 usual in-network cost sharing and/or copayment amounts.

1216           So, I have a couple of questions. Dr. King, how effective  
1217 have state efforts been to ban surprise out-of-network hospital  
1218 bills? And what more should we be doing to prevent this?

1219           Ms. King. Thank you. It's a great question.

1220           I think surprise billing is a really important issue for  
1221 just consumer protection in general. So I think that there have  
1222 -- we have seen a number of different types of laws to protect  
1223 consumers from surprise billing. So there are those that, as  
1224 Dr. Chernew said, ban the practice outright, just say you will  
1225 not be exposed, especially in emergency services, you will not  
1226 be exposed to prices that are higher than your out of -- than  
1227 your in-network copay for emergency services and other things.

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1228           There are also -- and I think those are very effective.  
1229           At least they're protecting the consumer. And then we allow the  
1230           bigger fish in the game, the insurance companies and the  
1231           providers, to hash it out over what are reasonable reimbursement  
1232           rates. And that's what we have in California.

1233           But there are others, there are lots of states that are  
1234           passing laws right now that just say that a person should be  
1235           informed that they may be being seen by an out-of-network  
1236           provider, or that they, when they arrive at the emergency room,  
1237           someone who takes care of them might be an out-of-network provider  
1238           and they might experience other charges.

1239           And I think that these laws, while well-intentioned, don't  
1240           reflect accurately the reality of the patient experience. If  
1241           you show up at the emergency room, you are in an emergency  
1242           situation. You are signing whatever it is that you're signing  
1243           and then you're going to get help. And I think that someone  
1244           telling you that you may be subject to out-of-network law,  
1245           out-of-network bills at that point is not that helpful for you.

1246           So, I think we need to focus on the laws that seven states  
1247           have passed that really just make it very clear that patients  
1248           in these specific situations will not be subject to copays that  
1249           are higher than what their in-network charges would be, and then

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1250 let everybody else hash it out.

1251 Ms. Clarke. Okay. And, Dr. Chernew, in your written  
1252 testimony you note that efforts in New Hampshire have had a modest  
1253 impact on health care spending. What was it about the reforms  
1254 in New Hampshire that have enabled costs to go down, albeit  
1255 slightly?

1256 Mr. Chernew. So, the study by Zach Brown in Columbia is  
1257 what I, who is at Columbia is what I was referring to. And they  
1258 found by looking at MRIs what I consider to be a modest impact  
1259 on a service where you often see impacts, like MRIs.

1260 So I think there were some things about that. They had  
1261 insurer-specific prices. They knew whether you were in your  
1262 deductible or were not in your deductible, things like that.

1263 So, I think as those laws go that's a reasonable law. I  
1264 think it's a mistake to believe that doing things like that are  
1265 going to solve the basic problems. And as far as I know, New  
1266 Hampshire has not really solved all of the problems. Maybe  
1267 there's someone here from New Hampshire.

1268 But I think in the end of the day through their All Payer  
1269 Claims Database they were able to do some things that were  
1270 valuable. And to the extent that you can support the All Payer  
1271 Claims Databases, I think you might be able to help on the margins

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1272 the system get a bit better.

1273 I still think private sector initiatives could have the  
1274 potential to be more impactful.

1275 Ms. Clarke. So, Dr. King, could you describe any other  
1276 promising state efforts to improve transparency of health care  
1277 costs for their citizens?

1278 Ms. King. Yes. I'll comment just really briefly on New  
1279 Hampshire and then I'll talk a little bit about Massachusetts  
1280 as well.

1281 So, one of the things that New Hampshire did through their  
1282 All Payer Claims Database is they have a website called New  
1283 Hampshire Health Costs which you can go into. And I, I checked  
1284 it out this morning because I had heard good things about it.

1285 And basically as a, as a patient you can go there and check off  
1286 this is the health insurance plan that I am in, I am in Anthem  
1287 and I want to get this kind of procedure, and I want to do it  
1288 with this particular provider. And they'll tell you, they'll  
1289 run down the cost. And they'll run down the cost for that provider  
1290 and they'll show you how it, how it compares to other providers.

1291 Now, that doesn't tell you your specific out-of-pocket costs  
1292 and it doesn't tell you where you are in your personal deductible,  
1293 but I think that is more helpful than what we've seen in a lot

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1294 of other states' price transparency initiatives.

1295 Now, the other, the other state that I want to highlight  
1296 here is Massachusetts. And Massachusetts has gone a long way  
1297 with their All Payer Claims Databases. But they also have their  
1298 Health Policy Commission, which is an arm that is designed to  
1299 analyze that information and really mine the All Payer Claims  
1300 Database for a whole host of policy reasons. And they've been  
1301 able to interject and produce reports, annual reports on spending,  
1302 annual reports on the drivers of costs, but also interject in  
1303 a number of different places where, where that information would  
1304 not have otherwise been available to inform policy decisions,  
1305 but also to inform patients in that case.

1306 So I think there are consumer-facing things that are very  
1307 useful, although I do agree that some of the private initiatives  
1308 from insurers are better. But I do think that having the Health  
1309 Policy Commission there to really analyze that data has been a  
1310 very useful step as well.

1311 Ms. Clarke. Thank you. I yield back.

1312 Mr. Harper. The gentlewoman yields back.

1313 The chair will now recognize the gentleman from Texas, Dr.  
1314 Burgess, for five minutes.

1315 Mr. Burgess. Thank you, Mr. Chairman. And I have got way

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1316 more questions than I can package into five minutes, but we will  
1317 do our best. And I may submit some for the record.

1318 I do appreciate both of you being here today. Let me just  
1319 ask you a question, Dr. Chernew, since you brought up about the  
1320 private sector initiatives versus the All Payer Claims Databases.

1321 I pointed out in my opening statement, Texas has Texas  
1322 PricePoint. I believe it is Texas Hospital Association that has  
1323 done that. So, good on them for having done that. But is, is  
1324 that not helpful for them to have done it? Does that delay getting  
1325 an All Payer Claims Database set up in the state? What are some  
1326 of the tensions there?

1327 Mr. Chernew. I think it is at the end of the day probably  
1328 marginally helpful as opposed to not. I don't think it delays  
1329 All Payer Claims Databases.

1330 I think because all health care is local and the states are  
1331 going to do different things, I'm sort of a state experimentation  
1332 kind of person in this space. I wish I could tell you I knew  
1333 what would work. I don't like sounding as skeptical as I am.

1334 So I think the more we can allow states to do different things  
1335 and then study what they're doing, I think the better.

1336 Mr. Burgess. And, Dr. King, do you have any thoughts on  
1337 that?

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1338 Ms. King. I tend to agree. I think that on balance it's  
1339 probably helpful. I think any attempts to provide transparency  
1340 are generally useful. I don't think it probably delayed an All  
1341 Payer Claims Database unless you were considering that as the  
1342 alternative option and went with this one.

1343 I think that an All Payer Claims -- so, in terms of the private  
1344 entity tools, I think those tend to be much more useful for the  
1345 -- for consumers. Right? And so, United Healthcare they go in,  
1346 you type in your name, you get into the system, and it tells you  
1347 what your actual, where you are in your deductible, what your  
1348 copay would be for different people.

1349 And I think All Payer Claims Databases allow you to use the  
1350 information for a lot of different purposes; right? So that's  
1351 the, that's sort of the difference. One is very targeted at  
1352 individuals, but you also have to be in the plan in order to see  
1353 that information.

1354 Mr. Burgess. Sure.

1355 Ms. King. Right? You can't get that information when  
1356 you're choosing your plan. Although Massachusetts I think just  
1357 has a law coming down that, that would enable that, for you to  
1358 see different prices as though you were in different plans.

1359 Mr. Burgess. Txpricepoint.org you would not have to be in

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1360 a plan. I mean, that is a --

1361 Ms. King. No. But it tells you --

1362 Mr. Burgess. -- public hospital provides database.

1363 Ms. King. But it doesn't tell you the price that you would  
1364 pay for your insurer.

1365 Mr. Burgess. No, it does not.

1366 Ms. King. Right. So that is very hard to know what to do  
1367 with those prices.

1368 Mr. Burgess. So, every time I see that TrueCar ad on T.V.  
1369 I wonder why we don't have TrueCar for health care. But then  
1370 as someone who had a health savings and account for years and  
1371 year and always has paid the highest out-of-pocket costs for  
1372 everything, hospital labs included, I was a big believer when  
1373 I first heard about Theranos. And I thought, oh man, a cheap  
1374 way to get a bunch of blood tests done. I'm all in. Except the  
1375 reliability suffers.

1376 Ms. King. Yeah.

1377 Mr. Burgess. So that is the -- there is a caveat there,  
1378 I guess. Is that correct, the correct observation?

1379 Mr. Chernew. Yeah. And remember, it's TrueCar, it's not  
1380 TrueCarborator; right? And it's TrueCar.

1381 Mr. Burgess. So, I think, Dr. Chernew, I think you mentioned

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1382 the alternative payment methods. And going back to when the  
1383 Secretary of Labor was Secretary of Health and Human Services  
1384 he did a demonstration project, a physician group practice  
1385 demonstration project where they dealt with some alternative  
1386 payment mechanisms. I think, if I understand the history  
1387 correctly, ACOs kind of grew out from there.

1388 But can you, can you speak to that? Is there a way to foster  
1389 the development of what perhaps Secretary Leavitt's original idea  
1390 was there?

1391 Mr. Chernew. Yeah. And I think, again maybe a little far  
1392 afield, Medicare has been very innovative in the whole range of  
1393 payment models. But I also can't tell you what the right type  
1394 of payment models are. But I think --

1395 Mr. Burgess. Neither can we. But we are learning, I hope.

1396 Mr. Chernew. There you go. But the more we support  
1397 alternative payment models, in many ways the better.

1398 One thing that I think does matter is to understand that  
1399 the price from the point of view from the physician is different  
1400 than the price from the point of view of the patient because the  
1401 patient is buying some episode of care. The physician is  
1402 delivering a small part of that, the same with the facilities.

1403 So, the more for example supporting bundled payments, which

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1404 Medicare is doing, the more you can support that type of thing,  
1405 and the more payment moves towards more consumer-oriented sets  
1406 of things that are being purchased, the closer you get to  
1407 transparency because then someone will know what does it cost  
1408 for a colonoscopy, not what does it cost for the technical  
1409 component, the professional component, the anesthesia component,  
1410 et cetera, et cetera.

1411 Mr. Burgess. But people still buy on provider as well as  
1412 on price. Which just brings me to the final thought, and I will  
1413 close my section out.

1414 In the lead-up to the Affordable Care Act there was a lot  
1415 of concern about physician-owned hospitals. And in fact,  
1416 remember, physician-owned hospitals got whacked in the Affordable  
1417 Care Act. Mr. Chairman, I am going to ask unanimous consent to  
1418 insert a letter or a article into the record about physician  
1419 behavior with physician-owned facilities.

1420 Back in my world it was all about time. I got paid the same  
1421 amount, regardless whether the patient went to an ambulatory  
1422 surgery center or to a community hospital. The lab processing  
1423 from my reimbursement's perspective was identical. But the cost  
1424 to the patients was a fixed rate in an ambulatory surgery center,  
1425 and the sky's the limit in the community hospital. I am

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1426 oversimplifying. But nevertheless, that is I think one of the  
1427 pressures that we are going to have to consider as we work through  
1428 these.

1429 But, again, I ask unanimous consent to put this article into  
1430 the record.

1431 Mr. Harper. Without objection.

1432 [The information follows:]

1433

1434 \*\*\*\*\* COMMITTEE INSERT 6\*\*\*\*\*

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1435 Mr. Harper. The gentleman yields back.

1436 The chair now recognize --

1437 Mr. Burgess. I want the gentlelady from Colorado to read  
1438 it before she accepts. I thought I had found a way to get you  
1439 to read my articles.

1440 Ms. DeGette. I will take your word.

1441 Mr. Burgess. All right. Thank you, Mr. Chairman, I yield  
1442 back.

1443 Mr. Harper. And that was on the record by the way.

1444 And the chair will now recognize --

1445 Ms. DeGette. But not under oath.

1446 Mr. Harper. Not under oath.

1447 But the chair will now recognize the gentleman from  
1448 California, Mr. Ruiz, for five minutes.

1449 Mr. Ruiz. Thank you, Mr. Chairman.

1450 Overall we know transparency is a good thing and leads to  
1451 better understandings of market dynamics and better ways to help  
1452 everybody come up with good policy that is going to really lead  
1453 to a more cost-efficient way of providing better health care for  
1454 the American people. However, there are certain things that  
1455 transparency is good for and the market really focuses on.

1456 Like, for example, if you had the ability to make the choice,

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1457 and knowledge to know the difference between the products in a  
1458 situation where you can actually make a decision, and not under  
1459 duress, or when you are in a coma, or when you are in cardiac  
1460 arrest or something going into the emergency department, and there  
1461 are some things that, that transparency, you know, obviously can  
1462 work.

1463 So, in your statement, however, Dr. Chernew, you note in  
1464 your testimony that "many studies, including several of my own  
1465 and those of my colleagues, find that transparency has minimal,  
1466 if any, impact on the market." You go on to explain why  
1467 transparency results in only minimal impact on price.

1468 Dr. Chernew, it sounds like the bottom line is that it is  
1469 somewhat folly to rely upon transparency as the magic bullet to  
1470 bring down health care costs. Is that correct?

1471 Mr. Chernew. Yes.

1472 Mr. Ruiz. Okay. In what situation does transparency work?

1473 Mr. Chernew. When there's more commodity type services,  
1474 when they're not as connected to things and you have time to shop  
1475 I think transparency works.

1476 I think independent of shopping, transparency works just  
1477 to tell people what they would have to pay out of pocket. Just  
1478 knowing. So, you're not going to shop, it's just you don't want

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1479 to get a bill after the fact that's way higher than you thought.

1480 So, I think transparency is useful. I think it needs to  
1481 be coupled with other things.

1482 Mr. Ruiz. But you are saying it is not what we should be  
1483 focusing on?

1484 Mr. Chernew. I think there's a lot of reasons why health  
1485 care markets don't function well. Transparency I would put down  
1486 on my list for what that's true.

1487 I think it's important, let me say, what I worry about, for  
1488 example, is insurance inherently, unlike most products is a pooled  
1489 product. I'm in with a lot of other people on the same plan.

1490 I worry that if we allow the benefit packages to deteriorate  
1491 to the point where people are paying a lot out of pocket and we  
1492 separate that market through a range of things that are going  
1493 on that I won't mention -- it might be too partisan, I don't mean  
1494 ti to be -- that people have higher out-of-pocket bills because  
1495 they won't understand when they bought the insurance plan what  
1496 was covered. They'll go to the doctor and they'll realize that  
1497 what they thought was insurance wasn't that good. And it's very  
1498 hard to make that work well.

1499 Mr. Ruiz. So, do you think that putting too much weight  
1500 on transparency to reduce health care costs is a distraction?

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1501 Mr. Chernew. I worry that that's the case.

1502 Mr. Ruiz. Okay. You know, I am a doctor. And I know that,  
1503 you know, patients rely on doctors' knowledge, and training, and  
1504 years of experience to make decisions that will be to the best  
1505 benefit for the patients. And I know that it is difficult for  
1506 patients to then, if an orthopedic surgeon says I recommend a  
1507 titanium type of metal for your knee replacement, that a patient  
1508 in general is not going to do the research or have the know-how  
1509 in order to determine what kind of equipment they want for their,  
1510 for their knee to make that best judgment.

1511 But I do think that there is some value in transparency.

1512 I think it is just what Dr. Burgess said earlier, you know, it  
1513 is insane that one hospital will charge, you know, I don't know,  
1514 I'm just making these numbers up, but 2,000 for a colonoscopy.

1515 And then, like, across the city in the same, same region another  
1516 hospital charges 10,000. So it is why is that?

1517 And we should understand where are the mechanics that go  
1518 into that so that we can identify, in those cases when you do  
1519 have the time to choose, which, which studies or which, which  
1520 equipment you want where you can have the knowledge and have the  
1521 time, and under the situation, to make that possible, I think  
1522 we should focus on that.

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1523           But, Dr. Chernew, you also mentioned that if the objective  
1524 is to meaningfully reduce health care costs, other strategies  
1525 such as addressing adverse selection in the individual market  
1526 for health care may be more fruitful. Can you, can you expand  
1527 on that?

1528           So, if the objective is to lower costs are there ways to  
1529 combine transparency initiative with some of these other efforts  
1530 to lower costs? Can you, can you go into that?

1531           Mr. Chernew. Well, let me talk about two separate things  
1532 very quickly. The first one is transparency is important to  
1533 support almost all of the various new benefit design things we  
1534 do. It's important for a range of public regulation things.  
1535 I think there's a bunch of reasons why transparency matters.  
1536 And I think it's unconscionable, some of the stories that I'm  
1537 sure your constituents have told you. I think that's a really  
1538 big deal.

1539           That said, the biggest problems we have in a lot of health  
1540 care markets aren't related to transparency, they're related to  
1541 how we hold the market together and how the benefit design packages  
1542 play out. So, at Harvard we control exactly the benefit package.  
1543 We push everybody into it. It's pooled, it works.

1544           If you allow markets to spin out of control and let people

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1545 do various things there's implications of that that differ from  
1546 markets for cars, or markets for asparagus, or things like that.  
1547 So, figuring out how to address those types of problems so you  
1548 don't have individuals that end up in insurance plans where  
1549 they're going to be charged a lot out of pocket I think are  
1550 important.

1551 Mr. Ruiz. Harvard. Harvard Business School?

1552 Mr. Chernew. Harvard University. Harvard University has  
1553 a Benefits Committee that offers benefits for all of the schools.

1554 Mr. Ruiz. Okay.

1555 Mr. Chernew. So, Business, the Medical School, the main  
1556 part. And we advise the Provost, for the non-union workers, about  
1557 how to deal with our challenges. And we have a lot of challenges.

1558 Mr. Harper. The gentleman yields back.

1559 The chair will now recognize the gentlewoman from Indiana,  
1560 the chair of our Ethics Committee, Ms. Brooks, for five minutes.

1561 Mrs. Brooks. Thank you, Mr. Chairman.

1562 And I want to stay on that line of questioning, Dr. Chernew.  
1563 Speaking of employers, and you mentioned Harvard specifically,  
1564 and even some insurers provide transparency tools to their members  
1565 or their employees, and have redesigned plans and networks to  
1566 encourage price shopping, can you describe some of the features

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1567 of the price transparency tools that are adopted by employers  
1568 and insurers, whether it is Harvard or others, and how they differ  
1569 from the state transparency initiatives?

1570 Mr. Chernew. Yeah. So, and again Dr. King mentioned, so  
1571 if you are in a plan that offers one of these types of transparency  
1572 tools and you know you need a service, you can go in and type  
1573 the service. Now, that actually sounds easy. But remember, if  
1574 you're shopping for a CT scan, there's 50 types of CT scans, and  
1575 it depends on what the dyes are, so it's not as easy as you think.

1576 It will aggregate out and try and come up with a number.  
1577 It will combine the physician and the hospital. Because you  
1578 don't care how much is going to the hospital and how much is going  
1579 to the physician, you care totally what are you going to pay --

1580 Mrs. Brooks. Right.

1581 Mr. Chernew. -- for the whole thing. It will know, and  
1582 again it won't know perfectly because there's time lags, it will  
1583 know within reason where you are in your deductible. So, if you  
1584 are over the top of your deductible it will give you a different  
1585 price quote than if you haven't yet spent your deductible.

1586 Most of the public non-insurer-based tools don't have all  
1587 that information, so they cannot tell you very accurately what  
1588 you would pay. They don't. We know what prices our carriers

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1589 have negotiated with all the different providers. But most  
1590 public tools don't know -- New Hampshire being an exception --  
1591 the prices that different providers have negotiated with  
1592 different insurers. And they certainly don't know where you are  
1593 in terms of your deductible.

1594 Mrs. Brooks. And do you, are you familiar with a lot of  
1595 private tools like what you have just described, and are these  
1596 types of tools, whether they are insurers or employers, are they  
1597 proving to be effective in changing consumer behavior --

1598 Mr. Chernew. So, the tools --

1599 Mrs. Brooks. -- and reducing steps?

1600 Mr. Chernew. -- are almost always tools that employers  
1601 offer but the insurers make. The employers don't do much. They  
1602 buy things. So, the insurers are the ones that offer the tools.

1603 Or other, there's a firm Castlight, for example, that's well  
1604 known for having these types of tools and selling to employers  
1605 who can buy access to them. And they have been, unfortunately,  
1606 disappointingly ineffective.

1607 Mrs. Brooks. Why, do you believe?

1608 Mr. Chernew. Well, for one, even the best of them are very  
1609 complicated. The people care more about their physician than  
1610 the tool, so they're hesitant to shop. And in many cases the

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1611 employers have provided the transparency tools but haven't  
1612 designed their benefit packages in ways that make them really  
1613 salient. So you get back the same result.

1614 Even if there -- you've mentioned, several people have  
1615 mentioned that there's wide variation in prices across markets,  
1616 \$2,000 and \$500. But most patients don't pay \$2,000 and \$500  
1617 to their employers, most of them only pay -- if you were at Harvard  
1618 you'd pay \$30 flat fee no matter where you went to. So the tool  
1619 doesn't help you that much.

1620 Mrs. Brooks. Dr. King, would you like to comment on this  
1621 private initiatives, private, the private tools?

1622 Ms. King. Yeah. So I would just basically reiterate what  
1623 Dr. Chernew said, that they haven't seen the kinds of results  
1624 that they would be looking for. And I know that Castlight has  
1625 been, is employers basically buy Castlight Health and offer it  
1626 to their employees. And they found very low engagement from  
1627 employees.

1628 I think a lot of employees don't, they don't want to shop  
1629 for providers. They don't necessarily want to shop. They will  
1630 shop a little bit for the shoppable services. But they haven't  
1631 seen the, like, the overall level of engagement has been about  
1632 3 to 6 percent on a lot of those tools.

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1633 Mrs. Brooks. Well, and I would like to ask both of you why  
1634 do you believe that is the case? Why is it that we have these  
1635 tools, whether it is a private sector, an employer, or at the  
1636 state base that states have invested in these, why do we have  
1637 such low engagement on this issue?

1638 Ms. King. I, I think that we, we largely have low  
1639 engagement, I mean, partly because people aren't incentivized  
1640 to use them. If you pay the same price you're not that much  
1641 incentivized to use them. But I also think it goes back to this  
1642 idea that when you go to your provider and they make a  
1643 recommendation for you of which provider to go to for your, you  
1644 know, hip surgery, or which, you know, lab to go to. Oh, go to  
1645 the lab down the street. It's your unlikely to then, to whip  
1646 out your laptop and figure out if there's a cheaper provider  
1647 elsewhere.

1648 Also, a lot of times individual providers prefer that their  
1649 patients use a particular lab --

1650 Mrs. Brooks. Right.

1651 Ms. King. -- because they know that they get the results  
1652 quickly, or it goes right into their EMR, or there are some  
1653 synergies within the system.

1654 And so I think that patients are reluctant to go against

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1655 their provider's advice or recommendation, which is why you should  
1656 try to get this information into the hands of the providers so  
1657 that if they think I would recommend five doctors to do your hip  
1658 surgery. Oh, two of them are only in -- are in your network.

1659 Let's talk about you'd pay \$500 for this doctor, and you'd pay  
1660 \$200 for this doctor, let's talk about the benefits and detriments  
1661 of that. That's what we need.

1662 Mrs. Brooks. And, Dr. Chernew, anything different on that  
1663 as to why we have such low rate of use?

1664 Mr. Chernew. Yeah. I, I think that it is a mistake to  
1665 believe that consumers fundamentally want to shop. They actually  
1666 fundamentally want to pay less out of pocket, and they want things  
1667 to be simpler. That's what they really want because of all these  
1668 sort of interactions with their physicians.

1669 And so they tend not to want to go find these things out.  
1670 You can push at the margins, but as a main view that we're going  
1671 to use market forces to fundamentally control our problems I think  
1672 is a little optimistic, as much as that pains me to say as an  
1673 economist.

1674 Mrs. Brooks. Thank you both. I yield back.

1675 Mr. Harper. The gentlewoman yields back.

1676 The chair will now recognize the gentleman from New York,

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1677 Mr. Tonko, for five minutes.

1678 Mr. Tonko. Thank you, Mr. Chair. And welcome to our  
1679 guests.

1680 Many states and health care systems have implemented a  
1681 variety of programs that are intended to give consumers additional  
1682 information about the price of health care services on the theory  
1683 that this will allow consumers to make more informed decisions  
1684 and perhaps lower their costs. They are listening to your  
1685 concerns there.

1686 But maybe you can develop for us a little better some of  
1687 the tools and some of the concerns that we should have.

1688 Academics, including both of you today, have studied these  
1689 reforms to see what works, what doesn't work, and where we might  
1690 go from here. I would like to spend a few minutes discussing  
1691 with our panelists what the academic literature has to say about  
1692 these efforts.

1693 Dr. Chernew, in your written testimony you use the example  
1694 of shopping for a car to describe why transparency doesn't always  
1695 work to bring down the cost of shopping for health care and the  
1696 like. Could you briefly describe what makes shopping for health  
1697 care different and more complicated than that which we would  
1698 utilize for products or services?

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1699 Mr. Chernew. Most products or services are bundled in a  
1700 way that you care about. So you're not buying the ingredients.  
1701 When you go buy a meal you don't price out all the individual  
1702 ingredients, it all comes together.

1703 Health care, because of the history of the way in which it  
1704 developed, and because the reimbursement system was really  
1705 provider focused so you, you know, remember, physicians and  
1706 hospitals, they're inputs to providing care. Right? But you  
1707 really care about the joint product. And so, that has made it  
1708 difficult to simply give prices that have been developed from  
1709 sort of a payer perspective to consumers who are purchasing from  
1710 a different perspective. And it, broadly speaking, has been hard  
1711 for people to shop in that way. Combine that with insurance  
1712 distorting prices, the reliance on physicians, the complexity  
1713 of the problem, the salience of the problem altogether has made  
1714 it very hard for people to shop.

1715 Mr. Tonko. And, also, you wrote in an August 2017 "Health  
1716 Affairs" article that, and I quote, "simply offering a  
1717 transparency tool is not sufficient to meaningfully decrease  
1718 health care prices or spending."

1719 So, what did you find regarding these transparency tools?  
1720 And why were they unable to bring down the prices on their own?

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1721 Mr. Chernew. They're often offered with the narrative of  
1722 they're going to help make markets work. And because most people  
1723 don't use them, because they're complicated, they don't make  
1724 markets work that well on their own, and as a result you don't  
1725 see prices respond.

1726 Mr. Tonko. So, could you describe what conditions would  
1727 be sufficient to meaningfully bring these costs down?

1728 Mr. Chernew. Well, there's bringing costs overall down is  
1729 challenging. What's sufficient to how transparency tools work,  
1730 which I believe are true in a limited number of cases, is you  
1731 need to have services bundled in a way that people can understand.

1732 You need to have benefit designs done in a way that make people  
1733 actually feel the cost at the margin. And you need to avoid a  
1734 situation in which the physicians that are making the  
1735 recommendations are, for example, owned by a system, so the  
1736 physician's going to refer within a system. And once you choose  
1737 your primary care doctor you're actually choosing a whole referral  
1738 network they use, and it's very hard to get them to work.

1739 So, I think Dr. King and I agree that the margins is all  
1740 valuable. There are specific cases. It's really valuable to  
1741 let people know what they might have to pay out of pocket. But  
1742 as a fundamental question about what could you all do to all of

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1743 a sudden use transparency to revolutionize the way that consumers  
1744 shop, and therefore to control health care spending, that's a  
1745 really tall order.

1746 Mr. Tonko. Thank you.

1747 And, Dr. King, your written testimony discusses the  
1748 usefulness of state efforts such as All Payer Claims Databases  
1749 to bring down prices for consumers. These databases are intended  
1750 to house a comprehensive collection of medical claims data from  
1751 both public and private payers on how much they pay for different  
1752 kinds of procedures.

1753 How can consumers use that information in these databases  
1754 to inform their health care decisions? And what are the  
1755 limitations on this, this kind of data?

1756 Ms. King. Thank you. So, basically the consumers wouldn't  
1757 use the database themselves. The information that's housed in  
1758 the database would then have to get put into a consumer-facing  
1759 website like what New Hampshire has on Health Costs. And that  
1760 has been demonstrated to bring down costs a little bit and allow  
1761 patients to use it.

1762 So if you have the negotiated rate between a provider and  
1763 an insurance company in all of these All Payer Claims Databases,  
1764 and all of the, you know, all of the utility, how we utilize health

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1765 care, who patients go to, what they charge, what the negotiated  
1766 rates are across the state, you could then generate really  
1767 meaningful information for patients because you would know which  
1768 insurance company they were in and what that insurance company  
1769 had negotiated its prices with providers for. And you could use  
1770 that to populate consumer-facing websites and consumer-facing  
1771 tools that would provide patients with information on their  
1772 out-of-pocket costs.

1773 I just want to say that one of the other things that we haven't  
1774 really discussed today as a driver of costs that affects  
1775 transparency is the fact that a huge majority of our markets for  
1776 health care are highly concentrated. And one of the reasons why  
1777 we have such a problem with transparency is that you have provider  
1778 organizations and provider systems with a large amount of market  
1779 power and they can demand to keep their prices secret. They can  
1780 negotiate things in ways that drive up costs and then, and then  
1781 hinder transparency to find that out.

1782 And so, if you were really looking, I think transparency  
1783 is important at the margins. I think it's useful. I think it's  
1784 generally a good thing in a capitalist society for people to know  
1785 what they're going to pay. But I also think if we want to talk  
1786 about competition and why the markets don't work you need to look

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1787 at the markets themselves and figure out that competition is  
1788 dwindling and dying because these markets are so consolidated.

1789 Mr. Tonko. Thank you very much. And, Mr. Chair, I yield  
1790 back my time.

1791 Mr. Harper. The gentleman yields back.

1792 And the chair will now recognize the gentleman from Georgia,  
1793 Mr. Carter, for five minutes.

1794 Mr. Carter. Thank you, Mr. Chairman. And thank both of  
1795 you for being here.

1796 Dr. King, I am going to let you continue on because you have  
1797 hit on the right point, the vertical integration that we are  
1798 experiencing right now. What you have is you have a PBM who owns  
1799 a pharmacy. Now the PBM and the pharmacy are talking about buying  
1800 an insurance company. Now you have got an insurance company,  
1801 Cigna, talking about buying the PBM, which also owns the  
1802 pharmacies.

1803 The vertical integration and lack of competition is  
1804 something. And then they can hide it all throughout that vertical  
1805 integration. They don't care where they make it, as long as they  
1806 make it. But that is the problem. You, I mean you hit the nail  
1807 on the head right there.

1808 Anything else you want to add to that?



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1809 Ms. King. I just want, I just want to pile on. So, I --

1810 Mr. Carter. Sure.

1811 Ms. King. I think that in some, I think that in some  
1812 instances we're seeing integration and it's not just vertical;  
1813 right? We're seeing horizontal integration. We're seeing  
1814 vertical integration. And now we're also starting to see  
1815 cross-market integration where hospitals are buying provider  
1816 systems in other parts of the state, other, and in other states.  
1817 And the more integrated these markets become overall, the less  
1818 competition we are able to have.

1819 Mr. Carter. And that is the whole key. Transparency is  
1820 eminently important, no question about it. But competition is  
1821 the key as well. And being able to see that competition, I mean  
1822 we have used the example about buying a car. I mean, you know,  
1823 I believe it is New Hampshire who has a database, a website you  
1824 can go to to compare medical costs. I mean, that is the kind  
1825 of thing we are talking about, and that is what is going to lead  
1826 to decreasing health care costs.

1827 Ms. King. Well, that's right. And if there's no, if  
1828 there's very little competition in the state, or you have an entity  
1829 with an extreme amount of market power, they are able to keep  
1830 prices very high, regardless of how transparent you make them.

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1831 Mr. Carter. Right.

1832 Ms. King. If you don't have a choice of where to go, they  
1833 can charge you whatever they want.

1834 Mr. Carter. Okay. Let me get to my part. First of all,  
1835 Mr. Chairman, I want to ask unanimous consent to submit two  
1836 letters, one from the National Community Pharmacists Association  
1837 and another from the American Pharmacists Association for the  
1838 record.

1839 Mr. Harper. Without objection, so ordered.

1840 [The information follows:]

1841

1842 \*\*\*\*\* COMMITTEE INSERT 7\*\*\*\*\*

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1843 Mr. Carter. Thank you very much.

1844 I need to get back very quickly to a question that  
1845 Representative Barton asked about the coupons being used in  
1846 Medicare Part D. The anti-kickback, as you know, that will  
1847 prohibit that from happening. But one thing my colleagues need  
1848 to keep in mind is that a lot, most of these coupons are for brand  
1849 name drugs. And if you get outside of that formulary it is going  
1850 to end up costing taxpayer more.

1851 And every quickly, the reason that happens is because when  
1852 a patient goes and meets their deductible, then goes into the  
1853 donut, if they increase the costs by buying the ones that are  
1854 off the formulary then they get into the catastrophic quickly,  
1855 more quickly, which means that the taxpayers are going to be paying  
1856 more for their insurance, for that patient's insurance. It is  
1857 going to end up actually costing taxpayers more.

1858 So that is one of the reasons why the Medicare Part D CMS  
1859 does not allow that to happen in there. So I want to make sure  
1860 we, we got that clear.

1861 Representative Griffith mentioned my legislation dealing  
1862 with gag clauses. Twenty-two states have implemented this thus  
1863 far. We need to implement it at the federal level. You know,  
1864 here we are in America with freedom of speech, and over 30 years

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1865 of experience in working in pharmacy and I could never tell a  
1866 patient, look, if you pay for this out of your pocket it will  
1867 only cost you \$7.00, but your copay is going to be \$20.00. And  
1868 that is just ridiculous for us, particularly here in America,  
1869 not to be able to do that.

1870 I wanted to talk also about PBMs and their licensure and  
1871 registration. A number of states have required PBMs to register  
1872 with their insurance commissions. And the most recent one was  
1873 Arkansas held a special session. And now they have to -- they  
1874 have enacted the Arkansas Pharmacy Benefit Licensure Act where  
1875 the state insurance department requires PBMs to license within  
1876 the state.

1877 One of the things, also, we talk about pharmacies. The  
1878 number one pharmacy in America, CVS, they have more stores.  
1879 Walgreens. You know what number three is? Express Scripts with  
1880 their mail order pharmacies. Yet, they do not have to register  
1881 in each state.

1882 Don't you think they should at least have to register in  
1883 each state, the third largest pharmacy chain in America? And  
1884 they are nothing but mail order pharmacies. Surely they should  
1885 have to register in every state.

1886 Any comment.

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1887 Ms. King. I know very little about it but it sounds like  
1888 you're right, yes.

1889 Mr. Carter. Okay. I know.

1890 So, anyway, Dr. King, Medicaid managed care organizations,  
1891 that is another way that we can attack some of these costs as  
1892 well because without having, without having the transparency  
1893 there to see what exactly the PBMs are charging in those, then  
1894 we are unable to control costs.

1895 In fact, West Virginia just did away with their managed --  
1896 they carved that out and saved \$30 million. In Ohio they saved  
1897 \$227 million. In Kentucky they figured their costs would be \$380  
1898 million. Why can't we control that on a federal level as well?

1899 We have a number of managed care organization contracts at  
1900 the federal level. If we could control those, do you think we  
1901 could have -- and had transparency in it, do you think we could  
1902 save costs there?

1903 We could. The answer is yes. I'm sorry.

1904 Mr. Harper. The gentleman yields back.

1905 The chair will now recognize the gentlewoman from Illinois,  
1906 Ms. Schakowsky, for five minutes.

1907 Ms. Schakowsky. Thank you.

1908 Dr. Chernew, I have never heard a witness, though I am sure

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1909 many are thinking of it, that I wish my time were over. And I  
1910 want to -- I have been chuckling over that for most of the hearing.

1911 You mentioned the idea that pharmaceutical companies,  
1912 manufacturers can charge whatever the market will, will bear.

1913 But the question is, what is the market?

1914 We have a briefing from a Dr. Anderson from Hopkins who said,  
1915 for example, Sovaldi, that they decided that all they really  
1916 needed to make back the money that they invested in Sovaldi, or  
1917 the marketing that they do, they need 20 percent of the market.

1918 So, we are not talking about widgets, we are not talking  
1919 about cars, we are talking about illness, life, death. And so  
1920 if they charge, which they did, \$86,000 for this cure to Hep C,  
1921 all they really care about is that if 20 percent of people who  
1922 have this, you know, really awful disease can get cured.

1923 And so it seems to me that we ought to have a better way.

1924 You know, when you say charge whatever they, whatever they want  
1925 to make the money they want, this isn't about free markets, this  
1926 is about a very segmented market. I just wonder if you would  
1927 comment on that?

1928 Mr. Chernew. I wrote in my written testimony that I was  
1929 going to avoid pharmaceutical markets because it raises so many  
1930 complicated issues. But since asked, I will dip my toe in.

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1931           The challenge, and I will use Sovaldi as an example, is  
1932           Sovaldi was a truly innovative drug. And all analyses suggest  
1933           at least most any value criteria you would have. And although  
1934           it may be difficult for people to swallow -- that's not a pill  
1935           joke -- but anyway, it turns out that the evidence suggests that  
1936           with greater incentives for prescription drug innovation you get  
1937           more innovation.

1938           The problem is that statement should not imply that the drug  
1939           companies get a blank check. And therein lies the basic problem.

1940           I do not think their goal was simply to make back their R&D  
1941           money. Their goal was to make more money.

1942           Ms. Schakowsky. Yeah.

1943           Mr. Chernew. Right? That's the goal in capitalist  
1944           societies, to make more money. And in fact they have created  
1945           a remarkably good product that for decades will benefit us and  
1946           everybody. Right?

1947           Ms. Schakowsky. Not everybody.

1948           Mr. Chernew. The challenge --

1949           Ms. Schakowsky. The people who can pay for it.

1950           Mr. Chernew. No, that's right. So the people who can't  
1951           pay for it and don't get it, they're in the same place off they  
1952           were before it got invented. So, the challenge is how to manage

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1953 the incentives for innovation, which are really important, with  
1954 the obvious egregious problems of pricing. Not simply for what  
1955 people who pay out of pocket. It's the out-of-pocket comments  
1956 that bring everybody here. But the charge, to deal with the  
1957 overall total amount of spending, and the prices, and the volume  
1958 for all of these drugs.

1959 Ms. Schakowsky. You know what, let me stop because I have  
1960 one more --

1961 Mr. Chernew. Thank you.

1962 Ms. Schakowsky. -- one more question about it.

1963 But I think it is worse if you know that there is the cure  
1964 right there, that there is a cure right there and you can't get  
1965 it. I think in some ways it is worse than thinking there isn't  
1966 one.

1967 But, again, about -- okay, so you don't want to talk about  
1968 markets, but I just want to mention this. One argument is that  
1969 increased competition or more generic drugs are going to lead  
1970 to lower drug prices. But recently Elizabeth Rosenthal described  
1971 the bizarre phenomenon economists call sticky pricing where  
1972 prices of competing prescription drugs simply rise together with  
1973 each new drug that is provided.

1974 So, we have got Novartis, a cancer drug. And Gleevec was

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1975 first listed at \$26,000 in the market. And the first generic  
1976 was list priced at around \$140,000 annually. And now many drugs  
1977 in the same family as Gleevec cost on average \$150,000 per year.

1978 So, we aren't seeing. Again, markets in drugs, very  
1979 different. We are seeing an increase. So, this thought that,  
1980 you know, competition is going to drive it down and generics will  
1981 drive it down, not working always.

1982 Mr. Chernew. Always. I agree.

1983 So, if you look at drugs at 15 years ago we could have been  
1984 arguing about Lipitor and a whole series of other blockbuster  
1985 drugs. They've all gone generic. We buy them at Harvard,  
1986 they're bought as generic. It's a great deal. And, you know,  
1987 there's a lot of real advances.

1988 The challenges that are presented through some of those  
1989 drugs, through biosimilars, which is a whole different issue,  
1990 becomes important, are really, really, really important. And  
1991 the issues you're raising I'm incredibly sympathetic with because  
1992 the basic problem is we've been very successful at encouraging  
1993 amazing innovation.

1994 We haven't found a good way to make sure that that innovation  
1995 is affordable for people. And even if you solve the problem that  
1996 people are paying a lot out of pocket, the prices getting passed

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1997 through through insurance premiums create a really fundamental  
1998 challenge.

1999 Ms. Schakowsky. Okay, but I just want -- and I know my time  
2000 is up -- but we are seeing increases in drugs that have been on  
2001 the market for decades. They charge what the market will bear,  
2002 and that means that the prices have kept going up out of control.

2003 So, I can't let you answer. I am sorry, I am out of time.  
2004 And you should be happy.

2005 Mr. Harper. The gentlewoman yields back.

2006 The chair will now recognize the gentleman from  
2007 Pennsylvania, Mr. Costello, for five minutes.

2008 Mr. Costello. Thank you, Mr. Chairman.

2009 Dr. Chernew, in your written testimony you noted that one  
2010 of the many reasons that many transparency initiatives have had  
2011 only a minimal impact on the market is because consolidation in  
2012 the health care markets limits choice. Consolidation in the  
2013 health care industry is something that is of great interest to  
2014 this committee. As Chairman Harper mentioned at the beginning  
2015 of the hearing, the O&I Subcommittee had a hearing on  
2016 consolidation in the health care market last February.

2017 Do you think that there has been too much consolidation in  
2018 the health care market? And, if so, what impact has it had on

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2019 health care costs?

2020 Second piece of the question, how does consolidation limit  
2021 the effectiveness of both private and public transparency  
2022 initiatives?

2023 Mr. Chernew. Yes, there's too much consolidation and it's  
2024 raised the prices and spending.

2025 And the consolidation makes it difficult for transparency  
2026 initiatives to work because they fundamentally require choice.

2027 If there's no choice, knowing the price of an office charge  
2028 doesn't help you all that much.

2029 The only thing I will say is don't think about transparency  
2030 as only working through consumers. Having the policy -- having  
2031 the regulators, having the policy commission, having journalists  
2032 see the prices can also be helpful. But by and large the more  
2033 consolidation, the harder it is to get markets to work and,  
2034 therefore, the harder it is to get transparency to work.

2035 Mr. Costello. I have a question for you. But would like  
2036 anything to add, Dr. King? You were shaking your head yes before.

2037 Ms. King. Yeah. Well, I'm in vehement agreement with most  
2038 of the things he has said today.

2039 So, I think that, I think that also transparency can help  
2040 with the consolidation problem because you can actually, if you

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2041 have a good All Payer Claims Database you can look and see how  
2042 a particular merger or acquisition over time drove up costs or  
2043 didn't drive up costs.

2044 Did they actually gain the efficiencies they said they were  
2045 going to get when they, when they actually merged?

2046 Did they pass it through to consumers? You'd be able to  
2047 know that. And you'd be able to then turn around and stop future  
2048 consolidation in the markets through that.

2049 So, I think that those work both ways.

2050 Mr. Costello. Dr. King, thank you. In your written  
2051 testimony you highlighted how states could use health care claims  
2052 data reported to an APCD to examine the drivers of health care  
2053 costs over time, the impact of mergers, acquisitions, and other  
2054 affiliations on health care price and quality, among other things,  
2055 similar to what you just were sharing with us right there.

2056 How would the health care claims data reported to an APCD  
2057 give states with an APCD unique insight into the impact of M&As  
2058 that states without an APCD would not have?

2059 Ms. King. So, currently because a lot of these private  
2060 prices are shrouded in secrecy, the states don't actually -- the  
2061 attorney general doesn't know and, you know, other state entities  
2062 don't actually have the data to examine how mergers in the past

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2063 have affected prices, or how a particular -- they don't have the  
2064 ability to project how mergers in the future might affect prices.

2065           And so, if you have this enormous database of health care  
2066 prices over time that allows you to look at utilization patterns,  
2067 how people went, you know, were funneled to different providers,  
2068 and the cost, you could then make much better economic projections  
2069 about how a merger might affect things in the future. And, also,  
2070 you'd be able to look back in the past and see if they kept their  
2071 promise.

2072           Mr. Costello. Can you describe the general approaches  
2073 states have been taking regarding the pharmaceutical price  
2074 transparency bills you have seen?

2075           Ms. King. Yes. So, states have looked at a number of  
2076 different things with regard to price to pharmaceuticals this  
2077 year. This has been the big topic amongst the states. They have  
2078 done everything from a lot of price, pharmaceutical price  
2079 disclosure anti-gag clauses this year.

2080           They have also looked at, they've also looked at pricing  
2081 reports or requiring pharmaceutical companies to submit reports  
2082 at the end of the year, annually or at some other time that  
2083 basically describe how much it cost them to produce a drug, what  
2084 their overall -- what they spent on development and marketing,

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2085 and then what, how they're pricing their drugs, both as an annual  
2086 cost, as an individual patient cost.

2087 States have also focused on gag prohibitions and  
2088 disclosures, pricing reports. And that's a lot of what we've  
2089 seen with respect to pharmaceuticals. And then a lot of PBM  
2090 regulation as well, trying to promote transparency amongst the  
2091 pharmacy benefit managers.

2092 Mr. Costello. Thank you. I will yield back.

2093 Mr. Harper. The gentleman yields back.

2094 I want to thank both of you for being here today, giving  
2095 us some very valuable insight and information as we tackle this  
2096 very important challenge that we have.

2097 So, I want to thank the members that have participated in  
2098 today's hearing. And I will remind members that they have 10  
2099 business days to submit questions for the record. And should  
2100 you receive any written questions, we would ask the witnesses  
2101 to respond as quickly as possible to those questions.

2102 The subcommittee is adjourned.

2103 [Whereupon, at 12:02 p.m., the subcommittee was adjourned.]