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Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality and Costs
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Chairman Wyden, Ranking Member Crapo, and distinguished members of the Committee, my name is Caroline Pearson, and I am the Executive Director of the Peterson Center on Healthcare ("the Center"), which is a division of the Peter G. Peterson Foundation. Thank you for the opportunity to testify before the Committee today as you examine opportunities to lower costs and improve the quality, accessibility, and affordability of healthcare by advancing healthcare transparency.

Founded in 2014, the Center is a nonprofit, nonpartisan organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. We are working to transform healthcare in the United States into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale. The Center collaborates with a wide range of healthcare stakeholders and engages in grant-making, partnerships, and research.

As the members of this Committee know well, and has been well-established by a plethora of research, our nation's per capita spending on healthcare is more than twice the average of other comparable countries[1] and it is growing explosively.[2] Yet, outcomes for patients in the U.S. are worse than many other nations.[3] Fundamental to the Center's mission is a belief that in order to

advance more effective, accessible care for patients, healthcare decisionmakers—including policymakers, business leaders, and families—need more and better data to correct inefficiencies in the market and ultimately lower healthcare spending growth to more sustainable levels.

I joined the Center as its Executive Director in January of this year. Prior to the Center, I spent twenty years working in research and consulting on a range of healthcare policy and business issues, including public and private insurance coverage, prescription drugs, and aging. I have conducted in-depth data analyses using healthcare claims, administrative, and survey data. Most recently, I was the Senior Vice President of Health Care Strategy at NORC at the University of Chicago, a nonpartisan, nonprofit social sciences research institution. Before NORC, I spent fourteen years at Avalere Health, a leading healthcare consulting and advisory firm, where I oversaw teams focused on policy, data analytics, and strategic communications. Based on my experience working with companies across the healthcare industry, I believe the path to a better, lower cost, and more accessible U.S. healthcare system depends on improving the availability and usability of healthcare data, including price transparency data.

My comments today will focus on how the evidence generated from the Center's work, as well as other independent studies conducted over the last several years, points to the need for continued advancements in healthcare data transparency. By increasing transparency regarding healthcare prices, spending, and utilization, improved healthcare data can help facilitate better-functioning markets and, when necessary, help inform policymaking to address market failures. End users for this data may include consumers, payers, providers, legislators, and regulators. In fact, our research and grantmaking underscores that greater healthcare data availability and usability is a critical ingredient to enable further action that lowers spending growth, increases quality, and improves access to care.

Thanks to the regulations promulgated and implemented over the last several years by the previous Administration, and then, the current Administration[4], along with the passage of the No Surprises Act as part of The Consolidated Appropriations Act of 2021[5] by Congress, we now have an unprecedented level of healthcare price transparency and have taken important steps toward democratizing information that has previously been proprietary. My testimony today offers a series of recommendations to build on that progress.

My testimony summarizes some of the key findings from the Center's work and other research on how transparency can shape healthcare markets. It also puts forth a range of policy options that Congress and the Executive Branch should consider to further advance discrete elements of healthcare data transparency, with an emphasis on how to improve the depth, breadth and usability of pricing data.

The Peterson Center on Healthcare Supports Increased Transparency

The Center's grantmaking portfolio provides us with ample evidence that additional healthcare data transparency that builds on the advancements already made at both the national and state level would be enormously beneficial. This portfolio includes the Peterson-Kaiser Family Foundation (KFF) Health System Tracker and the Peterson-Milbank Program for Sustainable Health Care Costs.

Launched in 2015, the Peterson-KFF Health System Tracker uses healthcare data and sound research methods to track U.S. health system performance, across four domains: Health Spending, Quality of Care, Access & Affordability, and Health & Wellbeing. Since implementation of the hospital price transparency regulations produced new information about hospital prices in machine-readable files, Peterson-KFF researchers have used the newly available data to conduct analyses for public consumption. The researchers have leveraged the data that has become available as a result of the Hospital Price Transparency rules (CMS-1694-

F, CMS-1717-F2, CMS-1753-FC), which require hospitals to post a single machine-readable file of their gross charges, discounted cash prices, payer-specific negotiated charges and de-identified minimum and maximum negotiated charges for all items and services offered by the hospital, and for hospitals to display the same information in plain language for consumers of at least 300 “shoppable services.” These requirements went into effect on January 1, 2021.

The Peterson-KFF hospital price transparency research finds that:

- Hospital compliance with the reporting requirements is lagging, but growing[6];
- Consumers have little to no awareness of the transparency requirements[7];
- There is significant variation in hospital prices[8]; and
- The usability of this new data remains challenging. [9]

Peterson-KFF researchers were among the first to examine hospital compliance and found very few hospitals were providing their payer-negotiated rates in April 2021, three months after the requirements went into effect.[10] Patient Rights Advocate, a non-profit organization active in the pursuit of price transparency, issued its first hospital compliance report a few months after the Peterson-KFF researchers, and found only a 5.6% compliance rate among 500 hospitals reviewed.[11] In January of 2023, the Centers for Medicare and Medicaid Services (CMS) concluded that 70% of hospitals are compliant with the posting requirements for the price transparency rule,[12] though a competing report issued by Patient Rights Advocate in February 2023 found only 24.5% of hospitals were fully compliant with the posting requirements.[13]

In addition to compliance challenges, consumer awareness of the new price transparency data remains very low. Peterson-KFF research conducted in the spring of 2021 showed that only 9% of U.S. adults were aware that hospitals are subject to price disclosure requirements—a finding that was consistent across age groups, income levels, and health status. In that same study, the researchers also found that 85% of U.S. adults had not spent time researching the price of

health services within the prior 6-month timeframe, a finding that is consistent with other research that shows very few U.S. consumers price-shop for healthcare.[14]

Most recently, in February 2023, the Peterson-KFF research team's report on hospital price transparency focused on the data quality of the hospital-generated pricing data. The researchers concluded that the hospital price transparency data are associated with significant usability limitations, namely there is a lack of consistency in how hospitals describe service and care episode prices, data quality across the files is poor and critical pieces of information are missing from the files ((Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code modifiers, contracting methods and payer type specification of commercial, Medicare, Medicaid).[15] For example, the research team examined charges and negotiated rates for a diagnostic colonoscopy—a procedure that is typically planned in advance, widely available in different settings in most geographies in the U.S., and therefore shoppable. Their analysis found that 96% of the negotiated rates for diagnostic colonoscopy included in the data set did not include associated standard CPT/HCPCS code modifiers that convey important information about the procedure that, in many cases, would affect pricing.[16]

The Peterson-KFF team also found that nearly half of the negotiated rates for diagnostic colonoscopy in the data currently lacks location specification—45% of negotiated rates for diagnostic colonoscopy have no location information provided.[17] This limits the utility of the data to demonstrate that, under current law, the same procedure performed by the same physician can cost much more or much less depending upon the physical setting in which it is performed (e.g., a physician office, an Ambulatory Surgical Center, a hospital outpatient setting, or hospital inpatient setting).

Price transparency will continue as a focus of the Tracker research over the course of the coming year, and the team will start to use the Transparency in Coverage (TiC)[18] data sets from the nation's payers to conduct new research briefs. Effective as of July 1, 2022, the TiC requires

most self-insured and fully-insured group and individual health insurance plans to post machine-readable files with the negotiated amounts for all covered items and services of in-network providers, and allowed amounts and billed charges from out-of-network providers. Further, insurers must create internet-based price comparison shopping tools, first for 500 items and services in 2023, and then for all items and services in 2024, available to enrollees online, by phone or in paper form by request. Among the researchers that have started to use the TiC data, they are finding the files challenging to work with due to file size, data quality, and ability to link to other data sets[19]. Yet, they also see tremendous opportunity to explore questions with the data, and the Peterson-KFF team looks forward to adding thoughtful literature in the future.

Overall, our Peterson-KFF work demonstrates that the price transparency data that has become available over the last several years from our nation's hospitals and payers, even in its imperfect form, is helping to improve the conditions for change. At the same time, it is also clear from our work and the work of other respected research organizations, that additional steps are needed to empower consumers, payers, and employers.

Since 2020, the Peterson-Milbank Program for Sustainable Health Care Costs has provided funding to states who wish to implement programs to reduce cost growth. The program provides technical assistance, analytic capacity, and communications resources to support states that have implemented healthcare cost growth targets. Currently, the program assists leaders in 5 states (Connecticut, New Jersey, Oregon, Rhode Island and Washington), by facilitating state-led policymaking that is data-informed and responsive to the unique dynamics at play in local and regional state markets driving healthcare spending growth.

The Peterson-Milbank initiative has shown that data transparency is a critical underpinning of state and private market efforts to identify, understand and address market trends, including those factors driving healthcare spending growth. In states pursuing cost growth targets, and in other states pursuing laws and infrastructure that create greater commercial pricing

transparency, healthcare pricing and utilization data can inform market understanding, policy decisions, and commercial negotiations on healthcare price and quality.

The Center believes that transparent healthcare pricing data will be impactful if that data can: enable more effective market negotiations; inform more competition-inducing policy actions; and change individual consumers' choices when enrolling in coverage and when accessing care. Research suggests that unlocking more effective market negotiations and informing policy action are the necessary precursors to unleashing the market power of consumers, since evidence to date finds that price transparency efforts targeting consumers have not yielded meaningful results.[20]

How Data Transparency Can Improve Health System Performance

Market failures in healthcare, as evidenced by sustained commercial price increases, have emerged as a compelling theme supported by the literature. Provider-payer negotiations are driven by local market dynamics, where either payer strength or hospital system strength is exerted.[21] Independent physician practices are increasingly rare. In 2022, 74% of physicians were employed by hospitals, health systems, health insurers, or other corporate entities, a vertical consolidation trend that was accelerated during the COVID-19 pandemic.[22]

The rapid consolidation of healthcare organizations overall during the last 10-15 years has, in many markets, led to imbalances of power at the negotiating table.[23] Often, this dynamic has resulted in increased prices, hidden or unclear financial incentives, and a subsequent opaqueness that leaves employers, families, and individuals with high out of pocket costs and growth in healthcare spending that is unsustainable.[24]

Healthcare pricing data helps to identify poorly functioning markets, highlight areas where consolidation and other factors are increasing prices and, over time, can help invigorate and re-balance payer-provider negotiations to ultimately reduce costs for consumers. However, as the

Peterson-KFF Health System Tracker researchers have found, data alone is not sufficient. Once released, not only does the pricing data need to be cleaned and organized[25], it must then be applied in ways that benefit those making healthcare purchasing decisions, including, but not limited to, payers, employers, consumers, and states. In some instances, the evidence suggests the pricing data can be deployed on its own—particularly if Congress and CMS act to improve the data quality and usability of the data files. However, in most instances, effective analysis requires combining pricing data with other data, including medical claims, financial reporting, contract terms, provider network data, and benefit design information.

Effective deployment could mean empowering a regional employer to use the pricing data, its own claims history, and benefit design data to work with its benefits broker to build a less expensive plan option with willing local hospitals and physician groups. Effective deployment also could mean combining pricing and medical claims data to understand which hospitals and physicians within their network have the best quality and price combination for maternity care, cardiac care, or colorectal screening, for example.

In other cases, policymakers may use the data to develop more pro-competitive policies, including increased oversight of mergers and acquisitions[26], site neutral payment policies[27], and prohibitions on "data ownership."[28] Further, policymakers can use this data to make the case that restrictions on anti-competitive market contracting behavior produce greater competition. Examples of such anti-competitive contracting practices include market dominant hospitals requiring all of their owned or affiliated hospital sites or physician offices to be in an insurance network, or none of them are in the network (all or nothing" clauses[29]) and "anti-tiering/anti-steering," where insurers are prohibited to direct enrollees to certain providers in the network for either price or quality reasons, and "most favored nation" contracting provisions, where dominant insurers require the healthcare provider that they not give an equal or more favorable price to any other insurer.[30] Some states also have responded to pricing data with stronger rate

regulation at both the provider and insurer level. Researchers and policymakers have an important role in analyzing the data, combining the data, identifying necessary reforms, and evaluating the impact of various policy and market interventions.

Better Pricing Information Can Help Influence Individual Consumer Choices

The opportunity for healthcare pricing information to impact consumer choices has been well-studied. The Center examined more than 30 peer-reviewed articles and industry publications which, collectively, indicate either negligible or modest impacts of making prices available on individual consumer healthcare consumption behavior, and overall reduction in prices.[31] The reasons for this lack of effectiveness are attributable to health insurance benefit design that limit consumer price sensitivity outside of the deductible phase of the benefit, the tax benefits for employer-sponsored insurance that shields employees from the majority of the annual premium burden[32], and a lack of effective price shopping tools offered by insurers to make price a strong driver in an individual consumer's care seeking behavior. That said, new and better data has the potential to stimulate the competition-inducing benefits of consumerism if new insurance designs and price-comparison tools are built to make prices clearer to consumers and prescribing clinicians at key decision-making points during care journeys. Thanks to advancements made by the No Surprises Act like payer price shopping tools, Good Faith Estimates, and Advanced Explanation of Benefits, individual consumer healthcare shopping behaviors may produce different outcomes in the future.

Policy Options

Having outlined the case for improved healthcare data and pricing transparency, I suggest six (6) specific policy recommendations to improve data transparency and enable a more efficient and effective healthcare system.

1. **Improve the quality of the price transparency data released by hospitals.**

As described above, the hospital price transparency data currently available as a result of federal laws and regulations suffers from a lack of completeness and standardization necessary to maximize its impact. The following changes by Congress or CMS would improve the utility of hospital price transparency files:

- Given the lagging compliance, Congress should consider providing CMS with the authority to increase the penalties for hospital non-compliance, and the flexibility to use other tools to improve compliance and accuracy of data.
- CMS should require hospitals to use a standardized format for their price transparency submissions and be much more prescriptive about what is required in each field.
- CMS should revisit the standardized format on a regular basis (not more often than annually) to ensure the fields remain relevant, and the data provided in those fields are useful to researchers, data analytics vendors, and end-users of the information.

2. Improve the quality of the payer data within the Transparency in Coverage rule.

As noted by researchers that have begun to use the TiC data, the data files submitted by payers are enormous[33], and often filled with either duplicative data files, or pricing data for procedures that clinicians do not typically perform.[34] Like the hospital requirements, there are variables that require additional definitions or specifications to ensure the data and definitions populated are ultimately decipherable.

- CMS should examine this first wave of TiC data submissions to identify and implement ways to reduce the file sizes and to make them easier to utilize by researchers, policymakers, physicians, providers, and other healthcare stakeholders.
- CMS should require standardized labeling of files so that users can see what provider/service codes are in each file, and they should require the use of standardized conventions for identifying providers (e.g. via National Provider Identifiers (NPIs))

- CMS should require that payers provide all detail necessary within the data files to make the key-pricing variable consistently useable by providing a means of describing how the prices were derived.
- To provide a more complete and accurate picture of market-negotiation dynamics, Congress should require payers to release both their Medicaid Managed Care (MMCO) and Medicare Advantage (MA) negotiated prices. Today, the Hospital Transparency rule provides some clarity into MMCO and MA negotiated rates, depending upon how hospitals are interpreting CMS requirements, but only commercial payers are subject to the TiC rules.

3. Release the prescription drug negotiated rate machine-readable file.

As finalized, the TiC rule required payers to release a machine-readable file that includes in-network negotiated rates and historical net prices for covered prescription drugs. CMS has indicated they are delaying this requirement[35], and it has yet to be implemented. The Administration was initially challenged in court over these provisions[36], though the lawsuits were dropped. Payers and PBMs must now release this data to HHS,[37] but as of today, this data remains inaccessible to the public.

- CMS should release in-network negotiated rates and historical net prices for covered prescription drugs. Congress should consider providing CMS the authority to compel the release of this data if necessary.

4. Ensure adequate implementation of the No Surprises Act "Good Faith Estimate" and "Advanced Explanation of Benefits."

The "Good Faith Estimate" (GFE) and "Advanced Explanation of Benefits" (AEOB) provisions of the No Surprises Act require providers to issue GFEs directly to uninsured or self-pay consumers. In the case of an insured consumer, providers must issue GFEs to their health plan, if such an estimate is requested or upon scheduling of the service or procedure. Plans must

take the GFE and turn it around to their enrollee and issue them an AEOB, which will include critical information in advance of the procedure to allow that enrollee to understand their potential financial liability for the procedure. These provisions were supposed to go into effect January 1, 2022. However, CMS, the Office of Personnel Management, the Employee Benefits Security Administration, the Department of Labor and the Department of Treasury have delayed enforcement of these rules, and most recently issued a request for information in September 2022 on these provisions.[38]

- Congress should work to ensure the Departments remain focused on implementing the requirements that must be met by providers and payers to issue GFEs and AEOBs so that consumers can use these tools to shop for care with the information they need upfront to understand their financial obligations given their health plan benefit design.

5. Improve medical claims quality by requiring more detailed site-of-service fields.

- To more fully understand how provider site-of-service impacts prices, spending, and quality of care, Congress and CMS should require more detailed information from hospitals and physicians about the site-of-service on medical claims.

6. Advance all-payer claims databases.

Without the ability to understand utilization trends at the plan, provider, and location levels, pricing data transparency alone cannot fully explain pricing variation or produce better networks or competition.

- Congress and states should do more to encourage the development of all-payer claims databases so that purchasers—payers, employers and states—have access to detailed utilization data that can be combined with pricing file data and network data to drive market changes.[39]

In closing, healthcare data transparency is necessary but not sufficient to improve system performance and reduce healthcare costs. Efforts to improve data availability and quality can enable better market performance and targeted policymaking efforts. Thank you for inviting me today to participate in this important hearing, and I look forward to answering your questions and continued dialogue.

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