AMERICAN BENEFITS COUNCIL

TESTIMONY OF

ILYSE SCHUMAN

SENIOR VICE PRESIDENT, HEALTH POLICY

AMERICAN BENEFITS COUNCIL

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE,

SUBCOMMITTEE ON HEALTH

HEARING ON

"LOWERING UNAFFORDABLE COSTS:

LEGISLATIVE SOLUTIONS TO INCREASE TRANSPARENCY

AND COMPETITION IN HEALTH CARE"

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1501 M Street NW Suite 600 Washington, DC 20005 202-289-6700 Facsimile 202-289-4582 www.americanbenefitscouncil.org

Chairs Rodgers and Guthrie, Ranking Members Pallone and Eshoo and distinguished subcommittee members:

Thank you for the opportunity to testify on behalf of the American Benefits Council ("the Council") at this important hearing about legislative solutions to lower unaffordable health care costs by increasing transparency and competition. I am Ilyse Schuman, the Council's senior vice president, health policy.

The Council is a national nonprofit organization dedicated to protecting employer-sponsored benefit plans. The Council represents more major employers – over 220 of the world's largest corporations – than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or support health and retirement plans covering virtually all Americans participating in employer-sponsored programs.

Providing health coverage to more than 178 million Americans,[1] employers play a critical role in the health care system and drive innovations from which the entire health system benefits. With a vested interest in securing the health and well-being of their employees, employers have been at the forefront of initiatives to lower health care costs and improve quality through various value-based strategies. However, employers are

[1] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2021* (September 2022), Table 1

deeply concerned about rising health care costs. Employers are increasingly frustrated by fundamental failures in the health care marketplace that stifle competition, cloud line of sight to price and quality information, impede innovation – and, ultimately, increase costs.

The only way to truly make health care more affordable for working families is to understand and address the root causes of rising health care spending, namely a lack of transparency and misaligned incentives that drive market consolidation. This hearing and the legislative solutions under consideration today represent a critical step forward in combatting the nation's health care affordability crisis. The Council applauds the subcommittee's willingness to take action to unleash the power of employer innovation by addressing the drivers of rising health care costs at their core.

The national health expenditure grew to $4.3 trillion in 2021, representing almost one-fifth (18.3%) of the U.S. gross domestic product.[2] The annual growth in national health spending is expected to average 5.1% over 2021-2030 and reach nearly $6.8 trillion by 2030.[3] During this same period, private health insurance spending growth is projected to average 5.7%. According to a study by the Kaiser Family Foundation, annual premiums for employer-sponsored family health coverage reached $22,463 for family coverage in 2022, with workers on average paying $6,106 toward the cost of their

[2] U.S. Centers for Medicare and Medicaid Services (CMS), *NHE Fact Sheet* (Updated December 14, 2022)

[3] CMS news release, "CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures" (March 28, 2022)

coverage.[4] The average premium for family coverage has *increased 20% over the last five years* and 43% over the last ten years. This trajectory is unsustainable for employers, employees and their families and it is being fueled by hospital consolidation and vertical integration of hospital -acquired physician practices and a lack of transparency in the health care system.

Top executives at nearly 87% of large employers surveyed in a 2021 poll believed the cost of providing health benefits to employees will become unsustainable in the next five-to-10 years.[5] The cost of health care is a top concern for voters as well. According to a Morning Consult poll for the Alliance to Fight for Health Care, 83% of insured adults say they are concerned about costs (with 44% saying they are very concerned.) Reducing health care costs was cited as *the* top health care reform priority for a majority (57%) of insured adults, topping covering more people (19%) and covering more health care services (24%). And almost 80% of voters want Congress to work to lower health care costs for *all* Americans, no matter how or where they get their health coverage.[6]

With the legislative solutions under review today, the subcommittee is responding to the concerns of employers, employees and voters and helping ensure a healthy and

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[4] Kaiser Family Foundation, *2022 Employer Health Benefits Survey* (October 27, 2022)

[5] Kaiser Family Foundation news release, "Vast Majority of Large Employers Surveyed Say Broader Government Role Will Be Necessary to Control Health Costs and Provide Coverage, Survey Finds" (April 29, 2021)

[6] Alliance to Fight for Health Care & Morning Consult, *Coverage and Reforming the System* (February 21, 2023)

affordable future for America's workers. It's time to pull back the curtain on health care costs and prices. It's time to see and to stem unchecked hospital pricing increases enabled and accelerated by the consolidation of hospital systems that have eliminated competition and by the proliferation of hospital-owned physician practices. It's time to shine a light on the prescription drug pricing system and require greater transparency for pharmacy benefit managers (PBMs).

In the Council's February 27 letter to Congress sharing our health policy priorities for the 118th Congress,[7] we urged congressional action on key policies to improve health care affordability and value by increasing transparency and competition. We are very pleased to see that a number of these important policies are among the proposals discussed today. I will focus my remarks on these proposals that:

- expand site neutral payment reforms;
- restrict hospital billing practices that fuel consolidation and mask what should be the appropriate payment amounts;
- support greater price transparency in the health care system; and
- require greater transparency and oversight of PBMs.

[7] American Benefits Council, "Health Policy Priorities for the 118th Congress" (February 27, 2023)

EXPAND SITE NEUTRAL PAYMENT REFORMS

The Council strongly supports:

- ***H.R. __, To amend title XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory 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, and***

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

Hospital spending is the largest health spending category in the United States, accounting for almost one-third of all expenditures. In 2021, according to the Centers for Medicare & Medicaid Services (CMS), hospital spending totaled $1.3 trillion.[8] Spending on hospital services accounts for 44% of total personal health care spending for the privately insured and hospital price increases are key drivers of recent growth in per

[8] CMS Office of the Actuary Press Release, "National Health Spending Grew Slightly in 2021" (December 14, 2022)

capita spending among the privately insured.[9]

Employer health plans already pay much higher prices for health care goods and services than public plans. According to a Rand Corporation report, in 2020, across all hospital inpatient and outpatient services, employers and private insurers paid hospitals 224%of what Medicare would have paid for the same services.[10] According to an analysis by the Congressional Budget Office (CBO),[11]

> The main reason for the growth of per-person spending by commercial insurers—and for the difference from the growth of per-person spending by Medicare [fee-for-service (FFS)]—has been rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services.

Moreover, providers' market power is a key reason for variation in the prices that commercial insurers pay for hospitals' and physicians' services across the United States.[12]

Consolidation corrodes the competitive market forces needed to align health care

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[9] Rand Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (2020)

[10] *Rand Corporation, Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative* (2022)

[11] Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* (January 20, 2022)

[12] Congressional Budget Office (CBO), *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (September 29, 2022)

cost with value, resulting in higher costs for plans and patients alike. As the 2020 report "Affordable Hospital Care Through Competition and Price Transparency" highlighted:

> One of the greatest challenges to affordable health care is the high cost of American hospitals. The most important driver of higher prices for hospital care, in turn, is the rise of regional hospital monopolies. Hospitals are merging into large hospital systems, and using their market power to demand higher and higher prices from the privately insured and the uninsured.[13]

An estimated 117 million Americans under age 65 live in a concentrated hospital market whereas 160 million reside in a competitive hospital market.[14] According to the Kaiser Family Foundation, between 2010 and 2017, there were 778 hospital mergers.[15] As a result of such consolidation, many local areas are now dominated by one large, powerful health system. By 2017, two thirds (66%) of all hospitals were part of a larger system, as compared to 53% in 2005[16] and, in most markets, a single hospital system

[13] The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* (January 31, 2020)

[14] Urban Institute, *Introducing a Public Option or Capped Provider Payment Rates into Concentrated Insurer and Hospital Markets* (March 2021)

[15] Martin Gaynor. "Examining the Impact of Health Care Consolidation," Committee on Energy and Commerce Oversight and Investigations Subcommittee (2018)

[16] Kaiser Family Foundation (KFF), *What We Know About Provider Consolidation* (September 2, 2020), citing American Hospital Association, *TrendWatch Chartbook* (2018)

had more than a 50% market share of discharges.[17]

In concentrated markets, prices do not flow from competitive market negotiations, but from the outsized leverage that market concentration affords. Substantial evidence links hospital consolidation to higher prices. The Medicare Payment Advisory Commission (MedPAC) reviewed the published research on hospital consolidation and concluded that the "preponderance of evidence suggests that hospital consolidation leads to higher prices for commercially insured patients."[18] For example, one analysis looking at 25 metropolitan areas with the highest rates of hospital consolidation from 2010 through 2013 found that the price private insurance paid for the average hospital stay increased in most areas between 11% and 54% in the subsequent years.[19] Prices at monopoly hospitals are 12% higher than those in markets with four or more rivals.[20] Moreover, consolidation has *not* come with demonstrated improvement in the quality of care.[21] Substantial economic literature has demonstrated that provider consolidation

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[17] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy* (March 2020)

[18] *Id.* at pp. 468

[19] KFF, citing Reed Abelson, "When Hospitals Merge to Save Money, Patients Often Pay More," New York Times (November 18, 2018)

[20] Zack Cooper, Stuart V Craig, Martin Gaynor and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics, vol. 134, no. 1* (February 2019), pp. 51–107

[21] As noted in Rand Corporation, *Impact of Policy Options for Reducing Hospital Prices Paid by Private Health Plans* (2021), pp. 2, "A review of all hospital mergers between 2009 and 2013 found that hospital mergers do not lead to improvements in quality (Beaulieu et al., 2020). Likewise, research has found that vertical

leads (on average) to "less bang for the buck" — in other words, higher prices without higher quality or access.[22]

At the same time, many private hospital systems are becoming vertically integrated with physician organizations. Hospitals and corporate entities owned half of America's physician practices and employed nearly 70% of physicians by the end of 2020.[23] Such integration can direct patient referrals to higher-priced hospitals within the system and away from lower-priced community providers. **Basic market dynamics are at play. When monopolistic hospital systems buy competing hospitals and physician practices, the resulting dominance in the local market allows them to raise their prices because plans and patients now have nowhere else to go.** Addressing hospital and provider consolidation, restoring competition and better aligning incentives with value are essential to lowering health care costs.

Ending Medicare payment policies that provide incentives for consolidation is a key action Congress can take to increase competition and, thereby, lower health care costs. One such incentive results from differences in Medicare payment rates for the same or

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integration does not lead to increases in the quality of care (Short and Ho, 2019; Post, Buchmueller and Ryan, 2018; Machta et al., 2019). See also Kaiser Family Foundation, *What We Know About Provider Consolidation* (September 2, 2020)

[22] The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market* (March 2020), pp 7

[23] Physicians Advocacy Institute, COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020 [Prepared by Avalere Health] (June 2021)

similar services at different sites of outpatient care - hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. Medicare (and private health insurance) generally pay the highest rates for services provided in HOPDs and the lowest rates for services performed in freestanding physician offices. For services provided in freestanding clinician offices, Medicare makes a single payment to the practitioner under the physician fee schedule. For services provided in HOPDs or ASCs, Medicare makes two payments: one for the clinician's professional fee and one for the HOPD or ASC facility fee under the relevant payment system. For example, in 2022, *Medicare paid 141% more in an HOPD than in a freestanding office for the first hour of chemotherapy infusion* (counting both the professional fee and facility fee).

According to MedPAC, this payment disparity incentivizes consolidation of physician practices with hospitals—that result in care being provided in settings with the highest payment rates. **Often physician offices are being purchased by hospitals and simply rebranded as part of the hospital's outpatient department (HOPD) in order to collect the resulting higher payments.** This increases costs on the overall health care system without significant improvements in patient outcomes.[24]

An important way to decrease incentives for consolidation is for Congress to expand implementation of site-neutral payment reform which aligns payment rates for certain

[24] Medicare Payment Advisory Commission (MedPAC), Report to Congress: Medicare Payment Policy (June 2021)

services across the three main sites where patients receive outpatient care. According to CBO, policies that reduce providers' incentive to consolidate would "deter some hospitals and physicians from merging with or acquiring rival firms, which would slow the consolidation of markets."[25]

The Council strongly supports legislation to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings as MedPAC recommends. The Council also strongly supports legislation to eliminate the "grandfathering" exception from site-neutral payments for HOPDs billing Medicare before 2015 and for cancer hospitals and notes that the legislation would maintain the exception for dedicated emergency departments. The Council also strongly supports legislation creating parity in Medicare payments for hospital outpatient department services furnished off-campus by requiring that drug administration out-patient department services furnished off-campus will be subject to the ASC rate rather than the HOPD rate. **By aligning payment differentials across sites of service, such legislation removes a powerful incentive for hospitals to purchase physicians' practices in order to receive the higher reimbursement rates of HOPDs. In so doing, such legislation will help stem the tide of hospital-physician consolidation and correct a significant distortion driving patients to higher cost care settings.**

The potential savings that would be generated to the government, to employers and

[25] CBO at pp 16

patients is significant. For example, MedPAC's recommendations to align payment rates across the different ambulatory settings for a greater number of services would have resulted in an estimated $6.6 billion savings to Medicare in 2019 as well as a $1.7 billion reduction in beneficiary cost-sharing. Effects for the commercial market are likely even greater. New research by University of Minnesota economist Steve Parente estimates that expanding site-neutral payment reform could result in nearly $60 billion in savings annually if adopted in the commercial market.[26] Another report estimated the "spillover" effect on the commercial market of MedPAC's recommendations to expand Medicare's site-neutral policies. Site-neutral payments were estimated to yield a reduction in costs and premiums for private insurance plans of $117 billion over 10 years – which amounts to a cut in costs and premiums of about three-quarters of 1%, relative to this paper's projections under current law.[27]

We anticipate that the savings generated from site-neutral polices may be characterized by hospitals as detrimentally impacting their bottom line in a time of ongoing economic pressure. Though these policies may well impact the profit margins of hospitals, it is important to bear in mind the misaligned practices that are generating those profits as well and the true source of losses hospitals may be experiencing.

[26] Alliance to Fight for Health Care briefing presentation, *The Untapped Potential of Site-Neutral Payment Reform* (February 1, 2023), pp 27

[27] Blue Cross Blue Shield Association, "Savings estimates for options to reduce spending on health care and private insurance premiums" (January 24, 2023)

Employers recognize that hospitals are an essential component of the nation's health system, providing care to communities across the country, particularly during the pandemic. Employers have a vested interest in ensuring that employees and families have access to the care they need. Employers also have a vested interest in ensuring that the care their employees receive is affordable and high quality. But the he reality of the hospital financial picture is that in 2021, hospitals' all-payer operating margin reached a record high of 8.7% with federal relief funds and to 7.2%without federal relief funds, both of which were higher than the prior all-time high in 2019. [28]

A recent *Health Affairs* article examined the financial performance of large nonprofit hospitals systems in the post-COVID-19 era.[29] Average overall profit margin fell from 9% in 2021 to -6% in 2022. However, a closer look at financial measures for 10 selected large nonprofit hospital systems revealed a more complex picture. Patient care revenue, revenue obtained from providing hospital services, slightly increased, by just below 1% in relative terms from 2021 to 2022. However, investment income, revenue from financial investments, declined by 185% between 2021 and 2022. Investment losses accounted for approximately 85% of overall financial losses. While other sources may attribute hospital financial losses to increased labor costs, particularly for nurses and health professionals, and increased

[28] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy* (March 2023)

[29] Christopher M. Whaley, Sebahattin Demirkan and Ge Bai, "What's Behind Losses At Large Nonprofit Health Systems?" *Health Affairs Forefront* (March 24, 2023)

supply costs, this analysis suggests that investment losses are actually the primary driver of these nonprofit health systems' overall losses. If hospitals now find themselves facing certain investment losses as a result of their risky or aggressive financial investment strategies, employers, patients and taxpayers should not have to foot the bill for hospitals' risky financial positions.

RESTRICT HOSPITAL BILLING PRACTICES THAT FUEL CONSOLIDATION AND MASK WHAT SHOULD BE THE APPROPRIATE PAYMENT AMOUNTS

The Council strongly supports:

- ***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.***

A long-standing patient returns to her physician's office for a check-up. She receives the same service from the same doctor, but she gets a very different and more costly bill this time. The only thing that has changed from her prior visit is that her doctor's practice was acquired by a hospital. The appointment was billed as being performed in a hospital-based setting with a hefty facility fee attached rather than in an office-based practice.

After hospitals acquire physician practices, the prices for the services provided by acquired physicians increase by an average of 14.1%.[30] A contributing factor to this increase is the use by hospitals of billing practices that portray services delivered at these sites as 'hospital services' as opposed to 'professional services' in order to receive the higher facility reimbursement fee. **Hospitals have leveraged the acquisition of physician practices to unfairly bill payers – including employer-sponsored group health plans – higher rates by portraying non-hospital-based professional services as if they were delivered in a hospital.** This unfair and opaque billing practice serves to incentivize vertical hospital-physician consolidation and increase costs for employers and patients.

Hospitals are able to use this billing practice because they are not required to specify where services are provided when they bill to Medicare or other health care payers. **The Council strongly supports legislation requiring each outpatient department of a provider to include a unique identification number on claims for services. This important legislation will promote "honest billing" practices by helping payors to distinguish between sites of service in order to apply the appropriate payment amount.**

[30] Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physician practices on prices and spending," *Journal of Health Economics* (May 2018)

SUPPORT GREATER PRICE TRANSPARENCY IN THE HEALTH CARE SYSTEM

The Council strongly supports:

- ***H.R. 2691, the Transparent PRICE Act***

Competition and transparency in the health care market are inextricably linked**.** Indeed, a competitive health care market is predicated on transparency. Conversely, the ability of hospitals to cloak the underlying price of health care services works hand-in-hand with consolidation to give hospitals free rein to increase prices. **Transparency is not an end in itself. It is, however, a means to fuel competition, check price increases, and make health care more value-driven.**

Many employers that have had success decreasing the rate of health care spending have done so by analyzing their plan data to better understand how much is being spent on specific services and then using plan design features to promote higher-value, relatively lower-cost providers. Harnessing the promise of technology, effective transparency tools in the hands of employers and consumers can be transformative, making health care both simpler and more affordable.

Despite important legislative and regulatory action to advance health care transparency, impediments remain to meaningful access and utilization of health pricing data. Removing barriers to accessing and using price information is foundational to unleashing the power of transparency to help employers drive lower cost and higher value health care.

Codifying and strengthening the U.S. Department of Health and Human Services (HHS) regulations requiring hospitals to make public standard charges, including negotiated rates, is critical to these efforts. We have urged HHS to undertake vigorous enforcement and to further increase the penalties for noncompliance. However, the fact remains that far too many hospitals across the country remain out of compliance - or meaningful compliance - with the rule.[31]

A report by Families USA noted recent estimates suggesting up to 45% of hospitals are not in full compliance with the rule, while other studies estimate that as few as one in five hospitals are in full compliance with the rule.[32] The Families USA report concluded that: "Hospitals are deploying various tactics to either buck the requirements outright or make the information they disclose very hard to understand." While many hospitals have posted no information on negotiated rates at all, the report notes that other hospitals post incomplete required information. The report includes one example of a hospital data file that discloses prices in multiple different formats in one file, making it nearly impossible to interpret. This report cites another example of a hospital data file that fails to display the required pricing information in a usable way, failing to break down the negotiated rates by payer and plan as required. These depictions of the myriad tactics hospitals are using to thwart the letter if not the spirit of the rule means

[31] Families USA, *The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs* (April 19, 2023)

[32] *Id.*

that more is needed to ensure meaning compliance. It is time for Congress to step in to codify and strengthen the hospital transparency rule. Accordingly, **we applaud the bipartisan Transparent PRICE Act for increasing the maximum penalty, directing HHS to implement a uniform method and format for hospitals to post data and regularly monitor and publicly report on hospital compliance.**

Our plan sponsor members are doing their part to support increased transparency. They recognize that access to pricing data is critical to unleashing the power of employers to drive lower cost and higher value health care. As such, we support the regulations implementing the transparency in coverage provisions under Section 2715A of the Public Health Service Act, and employers have made great efforts to comply with the full range of requirements. We want to ensure the optimal utility of these requirements to support those employer efforts and that this important transparency tool will not be rolled back by future administrations, while minimizing disruption to plan sponsors.

We appreciate that the legislation provides that the machine-readable file submission requirements shall ensure that such files are limited to an appropriate size and are made available in a widely available format that allows for information contained in such files to be compared across health plans. We hope that will allow employers meaningful and actionable access to the data that can be used to truly analyze how their health care dollars are spent, and take action to direct those resources to high-quality, cost-effective providers.

The Council recognizes that price is just one piece of the puzzle and that, in terms of value, the price of the health care service does not always correlate with the quality of care. Transparency with respect to both price and quality are the foundation for employer's innovative payment reforms. Price transparency will be most effective when coupled with quality, and we urge Congress to support quality transparency and meaningful, harmonized metrics. Yet, price transparency initiatives should proceed apace even if quality transparency will take additional time to realize.

REQUIRE GREATER TRANSPARENCY AND OVERSIGHT OF PBMS:

The Council strongly supports:

- ***H.R. 2769, the PBM Accountability Act***

The Council strongly supports legislation to require greater transparency and accountability with respect to PBMs. Employers appreciate that pharmaceutical drug therapies have played a significant role in treating and curing injury, illness and disease. They allow millions of Americans to overcome debilitating conditions, return to work and live longer, healthier, more productive lives. Moreover, money spent wisely on drugs can reduce hospital, physician and other medical expenditures.

Nonetheless, prescription drug costs continue to represent a considerable portion of overall plan costs. In an effort to manage drug costs, employers have implemented innovative strategies while ensuring that employees and families have access to needed

drugs and services. Many of these strategies have been developed by, or in concert with, PBMs. However, employers remain deeply concerned about prescription drug costs, particularly the cost of specialty drugs, and the absence of appropriate price – and cost – transparency across the entire drug pricing system.

The current rebate structure is complex and opaque for many employers, making it hard for them and plan participants and beneficiaries to understand the true prices and value of drugs. One of our main goals has been to support initiatives that increase transparency throughout the pharmaceutical distribution system. This includes increased transparency with respect to rebates paid by manufacturers to PBMs. **Increased transparency and accountability could help employers and employees make better informed purchasing decisions and lead to higher value pharmacy expenditures.**

Employers continue to encounter barriers to PBM pricing transparency. Federal legislation requiring strong transparency and accountability by PBMs to employers – their primary clients - is essential to employer efforts to manage prescription drug costs. Employers cannot effectively manage prescription drug costs unless they can see the full picture of rebates, fees and other renumeration generated from manufacturers and other parties, drug definition criteria, and amounts charged to pharmacies. This important legislation ensuring greater transparency and accountability for PBMs is critical to employer efforts to make prescription drugs more affordable for employees and their families.

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Something must be done to change the trajectory of rising health care costs. While employers continue innovating and experimenting with solutions to lower costs, federal legislative solutions are needed to create a more competitive and transparent health care marketplace. By addressing the root causes of rising health care costs, legislation that increases transparency and competition empowers employers to lower the cost and improve the quality of health care for employees and their families.

While I focused on several bills in my testimony, other legislation the subcommittee is reviewing today are also positive and important steps toward lowering health care costs by increasing transparency and competition. Individually, these bills represent an important piece in solving the health care cost puzzle. Taken together, they can help transform the health care marketplace, lowering the cost and improving the value of health care for working families in communities throughout the country.

I appreciate the opportunity to testify and the Council looks forward to working with this subcommittee, and all the members of the Energy and Commerce Committee, to advance these proposals.