JULY 2024

REVEAL THE PRICE

REDUCE THE COST

REFORM THE BROKEN SYSTEM

A REPORT ON HEALTH CARE PRICE TRANSPARENCY

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★U.S. SENATOR | INDIANA★

A Message from Senator Braun

As someone who has spent their life growing a small business into a larger one, I have wrestled with the impact health care costs have on employers and employees. I kept costs low and health care premiums flat for 15 years in my company by moving to a self-insured model that contracted directly with price-transparent providers and focused on preventative care.

Our country is rapidly aging and with it will come increased demand and spending for health care services. Skyrocketing health care costs are burdening patients, employers, and state, local, and federal governments. For too long the health care sector has operated as an unregulated utility with little to no transparency. Hospitals and insurers can charge astronomical prices without losing customers, but when armed with pricing information consumers can punish providers that over charge by going elsewhere. Price transparency forces providers and insurers to lower their rates to attract customers.

As Ranking Member of the Special Committee on Aging, I have made it my priority to pull back the curtain and put the power back in the hands of the American people. Transparency is not a cure all, but it will introduce competition into the health care industry and bring down prices. I hope this report will serve as an update on the implementation of existing price transparency measures and reveal the shortfalls that can be improved upon by Congress.

Sincerely,

Mike Braun
Ranking Member
Special Committee on Aging

Findings

- The United States is projected to have spent $4.8 trillion in 2023 on health care and this is expected to increase to nearly $8 trillion by 2032.
- The increase in health care spending is fueled primarily by skyrocketing health care prices as well as the increase in Americans ages 65 and older.
- Households are bearing the brunt of health care costs as four in ten adults have some form of medical debt, and half of Americans are vulnerable to falling into health care debt.
- Americans spend the most on hospital care and other provider services. However, prices vary wildly for the same service even within the same hospital system.
- The Hospital Price Transparency federal rule went into effect in 2021 and requires hospitals to post all prices online in an accessible format, but only 34.5 percent of hospitals are fully compliant with the requirements of the rule.
- Due to shortfalls with federal regulations, states are working to improve transparency with state-based legislation, but there are ways to increase transparency through federal legislation as well.
- Outside of provider spending, Americans spend the most on prescription drugs. More than 131 million Americans, or two thirds of adults take prescription drugs. However, there is limited information on the true price of pharmaceuticals.
- Transparency across the health care supply chain is key to empowering patients and increasing competition, which will ultimately lower health costs.

Recommendations

- Improve, expand, and enforce existing transparency measures for providers and insurers that enable consumers to shop for services.
    - The Hospital Price Transparency rule requires hospitals to make their prices public in a machine-readable file and in a “consumer-friendly” format, such as a price estimator. However, there are a number of shortfalls and limited compliance to this rule. Congress should act immediately to codify the rule, while also improving it by expanding the requirements to other providers, increasing enforcement through additional penalties, and requiring actual prices, not just estimates.
- Adopt new transparency measures for drug manufacturers and pharmacy benefit managers (PBMs) that unveil true prices and increase access to cheaper generics.
    - A complex pricing matrix makes it difficult for Americans and policymakers to discern true pharmaceutical prices. Congress and the administration should require additional transparency reporting requirements when drug companies increase the price of certain drugs and PBMs should disclose their fees, costs, markups, and discounts to show how they charge health plans and pharmacies. The Food and Drug Administration (FDA) should also be more transparent during the generic drug approval process by disclosing information about deficiencies so that generic drugs can meet regulatory requirements more quickly and come to the market at lower costs.

Introduction

When Americans go to the hospital for a procedure or to the pharmacy to buy prescription medications, they often don't know the cost beforehand. This lack of price transparency robs Americans of the ability to shop around for quality and value. Most Americans rely on their insurance to pay as much as possible and hope that the rest of the bill will be manageable. There is perhaps no other industry as cloaked under the guise of confidentiality as the one that we rely on the most when we are ill. The health care sector is running in the dark like an unregulated utility in the face of an unprecedented aging population and is failing to serve everyday Americans. The United States spent a whopping $4.8 trillion on health care in 2023, more than any other country, yet has the worst outcomes compared to peer nations. [1] Congress needs to increase transparency and put the power back in the hands of the American people in order to introduce real market competition into the health care industry and bring down prices.

By 2030, one out of five Americans will be over the age of 65. [2] By 2032, the number of older Americans will outnumber children for the first time in human history. [3] The demographic shift is no longer on the horizon—it is a reality and expected to rapidly grow. The aging of the population will put increasing demand on the health care system, and patients need a system that works.

Business as usual will not fix the nation's broken health care system: throwing money at the problem is not working, and continuing to do so will only dig the United States into deeper debt, endangering our children and grandchildren. Over the past two decades, career politicians in Washington have been printing and spending money we do not have. This irresponsible consumption has created a national debt of $34.8 trillion, and there are no signs of its abatement. [4] In fact, the federal government continues to spend to the tune of a trillion dollars every six months. We need common sense reforms that truly put patients first. Such reforms would help to rein in skyrocketing costs, improve transparency, and remove barriers to competition to allow everyday Americans to access the health care they need when they need it.

Accessible and affordable health care is crucial to the health of our nation, and a focus on transparency should be paramount in combatting skyrocketing health care costs. At each link in the health care supply chain, including drug manufacturers, insurers, PBMs, hospitals, and providers, uncovering costs will not only enlighten key players, but ultimately shift market forces to benefit patients. Employers need to know true costs, so they can provide the most value to their employees through insurance or directly with providers. Americans need to see the costs directly, so they are empowered to shop for the best price and have agency over their health care and wallets. [5]

Breaking Down Health Care Spending

Nearly each category of health care spending is on the rise, and not expected to slow down as the population ages. In 2023, it was estimated that a 65-year-old retiring could spend an average of $157,500 over the 20 years of retirement on health and medical care. This estimate nearly doubled since 2002. [6] The amount older Americans spent on health care in 2020 was over 5 times higher than spending per child and nearly 2.5 times the spending per working-age Americans. [7] By 2032, health care spending is projected to balloon to nearly $8 trillion. [8] Taxpayers and patients are paying the price as spending in each category grows. In 2021, people 55 and older accounted for 56 percent of the total health spending, despite only making up 31 percent of the population. [9]

Health care spending is typically broken down in several ways including by sponsor, source, or type of service or product. It is important to understand the difference between these breakdowns and not conflate the numbers. A sponsor is defined as the entity responsible for financing a health care bill, such as a household, private business, or government. These sponsors are the ones paying the insurance premium, out-of-pocket costs, or the taxes that go to different government health programs. The source is who the sponsor is financing such as private health insurance, Medicare, or out of pocket. Finally, the type of service or product is what the source is paying for such as hospital services, physician and clinical services, and prescription drugs.

Spending by Sponsor

In 2022, the federal government accounted for 33 percent of health spending, households for 28 percent, private businesses for 18 percent, and state and local governments for 15 percent. [10] For households this was an annual increase of 6.9 percent from the previous year, primarily due to growth in premiums and payroll taxes for Medicare as well as contributions to employer-sponsored private health insurance. [11] The share of spending by households is important to note as they are increasingly burdened as health care spending continues to grow.

Spending by Source

In 2023, the United States' health care spending is projected to have grown 7.5 percent to reach a total of $4.8 trillion. This rate was almost double the increase seen in 2022. Of the total spent on health care, American taxpayers paid the bill for roughly 40 percent ($1.9 trillion) through Medicare and Medicaid, while the other major sources of funds were 29 percent ($1.4 trillion) through private health insurance and 12 percent ($508.6 billion) in out-of-pocket spending. [12] The total amount that we spend on health care represents over 17 percent of the GDP, significantly more than what peer countries spend. [13]

Medicare Spending

As the population ages and health care costs grow at unprecedented rates, spending on health care will continue to climb. The number of those eligible for federal programs like Medicare will also increase. This growth in enrollment coupled with increasing health care costs is expected to substantially increase the cost of Medicare. The Congressional Budget Office (CBO) projects that Medicare spending will nearly double over the next 30 years, relative to the size of the economy. [14]

While this report will primarily focus on out-of-pocket and private health insurance spending and how transparency can lower costs in the private markets, these strategies can introduce competition that will improve the entire health care ecosystem, including for federal programs. In addition, there are targeted transparency measures that can reduce Medicare spending, lowering health care spending overall.

The 2015 Bipartisan Budget Act included a provision that established "site-neutral" payments under Medicare for services received at off-campus outpatient departments but exempted most hospitals. [15] As a result, even if care is received at an off-campus outpatient facility, it can be billed as though the care was provided at the main hospital campus. This loophole allows hospitals to charge higher rates and inflate costs in Medicare. This has become more prevalent as more physician-owned practices and off-campus facilities are acquired by larger hospital systems. In 2020, CBO estimated that taxpayers will pay close to $40 billion in excess costs to Medicare due to site neutral exemptions. [16]

Senators Braun and Hassan's ***Site-based Invoicing and Transparency Enhancement (SITE) Act*** **(S.1869)**, would end the 2015 Bipartisan Budget Act site neutral exemptions. The bill would prevent off-campus emergency departments from charging higher rates than on-campus emergency departments when standalone emergency facilities are located in close proximity to a hospital campus. The legislation also includes transparency provisions. It would require that health systems establish and bill using a unique National Provider Identifier number for each and every off-campus outpatient department, direct the Department of Health and Human Services (HHS) to treat outpatient departments as subparts of the parent organization and to issue these subparts unique provider identifiers, and remove liability for services rendered for payers that are not billed in accordance with this section's requirements.

Closing this loophole and introducing transparency in this Medicare payment system will save taxpayers billions of dollars. Throughout the entire health care supply chain, introducing transparency will fuel competition, put power back into the hands of patients, and improve health care and outcomes.

Out-of-Pocket Spending

Out-of-pocket spending includes all amounts paid by privately insured and other insured individuals for coinsurance, deductibles, and services not covered by insurance, as well as amounts paid by the uninsured for health care. In 2023, out-of-pocket spending was $508.6 billion. This spending grew 6.6 percent from 2021, to $471.4 billion in 2022, which is 11 percent of total health care spending, and it remains on the rise. One out of every four Americans finds it difficult to afford prescription drugs due to the high out-of-pocket costs. [17] Families spend over five percent of their household income on out-of-pocket health care costs every year. [18] Americans ages 65 and older have the highest average out-of-pocket spending. In 2021, adults ages 65 and older spent an average of $1,658 per year. [19] CMS estimates that out-of-pocket drug spending peaked in 2023, with $52.5 billion being spent towards Americans' prescription drugs. [20] For many, this can result in debt.

One of the largest contributing factors to personal debt is health care debt. Four in ten adults have some form of medical debt, and half of Americans are vulnerable to falling into health care debt. [21] The problem does not start and stop with debt caused by medical or dental bills. Rather, individuals often use other forms of borrowing or debt to pay these bills, including payment plans, credit cards, bank loans, and borrowing from friends and family members. These forms of debt are often not included in estimates of medical debt, indicating the problem is larger than it seems. After receiving medical services, Americans should not be left hoping that their private health insurance will cover the bill or otherwise be left drowning in debt.

Private Health Insurance

For most Americans, private health insurance is the leading source of health care coverage. It includes both group coverage and direct-purchase coverage, and impacts nearly 66 percent of Americans, many of whom receive coverage through their employer. [22] Group coverage consists of mostly employer-sponsored insurance, whereas direct-purchase coverage includes plans directly purchased from an insurer, both on the health insurance exchanges and outside of them. In 2022, private health insurance expenditures accounted for $1.29 trillion, amounting to nearly one third of total health spending. A large part of this spending was for hospital care and physician and professional services. [23]

In 2023, the average annual health insurance premiums were $8,435 for a single person, and $23,968 for family coverage. These average premiums have increased 7 percent in 2023, and the average family premium has increased 22 percent since 2018 and 47 percent since 2013. [24] For individuals, families and employers, the costs of health insurance premiums, deductibles and copayments have continued to increase without any justified increase in the value of services.

Private Health Insurance Cont.

Health care is the most expensive employee benefit. Approximately 54 percent of Americans receive coverage through an employer-sponsored health insurance plan. [25] If an individual gets health insurance through their employer, the employer contracts with a health insurance company or companies and then employees choose between those plans. Private health insurance companies' contract with health care providers to create networks, including physicians and hospitals. Those contracts then determine how much providers get paid. Members usually pay a health insurance premium to get health coverage, and employers are generally the ones who pay most of the premiums, making it another large cost for employers. [26]

As an employer, Senator Braun has found that knowing the costs and what value those costs are providing for the employer and their employees is critical. Employers want to be able to provide employees with insurance that is worth the cost that the employer is putting in, but also supplies employees with the coverage they need. However, employers struggle to manage the rising prices they pay for their employees' health insurance because they are kept in the dark. They are unable to compare prices; they are not able to shop around for the best cost of health care services against prices that other companies pay. [27]

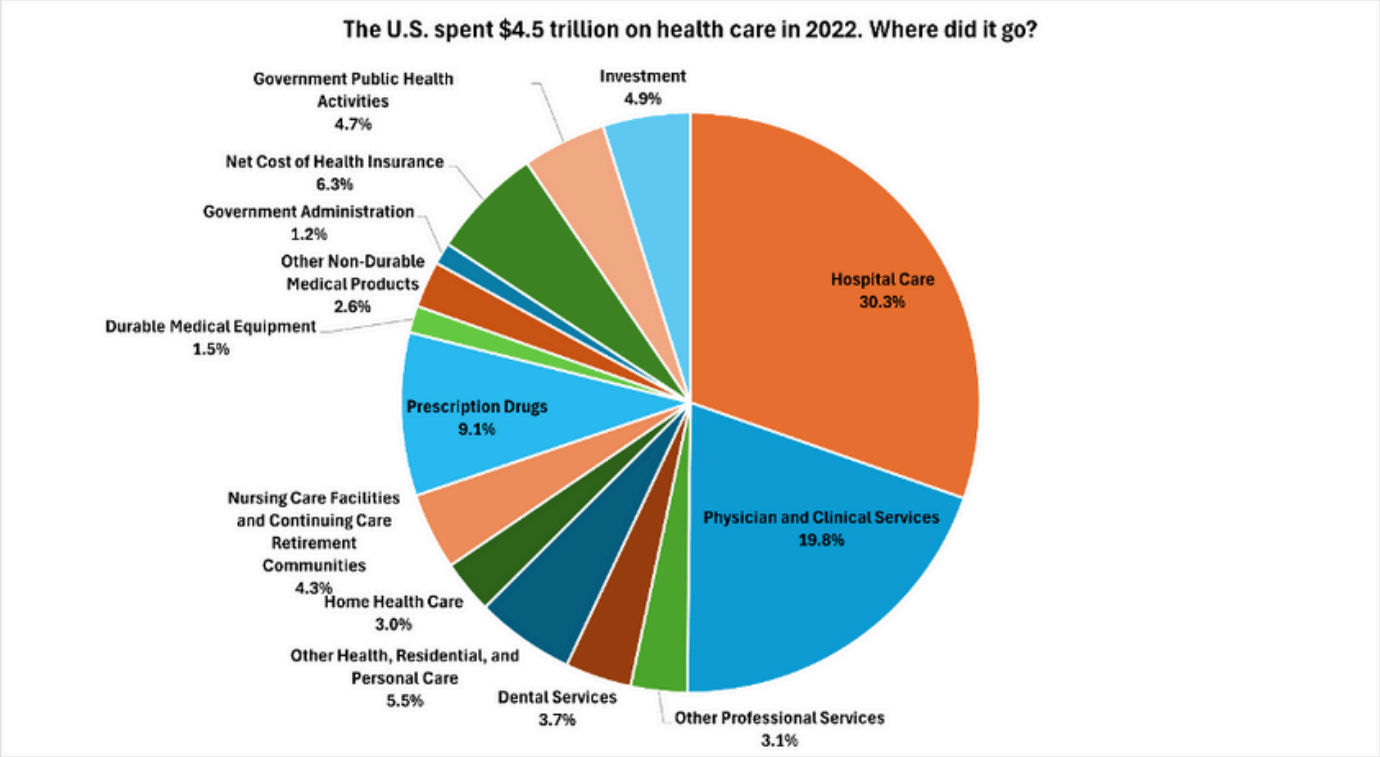
The lack of price transparency in health insurance is not an accident: it is by design. Baked into health insurance plans are secrecy clauses. These clauses are meant to protect confidential information regarding negotiated rates between insurance plans and providers. In practice, this means that pricing information is also hidden from those who pay for these services, including employers and individual Americans.

Health insurance plans also contain countless disclaimers, stringent requirements, and confusing terminology meant to protect the interests of the company, not the patient or the payer. These clauses result in the majority of Americans reporting that their health insurance is not serving them when they need it. More than half of Americans with health insurance (58 percent) reported that over the past year they had experienced an obstacle to coverage in the past year, including denied medical care, a lack of providers in network, higher bills than expected, and inability to qualify for necessary services. Nearly half of those facing obstacles to coverage were unable to satisfactorily resolve the issues with their insurance companies, leading them to pay more than expected or to delay or forego medical treatment altogether. [28] Foregoing care leads to worse health outcomes, including complications and progressions in disease illness, which ultimately may require more expensive interventions to treat, increasing costs overall. Due to a lack of transparency in health insurance plans, Americans are left in the dark financially, and the very system designed to protect health can lead to a decline in health instead.

Spending by Service and the Need for Transparency

The lack of transparency in the health care system hurts Americans and allows prices to multiply unchecked. From hospital care to clinical services and prescription drugs, the costs have trended upwards on average and are often unknown until the bill is received.

- Hospital spending growth is expected to have increased from 2.2 percent in 2022, to 10.1 percent in 2023. It reached $1.4 trillion in 2022, which is 30 percent of total health spending. [29]
- Physician and clinical services are expected to have increased by 8.4 percent in 2023 compared to 2.7 percent in 2022, when it hit $884.9 billion. [30]
- Prescription drugs spending is projected to have slowed in 2023, to 7.0 percent, which is down from a historic high of 8.4 percent in 2022, where it stood at $405.9 billion, representing 18 percent of total spending. [31],[32] Prescription drug prices are sometimes two to four times higher in the U.S., compared with prices in other high-income industrialized countries. However, unbranded generic drugs are an exception and are typically cheaper in the U.S. than in other countries. [33]



See CMS [34].

Americans struggle to pay for their medical bills and prescription drugs. Given that hospital care, physicians services, and prescription drugs are the primary drivers of health spending, Congress needs to pull back the curtain and introduce price transparency. Employers and patients are permitted to shop around for the best price in every other industry, but when it comes to health care costs and services, individuals are robbed of having agency over the health and their wallets. The impacts of health care costs and the benefits of transparency do not stop with patients. Price transparency not only empowers patients to make informed decisions about their care and treatment, but it also allows them to choose providers based on knowledge of quality and price. Opaque is the word often used to describe the ambiguous pricing in the health care market. It greatly undersells just how multifaceted the ramifications of the lack of transparency are.

Combatting health care costs through transparency is something that Republicans and Democrats agree on, and while there remains much to be done, we have made progress towards increasing transparency in recent years. In December 2020, President Trump signed into law the No Surprises Act, and put in place policies to require hospitals and insurers to disclose prices. In January 2021, President Biden issued an executive order tasking HHS with supporting these requirements. These actions represent significant steps in the right direction, but more must be done.

Hospital Care and Physician and Clinical Services

Hospitals and physician services work closely with health insurance plans to negotiate prices that suit each of their own interests. Americans obtain these services without knowing the cost. Without transparency and competition, hospitals can charge whatever they want. Hospitals are the largest recipient of health care spending, driven in large part by high prices. Hospital costs are on the rise and vary wildly from one hospital to another, and even within the same hospital based on the insurer.

Across the nation, the average per-day hospital cost is $2,883, and this number has increased 161.7 percent between 1999 and 2021. [35] Exact hospital costs depend on the hospital, the hospital location, the patient's coverage, and other factors. For example, the average per-day hospital cost in California is $4,181, whereas in Mississippi it is $1,305. [36] These costs don't factor in services rendered, such as surgeries, which can cost as much as $100,000. [37]

Hospital Care and Physician and Clinical Services Cont.

While patients with insurance may pay less, the amount covered varies dramatically, and often unbeknownst to the patient. [38] For example, at Rush University Medical Center in Chicago, the price of a standard treatment for lymphoma and leukemia, Rituximab, costs $899.33 in one plan and $9,260.13 in a different plan under the same insurer. [39] Even within the same city, state, and hospital system, prices can vary widely. [40] One analysis of 100 hospitals found that within the same hospital system "prices vary by an average range of 10.7 times for the same procedures." [41] When this analysis was expanded to hospitals in the same state, "prices vary by an average range of 31.3 times."[42] When compared to Medicare, employers and private insurers paid hospitals 254 percent more than what Medicare would have paid for the same services at the same facilities in 2022. [43]

Federal Transparency Efforts

As a result of sustained bipartisan Congressional and administrative actions over the past several years, CMS has implemented or is in the process of implementing policies to promote transparency across the health care system. [44] Since January 2021, the federal Hospital Price Transparency rule from CMS mandates that hospitals must make their prices public in two ways: in a machine-readable file that is useful for researchers and academics and in a "consumer-friendly" format. [45] This "consumer-friendly" format must be either a shoppable services list or a price estimator. [46] Additionally the Transparency in Coverage Rule (TiC) requires disclosure of systemwide prices and historical claims. [47]

With the ability to see prices, consumers can benefit from additional competition and ultimately lower their health care costs. Employers and unions can use pricing and claims data to improve their plans and direct participants to quality facilities with lower costs, while patients can utilize a price estimator to shop around for the lowest cost. [48] Despite these efforts at transparency, most providers are not currently in compliance with price transparency regulations, which has limited the impact of the rule.

Insurers and hospitals have been slow to publish negotiated rates and consumers are often unaware of price comparison tools or how to use them effectively. In March of 2024, only 34.5 percent of the sampled 2,000 hospitals are fully compliant with the federal price transparency rules. [49] This is a decrease from the 36 percent that were found to be compliant with the rule in July 2023. [50] Meanwhile, the price comparison tools may be buried in the provider's website, with little to no direction for where the tool may be found. Not only are the tools difficult for any American to find, but they are especially trying for older Americans, as they attempt to navigate the high-tech systems. Furthermore, the available tools are not often discussed by providers, leaving the patients in the dark. One survey found that only nine percent of Americans realize that hospitals must disclose prices online. [51] Once a patient finds the information, it is also difficult to utilize. Often the data is stored in files that are unwieldy to open and confusing to read. There remains a need for user friendly transparency data that patients can use to help guide their health care decisions.

State and Local Innovations

Some state and local policymakers are leading the way with additional actions to advance price transparency. Massachusetts, Minnesota, New York City, and Virginia have enacted their own price transparency requirements to ensure patients have access to the costs of services. [52] In Indiana, the General Assembly passed a law that requiring that in a contract between a group health plan and a third-party administrator (TPA), PBM, or prepaid health care delivery plan, the plan sponsor has ownership of the claims data. It also allows a contract holder to request an audit of a PBM one time per calendar year. Oklahoma has established a "Right to Shop" program, which provides financial incentives to enrollees for choosing lower-cost providers. Participating insurance plans must create a cost-comparison tool for health insurance enrollees shopping for lower-cost care. [53] Arizona and Virginia have codified the federal price transparency rules into state statute. Arizona's legislation requires that its health department annually verify price transparency compliance. Colorado, Arkansas, and Texas have established state-level penalties for hospitals not in compliance. Colorado took it a step further by prohibiting noncompliant hospitals from engaging in certain debt collection practices for unpaid medical bills. Texas codified health plan transparency requirements similar to the federal rules into state statute and required health plans to provide cost estimates to enrollees upon request.

Clear Need for Stronger Federal Policies

While some states and localities are making progress in advancing price transparency for their residents, there is hope that federal price tools will be implemented more effectively in the near future. One way to increase effectiveness and compliance is to increase enforcement of the federal price transparency rule. CMS has acknowledged that more than 30 percent of hospitals are not in full compliance with the rule, [54] yet as of March 1, 2024, CMS has only fined 14 hospitals for price transparency violations. Eight of those hospital have appealed their fines, which are under review. [55] CMS is taking steps to improve enforcement. The agency has shortened the timeframe hospitals have to respond to notices of noncompliance and has imposed automatic fines for failure to submit a Corrective Action Plan by the 45-day deadline. The agency should continue to take steps towards more timely enforcement as well as increased penalties to have an immediate impact towards increasing compliance. [56] Additionally, requiring attestation of accuracy and completeness of data by hospital executives would create additional liability and enforcement options if a hospital knowingly violates the rule.

Another shortfall of the current price transparency rule is that price estimator tools provide estimates, not actual prices. The estimates are non-binding and can lead to consumers being charged much more than the estimated price. For all intents and purposes this is a loophole that goes against the spirit and intent of the rule. Actual prices, including cash discounted prices, would provide real price information and certainty to consumers.

Clear Need for Stronger Federal Policies

Finally, price transparency requirements should be expanded to other providers such as clinical diagnostic labs, imaging centers, and ambulatory surgical centers. This would enhance the ability of consumers to shop for the best value-based care. These centers often provide care at substantially lower costs, but without the ability to see the prices of all providers, consumers are unable to make informed health care decisions.

The *Health Care PRICE Transparency Act 2.0 (S. 3548)*, introduced by Senators Braun and Sanders, would address many of these shortfalls and further the efforts to provide transparency, accountability, and ultimately lower costs. The bill does this through the following provisions: (1) requires machine-readable files of all negotiated rates and cash prices between plans and providers, not estimates; (2) expands price transparency requirements to clinical diagnostic labs, imaging centers, and ambulatory surgical centers; (3) requires pricing data standards including all billing codes for services; (4) requires actual prices for 300 shoppable services with all services by 2025; (5) requires attestation by executives that all prices are accurate and complete; (6) increases maximum annual penalties to $10,000,000 (includes specific minimum and maximum penalties according to number of hospital beds in the facility); (7) prevents federal pre-emption of state price transparency laws.

Americans should not go to the hospital and be unaware of how much their services will cost. Not only does this legislation come to the aid of patients, but it also addresses a lack of transparency regarding the agreements between insurance and providers. In recent years, it has been shown that employer-sponsored insurance plans have been able to review claims data for their employees and have discovered egregious payment disparities and wasteful practices. Insurers have tried to make this data inaccessible from plan sponsors. Although recent federal action has helped pull back the curtain, much more is needed.

The impact of price transparency in hospitals and practices associated with hospital systems spans far and wide. If transparency was the norm, not only would patients be benefiting from being made aware of the price of services up front, but physicians would also likely benefit, as patients are more likely to pay upfront when they know the cost before the service or visit takes place. Patients are then able to budget accordingly and arrive at the visit prepared to fulfill the payment. In fact, the Health First hospital system put this practice into use and saw an increase in upfront collection by 27 percent and experienced 2.7 percent net revenue in point-of-service collections. [57] By implementing price transparency in hospitals and physician offices, patients would have clearer paths to payment, minimizing bad debts and allowing providers to mitigate financial losses due to unpaid bills.

Clear Need for Stronger Federal Policies

A large benefit for physicians is that when patients know what they are paying for, and they feel that they are being treated fairly through transparency, patients are more likely to be loyal to their physician. According to recent studies, approximately 90 percent of patients state that their loyalty relies on a positive financial experience. [58] Ambiguous bills and unknown costs greatly impact how patients feel about their physicians and patient experience. Having patient loyalty benefits both the patient and the physician. Furthermore, patients are more likely to choose a provider who publishes their pricing for patients to see. Knowing the costs going into their appointment or service leads to trust in our health care system, which is foundational for success in any industry. [59]

Prescription Drugs

Outside of provider spending, Americans spend the most on prescription drugs. More than 131 million Americans, or 66 percent of all adults are taking prescription drugs. [60] Nearly 90 percent of adults over the age of 65 take a prescription drug. However, one in three adults are unable to afford taking their medication as prescribed. [61]

The astronomical costs of ordinary drugs put much-needed treatments out of reach for many Americans. From July 2021 to July 2022 alone, the price of over 1,200 medications increased greater than inflation. [62] The average increase was nearly four times the inflation rate and the median annual price of a new drug in 2022 cost more than $222,000. [63] In January 2022, drug companies increased prices of over 800 different drugs. [64] While prices continue to increase, drug companies are taking home record profits, but Americans are left struggling to pay for their prescription medications.

While insurance plans are intended to help participants pay for prescription drugs, levels of cost-sharing can vary significantly for different drugs and can also change at any point in time. [65] Insurance plans often contract with PBMs to design and administer prescription drug benefit plans. PBMs are intended to negotiate costs to give each stakeholder the best deal. Patients, however, often end up getting the worst deals. More than a third of Americans report that cost has prevented them from filling prescriptions. [66] A lack of transparency from drug manufacturers and PBMs only exacerbates the inaccessibility and unaffordability of prescription drugs for Americans.

Consumers often do not know the cost of their drug until they pick up their prescription and it is time to pay. Not only do drug manufacturers conceal prices, but copays also disguise the actual cost of medications. [67] A complex pricing matrix makes it difficult for Americans to discern true prices and can put necessary treatment out of reach. [68]

Generic Drugs: An American Success Worth Lifting

There is one category in which the U.S. pays less for prescription drugs: unbranded, generic drugs cost 33 percent less in the U.S. than in other countries. [69] Generic medicine works in the same way and provides the same clinical benefit as the brand-name medicine, and is far more affordable. These types of drugs account for about 90 percent of filled prescriptions in the U.S., yet make up only one-fifth of overall prescription spending. [70] When generic drugs enter the market, competition increases and overall prescription costs drop, allowing Americans access to prescription drug treatment. When the first generic drug enters the market, drug prices drop as much as 20 percent, and when multiple generics enter the market, prices drop as much as 85 percent. [71]

Incentivizing the development of generic drugs can help make prescription drugs more affordable for Americans. Supporting both accessible costs and increased transparency, the ***Increasing Transparency in Generic Drug Applications Act (S. 775)*** works to get generic drugs to market more quickly and at a lower cost for Americans. This bill increases patient access to lower-cost medications by improving transparency in the generic drug approval process. The legislation will expedite generic drug approvals by allowing the FDA to disclose critical information about any deficiencies identified during the assessment to generic drug manufacturers. This allows manufacturers to reformulate their proposed drugs to meet the regulatory requirements in a timely manner. [72] This bill was introduced by Senators Hassan, Paul, Braun, and Hickenlooper. [73]

Drug manufacturers may use patent webs to conceal true innovation and maintain market exclusivity. Pharmaceutical companies can currently unfairly extend the exclusivity period for a drug by submitting partial information for their initial patent, to help secure subsequent patents down the road. Senators Hassan and Braun introduced the ***Medication Affordability and Patent Integrity Act (S. 2780)*** which would require drug manufacturers to certify that they have not made inconsistent statements to the FDA and Patent and Trademark Office, ensuring that everything relevant to the innovation is disclosed. Additionally, Senators Welch and Braun have introduced S. 3583, a bill that would streamline patent litigation by limiting to one, the number of patents per patent thicket a pharmaceutical company can assert in litigation and prohibiting a patent owner from asserting multiple patents from the same thicket in separate actions against the same alleged infringer to circumvent the intent of the law.

Ensuring accessibility to patients and regulating drug manufacturers by cracking down on abuses in the medication patent process is necessary in order to continue to advocate for patients. By uncovering the abuses that exist in this system, transparency will increase, allowing Americans to know the cost of drugs before they're required to pay the bill.

Shedding Light on Drug Price Increases

The reasons for increases in spending on prescription drugs is not just an increase in the number of prescriptions and individuals using prescription drugs. Between January 2022 and January 2023, over 4,264 drug products had price increases. The average increase amongst the drugs that did in fact have price increases, was 15.2 percent. [74]

The *FAIR Drug Pricing Act (S. 935)*, which was introduced by Senator Baldwin and Senator Braun, is bipartisan legislation to require basic transparency for pharmaceutical corporations that increase drug prices. It would require drug companies to notify the HHS and submit a transparency and justification report 30 days before they increase the price of drugs that cost at least $100 more than ten percent over one year or 25 percent over three years. Drugs that have a list price that is higher than median family income, or $70,784 in 2021, manufacturers will also be required to submit a transparency and justification report. This report will include information on manufacturing, research, and development costs for the qualifying drug; net profits attributable to the qualifying drug; marketing and advertising spending on the qualifying drug; and other information as deemed appropriate. The bill will not prohibit manufacturers from increasing prices, but it will for the first time give taxpayers additional information on how drug prices are initially determined and give notice of price increases. HHS will make all the information from these reports publicly available within 30 days in an understandable online format and will submit an annual report to Congress summarizing the information submitted by drug manufacturers. [75]

Knowing whether the cost of a drug is going to increase is a step in promoting transparency for the consumer. This is another way in which patients can take back the control over their health. The ***Prescription Pricing for the People Act (S. 113)*** requires the Federal Trade Commission (FTC) to report about anticompetitive practices and other trends within the pharmaceutical supply chain that may impact the cost of prescription drugs. The FTC also must provide recommendations to increase transparency in the supply chain and prevent anticompetitive practices. This legislation was sponsored by Senator Grassley and cosponsored by Senator Braun and 19 others.

Reining in Middlemen

PBMs operate in the middle of the distribution chain for prescription drugs. They develop and maintain lists, or formularies, of covered medications on behalf of health insurers, which influence which drugs individuals use and determine out-of-pocket costs. Because PBMs have purchasing power, they negotiate rebates and discounts from drug manufacturers. They also contract with individual pharmacies to reimburse for drugs dispensed to beneficiaries. [76]

Reining in Middlemen

For years, three PBMs have controlled 80 percent of the market, and they use their size and scale to negotiate fees, rebates, and requirements for drugs for their own benefit. PBMs account for 42 percent of every dollar spent on brand medicines in the commercial market. PBMs negotiate rebates with drug manufacturers in exchange for placing the product favorably on formularies. These discounts and rebates, however, don't make their way to the consumer. In fact, consumers are often left paying higher prices, as the drug manufacturers raise their list prices to accommodate larger financial rebates from PBMs for more expensive drugs. [77]

PBMs use a myriad of tactics to get the best deal at the expense of the patient. PBMs can place certain drugs on preferred insurance tiers, compelling patients towards more expensive drugs even when cheaper alternatives exist. [78] PBMs can put in place lengthy and burdensome requirements, such as prior authorization, delaying treatment for patients and increasing costs. Often PBMs have their own pharmacies, which further perpetuates conflicts of interest, dismantling competition, and distorting drug pricing. PBMs garner the power to steer patients in the directions of certain pharmacies they control or own, making it difficult for smaller, independent pharmacies to thrive and taking agency away from patients. [79]

Market competition is essential for keeping prices low, and consumers being able to afford their prescriptions is vital to the health of our nation. The ***PBM Transparency Act (S. 127)***, which Senator Braun has cosponsored, along with 13 other Democrat and Republican senators, aims to increase transparency in prescription drug pricing and hold PBMs accountable for deceptive and unfair practice that drive up costs. [80] The bill would prohibit PBMs from unfair or deceptive pricing practices, such as "spread pricing", which is when they charge health plans and payers more for a prescription drug than what the reimburse to the pharmacy and pocket the difference. It would also increase transparency by encouraging PBMs to pass along 100 percent of rebates to health plans or payers and for PBMs to disclosure all their fees, costs, markups, and discounts. Finally, it would require PBMs to file an annual report with the FTC to show how they charge health plans and pharmacies. This will help the public and regulators understand how the market drives up costs for consumers. [81]

Conclusion

Price transparency will introduce an element to health care that we take for granted in almost every other sector; competition. In so many industries, competition fuels American success. It gives families the ability to shop around for products and services that meet their needs and put their money behind those that promise the best value. It should be no different for health care.

For patients, employers, unions, and the government, price transparency can inject competition to lead to a meaningful reduction in exorbitant health care costs, and ultimately improvement in quality. Not only should it be a right of the patient to access the cost of health care services prior to receiving them, but it should be enforced by federal laws to ensure uniform requirements to benefit all Americans. Price transparency cannot be implemented with a mere 34.5 percent compliance in hospitals. It cannot be implemented when penalties that are promised are not carried out. In addition, employers are legally obligated to act as fiduciaries for their employees, but anticompetitive contracting terms and unfair practices prevent them from ensuring they are getting the best prices and quality for their employees. Group health plans need to have explicit access to their claims data so they can determine whether their TPAs and PBMs are negotiating reasonable rates and aren't misrepresenting savings in order to keep a larger share of reimbursement coming from the plan.

Price transparency on services, prescription drugs, insurance coverage, and more should be something that a patient knows because it is not only required, but is right. It is time that Congress and America prioritize the patient; we must empower patients through accessibility, lower costs, and above all, transparency.

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