ENERGY & COMMERCE
CHAIR RODGERS

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Health Subcommittee Hearing on April 26, 2023

The Subcommittee on Health will hold a hearing on Wednesday, April 26, 2023, at 10:00 a.m. (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

I. Witnesses

Panel I

- **The Honorable Chiquita Brooks-LaSure,** Administrator, U.S. Centers for Medicare and Medicaid Services

Panel II

- **Ms. Ashley Thompson,** Senior Vice President, Public Policy Analysis and Development, American Hospital Association
- **Ms. Kristin Bass,** Chief Policy and External Affairs Officer, Pharmaceutical Care Management Association
- **Mr. Brian Connell,** Executive Director, Federal Affairs, The Leukemia and Lymphoma Society
- **Mr. Sean Cavanaugh,** Chief Policy Officer, Aledade, Inc.
- **Ms. Ilyse Schuman,** Senior Vice President, Health Policy, American Benefits Council
- **Mr. Loren Adler,** Fellow and Associate Director, USC-Brookings Initiative for Health Policy, Economic Studies Program, Brookings Institution

II. Background

On March 28, 2023, the Subcommittee on Health held a bipartisan hearing titled "Lowering Unaffordable Costs: Examining Transparency and Competition in Health Care." Witnesses, including patient advocates, stakeholders, and experts discussed the need to improve price transparency in health care as well as improve competition amongst payers and providers of health care to help lower costs for patients.

Health Care Costs

Americans rank the cost of health care as a top concern.[1] The United States spent $4.3 trillion on health care in 2021, which is more as a percentage of GDP than the rest of

[1] PowerPoint Presentation (usrfiles.com)

the developed world.[2,3] Major categories of spending include hospital care (31 percent), physician and clinical services (20 percent), and retail prescription drugs (9 percent). The federal government accounts for the plurality of health care spending (34 percent) followed by households (27 percent), private employers (17 percent), and state and local governments (15 percent).

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

Price Transparency

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

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

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

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[2] National Health Expenditures 2021 Highlights (cms.gov)
[3] Health resources - Health spending - OECD Data
[4] The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services (cbo.gov)
[5] Analytical Perspectives, Budget of the U.S. Government, Fiscal Year 2024 (whitehouse.gov)
[6] CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care | CMS
[7] Enforcement Actions | CMS
[8] Plans And Issuers | CMS
[9] CMS insurer price transparency rule has taken effect. Signs are good for compliance | Healthcare Dive

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

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

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

Consolidation

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

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

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

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[10] Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (cbo.gov)
[11] Estimating the Impact of New Health Price Transparency Policies - Stephen T. Parente, 2023 (sagepub.com)
[12] S. 1895 (cbo.gov)
[13] Ibid.
[14] Drug Channels: The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger
[15] FTC Launches Inquiry Into Prescription Drug Middlemen Industry | Federal Trade Commission

III. Legislation Being Considered

H.R. 1613, the Drug Transparency in Medicaid Act of 2023

H.R. 1613 would require pass-through pricing and prohibit spread-pricing for payment arrangements with pharmacy benefit managers under Medicaid.

H.R. 2665, the Supporting Safety Net Hospitals Act

H.R. 2665 would eliminate the disproportionate share hospital payment reductions under the Medicaid program for Fiscal Years 2024 and 2025.

H.R. 2666, the Medicaid VBPs for Patients (MVP) Act

H.R. 2666 would codify Medicaid rules that permit the use of varying best price points under value-based purchasing arrangements such as gene therapies.

H.R. 2691, the Transparent PRICE Act

H.R. 2691 would codify and improve upon existing price transparency requirements for hospitals and insurance companies. The bill requires hospitals to make their standard charges public through machine-readable files as well as payer-specific negotiated charges, including for cash-paying patients, for 300 shoppable services. Additionally, it requires health insurance companies to make personalized pricing information available to enrollees and post machine-readable files containing in-network negotiated rates, historical prescription drug prices, and out-of-network allowed amounts.

The bill makes improvements upon existing rules by creating a robust enforcement mechanism and increased penalties for noncompliance. Further, it takes action to improve the quality of the data reported by both hospitals and insurers to provide actionable information for patients and employers.

H.R. 2679, the PBM Accountability Act

H.R. 2679 would require pharmacy benefit managers (PBMs) regularly to furnish employers with detailed data on prescription drug spending, including the cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. Additionally, the Comptroller General of the United States would be required to submit a report to Congress on pharmacy networks of group health plans, health insurance issuers, and entities providing pharmacy management services under such group health plans or group or individual health insurance coverage.

H.R. 977, the Patient Access to Higher Quality Health Care Act of 2023

H.R. 977 would repeal provisions in the Stark Law that prohibit physician self-referrals to new or expanded physician-owned hospitals.

H.R.___, To establish patient protections with respect to highly rebated drugs

This discussion draft would establish deductible and cost-sharing limitations on highly rebated drugs. Specifically, cost-sharing would be capped at the price paid by the insurer for the drug in the previous year to ensure patients are never paying more than the cost of the drug.

H.R.___, To amend title XVIII of the Social Security Act to increase price transparency of diagnostic laboratory tests

This discussion draft would require diagnostic laboratories to disclose three data points for clinical diagnostic laboratory tests included on the list of shoppable services specified by the Centers for Medicare and Medicaid Services: the discounted cash price of each test, the de-identified minimum rate for each test, and the de-identified maximum rate for each test.

H.R.___, To amend title XI of the Social Security Act to increase transparency of certain health-related ownership information

This discussion draft would require hospitals, freestanding emergency centers, ambulatory surgical centers, physician practices with more than 25 physicians, physician practices owned by hospitals, insurance companies, and other entities, to report to the Department of Health and Human Services (HHS) upon changes in ownership. HHS would be required to use this data to submit annual reports on trends in health care consolidation.

H.R.___, To amend title XVIII of the Social Security Act to promote transparency of common ownership interests under Parts C and D of the Medicare Program

This discussion draft would require greater data reporting and transparency into how vertically integrated arrangements among companies contracting with Medicare are interacting with each other compared to when vertically integrated companies interact with other health care providers, like independent physicians, pharmacies, and other entities not owned by the insurance company or PBM.

H.R.___, To require the Secretary of Health and Human Services to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation, and for other purposes

This discussion draft would require HHS, during each of its annual hospital and other provider payment rules like those for inpatient and outpatient care, to consider the implications that its proposals may have on further consolidating the health care system by studying both horizontal and vertical consolidation among both providers and payers.

H.R.___, To amend title XVIII of the Social Security Act to provide for parity in Medicare payments for hospital outpatient department services furnished off-campus

The discussion draft equalizes the amount Medicare and Medicare beneficiaries pay for physician-administered drugs across outpatient settings.

H.R.___, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished

The discussion draft would expand upon the 2015 Bipartisan Budget Act, which required that new outpatient departments of hospitals be paid by Medicare and Medicare beneficiaries at the same rate as other outpatient providers (physician offices, non-hospital outpatient surgical centers) for the same services performed safely at such facilities. The discussion draft would apply this policy to off-campus outpatient hospital departments that existed prior to 2015 and currently get reimbursed at a higher rate than other providers for providing the same services.

H.R.___, To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings

This discussion draft implements a proposal designed by the Medicare Payment Advisory Commission (MedPAC) to ensure that for certain services performed safely in multiple care settings that patients and Medicare pay the same amount for the same services regardless of where they are furnished. The discussion draft limits Medicare revenue reductions at safety net hospitals to 4.1% annually, but the Secretary has discretion to set a lower amount.

H.R.___, To amend titles XI and XVIII of the Social Security Act to require each outpatient department of a provider to include a unique identification number on claims for services, and to require hospitals with an outpatient department of a provider to submit to the Centers for Medicare & Medicaid Services an attestation with respect to each outpatient department

This discussion draft would require hospitals to report clearly to the CMS on how they meet CMS requirements to be designated as a "provider-based" facility. Provider-based facilities receive greater Medicare reimbursement than freestanding facilities.

H.R.___, To amend title III of the Public Health Service Act to ensure transparency and oversight of the 340B drug discount program

This discussion draft would establish reporting requirements for hospitals participating in the 340B program. Specifically, participating hospitals would be required to report total 340B savings and other key metrics to the Health Resources and Services Administration on an annual basis.

H.R.___, To phase out certain services designated as inpatient-only services under the Medicare program.

This discussion draft would phase out certain musculoskeletal services that Medicare, through a regulatory policy known as the "Inpatient Only List," has required to be conducted in an inpatient care setting, rather than allowing for doctors and patients to decide if the procedure could be safely conducted in a potentially lower-cost outpatient setting. The draft would also require the Secretary of HHS to conduct a study and report on clinical outcomes and patient

safety as well as patient cost-sharing and the financial impact of the inpatient-only service list on Medicare.

IV. Staff Contacts

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