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Statement before the House Committee on Energy & Commerce Health Subcommittee on "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers"

Lowering Health Care Costs through Transparency and Competition

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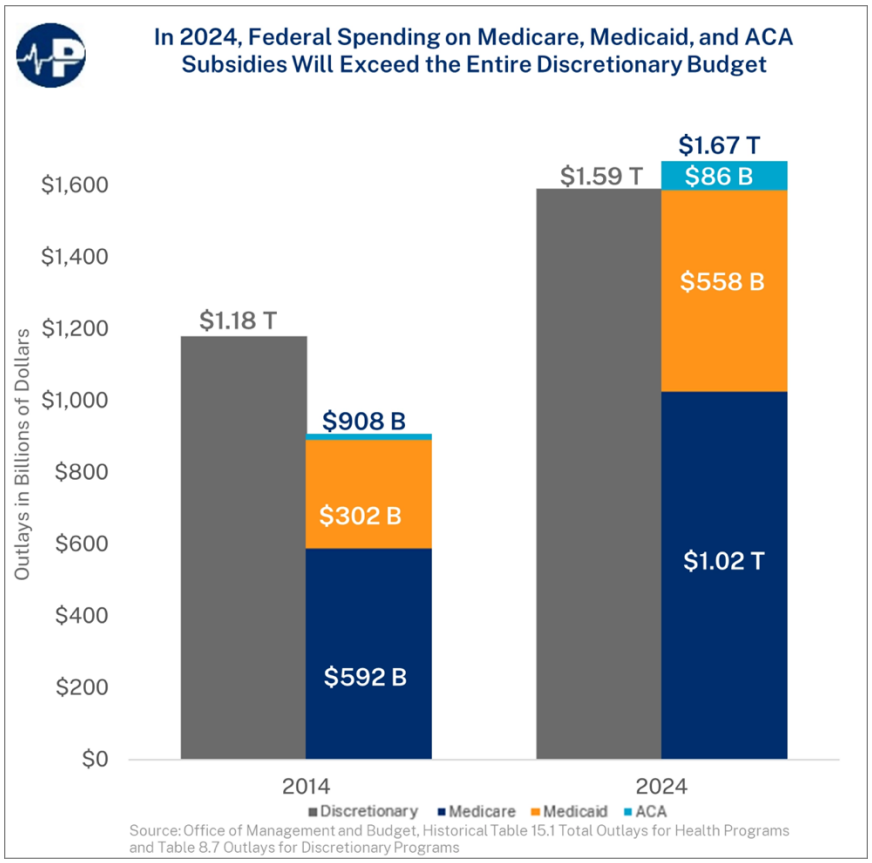
The high cost of health care represents a persistent challenge for consumers and governments alike. In the commercial market, the total premiums for a family plan average nearly $24,000.[1] That number is large relative to median household income, roughly $75,000 per year,[2] and contributes to lower wage growth and lower employment.[3] Meanwhile, high costs in Medicare and Medicaid stress government budgets and tax bases. For example, a recent analysis[4] shows that federal spending on Medicare, Medicaid, and ACA subsidies will exceed the entire discretionary budget in 2024—a remarkable statistic given the significant attention given to discretionary outlays.



[1] Claxton, G. et al. 2023. Employer Health Benefits Survey 2023 Annual Survey, *Kaiser Family Foundation*. October 18, 2023. https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/
[2] Guzman, G. & Kollar, M. 2023. Income in the United States: 2022. *U.S. Census Current Population Reports*. September 12, 2023. https://www.census.gov/library/publications/2023/demo/p60-279.html
[3] E.g., see Finkelstein, A. et al. (2020). The Health Wedge and Labor Market Inequality. *NBER Working Paper*. March 2023; Arnold D. & Whaley C. (2020). Who Pays for Health Care Costs? *RAND Working Paper*. July 2020.
[4] Gonshorowski D. & Merkel T. 2024. Government's Mandatory Health Care Spending Now Exceeds Entire Discretionary Budget. *Paragon Health Institute*. January 25, 2024. https://paragoninstitute.org/figure-private-health-merkel-gonshorowski-government-health-spending-exceeds-discretionary-budget-20250125/

The high costs of health care manifest in many other ways. For example, Americans hold significant levels of medical debt[5] and report that costs are a meaningful consideration in their decisions about seeking care.[6]

These data make it clear that there are broad benefits for lowering health costs. Every dollar saved is a dollar that can be used to raise wages, alleviate budgetary pressures, expand other non-health care programs, and much more. That does not, however, justify indiscriminate reductions to health care spending. Rather, it suggests policymakers should approach health care outlays with an appropriately critical eye and aim to identify spending that is least likely to reflect value.

The connection between health care spending and value is most tenuous when markets suffer from significant imperfections like a lack of information or choice. In such cases, there is little reason to believe resulting spending reflects the true preferences of consumers. As a result, such areas are ripe for policies that alleviate market frictions and increase cost pressures.

There are a number such areas, but I will emphasize a couple that have attracted significant, recent bipartisan interest—including in the Lower Costs, More Transparency Act which recently passed the House.

Lowering Medicare Costs and Decreasing Consolidation through Site Neutral Payments

In typical markets, prices are effectively determined by the most efficient producer of a product. For example, suppose a new firm can make an equally good cup of coffee as Starbucks for half the price. Customers would rapidly shift to their new competitor unless Starbucks was able to reduce their prices to competitive levels.

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[5] E.g., see Batty, M., Gibbs, C., & Ippolito, B. (2018). Unlike medical spending, medical bills in collections decrease with patients' age. *Health Affairs*, 37(8), 1257-1264; Rae, M., Claxton, G., Amin, K., Wager, E., Ortaliza, J., and Cox, C. 2022. The burden of medical debt in the United States; Consumer Financial Protection Bureau. 2022. Medical Debt Burden in the United States.

[6] Rakshit, S., Amin, K., Cox, C. (2024). How does cost affect access to healthcare? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/

The same phenomenon should exist in health care markets. If lower-cost providers are able to offer a service of similar quality for lower price, purchasers ought to shift towards those settings. Current Medicare policy interrupts this dynamic by often paying hospitals (and to a lesser degree, Ambulatory Surgery Centers) more than it would pay a doctor's office for services that can be safely performed in either setting.

This policy increases costs to Medicare and, in turn, taxpayers. It also raises beneficiary out-of-pocket spending who face coinsurance based on the service's price. In addition, this policy provides hospitals with a clear incentive[7] to acquire physician's offices, which can reduce competition between providers and increase costs outside of Medicare.[8]

In cases where a service can be safely delivered in a physician's office, there is a strong argument for Medicare paying the Physician Fee Schedule rate regardless of where a service is delivered. This would reduce costs to Medicare and beneficiaries while lessening consolidation incentives. One can argue for such a policy to apply to at least two groups of services. The first is any service delivered at off-campus hospital outpatient departments (HOPDs). Those services are unlikely to use hospital-based resources given that they are delivered away from the facility. The second is any service for which clinical evidence suggests it can be safely administered outside of a hospital (e.g., if that service rarely results in use of hospital-based follow-on care).[9]

[7] See Brady Post et al., "Hospital physician Integration and Medicare's Site based Outpatient Payments," *Health Services Research* 56, no. 1 (February 2021): 7–15, https://doi.org/10.1111/1475-6773.13613.
[8] E.g., Marah Noel Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* 77, no. 6 (December 2020): 538–48, https://doi.org/10.1177/1077558719828938; Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (May 2018): 139–52, https://doi.org/10.1016/j.jhealeco.2018.04.001; Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs* 33, no. 5 (May 2014): 756–63, https://doi.org/10.1377/hlthaff.2013.1279.
[9] MedPAC, "Medicare and the Health Care Delivery System," *Report to the Congress*, June 15, 2022.

The Lower Costs, More Transparency Act includes one subset of these services—drug administration in off-campus facilities. This policy is more modest than can be justified, but identifies a service for which the argument in favor of site neutrality in Medicare payments is particularly convincing.

That said, some observers have argued that this policy represent a serious threat to hospital finances. While hospital finances and patient access are important considerations for policymakers, they are not a particularly compelling argument in favor of maintaining a lack of site neutrality in this case. First, it is worth noting that the current proposal is fairly modest. One could argue in favor of using the physician fee schedule for all off-campus hospital outpatient departments and certain services at on-campus HOPDs—a policy that would likely lower Medicare spending by around $150 billion over ten years and save enrollees $90 billion.[10] The current proposal would save around $4 billion over that time.

Nonetheless, even if the financial vulnerability of some hospitals remains an acute concern, that is not a justification for paying *all hospitals* more for these services. If needed, policymakers can ameliorate this policy's effect on hospitals by capping potential revenue losses at hospitals with more tenuous baseline finances. In general, it would be preferrable to directly subsidize distressed hospitals rather than do so in an ill-targeted manner like the status quo. Doing so would make tradeoffs salient and allow for better targeting of funds.

Improving Transparency into Pricing

Health care markets are often defined by relatively opaque pricing—not only to researchers and policymakers, but those purchasing services (including individuals and employers selecting plans). Efforts to increase transparency into prices and spending have at least three key benefits. First, they can help purchasers make more effective choices about what they are willing to pay for. Second, they allow researchers to study health

[10] Committee for a Responsible Federal Budget. 2021. Equalizing Medicare Payments Regardless of Site-of-Care. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

care markets and better understand how prices and spending relate to value. Third, they give policymakers greater insight into where they should focus attention.

The LCMT Act improves transparency into health care markets in a host of ways. These include proposals that would increase transparency into the commercial and cash prices at hospitals, ambulatory surgery centers, imaging facilities, and laboratories. In addition, it would equip employers with greater information about their prescription drug spending, rebates, formulary, design and more. These are sensible efforts to better inform policy debates and are worth building on. As Congress continues to work on this topic, it is worth keeping in mind how such policies interact with each other. In particular, requiring information disclosures imposes some administrative burdens on firms. In an effort to minimize these costs, it is worth considering whether transparency efforts can be streamlined. For example, if the same data points are collected in both the hospital and insurer transparency efforts, it may make sense to avoid duplication.