



**Testimony of U.S. PIRG at a House Ways and Means Committee,
Subcommittee on Health hearing on Why Health Care Is Unaffordable**

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March 23, 2023

Thank you Chairman Buchanan, Ranking member Doggett and members of the subcommittee for this opportunity to discuss the high prices of health care

I am Patricia Kelmar, senior director for health care campaigns for U.S. PIRG, the Public Interest Research Group. With our state PIRG affiliates, I work to promote policies that advance high value health care. Our health care dollars should be spent effectively to achieve high quality outcomes. We are aligned in a common mission today to identify the best solutions to the high prices that we are paying in today's health markets. We know we can do better to bring costs down while achieving better individual care and improving population health.

Every week I interact with members of the public who contact us, usually in their attempt to solve a difficult medical billing problem. For example, David, an engineer, and Christy, an IT analyst, reached out to share their experience with the birth of their first child last fall. Little Theo arrived early and was having difficulty breathing. The doctors at their local hospital recommended specialist care at a nearby children's hospital to properly diagnose and treat their baby. Theo was transferred by ambulance to that hospital 16 miles away. There he was diagnosed with multiple heart and lung diseases and in his two week stay he received the care that allowed him to go home with his family.

Weeks later, David and Christy received a 7,000 bill from the ambulance company. Their insurance company covered \$1,000 of it. The couple was shocked to learn it was their responsibility to pay the remaining \$6,000. They didn't understand why they still owed this amount, when they had already paid their deductible and their out of pocket maximum. The problem arose because it was an out-of-network ambulance that transported Theo to the specialists. Dave and Christy had received the "balance bill" for the amount not covered by the health plan. Over the following weeks, they tried negotiating with the health plan and the

ambulance company to lower their amount due. Unsuccessful, they decided to set up a 30 month



payment plan to pay off the \$6,000. Theo will be nearly three by the time that debt is paid off.

Circumstances just like this can set families back for years, struggling to pay for expensive medical bills that they can't control or negotiate.

Insurance allows more people to access health care.

The U.S. relies on insurance programs to help people access health care prevention services and treatment. Insurance works to spread across a broader population the costs of caring for sicker patients, making it less financially devastating for individuals who need the most care. But insurance also is intended to encourage everyone to use health care services to stay healthier and prevent illnesses. In the U.S. we provide insurance through a mix of programs - Medicare, Medicaid, the plans offered on the Marketplace through the Affordable Care Act, and employer-sponsored and union coverage. To spread costs evenly, everyone should be insured. Since its passage 13 years ago, the Affordable Care Act (ACA) has helped cut the uninsured rate nearly in half¹ and thanks to our different programs, only about 8% remain uninsured today.²

Health care prices are driving our national health care spending.

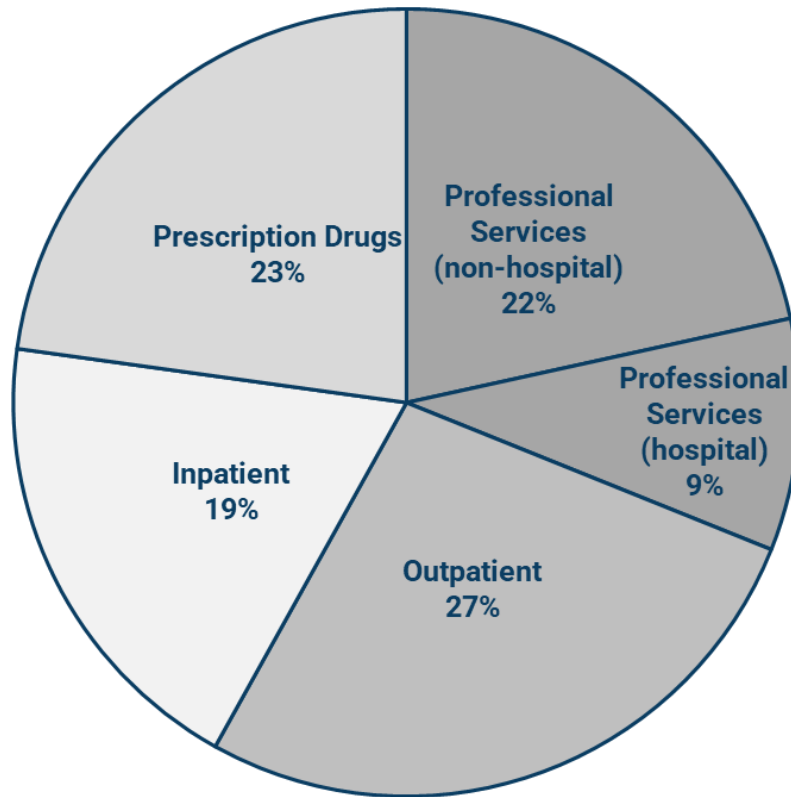
Per capita spending on health care is double the average of other wealthy countries.³ And the major reason is because of U.S. prices for health care. Our prices have been rising every year for decades. The two highest drivers of our national health care expenditure are the prices of prescription drugs, and the prices of inpatient and outpatient hospital services as seen clearly in this example of 2020 data. Hospital services and prescription drugs make up almost three-

¹ Aiden Lee et al., *National Uninsured Rate Reaches All-Time Low in Early 2022* (Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Aug. 2022) <https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf>

² See note 1.

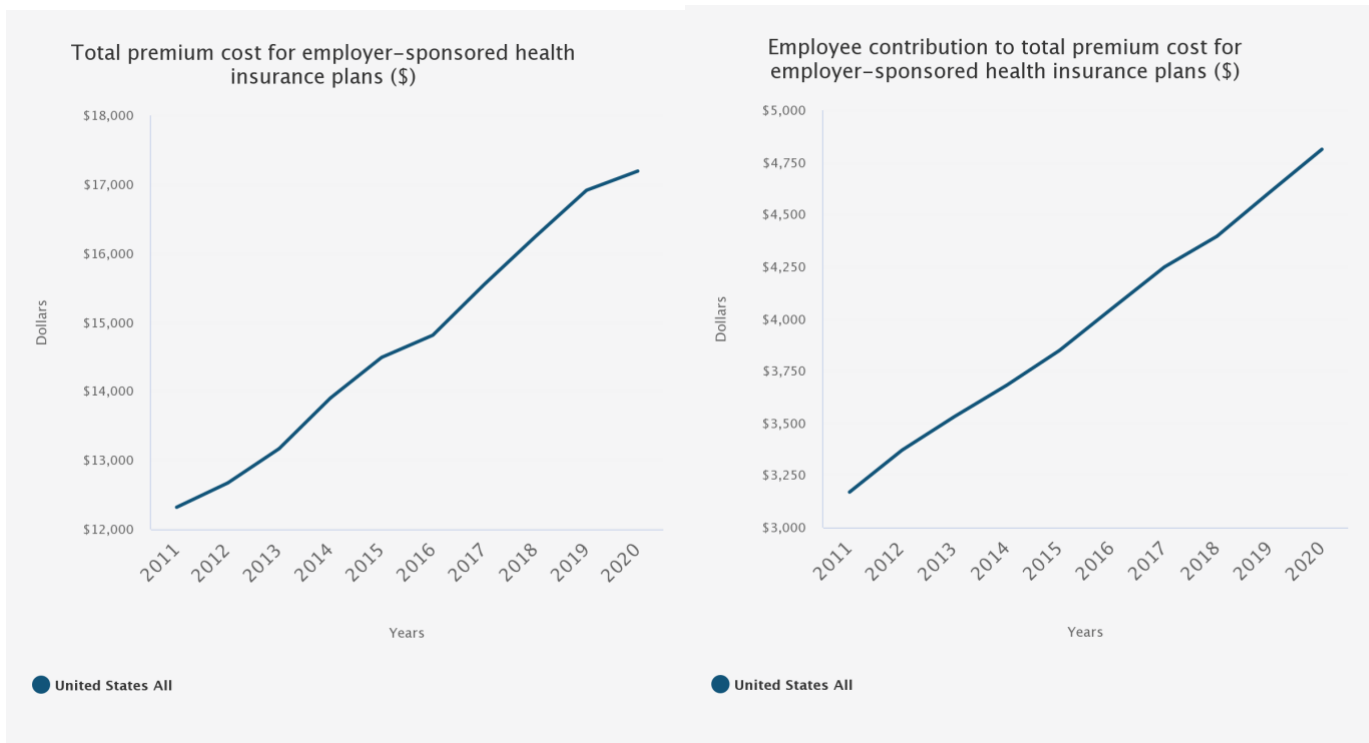
³ Peter G. Peterson Foundation, *Key Drivers of the National Debt*, <https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers>

quarters of the per-person health care spend for employer sponsored insurance. (See chart below).



Source: Health Care Cost Institute, 2020, Per person spend is \$5,607. <https://healthcostinstitute.org/hcci-research/hccur-data-point-use-and-spending-on-clinician-services-in-hospital-and-non-hospital-settings>

Employers and businesses find it difficult to pay for ever increasing costs of employee health care coverage and feel the pressure to offer or design plans that push more of the costs onto their workers, in an effort to keep down premium costs. That results in employees paying more in deductibles, co-payments and co-insurance. The price burden is real and has been growing every year since at least 2011. See chart below.



Source: The Commonwealth Fund: https://www.commonwealthfund.org/datacenter/total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356 and https://www.commonwealthfund.org/datacenter/employee-contribution-total-premium-cost-employer-sponsored-health-insurance-plans?performance_area=9356

So even with a good insurance plan by a well-meaning employer, many families still struggle to pay their out-of-pocket share for their health care. And for those with high deductible, minimal coverage plans, the out-of-pocket burden is even higher, and with no ability of the consumer to negotiate a lower price.

But why are prices for medications and hospital services so high? Lack of competition.

The lack of competition in prescription drugs.

U.S. prescription drug spending increased 60% over the last decade⁴ and prices continue to rise, sometimes multiple times in a year. Two-thirds of U.S. adults rely on prescription drugs.⁵ And yet 1 in 4 people struggle to pay for them.⁶ When people can't fit the cost of their medications

⁴ I-MAK, "Overpatented, Overpriced Curbing patent abuse: Tackling the root of the drug pricing crisis", September, 2022. <https://www.i-mak.org/wp-content/uploads/2018/08/I-MAK-Overpatented-Overpriced-Report.pdf>

⁵ Emily Ihara, "Prescription Drugs", Georgetown University Health Policy Institute, accessed at <https://hpi.georgetown.edu/rxdrugs/#:~:text=More%20than%20131%20million%20people,United%20States%20%E2%80%94%20use%20prescription%20drugs>

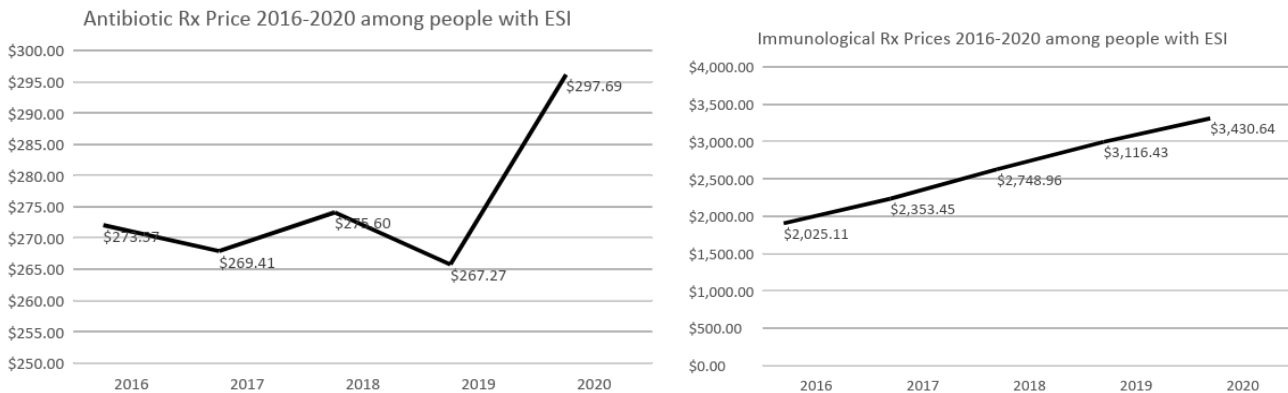
⁶ Ashley Kirzinger et al., "Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say it's Difficult To Afford Their Medicines, Including Larger Shares Among Those With Health Issues, With Low Incomes and Nearing Medicare Ages", KFF, March 1, 2019, <https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/>

into their monthly budgets, they make decisions that negatively impact their health such as not filling prescriptions or skipping doses.⁷ High drug prices impact all insured people, not just those taking medications. Because drug expenses make up 20% of our insurance costs, when drug prices go up⁸, employers find it more difficult to keep insurance premiums affordable. High prescription drug prices are also a huge burden on our important taxpayer-funded health programs like Medicare and Medicaid.

What should be done to address prescription drug prices?

What’s missing in the drug marketplace is competition. The FDA demonstrated that with the introduction of even one generic competitor, the price for that medication drops by almost 40%, and if we get four competitors, generic prices are almost 80% less than the brand name drug before competition was introduced.⁹ Savings from new generic drug approvals are dramatic - \$10-20 billion annually.¹⁰ That’s the power of a competitive marketplace.

Below you can see rising prices of just some of our most important classes of medications. However, note that in the cardiovascular area, where there are more competitors, prices are trending downwards.

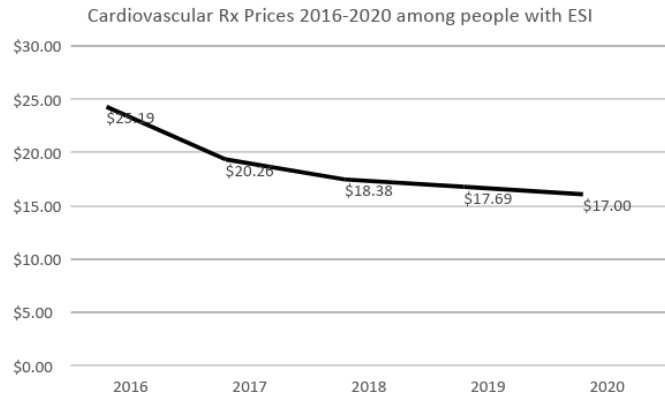
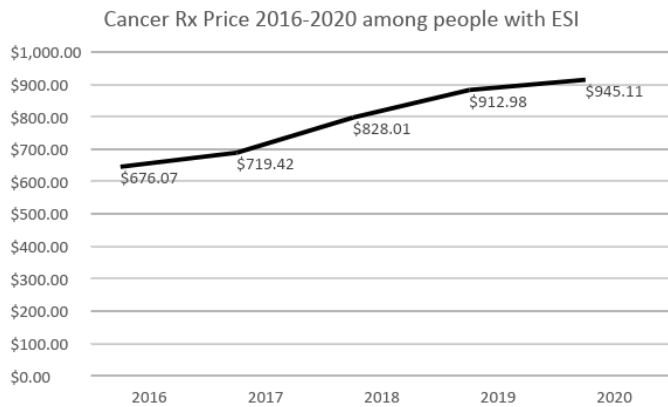


⁷ See note 6.

⁸ AHIP, “Your Health Care Dollar: Vast Majority of Premium Pays for Prescription Drugs and Medical Care”, Americas Health Insurance Plans, September 6, 2022, <https://www.ahip.org/news/press-releases/your-health-care-dollar-vast-majority-of-premium-pays-for-prescription-drugs-and-medical-care>

⁹ FDA, “New Evidence Linking Greater Generic Competition and Lower Generic Drug Prices”, 2019 <https://www.fda.gov/media/133509/download>

¹⁰ Ryan Conrad PhD et al., “Estimating Cost Savings from New Generic Drug Approvals in 2018, 2019, and 2020”, US Food and Drug Administration, August 2022, <https://www.fda.gov/media/161540/download>



Note: Price is price per 30 days supplied

Source: Health Care Cost Institute, Health Care Cost and Utilization Report 2020 Downloadable Data, <https://healthcostinstitute.org/health-care-cost-and-utilization-report/annual-reports>

Americans love the cost savings of generics. Congress, the Patent and Trademark Office and the FDA should break down the barriers that prevent generics and biosimilars from coming to the market to compete. Pharmaceutical companies are abusing patent law through tactics like product hopping, patent thickets and pay-for-delay.

While brand-name drugs make up only 8% of prescriptions, they account for 84% of all U.S. drug spending.¹¹ Imagine the kind of savings we could achieve if we made drugs compete in an active market. Without competition from generic drugs, brand-name companies can keep their prices high for decades. It's not just a huge financial hit impacting our insurance premiums and public health programs, but it's a budget buster for our out-of-pocket costs as well.

It's important to focus on all drugs, not just prescription drugs that folks take at home. Data shows even higher price increases for drugs administered in doctor's offices and hospitals, prices increased over 40% for those drugs between 2016-202.¹² Greater oversight of billing practices for these drugs should be conducted. Is this a competition issue, a site-payment issue, or is something else happening with these drugs?

High in- and outpatient hospital prices are rising in the wake of extensive market consolidation.

¹¹ IQVIA Institute for Human Data Science, *The Use of Medicines in the U.S. 2022*, April, 2022, 39. <https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2022>

¹² HCCUR Data Point: Trends in Total (Administered and Prescription) Drug Spending in ESI, <https://healthcostinstitute.org/hcci-research/hccur-data-point-trends-in-total-administered-and-prescription-drug-spending-in-esi>

Prices for hospital services are also driving our national health care expenditures. And there is one significant reason: consolidation. Health markets are becoming increasingly concentrated with recent unchecked merger activity, including both horizontal and vertical consolidation [among hospitals and physicians](#).¹³ Between 1998 and 2021, there were more than [1800 hospital mergers](#) reducing the number of hospitals in the country from 8,000 to 6,000.¹⁴ In [many metropolitan areas](#), just one health system has the majority of market power.¹⁵ Insurers with only one hospital system in a region have no leverage to negotiate lower market-based prices.

[One study](#) found that prices at monopoly hospitals are about 12 percent higher than at hospitals that have 4 or more competitors.¹⁶ [Another study](#) found that hospitals that are part of a health system charge 31 percent more for services than hospitals that are not part of a larger system.¹⁷ To be clear, these higher prices do not even result in an improvement in [quality outcomes](#).¹⁸

Although horizontal consolidation does not impact Medicare prices for physicians or hospitals that are generally paid based on the prospective payment systems, vertical mergers can result in higher Medicare charges. That's because physician offices purchased by a hospital can bill higher Medicare rates by coding the service as a hospital outpatient department, even though it is actually provided in that same physician's office location.¹⁹

But we know that prices don't have to be high for hospitals to keep their doors open. For example, in 2018 the average price for a knee or hip replacement at an in-network facility in the Baltimore area (\$23,000) was half the average price in the New York City Metro area (\$58,000).²⁰ These price differentials are seen across the country and with new transparency laws, we'll soon have a clearer understanding of which hospitals are better at controlling prices, which will make it even more obvious that the competitive market for hospital care is broken.

¹³ Michael Furukawa et al., "Consolidation of Providers into Health Systems Increased Substantially, 2011-2016" <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00017>

¹⁴ Hoag Levins, "Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality, Jan. 19, 2023 <https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/>

¹⁵ Health Care Cost Institute, HMI Interactive Report, <https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index>

¹⁶ Zack Cooper et al. "The Price Ain't Right?" Sept. 2018, <https://pubmed.ncbi.nlm.nih.gov/32981974/>

¹⁷ Nancy Beaulieu et al. "Organization and Performance of U.S. Health Systems," JAMA, January 2023, <https://jamanetwork.com/journals/jama/article-abstract/2800656>

¹⁸ Lovisa Gustafsson et al., "The Pandemic Will Fuel Consolidation in Health Care" Harvard Business Review, March 9, 2021, <https://hbr.org/2021/03/the-pandemic-will-fuel-consolidation-in-u-s-health-care>

¹⁹ Karyn Schwartz, KFF, "What we know about provider consolidation", Sept 2020, <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation>

²⁰ Nisha Kurani et al., "Price Transparency and Variation in U.S. Health Services", Jan 2021 <https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/>

With no cost constraints and almost no competition, employer and private insurers are paying 247 percent of what Medicare would have paid for the same in- and outpatient services services.²¹

Private equity investments in health care are pushing the business of health care toward maximum profits.

Private equity investment is further challenging our health markets, driving prices higher in even more sectors. The impact of a change in ownership to private equity is dramatic and swift. Private equity-controlled practices in the areas of dermatology, gastroenterology, and ophthalmology charged an average of 20 percent more per claim and increased the amount per claim allowed by payers by 11 percent shortly after the acquisition.²²

There is no doubt that private equity invests in the health care services in which they can charge whatever they want. But when we step in to address their anticompetitive practices, things are better for consumers. When the No Surprises Act banned balance billing by out-of-network air ambulances, private-equity backed air ambulance providers, notorious for staying out-of-network and charging higher prices, quickly started closing helicopter sites, allowing community-based air ambulance providers to serve the area with lower prices. Those same private-equity backed companies however do continue to run their ground ambulances, a service where the surprise billing prohibition does not apply and they can profit off of balance billing.

What can be done to address high prices in hospital-owned settings?

For geographic areas where markets haven't already undergone dramatic consolidation, greater oversight should be given to pending mergers. Regulators should carefully consider past behaviors of health systems and evaluate the potential impact of even "small" mergers on health markets. It is only a temporary fix when regulators approve mergers after gaining promises from the consolidating parties to hold costs down or keep service lines open. Three or five years pass and the promises expire. Regulators should also actively audit and monitor hospital and insurance contracts to ferret out anti-competitive agreements, such as all-or-nothing clauses that force health plans to include higher priced health systems in networks, driving up prices for everyone.

²¹ Christopher Whaley, Rand Corp., "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans", 2021, https://www.rand.org/pubs/research_reports/RR4394.html

²² Yashaswini Singh et al. JAMA, "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization" Sept 2022, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946>

States are innovating their own solutions - creating cost containment structures for both prescription drugs (Prescription Drug Affordability Boards) and for overall health care costs, such as the Massachusetts Health Policy Commission and Rhode Island's use of an Affordability Standard. These forays into cost containment can offer some new solutions which Congress should build upon and improve.

Congress should put an end to add-on charges simply because the service is offered in hospital-owned buildings. Consumers can't possibly be expected to figure out whether their physician's office is now owned by a hospital. Prohibit facility fees and establish site-neutral payments to start paying for the actual service, rather than the location of the service.

Additional Congress and regulators could better support employers by translating the new hospital price and health plan transparency data points into a format that can help plans create high value networks with reasonable prices and outstanding quality.

High-priced health care burdens families with medical debt.

In conclusion, it's important to remember that these high prices result in higher medical bills that hurt families in the near term and can have lasting negative financial consequences. One study shows almost 20% of individuals have medical debt with a mean amount of \$429.²³ But the patients I'm talking to have bills that are so much higher - and they are desperately trying to figure out how to pay them, knowing they are just one more illness away from losing their car or worse, their home.

Medical debt can carry a long tail. According to the Consumer Financial Protection Bureau, as of mid-2021, 58% of bills in collections and on credit reports were medical bills.²⁴ Bad credit scores follow people for years, impacting their ability to rent or buy a home. These lasting financial impacts shouldn't be the result when someone finally gets through chemo or survives a car crash.

While we work to get health care prices under control, we need to provide immediate relief to patients who need care.

- Every day I celebrate the millions of surprise out-of-network bills already prevented by the No Surprises Act. But of the 3 million insured patients who ride in an ambulance in the next year, half will be exposed to a potential out-of-network surprise bill. It's time to close that gap, and impose a ban on ground ambulance surprise billing.

²³ Raymond Kluender et al, JAMA, "Medical Debt in the U.S. 2009-2020"
<https://jamanetwork.com/journals/jama/fullarticle/2782187>

²⁴ CFPB Estimates \$88 Billion in Medical Bills on Credit Reports, CFPB news release, March 1, 2022,
<https://www.consumerfinance.gov/about-us/newsroom/cfpb-estimates-88-billion-in-medical-bills-on-credit-reports/>

- Congress should require reviews of nonprofit hospitals' financial statements and penalize hospitals which fail to fulfill their mandated nonprofit obligation to offer financial support for vulnerable patients. And hospitals must do a better job notifying patients about their financial assistance policies and help them use it.
- Patients deserve to know what their costs will be before they receive care. Regulations requiring Advanced Explanation of Benefits from insurers should not be delayed (No Surprises Act).
- And because medical debt is unlike other consumer debt, we need new rules against abusive medical debt collection actions. Patients need more time to heal and more time to fight inaccurate bills, up-coding, claim denials, or illegal balance billing. We should prohibit suing patients, garnishing wages or placing liens on homes for debts for medically necessary care.

I look forward to working with members of the subcommittee to work on these and other recommendations to achieve a high value health system that gives us the quality care we desire, without the high price tags we have today. Thank you for your commitment to solving this issue.