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Before the House Budget Committee

"Breaking Up Health Care Monopolies: Examining the Budgetary Effects of Health Care Consolidation"

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Chairman Arrington, Ranking Member Boyle, members of the Committee, thank you for the opportunity to testify at this critical hearing focused on the budgetary effects of health care consolidation and the negative impact of medical monopolies that flourish under our health care system's lack of transparency and healthy competition. It is an honor to be with you today. My name is Sophia Tripoli, and I am the Senior Director of Health Policy at Families USA.

For more than 40 years, Families USA has been a leading national, non-partisan voice for health care consumers working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all. In October 2022, we launched the Center for Affordable Whole Person Care to affirm and enhance our commitment to revolutionize America's health care system to hold the health care industry accountable for delivering affordable, equitable, high-quality and person-centered health care.

We greatly appreciate the work of this Committee to examine and advance bipartisan solutions to address unchecked health care consolidation and improve health care affordability. This work is urgently needed: Our health care system is in crisis, evidenced by a lack of affordability and poor quality.[1] And it is going to take all of us working together, across political party and health policy philosophy, from rural and urban communities alike, to fix it.

You have the support of the American public as you work to address these issues. Ninety-three percent of Americans agree that our country is paying too much for the quality of health care we receive, and more than half of adults in that same poll said that their most recent health care experience was not worth the cost.[2] The majority of Americans now rate the quality of health care as subpar, including 31% saying it is 'only fair' and 21% calling it 'poor.'[3] Recent polling shows that almost 90% of voters say it is important for this Congress to take action to reduce hospital prices, including 95% of Biden voters and 85% of Trump voters.[4]

The U.S. Health System in Crisis

At its core, our nation's affordability crisis is driven by a fundamental misalignment between the business interests of the health care sector and the health and financial security of our nation's families – a business model that allows industry to set prices that have little to do with the quality of the care they offer. These high and irrational prices are largely due to trends in health care industry consolidation that have eliminated competition and allowed monopolistic pricing to push our nation's families to the brink of financial ruin.[5]

Almost half of all Americans have reported having to forgo medical care due to the cost, and almost a third have indicated that the high cost of medical care is interfering with their ability to secure basic needs like food and housing.[6] Over 40 percent of American adults – 100 million people – face medical debt.[7] High and rising health care costs are a critical problem for national and state governments, and affect the economic vitality of middle-class and working families by crippling the ability of working people to earn a living wage. Today's real wages — wages after accounting for inflation — are roughly the same as four decades ago, while employer health insurance premiums have risen dramatically.[8] A recent analysis by Families USA found that if policymakers do not take action to rein in high and rising hospital prices and the harmful business practices of large heath care corporations, low- and middle-income workers, a group that disproportionately includes people of color, could lose nearly $20,000 in wages over the next decade.[9] At the same time, nearly 90% of large employers say that rising health care costs will threaten their ability to provide health care benefits to employees over the next five to 10 years if costs are not lowered.[10]

National health expenditures (NHE), which includes both public and private spending on health care, have grown from $27.1 billion in 1960 to nearly *$4.5 trillion* in 2022.[11] Relative to the size of the economy, NHE grew from 5% of gross domestic product (GDP) in 1960 to 17.4% in

2022.[12] The largest proportion of this spending is on hospital care, which accounts for a 30 percent share at a whopping $1.4 trillion annually.[13]

And the situation is expected to get much worse, with NHE projected to climb to $7.2 trillion by 2031, and high and rising health care costs projected to continue to grow faster than the economy, hitting nearly 20% of GDP by 2031.[14] That means a fifth of our economy will be spent on health care. This far outpaces what similarly situated countries spend on health care: On a per capita basis, the U.S. spent $12,555 in 2022 – over $4,000 more per person than any other peer nation.[15]

Notably, the excessive cost of health care does not generally buy Americans higher-quality care or even higher volumes of care. In fact, the opposite is true. Despite spending two to three times more on health care than other peer countries, the United States has some of the worst health outcomes, including some of the lowest life expectancy and highest infant mortality rates.[16] These health outcomes are even worse for people of color who experience higher rates of illness and death across a range of health conditions compared with their white counterparts.[17]

These abysmal health outcomes and extraordinarily high prices are the product of broken financial incentives within the U.S. health care system. Our current system rewards building local monopolies and price gouging instead of rewarding success in promoting the health, well-being and financial security of the community.[18] And hospital prices in particular have become highly problematic as the role of hospitals in our economy has shifted over the last 60 years from charitable institutions to corporate entities, resulting in a fundamental misalignment between the business interests of the hospital sector and the interests of the patients they serve.[19] These higher prices result in $240 billion annually coming out of workers' paychecks and instead becoming profits for large health care corporations.[20]

Health Industry Consolidation Driving High Prices

America's health care affordability crisis stems from high, rising, and variable prices across a wide range of health care goods and services, including prescription drugs and diagnostic tools such as MRIs and CT scans. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in our country as in the United Kingdom and almost twice as expensive as in Germany.[21] The average price of a hospital-based MRI in the United States is $1,475.[22] That same scan costs $503 in Switzerland and $215 in Australia.[23]

These exorbitant and unjustifiable prices are largely due to trends in health care industry consolidation across the U.S. that have eliminated competition and allowed monopolistic pricing to flourish.[24] This consolidation has taken place without meaningful regulatory oversight or intervention, and is becoming more acute.[25] In fact, there are few truly competitive health care markets left, with 95% of metropolitan statistical areas (MSAs) having highly concentrated hospital markets, nearly 80% of MSAs having highly concentrated specialist physician markets, and 58% of MSAs having highly concentrated insurer markets.[26]

- **Hospital consolidation:** Hospitals that were once community and charitable institutions have consolidated, via horizontal and vertical integration, into large health care corporations that amass market power and charge high and rising prices for health care. Hospital mergers are occurring more frequently both within and across health care markets, leading to higher prices in both cases. According to the American Hospital Association, there were 1,577 hospital mergers from 1998 to 2017.[27] An estimated 40% of those mergers took place from 2010 to 2015.[28]

- **Insurance consolidation:** Insurance markets are not as highly concentrated as providers, but there is evidence of markets with little competition between insurers. Between 2006 and 2014, the four firm concentration ratio — the extent of market control held by the four largest firms, Aetna, Blue Cross Blue Shield, United and Anthem — for the sale of private insurance increased from 74% to 83%.[29]

- **Vertical Integration:** Between 2013 and 2021, the percentage of physician practices that were hospital-owned rose from 15% to 53%, and the percentage of physicians employed by a hospital rose from 27% to 52%.[30] Recent research found that over 55% of physicians are now employed in hospital-owned practices.[31] This trend was accelerated by the COVID-19 pandemic, which exacerbated the financial vulnerabilities of independent and smaller physician practices and threatened the near collapse of entire sectors of the health care system — particularly primary care.[32] Nearly 23,000 physicians left independent practice to work for a hospital or other corporate entity after the onset of the pandemic, while hospitals and other corporate entities acquired nearly 21,000 additional physician practices from 2019 to 2020, representing a 25% increase in corporate-owned practices.[33]

- **Consolidation in the Prescription Drug Market:** Players in the prescription drug market are also taking advantage of unchecked consolidation. Drug manufacturers have increasingly engaged in anti-competitive behaviors and transactions to similarly amass significant market power, regularly buying up their competition in order to game the U.S. patent system and price gouge our nation's families for prescription medications. Pharmacy benefit managers – as third-party administrators designed to serve as middlemen between health insurers and drug makers – have increasingly merged with insurers and pharmacies to strengthen their own market power to negotiate pricing structures that serve their financial interests, often to the detriment of securing more affordable prescription medicines for Americans. The top three PBMs, all of which are affiliated with major insurers and/or pharmacies, control 80% of the market: CVS, including Caremark and Aetna; Express Scripts owned by Cigna; and Optum owned by UnitedHealth Group.[34] Consolidation in the PBM market also allows PBMs to prioritize the pharmacies they own, which reduces patient choice and access to some drugs by "steering" patients to specific pharmacies.[35] As of 2017, PBM-owned pharmacies represented 46% of the industry's revenue growth.[36] This is a major threat to the ability of independent pharmacies to operate and threatens access to pharmaceuticals for millions of families living in rural and underserved communities.

Widespread consolidation across the health care system has been compounded by the growing role of private equity (PE) firms over the last decade. Once largely uninvolved in the U.S. health

care system, in 2020 health care became the second largest sector for private equity investment, accounting for 18 percent of all reported deals, up from 12 percent in 2010.[37] Private equity investors spent more than $750 billion on health care acquisitions between 2010 and 2019.[38]

The business model of private equity firms is fundamentally misaligned with ensuring that our nation's families have the high quality, affordable, and equitable health care they need and deserve. PE firms often apply a very short-term profit driven business model (a three-to-seven-year period) to their investment strategy, characterized by buying a health care entity that is struggling financially or offers short-term growth potential, investing in it, saddling it with debt, and then selling their stake to generate profit.[39]

Further, recent studies show that PE ownership was associated with a number of harmful health care impacts, including but not limited to:

- Decreases in health care quality and patient safety: PE owned hospitals experience a 25% increase in hospital-acquired conditions, including a 27% increase in patient falls and an almost 38% increase in infections.[40] Researchers say that these outcomes may be partially due to "decreased staffing, changes in operator technique, poorer clinician experience," among other potential causes;[41]
- Increases in health care prices and charge-to-cost ratios:[42] PE owned hospitals charge $400 more per inpatient day on average compared to non-PE owned hospitals;[43] and
- Increased out-of-network costs due to PE firms buying up specialty physician staffing firms.[44]

A Closer Look at Hospital Consolidation

Nowhere is the negative impact of consolidation more evident than the rising cost of hospital stays and services, which have increased dramatically in the last decade and make up a large portion of increasing health care costs overall.[45] These cost increases have occurred despite lower hospital utilization and are largely due to escalating prices, which are the result of hospitals

buying other hospitals and community doctors to eliminate competition and form big health care corporations and medical monopolies.[46]

Americans in many communities have watched as their local hospitals became health systems, and those health systems were bought by large health care corporations. What most in the public and policymaking community have not realized is how much this has destroyed any real competition in our health care sector, allowing hospitals to dramatically increase their prices every year.[47] Between 1990 and 2023, hospital prices increased 600% - and just since 2015, hospital prices have increased as much as 31% nationally, now accounting for nearly one-third of U.S. health care spending, and growing more than four times faster than workers' paychecks.[48] Importantly, hospital prices are not only high, but have become essentially irrational:

- In 2020, across all hospital inpatient and outpatient services, employers and private insurers paid on average 224% of what Medicare pays for the same services.[49]
- Prices at hospitals in concentrated markets are 12% higher than those in markets with four or more rivals without any demonstrated improvement in quality or access to care.[50]
- Prices for the exact same service vary widely, sometimes even within a single hospital system:
    - A colonoscopy at a single medical center in Mississippi can range from $782 to $2,144 depending on insurance.[51]
    - At one health system in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[52]
    - Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento, California.[53]
    - The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200, depending on the insurance carrier.[54]

What's more, consumers and employers, who are the ultimate purchasers of health care, have limited insight into what the prices of health care services are until *after* they've received a

bill. For the majority of Americans (66%) who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[55] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[56] Health care is one of the only markets in the U.S. economy in which consumers are blinded to the price of a service until they receive a bill after the services are delivered.[57] It is the epitome of a broken market that threatens the financial security of America's families and fails to serve their needs. Although the current Hospital Price Transparency and Transparency in Coverage (TiC) regulations require hospitals and health plans to publicly disclose health care prices, including the negotiated rate, most large hospital corporations have bucked the federal requirements and are actively working to keep their prices hidden.[58]

Impact of Consolidation on America's Health Care Workers

Health care workers are also suffering ill-effects of being trapped in this greed-driven system. Following hospital mergers, wages for nurses and skilled workers stagnate: Wage growth was found to be 1.7% below the average national wage growth for these workers following horizontal mergers.[59] Research on high-impact mergers shows that over the four years post-merger, wages might be 6.8% lower for nurses and pharmacy workers and 4% lower for other skilled workers, in comparison to what wages could have been without the merger.[60] This is compounded in rural areas. Research from 2015 showed that after a merger some rural hospitals decreased their spending on employee salaries over $1000 per full-time equivalent employee.[61] Hospital consolidation has also been shown to have negative impacts on staffing ratios. Following

an acquisition in North Carolina by HCA Healthcare in 2019, nurses in that system experienced nurse-patient ratio changes and staffing cuts, in addition to closures of primary care offices and cutbacks of other services.[62] This left nurses and other health care workers caring for more patients with less time and fewer resources, which the Federal Trade Commission (FTC) cautioned would lead to patient harm in the form of "higher health care costs, lower quality, reduced innovation and reduced access to care."[63]

Congress has the Power to Fix our Broken System

It does not have to be this way. We know what the major drivers of high and irrational health care prices are, and we know how to fix them. The House of Representatives has already advanced well-vetted, bipartisan, and commonsense legislation that would remedy some of the most obvious health system failings. The *Lower Costs, More Transparency Act*, which passed the House in an overwhelming bipartisan vote in December 2023, would make crucial progress by codifying and strengthening price transparency rules, expanding site neutral payments, and advancing billing transparency, among other reforms. Some of these provisions, in addition to other important policy solutions, are discussed in further detail below.

<u>Strengthen Price Transparency</u>

The *Lower Costs, More Transparency Act* makes clear, without any exception, that all hospitals and insurers are required to post the underlying price of health care services, in a machine readable and consumer-friendly format. Unveiling prices is a critical step towards achieving truly affordable health care, improved health, and more competitive health care markets across the U.S. health care system. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses.[64] Further, unveiling prices can specifically

inform where the highest and most irrational prices are occurring in the health care system, so policymakers can implement targeted policy solutions to bring down the cost of health care.[65]

The American public is in broad agreement about the need for action on price transparency, with polling showing that a large majority (95%) of the public say it is important for Congress to pass a law to make health care costs more transparent to patients, including 60% who call this a top priority.[66]

Enact Site Neutral Payment and Billing Transparency

Market inefficiencies that stem from site-specific payment rates in Medicare are a significant problem which, if addressed, could save American families and health care payers billions of dollars.[67] Since commercial insurance and Medicaid often adopt Medicare payment policies, the broken payment incentives in Medicare are amplified across payers. These site-of-service payment differentials drive care delivery from physician offices to higher-cost hospital outpatient departments.[68] This shift is a major driver of higher spending on health care services which require lower resources such as office visits and minor procedures.[69] Additionally, these payment differentials create a financial incentive for hospitals to consolidate by buying physician offices and rebranding them as off-campus outpatient hospital departments (HOPDs) and facilities in order to receive higher payments.[70] This type of consolidation – vertical integration between hospitals and physicians – leads to a growingly anticompetitive market where hospitals increase market power to demand even higher prices from commercial payers.[71] These higher commercial prices are then passed on to American families and come directly out of workers' paychecks, typically as monthly health insurance premiums.[72]

Currently, hospitals that own doctors' offices that have been rebranded as off-campus HOPDs are allowed to charge a "facility fee" in addition to the higher fees they bill for the physician services they provide.[73] The result is that consumers not only receive a bill for the visit with the

physician but also for the use of the hospital facility where the visit occurred.[74] These bills together (the physician fee and the facility fee) amount to a higher total cost for the consumer than if the service was just provided in the physician's office.[75]

We are encouraged that Members of Congress are working to address payment differentials across sites of service that incentivize further consolidation and are a major driver of unaffordable care for America's families. The *Lower Costs, More Transparency Act* takes important steps toward fostering healthier competition in health care markets by advancing billing transparency reforms and expanding site neutral payments for drug administration services to help ensure consumers pay the same price for the same service regardless of where that service is performed. It enacts billing transparency reforms so that off-campus hospital outpatient departments are required to use a separate identifier when billing to Medicare or commercial insurers to ensure large hospital systems do not overcharge for the care they deliver in outpatient settings. It also enacts site neutral payments for physician-administered drugs in outpatient settings, which is estimated to save the highest-need chemotherapy patients more than $1,000 on cost sharing a year.[76] The Congressional Budget Office (CBO) estimates that site neutral payments for physician-administered drugs and billing transparency reforms would generate $3.74 billion and $403 million in savings, respectively, over ten years.[77] These policies are welcome first steps to addressing misaligned payment incentives that lead to higher costs for patients without meaningfully improving quality.

Bipartisan legislation introduced in the Senate, S. 1869 *Site-based Invoicing and Transparency Enhancement (SITE) Act*, would go even further to expand site neutral payments for outpatient services, and is projected to save the government as much as $40 billion based on previous CBO estimates.[78]

Ultimately, Congress could make significant strides in addressing medical monopolies by implementing comprehensive site-neutral payment policies as recommended by MedPAC in 2023,

and eliminating site-dependent reimbursement distortions that indirectly incentivize acquisition of non-hospital patient access points.[79] CBO estimates that this policy could save Medicare approximately $140 billion over the next decade.[80] And, the Committee for a Responsible Federal Budget projects that these policies could reduce health care spending by $153 billion over the next decade including lowering premiums and cost-sharing for Medicare beneficiaries by $94 billion and for those in the commercial market by $140 - $466 billion.[81]

Ban Anticompetitive Contracting Practices

We also urge Congress to take a close look at anticompetitive practices and clauses in health care contracting agreements, which when occurring between providers and insurers give large entities in highly consolidated markets the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit patient access to alternative sources of higher-quality, lower-cost care. Congress made important progress by banning gag clauses in executed contracts between insurance plan issuers and providers or provider networks as part of the Consolidated Appropriations Act of 2021. This policy has the potential to enable consumers and employers to be more informed purchasers of health care and to unveil fundamental information that policymakers, employers, researchers and other stakeholders need to identify health care markets with the highest prices and build policy that encourages healthier competition.

Congress should further prohibit large hospital systems from using their monopoly power to employ anti-competitive contracting practices when negotiating with insurers and other health care providers, as this is one of the primary ways medical monopolies are able to charge high and

rising prices.[82] These prohibitions should include the use of "all-or-nothing," "anti-steering," and "anti-tiering" clauses in contracts between health care providers and insurers. "Anti-tiering" and "anti-steering" clauses restrict the plan from directing or incentivizing patients to use other providers and facilities with higher quality and lower prices; and "all-or-nothing" clauses require health insurance plans to contract with all providers in a particular system or none of them. These contracting terms too often limit consumers from accessing higher-quality and lower-cost care.[83]

Bipartisan legislation introduced in the Senate[84] includes provisions to ban anticompetitive terms in facility and insurance contracts, estimated by CBO to increase revenues by $3.2 billion over a 10-year window.[85]

Ensure Transparency in Ownership

Additionally, we urge the Committee to continue to explore opportunities to improve transparency around the ownership interest of health care corporations, particularly when it comes to private equity (PE). We applaud provisions previously considered by other committees in this House that would require providers to annually report changes in ownership, and hope that Congress will consider integrating these or similar provisions back in to any final health care transparency legislation that is sent to the President's desk. Without insight into how profits from health systems are ultimately being funneled, it is very difficult to identify potential abuses, leaving private equity firms free to purchase health systems in order to drive profits through upcoding, surprise billing, and other questionable business practices.

Strengthen FTC Oversight Authority

Policymakers should prevent future horizontal, vertical, and cross market mergers that undermine healthy competition in health care markets and drive unaffordable care by ensuring the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) are fully applying federal antitrust laws to horizontal integration, such as mergers between hospitals and other health

systems, pharmacy benefit managers and drug companies; and vertical integration, such as mergers between physician practices and hospitals, health plans and pharmacy benefit managers. Specifically, Congress should improve the infrastructure needed to monitor anti-competitive mergers and contracting practices among health care corporations by increasing FTC and DOJ funding for anti-trust enforcement, and by giving the FTC authority to investigate and rein in anti-competitive practices by non-profit hospitals. Special attention should be given to PE firms and the smaller transactions that may traditionally fall below existing thresholds of review. Congress should increase the number of health care transactions reported to FTC and DOJ and subject to anti-trust review and enforcement by reducing the *Hart-Scott-Rodino Act* reporting threshold.[86]

Congress has the Power to Fix our Broken System – And Families Can't Afford to Wait

This Committee is responsible for identifying budget priorities that reflect the values of families across the country and that invest in our nation's future, build a strong economy, and protect and improve health care and other vital services for America's families. When it comes to addressing the negative impacts of consolidation, this Committee has a clear opportunity to put the needs of these families ahead of the demands of corporate greed.

Consider the story of Ben Los:

> *In September of 2022, Ben Los's 5-year-old son began experiencing seizures. After rushing him to the doctor, Ben and his wife were referred to a specialist within their insurance network, an hour and a half away from their Colorado Springs home. They got the EEG scan for their son and were in and out of the specialist's office in 45 minutes where they were assured, "yes, absolutely this is covered." Yet two months later, the Los family received a bill for $2,518 for the appointment. After calling the hospital to find out why they were being charged for something they had confirmed multiple times was covered, the hospital claimed this was for "facility fees". The appointment itself was covered, but now the hospital was defending the charge stating, "Well, you paid the clinic staff, but now you also have to pay the hospital."*
>
> *After extensive efforts, Ben was able to speak to somebody near the top of the hospital's administration, who negotiated the bill down to a 75% reduction under a classification of charity care. During this time Ben engaged with an investigative journalist in Denver and found out the hospital is owned by one company, which is owned by another company, and so on. When they finally identified the overarching owners of the health system, they discovered those owners profited billions of dollars in the first nine months of 2022 alone. "You can't tell me that there is no way for the hospitals to pay their employees when they're raking in the kinds of net profits that they're claiming every single year," said Ben.*[87]

In some cases, patients receive bills for facility fees when they never even set foot inside a medical facility of any kind. Take the story of Brittany Tesso and her then 3-year-old son Roman from Aurora, Colorado:

> *In 2021, Roman's pediatrician referred him to Children's Hospital Colorado to receive an evaluation for speech therapy. With in-person visits on hold due to the COVID-19 pandemic, the Tessos met with a panel of specialists via videoconference. The specialists, who appeared to be calling from their homes, observed Roman speaking, playing, and eating. Later, Mrs. Tesso received a $700 bill for the one-hour video appointment. Then, she received another bill for nearly $1000. Thinking it was a mistake, Mrs. Tesso called to question the second bill. Despite the fact that the Tessos never set foot inside the hospital, she was told the bill was a "facility fee" designed to cover the costs of being seen in a hospital-based setting.*[88]

In addition to jeopardizing financial security for individual patients and their families, widespread health system consolidation risks the health and economic security of entire communities: [89]

> *Hahnemann University Hospital opened in Philadelphia, Pennsylvania in 1885. For more than 130 years, it served primarily lower income residents, until 2018 when it was purchased by Paladin Healthcare, a private equity firm. Over the course of about 18 months, Paladin Healthcare laid off physicians, nurses, and other workers, while steering the hospital towards bankruptcy and closure.*[90] *Questions and concerns were raised by local, state, and national officials as to whether the motivation for these decisions came from the value of the land on which the hospital sat being seen as more valuable to the private equity firm than the nearly 500-bed charity hospital itself.*[91] *Despite the local community's longstanding reliance on this centrally located hospital, Hahnemann University Hospital closed its doors in August 2019. Shortly thereafter, the land was put up for sale. In addition to residents losing access to care, thousands of employees lost their jobs and 550 medical residents were displaced.*[92]

The American People Want Action

A broad range of stakeholders have endorsed and supported critical policy solutions to address consolidation and improve transparency, including organizations representing consumers, patients, workers, small and large employers, and primary care clinicians.[93] And large majorities of voters support a range of policies to lower prices. Voters from both sides of the aisle broadly support:[94]

- Requiring hospitals to provide real prices in advance, not estimates (93%)
- Limiting outpatient fees to the same price charged by doctors in the community (85%)
- Preventing hospitals from engaging in business tactics that reduce competition (75%)
- Limiting mergers and acquisitions (74%)

Beyond these immediate steps, policymakers should focus on a broader redesign of the economic incentives of the health care sector to align with consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

Thank you again for holding this hearing today and for your leadership in addressing the challenges created by health care consolidation in order to lower health care costs and improve affordability for consumers. Congress should seize this momentum to immediately implement commonsense policies that rein in abusive health care prices and make health care more affordable for everyone: patients, workers, and taxpayers alike. The journey to fully transform our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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