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EXAMINING STATE EFFORTS TO IMPROVE TRANSPARENCY OF HEALTH CARE COSTS FOR CONSUMERS

TUESDAY, JULY 17, 2018

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Members present: Representatives Harper, Griffith, Barton, Burgess, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, and Pallone (ex officio).

Staff present: Jennifer Barblan, Chief Counsel, Oversight & Investigations; Lamar Echols, Counsel, Oversight &

Investigations; Ali Fulling, Legislative Clerk, Oversight & Investigations, Digital Commerce and Consumer Protection; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; C.J. Young, Minority Press Secretary; and Perry Lusk, Minority GAO Detailee.

Mr. Harper. Call to order the hearing of the Subcommittee on Oversight and Investigations.

Today, the Subcommittee on Oversight and Investigations is holding a hearing entitled, "Examining State Efforts to Improve Transparency of Health Care Costs for Consumers." We are here today because health care costs continue to rise in the United States and many Americans are struggling to budget and pay for their health care expenses.

According to the Centers for Medicare and Medicaid Services, we spent $3.3 trillion on health care costs in 2016, which means that nearly 18 percent of the overall share of gross domestic product was related to health care spending. About 32 percent of health care spending in 2016 was on hospital care, 20 percent was on physician and clinical services, and about 10 percent of the spending was on prescription drugs.

The committee has been actively looking at these concerning trends and has held a number of hearings examining some of the causes of increased health care costs, and increasing health care costs. Last year, the Oversight and Investigations Subcommittee held two hearings on the 340B Drug Pricing Program and issued a report with the findings from our investigations. In February, the subcommittee held a hearing examining consolidation in the health care market, and examined the impact of consolidation on health care competition and innovation.

As health care costs continue to rise, many Americans still

have no idea how much something will cost them before they receive care. Oftentimes, they only know their out-of-pocket costs once they have gotten the care and get their bill weeks, sometimes months later. The purpose of today's hearing is to examine state laws and policies that have an impact on health care costs and what can be done to lower costs for all Americans through more transparency of health care costs.

These transparency efforts have generally attempted to provide consumers information about different types of health care costs, including information about the cost of health care services and the cost of prescription drugs. In our work, we have heard that thee are a number of issues that make it difficult for some of these efforts to be effective.

For example, sometimes there may be contractual provisions that limit the sharing of certain price information or concerns that the sharing of certain price information may be anti-competitive. Moreover, health care billing is complex and it can be difficult to provide the information to consumers in a meaningful way that is useful to them. Similarly, only a small percentage of health care services may be "shoppable." I hope to hear more about some of the barriers to transparency and what, if anything, Congress can do to help.

Unfortunately, early evidence suggests that some price transparency tools have not helped facilitate price shopping and lower consumer costs. I, therefore, look forward to hearing more

from the witnesses about why this is the case, and what forms of transparency might help consumers as they budget for their care and make better health care decisions. For example, do we need to pair transparency with some other mechanism for it to be most effective?

The cost of certain health care services can vary significantly in the same geographic region at different sites of care. For instance, a 2014 study by the U.S. Government Accountability Office found that the estimated cost of maternity care at select, high-quality acute care hospitals in the Boston area ranged between $6,834 and $21,554, over a 200 percent difference.

A more recent 2018 study found that median price of magnetic resonance imaging, an MRI, of the spine ranges from $500 to $1,670 in Massachusetts, also over a 200 percent difference.

Empowering consumers with more information about the cost and quality of their care helps to reduce wasteful spending and save families money.

As we move forward, we have to keep in mind that there is a delicate balance between beneficial transparency and transparency that ultimately harms competition and consumers. The Federal Trade Commission has highlighted that it is important to give consumers the precise information they need to make better health care decisions. The agency also has cautioned, however, that it is important to avoid broad disclosures that may chill

competition in the health care market.

I welcome and thank the witnesses for being here today. I look forward to their testimony.

And I will now recognize Ms. Castor for purposes of an opening statement.

Ms. Castor. Well, thank you, Mr. Chairman. Thank you for calling this important hearing. I think it is a worthy topic.

But, I wanted to note at the outset it has been almost one month since the Democrats on this committee have requested an oversight hearing on the Administration's family separation policy. The Energy and Commerce Committee has primary responsibility for oversight of the Department of Health and Human Services. We have had over the last month a number of hearings on many varied topics, but none are as important as what is happening as children who are ripped away from their family. Now, courts have ordered reunification.

It is our responsibility as members of Congress, especially in the Oversight Committee of Energy and Commerce, to have an oversight hearing to get to the bottom of this. We hear horrifying stories every day about the impact on children.

And so at this time I am going to renew the request of the Democrats on Energy and Commerce to schedule an oversight hearing as soon as possible on the family separation policy.

Now, health care costs, also a very worthy topic. And if we were to schedule another important oversight hearing, it

certainly should be on the impact of the Trump administration's lawsuit that where they claim that preexisting conditions should not be a right of American families, especially in their health care policy. That would be another very worthy oversight hearing. But, right now we are here on transparency, so let's talk about that.

I understand that every family feels a very significant impact of rising prices. And part of the, part of the problem is the fact that health care consumers often have no visibility into how much services are actually going to cost.

And depending on multiple factors, such as where you live, your insurance, the type of provider, costs can very greatly and are unpredictable. That makes health care unlike virtually any other purchase, and it makes it more difficult to constrain costs.

There are all sorts of reports out there -- many of you all have experienced this -- of outrageously high bills received by unsuspecting consumers. Plus, it is darn confusing sometimes. You get a bill and it says this is your responsibility, this is what is paid, and people simply don't, don't, get it.

There was a couple in California recently who were reportedly charged over $18,000 for a 3-hour visit to an emergency room where their baby was examined, took a nap, and drank formula. And another patient received two CT scans that varied between $268 and $9,000.

These shockingly high bills are frustrating and can

devastate a family's finances. For that reason, greater transparency can theoretically provide consumers with more information to make decisions and to predict the costs that they are going to incur.

To that end, many states have taken some action to bring more transparency to health care. But it isn't always easy. My home State of Florida, for example, established a website that allows consumers to search for health care prices at hospitals and outpatient surgery centers in 2007, but consumers don't know about it. And one of the problems is it doesn't even contain all of the hospitals that are in your market, and it doesn't contain a lot of the leading health insurers' information in our state.

So there, Florida is currently struggling with trying to launch another health care transparency website but now the cost is really escalating. It has been $4 million to get that up and running, and we don't have a lot to show for it.

Other states now require pharmaceutical companies to publicize and provide information related to large increases in prices for certain drugs. And here in the House I am a proud cosponsor of Congresswoman Schakowsky's Fair Accountability and Innovative Research Drug Pricing Act, which would require drug companies to report an increase in certain drug prices by more than 10 percent in a year to HHS, and submit transparency and justification reports before they increase the price of certain

drugs by 10 percent.

We should move initiatives that can help consumers control their health care costs. But transparency in our health care system shouldn't be the only tool in our tool box. It has to be accompanied with other improvements to have a meaningful impact on the actual cost of care.

So, I am looking forward to hearing the witnesses today. I look forward to hearing from you on how we can use health care transparency to lower costs for our neighbors back home.

Thank you, and I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Mr. Walden, for five minutes.

The Chairman. Thank you very much, Mr. Chairman. I appreciate your holding this hearing on the various transparency efforts at the state level to engage patients in health care decision making processes.

As Chairman Harper mentioned in his opening statement, health care costs are increasing and are expected to continue to rise. In 2016, the U.S. spent approximately $3.3 trillion on health care, and the Center for Medicare and Medicaid Services, CMS, estimates that spending will reach $5.7 trillion in 2026.

Health care costs are having a substantial impact on the budgets of American families and individuals. In addition to health insurance premiums increasing, patients are also directly responsible for more of their health care costs. In 2016, about 11 percent of the $3.3 trillion spent on health care was paid for directly by consumers through out-of-pocket costs, which was about $352 billion.

Unsurprisingly, as health care costs increase, most patients want to know more about how much different medical services and products are going to cost them. We all do. That is why we are having this hearing. I have heard numerous stories about individuals who were going to have a medical procedure or lab work performed, found it nearly impossible, and in some instances literally impossible, to learn how much it was going to cost them before they got the care. A lot of doctors don't even know how much different services are going to cost.

Many states have adopted policies to prohibit some types of "gag clauses" and help patients get access to the prices for prescription drugs. Twenty-two states have passed legislation prohibiting clauses in contracts that prohibit pharmacists from telling patients price options for their prescription medicine.

In addition to these recent efforts to encourage price information sharing with patients at the pharmacy counter, several states have engaged in efforts to provide patients with more information about the price and quality of different health care services. Some of these efforts include creating websites that give patients information about the prices of different procedures, requiring insurers to provide these tools to their members, and requiring providers to give patients information about the estimated prices for their treatment before they get the treatment. Unfortunately, to date, some of the preliminary evidence has shown that these some -- that these tools haven't been very effective in getting patients to price shop.

If we are going to successfully reduce health care costs, we need to empower patients and we need to engage them in the decision-making process. So there needs to be greater transparency so patients can have more information about the prices for different medical products and services, and that information needs to be given to them in a meaningful way.

Given that some of the existing price transparency tools are still able to be improved, I am eager to hear from our witnesses

today about why there are some of these barriers, and then also what else we can do to empower patients with the information. I also want to hear about the role the Federal Government can play in promoting transparency and making patients more informed about the cost of their care.

Patients should be able to learn about how much something is going to cost before they get it. This includes having information about different price options for prescription drugs at the pharmacy counter, and information about different procedures and lab work, among other things.

So, we have got a lot of questions for our witnesses today. We really appreciate your being here. But one of my main questions is what is the best way for patients to get health care price information, and how can we empower the consumer?

I am also interested in hearing about any market behaviors that work against transparency and ultimately harm any attempts to bring down health care costs.

So, thanks for being here. This is a big priority for me and for the committee to look into all the costs of health care.

With that I will just warn you, I have got another hearing going on downstairs so I have to bounce back and forth. But I will yield the balance of my time to Dr. Burgess, who chairs our Health Subcommittee.

Mr. Burgess. Well, thank you, Mr. Chairman. And, Mr. Chairman, it is my fondest wish that one day I will come into

a hearing in the Energy and Commerce Committee and there will be five doctors at the witness table, and they are going to expound for us on how much economists should be paid. I am still waiting for that hearing. We haven't had it yet.

Thanks to our witnesses for being here today. And, Mr. Chairman, to you I have a couple of things that I would just like to place into the record.

This is a copy of H.R. 5547, a bill that was introduced in the last Congress by Mr. Green and I that dealt with transparency. And, in fact, Mr. Green and I have been working on transparency for the past several years. And a version of this was actually included as an amendment in the Affordable Care Act, but I think it got lost on its way to the Senate.

Mr. Harper. Without objection.

[The information follows:]

********** COMMITTEE INSERT 1**********

Mr. Burgess. Also, I would like to place for the record, I printed off some sheets from a website called txpricepoint.org. Texas PricePoint is a website that is at the least sponsored by the Texas Hospital Association, and it is useful information for your county or for your city, for the hospital in your county or for your city.

For example, I printed off a sheet that I will, I will leave for the record that deals with the cost of an uncomplicated cesarean section in the hospital where I used to practice. And I note that although my hospital is a little lower than some of the other hospitals in the area, it is higher than other hospitals in the state.

And as a physician, I also will submit to you that is useful information. And if recognizing the decision that a patient makes to go to a hospital is likely driven by the physician, making this type of information more available to physicians perhaps could help with physician behavior as far as directing the course for hospital care.

So, I ask unanimous consent to place this into the record, and look forward to hearing from our witnesses.

Ms. DeGette. Mr. Chairman, I reserve the right to object till I review the documents, although I am sure they will be fine. If I could just review the documents.

Mr. Harper. Well, as we review that we will come back to approving the entering that into the record as soon as Ms. DeGette

has had an opportunity to review that.

At this time I would ask unanimous consent -- Oh, sorry. I will now recognize Mr. Pallone, the ranking member for purposes of an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

The cost of health care is consistently a top concern for American families. But all too often, consumers face an initial problem before they even receive care, knowing how much a certain health care service is going to cost them. And that is because there are so many players in the health care industry making it difficult to bring clear cost transparency to the consumer.

Two different patients can receive the same service from a doctor but end up being charged starkly different prices. And this makes it difficult for a patient to make an informed decision about their care.

There are multiple factors contributing to this lack of transparency in health care. For example, a provider may have a set of rates it changes for private-pay customers, but depending on a person's insurance and deductible, their price could vary greatly.

This differs from most other markets the consumer has a clear understanding of how much a product or service will cost, and can shop around to obtain the best deal. The nature of health care makes this more complicated. And it is particularly noticeable in emergency situations where a patient's top concern

is receiving the lifesaving care they need, rather than what the care will cost. In other expensive specialties such as oncology, patients trust their doctors to provide them with referrals based on quality of care.

With that being said, consumers can certainly benefit from more information, and there are opportunities to bring more transparency to the health care industry. As we will hear from the witnesses today, just about every state has implemented some type of transparency initiative. For instance, my home State of New Jersey recently passed a law requiring providers to notify patients if they are out-of-network, helping to avoid surprise bills for patients.

Many states have also created websites that post the prices of common procedures, and allow consumers to browse the prices of various providers. And this kind of reform can empower consumers just by giving them greater access to information.

So, I look forward to hearing from the witnesses what the research says about these efforts, and what other reforms are being attempted in other states. However, we should be cautiously optimistic about greater transparency, as we have seen only modest results in actually bringing down costs. Some studies have found an increase in prices with more transparency, so we should be mindful of these results before considering any reforms.

I also think it is important that we keep the big picture

in mind here. It is one thing to bring more transparency to health care, and give consumers information on what they are being charged, but we should also encourage meaningful efforts to actually reduce health care costs for American families.

And one of the primary ways to do that is by ensuring access to affordable health coverage. Whether it be Medicaid, essential health benefits in private insurance, or a robust marketplace for individuals who shop for insurance, transparency matters only if consumers have access to high-quality, affordable health care.

And, finally, while I appreciate the efforts of this subcommittee to explore these issues, I would be remiss if I did not note that there is an emergency taking place right now within HHS that this committee should be holding an oversight hearing on. Today, there are still more than 2,500 children in the custody of HHS who have yet to be reunited with their families after being forcibly separated by the Trump administration. This committee has a responsibility to conduct vigorous oversight of the Federal Government, and today would have been a perfect day to have HHS Secretary Azar and Scott Lloyd, the Director of the Office of Refugee Resettlement to be here.

So, I again urge the Republican majority to schedule a hearing as soon as possible so we can work to fix this crisis, and so we can finally get some answers.

I don't know if anybody wants my time. If not, I will yield back. Thank you, Mr. Chairman.

Mr. Harper. The gentleman yields back.

Ms. DeGette. Mr. Chairman, I withdraw my right to object. I have no objection to these documents from Mr. Burgess.

Mr. Harper. The documents are so entered.

[The information follows:]

********** COMMITTEE INSERT 2**********

Mr. Harper. I ask unanimous consent that the members written opening, opening statements be made part of the record.

Without objection, they will be entered into the record.

[The opening statements follow:]

********** COMMITTEE INSERT 3**********

Mr. Harper. I would now like to introduce our witnesses for today.

Today we have Dr. Jaime King, Professor at UC Hastings College of Law; and Dr. Michael Chernew, Professor at the Department of Health Care Policy at Harvard Medical School.

Unfortunately, our third witness, Dr. Kavita Patel, was unable to be here today due to a family emergency. And Dr. Patel and her family will remain in our thoughts and prayers as we send them our best wishes.

You are both aware that the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do either of you have any objection to testifying under oath?

Mr. Chernew. No objection.

Ms. King. No objection.

Mr. Harper. Both witnesses have stated no.

The Chair then advises you that under the rules of the House and the rules of the committee you are entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

Mr. Chernew. No.

Ms. King. No.

Mr. Harper. Both witnesses have responded no.

In that case, if you would please rise and raise your right hand and I will swear you in.

[Witnesses sworn.]

Mr. Harper. You may be seated.

You are now under oath and subject to the penalties set forth in Title 18, Section 1001, of the United States Code. You may now each give a five-minute summary of your written statement. And Dr. King, we will recognize you for five minutes.

STATEMENT OF JAIME KING, PH.D., PROFESSOR, UC HASTINGS COLLEGE OF LAW; AND MICHAEL CHERNEW, PH.D., PROFESSOR, DEPARTMENT OF HEALTH CARE POLICY, HARVARD MEDICAL SCHOOL

STATEMENT OF JAIME KING

Ms. King. Thank you. Committee Chairman Walden, Subcommittee Chairman Harper, Committee Ranking Members Pallone and DeGette, Subcommittee Chairmen Griffith and Castor, and members of the Subcommittee on Oversight and Investigations, I very much appreciate the opportunity to testify on price transparency in the health care market today.

As you know, the cost of health care in the United States currently threatens the economic stability of our citizens, our businesses, and our nation. A 2018 Gallup poll found that more Americans worry about the availability and affordability of health care than any of the 14 other major social issues, like crime, the economy, and the availability of guns.

Economic theory suggests that if consumers had better access to price information prior to choosing providers and receiving health care services that they would choose less expensive options, thereby lowering overall health care spending. As a result, states have been very active in this endeavor, introducing 163 price transparency bills so far in 2018.

Historically, most state price transparency initiatives have focused on changing consumer behavior to encourage them to

select providers and services that offer the greatest value at the lowest cost. Yet, health services research examining the impact of these efforts suggest that most of them have not engaged patients in a sufficient way to curb health care spending. Controlling health care spending requires engagement not just form patients but from all actors in the health care market: providers, payers, and policy makers.

Twenty states, including Oregon, Maryland, Maine, and New Hampshire, have all developed All Payer Claims Databases which collect information on both health care services Americans use, and amounts paid for those services. States can use these health care claims data to report better reporting to an All Care Claims Database, to inform patient and provider decisions regarding care; to allow payers to compare their rates to make sure that they are getting, you know, close to average or somewhere in there; and to allow policy makers to examine the drivers of health care costs over time; evaluate the effectiveness of various reform efforts; and measure the impact of mergers and acquisitions on health care price and quality.

However, legal barriers including contractual provisions, ERISA preemption, and trade secret laws currently hinder the utility of many existing price transparency initiatives.

So, what can Congress do? For transparency initiatives to receive -- to achieve their full effect at the state level, changes are needed at the federal level. And, fortunately, Congress has

the ability to address some of the most significant barriers to price transparency. There are five things Congress can do to improve health care price transparency:

Number one, and most important, address the ERISA preemption challenges. The main goal of ERISA is to promote uniformity in state regulations governing employee benefit plans. But over time, ERISA's preemptive reach has expanded in ways that put this goal of uniformity for employers over transparency, competition, and affordability of health care for all Americans.

The Supreme Court decision in Gobeille v. Liberty Mutual Insurance held that ERISA preempted state All Payer Claims Databases, preempted their reporting requirements as applied to self-insured employer plans. And this decision left state All Payer Claims Databases without health care claims data for about a third of their population, which greatly limits their accuracy and their utility.

Essentially, trying to analyze the health care landscape using data from an All Payer Claims Database without the self-insured employer population is kind of akin to Google Maps, trying to use Google Maps without a third of the road; right?

Enabling All Payer Claims Databases to collect the full set of health care claims data would dramatically increase the utility and reliability of these initiatives. While addressing ERISA preemption of state health reform laws is the most important thing that Congress can do to promote price transparency and bring down

health care costs, additional actions by Congress could also help illuminate health care prices, which brings me to number two.

Congress should seek to encourage price shopping incentives like reference pricing, rewards, and shared networks, through demonstration and pilot projects.

Number three, Congress should create a public interest exemption to Defend Trade Secrets Act of 2016. Health care providers and insurers currently invoke trade secrets protection to avoid disclosing negotiated health care prices and other information to consumer, employers, researchers, and state officials.

Trade secrets protections were designed to encourage and protect innovation, like the Coca-Cola formula, not to permit Coca-Cola and restauranteurs to hide its price on the menu and then after you eat your meal give you a bill for a $25 Coke. Right?

Number four, Congress should require manufacturers of electronic medical records and insurance companies to establish uniform standards of interoperability and standard bundles of care for billing purposes so that providers and patients can access meaningful and actionable information about the cost to the patient, who and what is in the patient's network, and the quality of providers and services being offered to them when the provider is making referrals during appointments.

And, number five, they should develop billing codes for a

physician's time spent in these efforts.

Thank you.

[The prepared statement of Ms. King follows:]

********** INSERT 4**********

Mr. Harper. Thank you very much, Dr. King.

And the chair will now recognize Dr. Chernew for five minutes for purposes of his opening statement.

STATEMENT OF MICHAEL CHERNEW

Mr. Chernew. Thank you very much, Chairman Harper, Ranking Member DeGette, members and staff. Thank you for the opportunity to speak with you today about price transparency in health care.

Before I launch into the main thrust of my comments I would like to emphasize that as an economist I believe strongly in markets. Well-functioning markets require buyers to effectively shop for the combination of price and quality that best meets their needs. And in the market for medical services, buyers, in this case patients, do not have the necessary information.

For that reason, one would think that efforts to promote price transparency in health care would be able to significantly lower the cost and perhaps improve the quality of care. In fact, this logic has spawned the creation of numerous transparency initiatives and tools, launched several innovative companies. All of the major insurers that I'm aware of have some price transparency tools -- not all are great -- as do many other vendors in several states who are pursuing transparency-related programs.

Although there are a few studies that suggest transparency initiatives may be helpful, such as the one in New Hampshire, they've had a modest impact on the -- only had a modest impact on the spending for some services, at best. Overall, the evidence, unfortunately, suggests that the impact of transparency has been minimal.

This reflects several institutional features of health care. First, health care is complex. Any course of treatment or diagnostic pathway is comprised of many individual services. An accurate price quote requires knowing the exact service. This is complex.

For example, there are over 50 codes for CT scans. In some cases it is even unknowable because the exact service delivered may change during the course of treatment based on clinical information that arises during that treatment. Moreover, the fees to the hospital and the physician are often separate. To get an accurate price, they have to be combined. This makes it hard, particularly for providers, to provide the information.

Imagine when shopping for a car consumers could only get the average price of a specific car, and that the actual price that they would pay depended on who put them together and the customer's employer. The information would be of limited value.

Most transparency tools seek ways around this, but so far there have not been great successes.

Second, physicians are central to almost all consequential decisions in health care. Physician recommendations about where to seek care appropriately carry enormous weight. As a result, few patients shop for care. In our work, we find around 10 to 15 percent of patients use transparency tools when offered. This result seems pretty standard in the literature. While it's certainly true that patients can question or even ignore their

physician's referral recommendations, few do.

Third, consolidation in health care markets limits choice and, thus, competition in some markets. Specifically, competitive forces can only work when there are competing firms. As markets have consolidated, the potential for transparency or shopping more broadly diminishes.

Finally, insurance distorts choices. Patients fundamentally care about what they pay out of pocket. The out-of-pocket price will depend on the details of the patient's insurance plan and will change over time depending on things like whether they've met their deductible. As a result, one cannot accurately quote an out-of-pocket price without knowing details about the patient's health plan and how much they've often spent -- already spent, often for specific services. This implies that insurers are best suited to provide transparency information and, as noted, many do, although, as we've mentioned, with relatively little impact.

I do not mean to imply that transparency, or more generally price shopping for medical services, cannot work. Very simplified indicators such as flagging high-priced providers, as happened in some tiered insurance projects -- products can help, particularly when tied to benefit design. Moreover, transparency can have an impact even if this, even if it does not alter consumer behavior. The widespread availability of data may shame high-priced providers to lower their prices,

particularly when journalists have access.

There's some evidence that this can be salient in health care. However, one has to proceed with caution, caution because it's also possible that widespread availability of information could alter the negotiation dynamics in other ways, leading to higher prices for some patients. Because payers negotiate price discounts with providers, if forced to reveal those discounts the providers may be more reticent to offer them. And there's some evidence of that in markets outside of health care.

So, where does this leave us? I'm generally supportive of the initiatives, particularly the private sector ones that simplify the information and focus on out-of-pocket prices. I'm more skeptical about public sector initiatives that entail new mandates on providers to provide data because it's particularly hard to get that data right. I worry it will not substantially improve the system, and may impose administrative costs.

There is certainly a lot we do not know. And while there may be deleterious unintended consequences, most evidence is either neutral or positive, and I think the shaming effect may be important in the most egregious cases. Moreover, states are experimenting in many ways, which should be allowed to play out.

So, there are a few fundamental things the Federal Government could support those efforts.

The first, as was mentioned, is report the -- support the ERISA exemption or get rid of the ERISA exemption.

Providing financial support for All Payer Claims Databases could be a wise investment.

And providing more funding to AHRQ or other federal agencies to study what is actually working.

We have a lot of problems in health care, and I very much applaud your efforts to seek a solution. But please do not let transparency distract you from other strategies such as supporting alternative payment models or addressing adverse selection in the individual markets of health care that may be more impactful.

Thank you.

[The prepared statement of Mr. Chernew follows:]

********** INSERT 5**********

Mr. Harper. Thank you both for your testimony. It is now the opportunity, the moment that you have waited for, our members get to ask questions of each of you. That will help us very much in that process. And I will now recognize myself for five minutes for the purpose of that. And I will start with you, if I may, Dr. King.

You know, obviously it is clear that, you know, a lot of Americans struggle greatly with how to pay for their health care costs. And part of that is they never know how much it is going to cost until they see a bill sometime later. And as you noted in your testimony, a lot of transparency initiatives have focused on changing consumer behavior to encourage them to select lower price providers and services.

But can you elaborate on why these initiatives seem to have limited usage and have mixed results?

Ms. King. Yes.

Mr. Harper. Your mike.

Ms. King. Okay. So, I think there are largely four reasons why consumers don't tend to use these as much as we would like them to. And the first is that insurance often, the structure of insurance often insulates consumers from feeling the price, different prices for different providers.

If you pay a $20 copay every time you go to the doctor, it doesn't really matter to you what type of doctor you go to; right? So there is some, some function of that.

The second is that the provider relationship is really important to patients. And it turns out where we have seen price transparency work is exactly on the thing that you noted before, Chairman Harper, is on shoppable goods. We have seen some movement there, where things that people find interchangeable. Right?

So, you might go, you don't care where you go to an MRI, to have your MRI tested or have your CT scan done. Those seem likely to go to this lab or that lab, unless this lab or that lab automatically supplies the results, you know, into your electronic medical record and it, you know, goes directly to your provider. That might make a difference to you.

But, generally, those are places where people are more willing to shop.

Where they're less willing to shop is on provider; right? They want a recommendation. Let's say that you, your child, or your spouse, or your loved one just got diagnosed with cancer. Are you really going to look at a list of providers and their charges to decide where you're going to go? You're not. You're going to go to a trusted primary care physician, or a family member that's had experience with cancer and ask them who they went to and who they had a good experience for.

So, I think the reality is is that health care is so important that patients really want to get advice from someone they trust and not the provider. And that's really why price transparency

initiatives that put pricing information that is relevant to the patient in terms of their out-of-pocket costs in the hands of the provider so it's there when they're making that decision, I think have the most, the most, the greatest possibility of a shifting choice on the provider side.

Mr. Harper. Okay.

Ms. King. And the last thing is that there's very, as Dr. Chernew pointed out, there's very little standardization in health care pricing; right? So, if you look at one, if you look at one sheet and it says, well, you can get an MRI for $300, but then you don't know if the MRI needs specific, you know, dyes or other things accompanying it, it's very hard for a patient to navigate that and to figure out what the overarching price will be for that.

Mr. Harper. All right. Thank you very much.

Dr. Chernew, in your testimony you noted that there are several institutional features of health care that make it difficult for transparency alone to have a significant impact on the market. You do highlight, highlight however, that the transparency initiatives are important as we move to a newer innovative benefit designs that attempt to help patients shop.

Can you please elaborate on that point?

Mr. Chernew. Of course. So, let me say for those of you that don't know or may not care, I chair the Benefits Committee at Harvard University, which means I advise the provost on what

we, as an employer, should do for the benefits for our workers. And we've been very worried about the variation of prices within Massachusetts, which was pointed out. And so that was painful, thank you.

So, when we think about what to do we start with how we might change our benefit designs to incent our workers to make more informed choices about providers. One cannot do that without having the relevant information available. So, if you want to do tiered network, if you want to do reference pricing, if you want to do any type of benefit design that involves incenting patients beyond a flat, say, $20 copay, it's important that you have the tools to provide information to them. In that way I think transparency is important. And you should know all of our vendors will provide such transparency tools should you decide to do that.

Mr. Harper. Are the right to shop laws that also provide the financial incentives for consumers to choose the lower cost options perhaps, are they likely to have an impact do you think, a bigger impact on spending?

Mr. Chernew. I'm not familiar enough with all of all the laws, so I would defer to Dr. King. But I think that the general sense that allowing patients to shop and supporting their ability to shop when they want to I think is valuable. But because of all of the institutional features I think that alone is not really what's going to be helpful.

What we really care a lot about is even if you're not shopping you just may want to know up front what you're going to have to pay. And just getting that, which seems incredibly reasonable, is hard to do. And we're working through that.

Mr. Harper. Thank you very much.

The chair will now recognize the ranking member of the subcommittee, Ms. DeGette, for five minutes.

Ms. DeGette. Thank you. Mr. Chairman, just to show how bipartisan this subcommittee can be, you just asked my question. So I am going to follow up on what you were talking about. And I will start with you, Dr. King.

And what I want to ask you is what percentage of health care costs are these things that would be negotiable to most patients, the MRI, the lab tests, issues like that? And what percentage is the things they are less likely to want to negotiate on, like physician services?

Ms. King. I think it's a great question. And I am not, I am not a health economist. I'm not studying, somebody who studies all of that percentage, so I don't know exactly.

I know that in studies, there was a study done that looked at Anthem, and United, and some other big health insurers, and it suggested that if they had, if they used reference pricing to -- for their shoppable items, for their laboratory tests, that they would be able to bring down costs. I think it was on the order of around 10 to 15 percent.

So it may not be -- so I don't know the exact number of laboratories. So maybe Dr. Chernew knows that.

Ms. DeGette. Well, he is a health economist.

Ms. King. Yes. He may know.

Ms. DeGette. So I think I will ask him that.

Mr. Chernew. In great humility, there's a lot of things I don't know.

Ms. DeGette. Even though you are at Harvard?

Mr. Chernew. Especially because I'm at Harvard.

Ms. DeGette. Good answer.

So, so you don't have any idea what the percentage would be reduced?

Mr. Chernew. Advocates of shopping will give you a very big number, 60, 70 percent.

Ms. DeGette. Uh-huh.

Mr. Chernew. In for realistic numbers about what really could be shopped, I think you're probably talking closer to 10 to 15 percent of services.

Ms. DeGette. That is the same thing Dr. King just said.

Now, now if you, if you did have increased transparency and if you could encourage patients to actually look at the sources, with physician costs even though, even though people, I mean I am not going to pick the cut-rate physician over the, over the, you know, more expensive one that I might -- that might have gotten a good reference, or whatever. But, but would there be some

incentive for physicians to, on their own, maybe tamp down some of their rates?

Mr. Chernew. So, the answer is if the markets were working well there would be an incentive for physicians to change and facilities to change their prices. And you've seen some of that. I really don't associate that with transparency, I associate that with benefit design, things like reference pricing.

I also think there's evidence, we've done a lot of work on alternative payment models, which I know is not the specific subject of this hearing, but when physicians are in payment models that give them an incentive to shop --

Ms. DeGette. Right.

Mr. Chernew. -- they are much more active in shopping because they, they will change their referral patterns if they get to keep some of the savings if they're more efficient in their referral patterns.

So, really I think transparency should be thought of as a tool that supports other impactful things as opposed to an end in and of itself.

Ms. DeGette. Dr. King, did you want to add to that?

Ms. King. Yes. So, on the, on the reference pricing point, so the way that reference pricing works is if, you know, that an insurer will pick, will pick a fee that it decides that it's, an amount that it's willing to pay for a particular service. And then any provider that charges above that, the patient has

to pay that out of pocket.

And what the studies have shown with respect to that is that a number -- there's been a decent amount of savings from patients saying they don't actually want to go to a higher-priced provider, but there's been a 30 percent reduction in provider costs overall, that they have dropped their prices to be under the reference price to get a broader volume of patients. And so that might be, that might prove to be helpful.

Ms. DeGette. Dr. Chernew, do you want to?

Mr. Chernew. I think Dr. King's referring to a study by Jamie Robinson and colleagues about a program that CalPERS did in California Anthem. There's a lot of things they did besides just reference pricing. So it's a very complicated thing. And they were a very big purchaser, which is helpful.

I think we looked at reference pricing for our employees. And one of the problems we had was if you pick a price and then the patient's responsible for the amount above that price, you actually have a lot higher bills that they have to play.

Ms. DeGette. Right.

Mr. Chernew. Substantially higher bills. And the whole reason you're here is because you're upset, I'm upset that the patients are facing very substantial bills.

So, we are trying to find ways in our benefit design to support shopping without going through the full risk that reference pricing might impose on patients should they not shop.

So, it's a complicated tradeoff.

Ms. DeGette. So, what did you do?

Mr. Chernew. We decided not to recommend reference pricing.

Ms. DeGette. Okay.

Mr. Chernew. And you should know, going in I really wanted to recommend it because as an economist I thought it would be a victory.

Ms. DeGette. Yeah. And so what it is sounding like to me is that while we can, we can work on some of these transparency issues -- Dr. King, you mentioned your five items and, don't worry, they are in your testimony, too, so even though you were kind of cut short -- but, but we should also look at other ways of structuring these insurance plans which may make, which may make incentives for providers versus just the patients.

Thank you. Thank you, I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the vice chairman of this subcommittee, the gentleman from Virginia, Mr. Griffith, for five minutes.

Mr. Griffith. Thank you very much. Appreciate you all being here today. And obviously this is a very complicated subject, and I do appreciate it.

I wish there was some way people could go in and say I have got to have this procedure and, like a car, you could say if you are getting this, you know, the fancy wheels then you pay more,

et cetera. But it seems that that is outside of our realm right now. Although one would hope that with all these young computer whizzes coming on that somebody might be able to figure out how to, how to plug all that in.

And I do agree that there are some things, I mean, I am going to pay more for the doctor that I know. Happy to do that, and able to do that, fortunately. Some people aren't. And so we have to try to look at some of the things that you all already talked about in relationship to insurance and getting, you know, the ability to say, you know, how much is this going to cost me out of pocket before you go forward I think is important. And you all touched on that as well.

So, you all are dealing with this huge, complicated matter. And my questions are much simpler. We, you know, I have just been really concerned. We had a hearing in the Health Subcommittee where we had all the providers lined up. And it was shocking, I had heard rumors but they actually confirmed that because of the way the system currently works there are cases where you could go to your pharmacist with your insurance company and your PBM and say, I want to get this drug, how much will it cost me if I don't use my insurance? And sometimes it is less if you don't use your insurance than it is if you do use your insurance because of the complicated formulas, and so forth.

And Todd Pillion, Delegate Todd Pillion in my district out of Abingdon, Virginia, got a bill through the Virginia legislation

-- I heard there were 22 others this morning -- that said you can't have those gag orders anymore.

Dr. King, do the states eliminating those gag orders, do we find that that make a whole lot of difference when they go to the pharmacy? Do they sometimes figure out that they are better off nothing using their insurance because of the PBMs, et cetera?

Ms. King. Thank you. It's a great question.

So, I think a lot of these laws are new and so we haven't been able to really do the studies on them. But I think in terms of allowing pharmacists to actually say to the client at the desk, by the way, if you go outside your insurance or you get this generic you can save a lot of money, I can't, because pharmaceutical drugs in a large respect are those kinds of interchangeable drugs, you know, interchangeable products, and so I think that that will have, should have some substantial effect. And the idea that they were prevented from doing so by contract before is unconscionable to me. So, I think it's great.

Mr. Griffith. Mr. Carter has a bill I am glad to be a cosponsor of to make that a federal policy. And it is really interesting. I was discussing it back home and lady said, yeah, that happened to my sister by accident. Her insurance company initially stated that they wouldn't pay. And so she paid for the prescription herself. Then when it came time to renew they said, oh, we changed our minds, we will pay for that particular

prescription, and she found out it was more.

She called her pharmacy and said, what is this, it cost me more when I am using my insurance?

Ms. King. Yes.

Mr. Griffith. He says, yeah, I can't tell you about that but, you know, if you will ask me to do it outside of your insurance you will only have to 17 instead of paying 50.

Ms. King. Right.

Mr. Griffith. And so, I think it is something we need to pass. And there are a fair number of patrons on that.

But it was clear to me that we need to look at the PBMs along with all the other things that you all are mentioning as part of the transparency. I know they serve good purpose.

But, again, Virginia on this, and it is my home state, that is why I keep referencing, but we had Delegate Keith Hodges out of Gloucester directed the State Bureau of Insurance to report to the General Assembly about how PBMs charge for their services and whether they save money or make health care costlier. Among the findings of the first PBM transparency report as a result of his work, mandated by that language, last year there were 152,250 payments, with total PBM markups of 3.5 million between July 1 and September 21.

The differential or spread on each claim ranged from 1 penny to $4,932.

Do you think that having more transparency and more oversight

over PBMs and what they are doing -- I know they work hard in some cases and save money, but in other cases they are actually costing the consumer -- do you think that would help?

Ms. King. Yes, I do.

Mr. Griffith. Dr. King, you do.

Dr. Chernew, do you have an opinion?

Mr. Chernew. You can call me Michael, please.

Mr. Griffith. Michael.

Mr. Chernew. I think as a matter of principle people should be able to get the information that they need. So, just on the pure principle of it.

In terms of the market demand, that gets much more complicated. I, I didn't talk about prescription drugs because a lot of the situation that you're discussing arises because of the complicated rebate rules that are going on in the prescription drug market. And those rebates both, they both in some ways they help markets work, but in other ways, and I think more dominantly, they make it much more complicated and much more difficult to have markets work well in health care.

And so, I think that while we could debate conceptually what the ability, you should have the ability to negotiate, I think the fact though we live in an environment where it's just so complex for people to get the price and get simple information, they're told that by contract they're not allowed to tell them, I think it's just a matter of principle that the situation

shouldn't arise, even though it may well result in some people paying more because the discount that currently the PBMs can get might be less because they don't want everybody to know when they're getting the discount. That's basically what the problem is.

Mr. Griffith. All right, I appreciate it. And I think that for a lot of our folks back home, they don't understand all the big stuff. But they understand when they go to their pharmacist and they feel like they are being overcharged.

I appreciate it, and yield back.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from Florida, Ms. Castor, for five minutes.

Ms. Castor. Thank you, Mr. Chairman.

I want to return to what providers and insurers can do to help lower the costs through their transparency efforts. Because I think you correctly stated how folks feel, that if their doctor recommends something, I mean, it is pretty rare that a patient, a neighbor is going to go shop and do something else.

So, Dr. Chernew, you, you said, okay, alternative payment models can be one way. What else on physicians, because they play such a central role on consumer behavior?

Mr. Chernew. So, first let me say I really wish I could come here with some silver bullet and solve the problem. And I can't. Because anything I'm about to say is going to have

potential deleterious consequences.

Most of the insurers I know, all of the insurers I actually know, are struggling to find ways to address the health care cost problem. It is not that insurers want health care spending to be high or they're not working on it.

Essentially what matters is the interaction between the patient and the physician, the treatment that's given, and the price that we pay for that. The way to address that is some combination of payment reform and benefit design. And you're seeing a ton of private sector initiatives to do that. And where we are right now is employers in the market sorting through which ones work for them in which particular ways, and we're trying to learn what works better than not.

So, alternative payment models honestly is my favorite. I'm a big believer in benefit design changes. So the evidence on high deductible health plans that are HSA coupled isn't as strong as I would like as an economist in general. There's some things that I would recommend, like the way chronic care medications are treated in the HSAs is something I think are probably a good thing to help people being able to shop. Things like that.

But there is not a specific federal thing that one can do. And the challenge that you will face -- and again I say this in a totally non-partisan way -- is where the regulations should step in and stop at least the most egregious cases. Because there

are some really out-of-network billing things, there's some really egregious cases that are just unconscionable that should probably be stopped by regulation. And I honestly think that transparency is not the mechanism to get at those types of things.

To the extent that the private sector can build transparency tools, which I am supportive of, and the states can try different ways through their All Payer Claims Databases, I think that is wonderful. But I think fundamentally my advice would be focus on rules to prevent the most egregious situations where people in an emergency room are paying some huge out-of-pocket thing.

Ms. Castor. Right.

Mr. Chernew. And telling them that matters. But, honestly, I would say just prevent that.

Ms. Castor. So and, Dr. King, your number one recommendation was on ERISA. And ERISA was a law passed in the 1970s that said, you know, across the country you have to have certain standards.

Ms. King. Uh-huh.

Ms. Castor. So, why would that be so important for us to get into to help lower health care costs? You want to empower the states to do additional things I guess?

Ms. King. So, basically ERISA, the way that it is written because it's trying to promote uniformity and place benefit plan regulation across all 50 states has a very broad preemption scheme. Which means that it will come in and negate any state

law that relates to an employee benefit plan, including all the employer health plans.

Now, there is a savings clause as a part of ERISA which says that any state insurance law that directly regulates insurance will be saved from ERISA preemption. But there's the next part of ERISA says that it doesn't deem self-insured employer plans to be insurance, even though that's the way that the vast majority, you know, or at least half of our employees get their insurance is through self-insured employer plans. Right?

So, any law that's passed by a state to regulate health insurance or employer-based insurance is going to be preempted by ERISA as it applies to about half of our employees. And --

Ms. Castor. Who would oppose it?

Ms. King. I think, I think industry would oppose it. Right? They, they like not having regulations apply to them in that way. But it is crippling state All Payer Claims Databases, which have demonstrated that they can do a lot.

They're doing a lot with the information they have. But if they had all the claims, health care claims in a particular state, they could really get a handle on what's driving cost, where is competition not working, what thing, what mergers and acquisitions should or shouldn't go through.

And it also provides the foundation for every, like, for the majority of other, the other solutions we're talking about, so, allowing individuals to have better price information for

what it would cost them, for putting that information into the hands of providers, I mean providers and insurers. Like, it would just sort of seed a lot of other efforts. Reference pricing would be based on that, and other things.

So, I think addressing the ERISA problem -- and I have a number of ways, a number of ideas of how you could do that -- I think is foundational to any sort of transparency initiative that you would propose.

Ms. Castor. Thank you very much. I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Texas, Mr. Barton, for five minutes.

Mr. Barton. Thank you, Mr. Chairman. And it is always good to have hearings like this to try to, through bipartisan basis, get facts on the table.

My first question is just kind of a general question. I have been on this committee 32 years. I have been involved with some of the major health care issues over a number of times. One of the most vexing issues we face is pricing drugs. And to my mind, except for the long-time over-the-counter drugs like aspirin and things of this sort, there is no rational explanation for how we price drugs.

I think, I think the over-the-counter drugs that have been on the market for decades, in some cases hundreds of years, they are pretty much priced like any other commodity and it is

cost-based, distribution-based, advertising, you know. You pay more for Bayer aspirin than you do for the Walmart generic brand, but they are basically aspirin.

But I, I would like you, Dr. Chernew, to go back to the Harvard Business School and have them come up with a flow chart and explanation of how we price Lipitor, or how we price Plavix, or how we price the new stem cell-based drugs. Do either one of you want to defend the current pricing system for these, these new drugs that are coming on the market, or even try to explain it?

Mr. Chernew. When you said comment, I thought you were going to say comment, I was going to jump in. When you said defend I had to back off.

But I, I will do my best. The --

Mr. Barton. Do it in about 30 seconds because I have got two or three questions. Give me the executive summary.

Mr. Chernew. New drugs provide great value. I think that is undisputable.

Mr. Barton. I agree with that.

Mr. Chernew. We have a patent system that supports them. And the drug companies charge what the market will bear. And that, fundamentally, both gets us really good drugs and creates huge amounts of problems.

And that was my 30 seconds. I'm happy to talk more.

Mr. Barton. Well, that is pretty rational. The drug

manufacturers charge what they think the market will bear. But you go through these convoluted, you know, average wholesale pricing and 340B discount drug program.

Mr. Chernew. That's all just a distraction. They're basically charging what the market would bear. And because of a bunch of rules, it's much more complicated than that. And the question is how we want to support innovation and pharmaceuticals, which we want to support because it --

Mr. Barton. We do.

Mr. Chernew. And that's where the problem comes in.

Mr. Barton. Dr. King. Then I have got two more questions.

Ms. King. I just want to interject that I think Dr. Chernew is totally right that we get, we tend to get good value for new drugs, for most of them. Where we're really not getting good value is where we've already had a drug that has been on patent, expired its patent life, and then they change a tiny little bit of this drug, get an entirely new patent, run prices up for 20 more years. There's a lot of things that we are not getting good value for that remain in patent.

And if you want to look strongly at how to fix drug pricing, I would look at how drugs are patented and what we allow a whole re-upping on the patent.

Mr. Barton. I think that is valid.

All right, I want to go to the very bottom line here. I have a constituent in Texas, a real estate agent who is on

Medicare. And her doctor gave her a coupon for a prescription drug covered by Medicare. She took it to her pharmacist and the pharmacist said, Great, but I can't, I can't take this coupon because you are on Medicare. Medicare doesn't take coupons.

So I got with the Congressional Research Service and some other groups and found out that for some reason when we established Medicare we don't allow senior citizens -- and we started covering prescription drugs -- we don't allow senior citizens to use coupons if they are under Medicare.

So, Congressman Doyle and I have got a bill, we are going to introduce it either this week or next week, that says if you are on Medicare you can -- and you have got a coupon from your doctor, you can't use them for generic drugs, but for any other drug you can. Good idea, bad idea?

Mr. Chernew. So, I appreciate your constituent's problems. I think the challenge is most of the time in the patent system what the market will bear is not distorted by insurance. In health care it's distorted by insurance. So the problem is if you take any consumer incentive away by the coupon, the actual price for the drug the market will bear goes up. And that's what the tension is, is that if you want the consumers to --

Mr. Barton. Well, then the manufacturer doesn't have to give the coupon. If they don't give the coupon to the doctor, the doctor doesn't give it to the patient.

Mr. Chernew. No, the manufacturer likes giving coupons

because then they charge a higher price and the insurer can't use the cost function.

Mr. Barton. Then we should just stiff the Medicare recipients?

Mr. Chernew. Is my time up? I hope so.

[Laughter.]

Mr. Barton. It is not complicated if you are an elected member of Congress and all of a sudden Medicare recipients start showing up at their town, town hall.

Mr. Chernew. Yes. I, I totally agree. The challenge at the core is you want the market to discipline the providers, which requires people having to pay. And when people have to pay, it turns out they don't like having to pay. And therein lies the problem with coupons and a bunch of other distortionary things.

So, I agree with you. And we'll have to have a longer conversation on how to deal with it.

Mr. Barton. I think that is yes, he agrees with me.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from New York, Ms. Clarke, for five minutes.

Ms. Clarke. I thank you, Chairman Harper, Ranking Member DeGette, for convening this important hearing examining state efforts to improve transparency of health care costs for consumers. Additionally, I want to thank our witnesses for providing your expert testimony here this morning.

This is a critical issue that is most deserving of Congress' attention as we work with industry to ensure consumers have a positive experience on their health care journey. In my home State of New York, since 2015 we have an out-of-network law that protects patents from surprise billing when services are performed by non-participating providers. This same law also protects New Yorkers from bills for emergency services.

The focus on transparency and consumer protection are needed so that consumers will not have to continue paying more than their usual in-network cost sharing and/or copayment amounts.

So, I have a couple of questions. Dr. King, how effective have state efforts been to ban surprise out-of-network hospital bills? And what more should we be doing to prevent this?

Ms. King. Thank you. It's a great question.

I think surprise billing is a really important issue for just consumer protection in general. So I think that there have -- we have seen a number of different types of laws to protect consumers from surprise billing. So there are those that, as Dr. Chernew said, ban the practice outright, just say you will not be exposed, especially in emergency services, you will not be exposed to prices that are higher than your out of -- than your in-network copay for emergency services and other things.

There are also -- and I think those are very effective. At least they're protecting the consumer. And then we allow the bigger fish in the game, the insurance companies and the

providers, to hash it out over what are reasonable reimbursement rates. And that's what we have in California.

But there are others, there are lots of states that are passing laws right now that just say that a person should be informed that they may be being seen by an out-of-network provider, or that they, when they arrive at the emergency room, someone who takes care of them might be an out-of-network provider and they might experience other charges.

And I think that these laws, while well-intentioned, don't reflect accurately the reality of the patient experience. If you show up at the emergency room, you are in an emergency situation. You are signing whatever it is that you're signing and then you're going to get help. And I think that someone telling you that you may be subject to out-of-network law, out-of-network bills at that point is not that helpful for you.

So, I think we need to focus on the laws that seven states have passed that really just make it very clear that patients in these specific situations will not be subject to copays that are higher than what their in-network charges would be, and then let everybody else hash it out.

Ms. Clarke. Okay. And, Dr. Chernew, in your written testimony you note that efforts in New Hampshire have had a modest impact on health care spending. What was it about the reforms in New Hampshire that have enabled costs to go down, albeit slightly?

Mr. Chernew. So, the study by Zach Brown in Columbia is what I, who is at Columbia is what I was referring to. And they found by looking at MRIs what I consider to be a modest impact on a service where you often see impacts, like MRIs.

So I think there were some things about that. They had insurer-specific prices. They knew whether you were in your deductible or were not in your deductible, things like that.

So, I think as those laws go that's a reasonable law. I think it's a mistake to believe that doing things like that are going to solve the basic problems. And as far as I know, New Hampshire has not really solved all of the problems. Maybe there's someone here from New Hampshire.

But I think in the end of the day through their All Payer Claims Database they were able to do some things that were valuable. And to the extent that you can support the All Payer Claims Databases, I think you might be able to help on the margins the system get a bit better.

I still think private sector initiatives could have the potential to be more impactful.

Ms. Clarke. So, Dr. King, could you describe any other promising state efforts to improve transparency of health care costs for their citizens?

Ms. King. Yes. I'll comment just really briefly on New Hampshire and then I'll talk a little bit about Massachusetts as well.

So, one of the things that New Hampshire did through their All Payer Claims Database is they have a website called New Hampshire Health Costs which you can go into. And I, I checked it out this morning because I had heard good things about it. And basically as a, as a patient you can go there and check off this is the health insurance plan that I am in, I am in Anthem and I want to get this kind of procedure, and I want to do it with this particular provider. And they'll tell you, they'll run down the cost. And they'll run down the cost for that provider and they'll show you how it, how it compares to other providers.

Now, that doesn't tell you your specific out-of-pocket costs and it doesn't tell you where you are in your personal deductible, but I think that is more helpful than what we've seen in a lot of other states' price transparency initiatives.

Now, the other, the other state that I want to highlight here is Massachusetts. And Massachusetts has gone a long way with their All Payer Claims Databases. But they also have their Health Policy Commission, which is an arm that is designed to analyze that information and really mine the All Payer Claims Database for a whole host of policy reasons. And they've been able to interject and produce reports, annual reports on spending, annual reports on the drivers of costs, but also interject in a number of different places where, where that information would not have otherwise been available to inform policy decisions, but also to inform patients in that case.

So I think there are consumer-facing things that are very useful, although I do agree that some of the private initiatives from insurers are better. But I do think that having the Health Policy Commission there to really analyze that data has been a very useful step as well.

Ms. Clarke. Thank you. I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Texas, Dr. Burgess, for five minutes.

Mr. Burgess. Thank you, Mr. Chairman. And I have got way more questions than I can package into five minutes, but we will do our best. And I may submit some for the record.

I do appreciate both of you being here today. Let me just ask you a question, Dr. Chernew, since you brought up about the private sector initiatives versus the All Payer Claims Databases.

I pointed out in my opening statement, Texas has Texas PricePoint. I believe it is Texas Hospital Association that has done that. So, good on them for having done that. But is, is that not helpful for them to have done it? Does that delay getting an All Payer Claims Database set up in the state? What are some of the tensions there?

Mr. Chernew. I think it is at the end of the day probably marginally helpful as opposed to not. I don't think it delays All Payer Claims Databases.

I think because all health care is local and the states are

going to do different things, I'm sort of a state experimentation kind of person in this space. I wish I could tell you I knew what would work. I don't like sounding as skeptical as I am. So I think the more we can allow states to do different things and then study what they're doing, I think the better.

Mr. Burgess. And, Dr. King, do you have any thoughts on that?

Ms. King. I tend to agree. I think that on balance it's probably helpful. I think any attempts to provide transparency are generally useful. I don't think it probably delayed an All Payer Claims Database unless you were considering that as the alternative option and went with this one.

I think that an All Payer Claims -- so, in terms of the private entity tools, I think those tend to be much more useful for the -- for consumers. Right? And so, United Healthcare they go in, you type in your name, you get into the system, and it tells you what your actual, where you are in your deductible, what your copay would be for different people.

And I think All Payer Claims Databases allow you to use the information for a lot of different purposes; right? So that's the, that's sort of the difference. One is very targeted at individuals, but you also have to be in the plan in order to see that information.

Mr. Burgess. Sure.

Ms. King. Right? You can't get that information when

you're choosing your plan. Although Massachusetts I think just has a law coming down that, that would enable that, for you to see different prices as though you were in different plans.

Mr. Burgess. Txpricepoint.org you would not have to be in a plan. I mean, that is a --

Ms. King. No. But it tells you --

Mr. Burgess. -- public hospital provides database.

Ms. King. But it doesn't tell you the price that you would pay for your insurer.

Mr. Burgess. No, it does not.

Ms. King. Right. So that is very hard to know what to do with those prices.

Mr. Burgess. So, every time I see that TrueCar ad on T.V. I wonder why we don't have TrueCar for health care. But then as someone who had a health savings and account for years and year and always has paid the highest out-of-pocket costs for everything, hospital labs included, I was a big believer when I first heard about Theranos. And I thought, oh man, a cheap way to get a bunch of blood tests done. I'm all in. Except the reliability suffers.

Ms. King. Yeah.

Mr. Burgess. So that is the -- there is a caveat there, I guess. Is that correct, the correct observation?

Mr. Chernew. Yeah. And remember, it's TrueCar, it's not TrueCarborator; right? And it's TrueCar.

Mr. Burgess. So, I think, Dr. Chernew, I think you mentioned the alternative payment methods. And going back to when the Secretary of Labor was Secretary of Health and Human Services he did a demonstration project, a physician group practice demonstration project where they dealt with some alternative payment mechanisms. I think, if I understand the history correctly, ACOs kind of grew out from there.

But can you, can you speak to that? Is there a way to foster the development of what perhaps Secretary Leavitt's original idea was there?

Mr. Chernew. Yeah. And I think, again maybe a little far afield, Medicare has been very innovative in the whole range of payment models. But I also can't tell you what the right type of payment models are. But I think --

Mr. Burgess. Neither can we. But we are learning, I hope.

Mr. Chernew. There you go. But the more we support alternative payment models, in many ways the better.

One thing that I think does matter is to understand that the price from the point of view from the physician is different than the price from the point of view of the patient because the patient is buying some episode of care. The physician is delivering a small part of that, the same with the facilities.

So, the more for example supporting bundled payments, which Medicare is doing, the more you can support that type of thing, and the more payment moves towards more consumer-oriented sets

of things that are being purchased, the closer you get to transparency because then someone will know what does it cost for a colonoscopy, not what does it cost for the technical component, the professional component, the anesthesia component, et cetera, et cetera.

Mr. Burgess. But people still buy on provider as well as on price. Which just brings me to the final thought, and I will close my section out.

In the lead-up to the Affordable Care Act there was a lot of concern about physician-owned hospitals. And in fact, remember, physician-owned hospitals got whacked in the Affordable Care Act. Mr. Chairman, I am going to ask unanimous consent to insert a letter or a article into the record about physician behavior with physician-owned facilities.

Back in my world it was all about time. I got paid the same amount, regardless whether the patient went to an ambulatory surgery center or to a community hospital. The lab processing from my reimbursement's perspective was identical. But the cost to the patients was a fixed rate in an ambulatory surgery center, and the sky's the limit in the community hospital. I am oversimplifying. But nevertheless, that is I think one of the pressures that we are going to have to consider as we work through these.

But, again, I ask unanimous consent to put this article into the record.

Mr. Harper. Without objection.

[The information follows:]

********** COMMITTEE INSERT 6**********

Mr. Harper. The gentleman yields back.

The chair now recognize --

Mr. Burgess. I want the gentlelady from Colorado to read it before she accepts. I thought I had found a way to get you to read my articles.

Ms. DeGette. I will take your word.

Mr. Burgess. All right. Thank you, Mr. Chairman, I yield back.

Mr. Harper. And that was on the record by the way.

And the chair will now recognize --

Ms. DeGette. But not under oath.

Mr. Harper. Not under oath.

But the chair will now recognize the gentleman from California, Mr. Ruiz, for five minutes.

Mr. Ruiz. Thank you, Mr. Chairman.

Overall we know transparency is a good thing and leads to better understandings of market dynamics and better ways to help everybody come up with good policy that is going to really lead to a more cost-efficient way of providing better health care for the American people. However, there are certain things that transparency is good for and the market really focuses on.

Like, for example, if you had the ability to make the choice, and knowledge to know the difference between the products in a situation where you can actually make a decision, and not under duress, or when you are in a coma, or when you are in cardiac

arrest or something going into the emergency department, and there are some things that, that transparency, you know, obviously can work.

So, in your statement, however, Dr. Chernew, you note in your testimony that "many studies, including several of my own and those of my colleagues, find that transparency has minimal, if any, impact on the market." You go on to explain why transparency results in only minimal impact on price.

Dr. Chernew, it sounds like the bottom line is that it is somewhat folly to rely upon transparency as the magic bullet to bring down health care costs. Is that correct?

Mr. Chernew. Yes.

Mr. Ruiz. Okay. In what situation does transparency work?

Mr. Chernew. When there's more commodity type services, when they're not as connected to things and you have time to shop I think transparency works.

I think independent of shopping, transparency works just to tell people what they would have to pay out of pocket. Just knowing. So, you're not going to shop, it's just you don't want to get a bill after the fact that's way higher than you thought.

So, I think transparency is useful. I think it needs to be coupled with other things.

Mr. Ruiz. But you are saying it is not what we should be focusing on?

Mr. Chernew. I think there's a lot of reasons why health

care markets don't function well. Transparency I would put down on my list for what that's true.

I think it's important, let me say, what I worry about, for example, is insurance inherently, unlike most products is a pooled product. I'm in with a lot of other people on the same plan. I worry that if we allow the benefit packages to deteriorate to the point where people are paying a lot out of pocket and we separate that market through a range of things that are going on that I won't mention -- it might be too partisan, I don't mean ti to be -- that people have higher out-of-pocket bills because they won't understand when they bought the insurance plan what was covered. They'll go to the doctor and they'll realize that what they thought was insurance wasn't that good. And it's very hard to make that work well.

Mr. Ruiz. So, do you think that putting too much weight on transparency to reduce health care costs is a distraction?

Mr. Chernew. I worry that that's the case.

Mr. Ruiz. Okay. You know, I am a doctor. And I know that, you know, patients rely on doctors' knowledge, and training, and years of experience to make decisions that will be to the best benefit for the patients. And I know that it is difficult for patients to then, if an orthopedic surgeon says I recommend a titanium type of metal for your knee replacement, that a patient in general is not going to do the research or have the know-how in order to determine what kind of equipment they want for their,

for their knee to make that best judgment.

But I do think that there is some value in transparency. I think it is just what Dr. Burgess said earlier, you know, it is insane that one hospital will charge, you know, I don't know, I'm just making these numbers up, but 2,000 for a colonoscopy. And then, like, across the city in the same, same region another hospital charges 10,000. So it is why is that?

And we should understand where are the mechanics that go into that so that we can identify, in those cases when you do have the time to choose, which, which studies or which, which equipment you want where you can have the knowledge and have the time, and under the situation, to make that possible, I think we should focus on that.

But, Dr. Chernew, you also mentioned that if the objective is to meaningfully reduce health care costs, other strategies such as addressing adverse selection in the individual market for health care may be more fruitful. Can you, can you expand on that?

So, if the objective is to lower costs are there ways to combine transparency initiative with some of these other efforts to lower costs? Can you, can you go into that?

Mr. Chernew. Well, let me talk about two separate things very quickly. The first one is transparency is important to support almost all of the various new benefit design things we do. It's important for a range of public regulation things.

I think there's a bunch of reasons why transparency matters. And I think it's unconscionable, some of the stories that I'm sure your constituents have told you. I think that's a really big deal.

That said, the biggest problems we have in a lot of health care markets aren't related to transparency, they're related to how we hold the market together and how the benefit design packages play out. So, at Harvard we control exactly the benefit package. We push everybody into it. It's pooled, it works.

If you allow markets to spin out of control and let people do various things there's implications of that that differ from markets for cars, or markets for asparagus, or things like that. So, figuring out how to address those types of problems so you don't have individuals that end up in insurance plans where they're going to be charged a lot out of pocket I think are important.

Mr. Ruiz. Harvard. Harvard Business School?

Mr. Chernew. Harvard University. Harvard University has a Benefits Committee that offers benefits for all of the schools.

Mr. Ruiz. Okay.

Mr. Chernew. So, Business, the Medical School, the main part. And we advise the Provost, for the non-union workers, about how to deal with our challenges. And we have a lot of challenges.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from Indiana,

the chair of our Ethics Committee, Ms. Brooks, for five minutes.

Mrs. Brooks. Thank you, Mr. Chairman.

And I want to stay on that line of questioning, Dr. Chernew. Speaking of employers, and you mentioned Harvard specifically, and even some insurers provide transparency tools to their members or their employees, and have redesigned plans and networks to encourage price shopping, can you describe some of the features of the price transparency tools that are adopted by employers and insurers, whether it is Harvard or others, and how they differ from the state transparency initiatives?

Mr. Chernew. Yeah. So, and again Dr. King mentioned, so if you are in a plan that offers one of these types of transparency tools and you know you need a service, you can go in and type the service. Now, that actually sounds easy. But remember, if you're shopping for a CT scan, there's 50 types of CT scans, and it depends on what the dyes are, so it's not as easy as you think.

It will aggregate out and try and come up with a number. It will combine the physician and the hospital. Because you don't care how much is going to the hospital and how much is going to the physician, you care totally what are you going to pay --

Mrs. Brooks. Right.

Mr. Chernew. -- for the whole thing. It will know, and again it won't know perfectly because there's time lags, it will know within reason where you are in your deductible. So, if you are over the top of your deductible it will give you a different

price quote than if you haven't yet spent your deductible.

Most of the public non-insurer-based tools don't have all that information, so they cannot tell you very accurately what you would pay. They don't. We know what prices our carriers have negotiated with all the different providers. But most public tools don't know -- New Hampshire being an exception -- the prices that different providers have negotiated with different insurers. And they certainly don't know where you are in terms of your deductible.

Mrs. Brooks. And do you, are you familiar with a lot of private tools like what you have just described, and are these types of tools, whether they are insurers or employers, are they proving to be effective in changing consumer behavior --

Mr. Chernew. So, the tools --

Mrs. Brooks. -- and reducing steps?

Mr. Chernew. -- are almost always tools that employers offer but the insurers make. The employers don't do much. They buy things. So, the insurers are the ones that offer the tools. Or other, there's a firm Castlight, for example, that's well known for having these types of tools and selling to employers who can buy access to them. And they have been, unfortunately, disappointingly ineffective.

Mrs. Brooks. Why, do you believe?

Mr. Chernew. Well, for one, even the best of them are very complicated. The people care more about their physician than

the tool, so they're hesitant to shop. And in many cases the employers have provided the transparency tools but haven't designed their benefit packages in ways that make them really salient. So you get back the same result.

Even if there -- you've mentioned, several people have mentioned that there's wide variation in prices across markets, $2,000 and $500. But most patients don't pay $2,000 and $500 to their employers, most of them only pay -- if you were at Harvard you'd pay $30 flat fee no matter where you went to. So the tool doesn't help you that much.

Mrs. Brooks. Dr. King, would you like to comment on this private initiatives, private, the private tools?

Ms. King. Yeah. So I would just basically reiterate what Dr. Chernew said, that they haven't seen the kinds of results that they would be looking for. And I know that Castlight has been, is employers basically buy Castlight Health and offer it to their employees. And they found very low engagement from employees.

I think a lot of employees don't, they don't want to shop for providers. They don't necessarily want to shop. They will shop a little bit for the shoppable services. But they haven't seen the, like, the overall level of engagement has been about 3 to 6 percent on a lot of those tools.

Mrs. Brooks. Well, and I would like to ask both of you why do you believe that is the case? Why is it that we have these

tools, whether it is a private sector, an employer, or at the state base that states have invested in these, why do we have such low engagement on this issue?

Ms. King. I, I think that we, we largely have low engagement, I mean, partly because people aren't incentivized to use them. If you pay the same price you're not that much incentivized to use them. But I also think it goes back to this idea that when you go to your provider and they make a recommendation for you of which provider to go to for your, you know, hip surgery, or which, you know, lab to go to. Oh, go to the lab down the street. It's your unlikely to then, to whip out your laptop and figure out if there's a cheaper provider elsewhere.

Also, a lot of times individual providers prefer that their patients use a particular lab --

Mrs. Brooks. Right.

Ms. King. -- because they know that they get the results quickly, or it goes right into their EMR, or there are some synergies within the system.

And so I think that patients are reluctant to go against their provider's advice or recommendation, which is why you should try to get this information into the hands of the providers so that if they think I would recommend five doctors to do your hip surgery. Oh, two of them are only in -- are in your network. Let's talk about you'd pay $500 for this doctor, and you'd pay

$200 for this doctor, let's talk about the benefits and detriments of that. That's what we need.

Mrs. Brooks. And, Dr. Chernew, anything different on that as to why we have such low rate of use?

Mr. Chernew. Yeah. I, I think that it is a mistake to believe that consumers fundamentally want to shop. They actually fundamentally want to pay less out of pocket, and they want things to be simpler. That's what they really want because of all these sort of interactions with their physicians.

And so they tend not to want to go find these things out. You can push at the margins, but as a main view that we're going to use market forces to fundamentally control our problems I think is a little optimistic, as much as that pains me to say as an economist.

Mrs. Brooks. Thank you both. I yield back.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from New York, Mr. Tonko, for five minutes.

Mr. Tonko. Thank you, Mr. Chair. And welcome to our guests.

Many states and health care systems have implemented a variety of programs that are intended to give consumers additional information about the price of health care services on the theory that this will allow consumers to make more informed decisions and perhaps lower their costs. They are listening to your

concerns there.

But maybe you can develop for us a little better some of the tools and some of the concerns that we should have.

Academics, including both of you today, have studied these reforms to see what works, what doesn't work, and where we might go from here. I would like to spend a few minutes discussing with our panelists what the academic literature has to say about these efforts.

Dr. Chernew, in your written testimony you use the example of shopping for a car to describe why transparency doesn't always work to bring down the cost of shopping for health care and the like. Could you briefly describe what makes shopping for health care different and more complicated than that which we would utilize for products or services?

Mr. Chernew. Most products or services are bundled in a way that you care about. So you're not buying the ingredients. When you go buy a meal you don't price out all the individual ingredients, it all comes together.

Health care, because of the history of the way in which it developed, and because the reimbursement system was really provider focused so you, you know, remember, physicians and hospitals, they're inputs to providing care. Right? But you really care about the joint product. And so, that has made it difficult to simply give prices that have been developed from sort of a payer perspective to consumers who are purchasing from

a different perspective. And it, broadly speaking, has been hard for people to shop in that way. Combine that with insurance distorting prices, the reliance on physicians, the complexity of the problem, the salience of the problem altogether has made it very hard for people to shop.

Mr. Tonko. And, also, you wrote in an August 2017 "Health Affairs" article that, and I quote, "simply offering a transparency tool is not sufficient to meaningfully decrease health care prices or spending."

So, what did you find regarding these transparency tools? And why were they unable to bring down the prices on their own?

Mr. Chernew. They're often offered with the narrative of they're going to help make markets work. And because most people don't use them, because they're complicated, they don't make markets work that well on their own, and as a result you don't see prices respond.

Mr. Tonko. So, could you describe what conditions would be sufficient to meaningfully bring these costs down?

Mr. Chernew. Well, there's bringing costs overall down is challenging. What's sufficient to how transparency tools work, which I believe are true in a limited number of cases, is you need to have services bundled in a way that people can understand. You need to have benefit designs done in a way that make people actually feel the cost at the margin. And you need to avoid a situation in which the physicians that are making the

recommendations are, for example, owned by a system, so the physician's going to refer within a system. And once you choose your primary care doctor you're actually choosing a whole referral network they use, and it's very hard to get them to work.

So, I think Dr. King and I agree that the margins is all valuable. There are specific cases. It's really valuable to let people know what they might have to pay out of pocket. But as a fundamental question about what could you all do to all of a sudden use transparency to revolutionize the way that consumers shop, and therefore to control health care spending, that's a really tall order.

Mr. Tonko. Thank you.

And, Dr. King, your written testimony discusses the usefulness of state efforts such as All Payer Claims Databases to bring down prices for consumers. These databases are intended to house a comprehensive collection of medical claims data from both public and private payers on how much they pay for different kinds of procedures.

How can consumers use that information in these databases to inform their health care decisions? And what are the limitations on this, this kind of data?

Ms. King. Thank you. So, basically the consumers wouldn't use the database themselves. The information that's housed in the database would then have to get put into a consumer-facing website like what New Hampshire has on Health Costs. And that

has been demonstrated to bring down costs a little bit and allow patients to use it.

So if you have the negotiated rate between a provider and an insurance company in all of these All Payer Claims Databases, and all of the, you know, all of the utility, how we utilize health care, who patients go to, what they charge, what the negotiated rates are across the state, you could then generate really meaningful information for patients because you would know which insurance company they were in and what that insurance company had negotiated its prices with providers for. And you could use that to populate consumer-facing websites and consumer-facing tools that would provide patients with information on their out-of-pocket costs.

I just want to say that one of the other things that we haven't really discussed today as a driver of costs that affects transparency is the fact that a huge majority of our markets for health care are highly concentrated. And one of the reasons why we have such a problem with transparency is that you have provider organizations and provider systems with a large amount of market power and they can demand to keep their prices secret. They can negotiate things in ways that drive up costs and then, and then hinder transparency to find that out.

And so, if you were really looking, I think transparency is important at the margins. I think it's useful. I think it's generally a good thing in a capitalist society for people to know

what they're going to pay. But I also think if we want to talk about competition and why the markets don't work you need to look at the markets themselves and figure out that competition is dwindling and dying because these markets are so consolidated.

Mr. Tonko. Thank you very much. And, Mr. Chair, I yield back my time.

Mr. Harper. The gentleman yields back.

And the chair will now recognize the gentleman from Georgia, Mr. Carter, for five minutes.

Mr. Carter. Thank you, Mr. Chairman. And thank both of you for being here.

Dr. King, I am going to let you continue on because you have hit on the right point, the vertical integration that we are experiencing right now. What you have is you have a PBM who owns a pharmacy. Now the PBM and the pharmacy are talking about buying an insurance company. Now you have got an insurance company, Cigna, talking about buying the PBM, which also owns the pharmacies.

The vertical integration and lack of competition is something. And then they can hide it all throughout that vertical integration. They don't care where they make it, as long as they make it. But that is the problem. You, I mean you hit the nail on the head right there.

Anything else you want to add to that?

Ms. King. I just want, I just want to pile on. So, I --

Mr. Carter. Sure.

Ms. King. I think that in some, I think that in some instances we're seeing integration and it's not just vertical; right? We're seeing horizontal integration. We're seeing vertical integration. And now we're also starting to see cross-market integration where hospitals are buying provider systems in other parts of the state, other, and in other states. And the more integrated these markets become overall, the less competition we are able to have.

Mr. Carter. And that is the whole key. Transparency is eminently important, no question about it. But competition is the key as well. And being able to see that competition, I mean we have used the example about buying a car. I mean, you know, I believe it is New Hampshire who has a database, a website you can go to to compare medical costs. I mean, that is the kind of thing we are talking about, and that is what is going to lead to decreasing health care costs.

Ms. King. Well, that's right. And if there's no, if there's very little competition in the state, or you have an entity with an extreme amount of market power, they are able to keep prices very high, regardless of how transparent you make them.

Mr. Carter. Right.

Ms. King. If you don't have a choice of where to go, they can charge you whatever they want.

Mr. Carter. Okay. Let me get to my part. First of all,

Mr. Chairman, I want to ask unanimous consent to submit two letters, one from the National Community Pharmacists Association and another from the American Pharmacists Association for the record.

Mr. Harper. Without objection, so ordered.

[The information follows:]

********** COMMITTEE INSERT 7**********

Mr. Carter. Thank you very much.

I need to get back very quickly to a question that Representative Barton asked about the coupons being used in Medicare Part D. The anti-kickback, as you know, that will prohibit that from happening. But one thing my colleagues need to keep in mind is that a lot, most of these coupons are for brand name drugs. And if you get outside of that formulary it is going to end up costing taxpayer more.

And every quickly, the reason that happens is because when a patient goes and meets their deductible, then goes into the donut, if they increase the costs by buying the ones that are off the formulary then they get into the catastrophic quickly, more quickly, which means that the taxpayers are going to be paying more for their insurance, for that patient's insurance. It is going to end up actually costing taxpayers more.

So that is one of the reasons why the Medicare Part D CMS does not allow that to happen in there. So I want to make sure we, we got that clear.

Representative Griffith mentioned my legislation dealing with gag clauses. Twenty-two states have implemented this thus far. We need to implement it at the federal level. You know, here we are in America with freedom of speech, and over 30 years of experience in working in pharmacy and I could never tell a patient, look, if you pay for this out of your pocket it will only cost you $7.00, but your copay is going to be $20.00. And

that is just ridiculous for us, particularly here in America, not to be able to do that.

I wanted to talk also about PBMs and their licensure and registration. A number of states have required PBMs to register with their insurance commissions. And the most recent one was Arkansas held a special session. And now they have to -- they have enacted the Arkansas Pharmacy Benefit Licensure Act where the state insurance department requires PBMs to license within the state.

One of the things, also, we talk about pharmacies. The number one pharmacy in America, CVS, they have more stores. Walgreens. You know what number three is? Express Scripts with their mail order pharmacies. Yet, they do not have to register in each state.

Don't you think they should at least have to register in each state, the third largest pharmacy chain in America? And they are nothing but mail order pharmacies. Surely they should have to register in every state.

Any comment.

Ms. King. I know very little about it but it sounds like you're right, yes.

Mr. Carter. Okay. I know.

So, anyway, Dr. King, Medicaid managed care organizations, that is another way that we can attack some of these costs as well because without having, without having the transparency

there to see what exactly the PBMs are charging in those, then we are unable to control costs.

In fact, West Virginia just did away with their managed -- they carved that out and saved $30 million. In Ohio they saved $227 million. In Kentucky they figured their costs would be $380 million. Why can't we control that on a federal level as well?

We have a number of managed care organization contracts at the federal level. If we could control those, do you think we could have -- and had transparency in it, do you think we could save costs there?

We could. The answer is yes. I'm sorry.

Mr. Harper. The gentleman yields back.

The chair will now recognize the gentlewoman from Illinois, Ms. Schakowsky, for five minutes.

Ms. Schakowsky. Thank you.

Dr. Chernew, I have never heard a witness, though I am sure many are thinking of it, that I wish my time were over. And I want to -- I have been chuckling over that for most of the hearing.

You mentioned the idea that pharmaceutical companies, manufacturers can charge whatever the market will, will bear. But the question is, what is the market?

We have a briefing from a Dr. Anderson from Hopkins who said, for example, Sovaldi, that they decided that all they really needed to make back the money that they invested in Sovaldi, or the marketing that they do, they need 20 percent of the market.

So, we are not talking about widgets, we are not talking about cars, we are talking about illness, life, death. And so if they charge, which they did, $86,000 for this cure to Hep C, all they really care about is that if 20 percent of people who have this, you know, really awful disease can get cured.

And so it seems to me that we ought to have a better way. You know, when you say charge whatever they, whatever they want to make the money they want, this isn't about free markets, this is about a very segmented market. I just wonder if you would comment on that?

Mr. Chernew. I wrote in my written testimony that I was going to avoid pharmaceutical markets because it raises so many complicated issues. But since asked, I will dip my toe in.

The challenge, and I will use Sovaldi as an example, is Sovaldi was a truly innovative drug. And all analyses suggest at least most any value criteria you would have. And although it may be difficult for people to swallow -- that's not a pill joke -- but anyway, it turns out that the evidence suggests that with greater incentives for prescription drug innovation you get more innovation.

The problem is that statement should not imply that the drug companies get a blank check. And therein lies the basic problem.

I do not think their goal was simply to make back their R&D money. Their goal was to make more money.

Ms. Schakowsky. Yeah.

Mr. Chernew. Right? That's the goal in capitalist societies, to make more money. And in fact they have created a remarkably good product that for decades will benefit us and everybody. Right?

Ms. Schakowsky. Not everybody.

Mr. Chernew. The challenge --

Ms. Schakowsky. The people who can pay for it.

Mr. Chernew. No, that's right. So the people who can't pay for it and don't get it, they're in the same place off they were before it got invented. So, the challenge is how to manage the incentives for innovation, which are really important, with the obvious egregious problems of pricing. Not simply for what people who pay out of pocket. It's the out-of-pocket comments that bring everybody here. But the charge, to deal with the overall total amount of spending, and the prices, and the volume for all of these drugs.

Ms. Schakowsky. You know what, let me stop because I have one more --

Mr. Chernew. Thank you.

Ms. Schakowsky. -- one more question about it.

But I think it is worse if you know that there is the cure right there, that there is a cure right there and you can't get it. I think in some ways it is worse than thinking there isn't one.

But, again, about -- okay, so you don't want to talk about

markets, but I just want to mention this. One argument is that increased competition or more generic drugs are going to lead to lower drug prices. But recently Elizabeth Rosenthal described the bizarre phenomenon economists call sticky pricing where prices of competing prescription drugs simply rise together with each new drug that is provided.

So, we have got Novartis, a cancer drug. And Gleevec was first listed at $26,000 in the market. And the first generic was list priced at around $140,000 annually. And now many drugs in the same family as Gleevec cost on average $150,000 per year.

So, we aren't seeing. Again, markets in drugs, very different. We are seeing an increase. So, this thought that, you know, competition is going to drive it down and generics will drive it down, not working always.

Mr. Chernew. Always. I agree.

So, if you look at drugs at 15 years ago we could have been arguing about Lipitor and a whole series of other blockbuster drugs. They've all gone generic. We buy them at Harvard, they're bought as generic. It's a great deal. And, you know, there's a lot of real advances.

The challenges that are presented through some of those drugs, through biosimilars, which is a whole different issue, becomes important, are really, really, really important. And the issues you're raising I'm incredibly sympathetic with because the basic problem is we've been very successful at encouraging

amazing innovation.

We haven't found a good way to make sure that that innovation is affordable for people. And even if you solve the problem that people are paying a lot out of pocket, the prices getting passed through through insurance premiums create a really fundamental challenge.

Ms. Schakowsky. Okay, but I just want -- and I know my time is up -- but we are seeing increases in drugs that have been on the market for decades. They charge what the market will bear, and that means that the prices have kept going up out of control.

So, I can't let you answer. I am sorry, I am out of time. And you should be happy.

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the gentleman from Pennsylvania, Mr. Costello, for five minutes.

Mr. Costello. Thank you, Mr. Chairman.

Dr. Chernew, in your written testimony you noted that one of the many reasons that many transparency initiatives have had only a minimal impact on the market is because consolidation in the health care markets limits choice. Consolidation in the health care industry is something that is of great interest to this committee. As Chairman Harper mentioned at the beginning of the hearing, the O&I Subcommittee had a hearing on consolidation in the health care market last February.

Do you think that there has been too much consolidation in

the health care market? And, if so, what impact has it had on health care costs?

Second piece of the question, how does consolidation limit the effectiveness of both private and public transparency initiatives?

Mr. Chernew. Yes, there's too much consolidation and it's raised the prices and spending.

And the consolidation makes it difficult for transparency initiatives to work because they fundamentally require choice. If there's no choice, knowing the price of an office charge doesn't help you all that much.

The only thing I will say is don't think about transparency as only working through consumers. Having the policy -- having the regulators, having the policy commission, having journalists see the prices can also be helpful. But by and large the more consolidation, the harder it is to get markets to work and, therefore, the harder it is to get transparency to work.

Mr. Costello. I have a question for you. But would like anything to add, Dr. King? You were shaking your head yes before.

Ms. King. Yeah. Well, I'm in vehement agreement with most of the things he has said today.

So, I think that, I think that also transparency can help with the consolidation problem because you can actually, if you have a good All Payer Claims Database you can look and see how a particular merger or acquisition over time drove up costs or

didn't drive up costs.

Did they actually gain the efficiencies they said they were going to get when they, when they actually merged?

Did they pass it through to consumers? You'd be able to know that. And you'd be able to then turn around and stop future consolidation in the markets through that.

So, I think that those work both ways.

Mr. Costello. Dr. King, thank you. In your written testimony you highlighted how states could use health care claims data reported to an APCD to examine the drivers of health care costs over time, the impact of mergers, acquisitions, and other affiliations on health care price and quality, among other things, similar to what you just were sharing with us right there.

How would the health care claims data reported to an APCD give states with an APCD unique insight into the impact of M&As that states without an APCD would not have?

Ms. King. So, currently because a lot of these private prices are shrouded in secrecy, the states don't actually -- the attorney general doesn't know and, you know, other state entities don't actually have the data to examine how mergers in the past have affected prices, or how a particular -- they don't have the ability to project how mergers in the future might affect prices.

And so, if you have this enormous database of health care prices over time that allows you to look at utilization patterns, how people went, you know, were funneled to different providers,

and the cost, you could then make much better economic projections about how a merger might affect things in the future. And, also, you'd be able to look back in the past and see if they kept their promise.

Mr. Costello. Can you describe the general approaches states have been taking regarding the pharmaceutical price transparency bills you have seen?

Ms. King. Yes. So, states have looked at a number of different things with regard to price to pharmaceuticals this year. This has been the big topic amongst the states. They have done everything from a lot of price, pharmaceutical price disclosure anti-gag clauses this year.

They have also looked at, they've also looked at pricing reports or requiring pharmaceutical companies to submit reports at the end of the year, annually or at some other time that basically describe how much it cost them to produce a drug, what their overall -- what they spent on development and marketing, and then what, how they're pricing their drugs, both as an annual cost, as an individual patient cost.

States have also focused on gag prohibitions and disclosures, pricing reports. And that's a lot of what we've seen with respect to pharmaceuticals. And then a lot of PBM regulation as well, trying to promote transparency amongst the pharmacy benefit managers.

Mr. Costello. Thank you. I will yield back.

Mr. Harper. The gentleman yields back.

I want to thank both of you for being here today, giving us some very valuable insight and information as we tackle this very important challenge that we have.

So, I want to thank the members that have participated in today's hearing. And I will remind members that they have 10 business days to submit questions for the record. And should you receive any written questions, we would ask the witnesses to respond as quickly as possible to those questions.

The subcommittee is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]