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Wyden Statement at Finance Committee Hearing on Corporatization and Consolidation in Health Care

As Prepared for Delivery

The Finance Committee meets this morning to discuss corporatization and consolidation in the health care system and the effect that has on what American families pay and how they get their health care.

When I hold town halls back home, the two challenges I hear about most often when it comes to health care are that it is too expensive and complex for a typical American family to navigate.

As the committee responsible for much of federal health care policy, including Medicare and Medicaid, the Finance Committee has a responsibility to identify the financial incentives that are leading to increased corporatization in America's health care system. It's increasingly clear that these trends are increasing costs without improving the quality of care that families and taxpayers are paying for.

Before the committee dives in, I'd like to take a moment to define a few terms that will come up frequently during the hearing. Although they sound academic at first blush, these trends are having a direct impact on American families and health care workers every day.

First is vertical consolidation. Vertical consolidation is when one company buys another company that operates in a different part of the health care supply chain. For example, if a pharmacy benefit manager also owns an insurance company and a chain of pharmacies, or if an insurance company buys up primary care physician practices, that's vertical consolidation.

The other side of the coin is horizontal consolidation, which occurs when one company buys another company that operates in the same part of the health care supply chain. When one hospital buys up a cross-town rival hospital, or two insurance companies merge, this is horizontal consolidation.

Finally, private equity. In the simplest terms, private equity typically entails a group of investors buying a stake in a company in order to increase its financial value by restructuring or changing the business practices of the target company.

While all of those terms sound like a whole lot of word salad to an American family working every day to pay the bills, the Finance Committee is holding this hearing to examine whether these practices are hotwiring our health care system to favor mega-corporations at the expense of patients and taxpayers.

With these terms in mind, I will briefly touch on several examples of some of the practices I outlined above.

I'll start with an area that the committee has already begun working to address - pharmacy benefit managers. Just over two months ago, the Finance Committee held a hearing that came to the overwhelming conclusion that PBM business practices are driving up the cost of prescription drugs. Since that time, Ranking Member Crapo and I, and the members of this committee, have been hard at work writing legislation that will take on some of the key challenges facing consumers and taxpayers when it comes to PBMs, and we'll have more to say about that in the coming weeks.

Pharmacy benefit managers are in many ways Exhibit A for the consequences of consolidation in the health care system. In the 1990s, there were over 40 PBMs. In the last two decades, they've been slowly rolled up into mega-PBMs, and today the three largest PBMs now control more than 80 percent of claims for prescription drugs, and they are all among the top 15 largest companies in America.

Each of these companies is also affiliated with an insurance company and at least one pharmacy chain. This means PBMs can provide advantages to pharmacies they own, at the expense of other competing pharmacies. In many cases, this hurts community, independent pharmacies. In my part of the country, Bi-Mart, a regional pharmacy chain, closed its doors in dozens of communities, which had a particularly acute impact on rural areas where a pharmacy closure can turn a 45 minute drive for a prescription into a two hour trip.

Next I'd like to talk about health care costs and quality. Advocates for proposed mergers often say they will bring lower health costs due to increased efficiency. Time after time, it's simply not proven to be the case. When hospitals merge, prices go up, not down. When insurers merge, premiums go up, not down. And quality of care is not any better with these higher costs. A deeply troubling study from last fall showed that medication adherence significantly decreased among communities of color and the elderly if they visited a primary care provider that was run by a hospital system rather than an independent physician.

The consequences of increased consolidation in health care are just beginning to be understood, and there will be more to come. I'm growing increasingly concerned by the potential for abuse when it comes to the use of big data and algorithms in health care. There have already been numerous reports of questionable claims denials by insurance companies using technology. Trends like these are going to require vigorous oversight and transparency to ensure Americans are protected.

I'll wrap up by speaking about private equity ownership in health care. When a private equity firm buys out a nursing home, physician group, hospice agency, or any other piece of the health care system, their goal is to restructure the business and sell it for a profit in just a few years. The most straightforward way to do that is to increase prices and reduce costs, which is hardly a winning proposition for patients or health care workers.

Here's one example. A private equity firm bought up ManorCare Health, which at the time was the second largest long-term care provider in the country. The firm sold ManorCare's properties to a real

estate company, which began charging rent to these nursing homes. These facilities simply couldn't keep up, which led to a spiral of layoffs, health code violations, and closures. Eventually, ManorCare went bankrupt, but not before thousands of Americans lost their jobs or suffered in poor living conditions. Of course, the private equity firm made a profit on their purchase and moved on.

These are just a few examples of trends that have been growing in the health care system over the past decade and more. The consequences are becoming more clear each year. I look forward to working with committee members to identify financial incentives that are leading to consolidation in health care and continuing our work to improve the health care system by shoring up the workforce and improving mental health care for all Americans. I want to thank our witnesses for joining the committee.

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