Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

ANSWERS TO QUESTIONS FOR THE RECORD

Following a Hearing on

Hospital and Physician Consolidation and Its Impact on the Federal Budget

Conducted by the
Committee on the Budget
U.S. House of Representatives

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On May 23, 2024, the House Committee on the Budget convened a hearing at which Chapin White, the Congressional Budget Office's Director of Health Analysis, testified about how consolidation among hospitals and physicians affects the federal budget.[1] *After the hearing, Chairman Jodey Arrington and Representatives Drew Ferguson and Rudy Yakym submitted questions for the record. This document provides CBO's answers. It is available at* www.cbo.gov/publication/60278.

Chairman Arrington's Questions About Vertical Integration and Site-Neutral Payment Reform

Question. How does vertical integration within the prescription drug supply chain impact spending for both the federal government and patients within both Medicare Part D and commercial health insurance?

Answer. When insurance companies merge with pharmacy benefit managers (PBMs), such vertical integration can align the incentives of insurers and PBMs. In CBO's assessment, that alignment tends to lower the prices paid for drugs and thus reduces spending on drugs for patients in vertically integrated health insurance plans. At the same time, evidence suggests that when a PBM integrates with an insurer, drug costs and premiums rise for other insurers that use the PBM, and any reductions in spending by the newly integrated plan may not be passed on to the plan's enrollees in the form of lower premiums.[2]

In the case of vertical integration between PBMs and pharmacies, the evidence to date is inconclusive. Vertical integration could reduce drug costs by increasing efficiency or giving PBMs more leverage in negotiations with manufacturers. Alternatively, mergers between PBMs and pharmacies could lead to higher drug costs for patients, insurance plans, and the federal government because such integrated companies would not face the same incentives to negotiate the lowest possible pharmacy markups.

Recent evidence on that issue comes from a 2023 study by the Medicare Payment Advisory Commission (MedPAC) of six therapeutic classes of drugs.[3] MedPAC found that in the majority of cases, the highest prices (net of manufacturers' rebates) were paid by vertically integrated plans to vertically integrated pharmacies. (A vertically integrated plan is one offered by an insurer that is integrated with a PBM; a vertically integrated pharmacy is one integrated with a PBM.) However, the study was unable to account for postsale fees or rebates made by pharmacies after the point of sale, so it is unclear whether spending on prescription drugs, including those postsale fees and rebates, is higher when insurers, PBMs, and pharmacies are integrated. CBO is continuing to research how vertical integration among PBMs and pharmacies could affect health spending.

Question. How does vertical integration within the prescription drug supply chain impact patient access to timely and quality care?

Answer. CBO is not aware of a comprehensive study of the relationship between vertical integration in the prescription drug industry and patients' access to drugs or the quality of care that they receive. CBO is actively tracking research on the effects of vertical integration and is interested in hearing from stakeholders and receiving additional evidence.

Question. Can you address profit maximization and whether hospitals are cost-shifting to make up for underpayment in other markets? Does CBO believe that site neutral payment reform in Medicare would lead to increased commercial market prices?

Answer. The idea behind cost shifting is that in order to cover their fixed costs, hospitals need to negotiate higher prices with commercial insurers to offset payment cuts made by Medicare and Medicaid. From the perspective of economic theory, it is unclear why hospitals would negotiate higher prices with private payers only after

1. Testimony of Chapin White, Director of Health Analysis, Congressional Budget Office, before the House Committee on the Budget, *Hospital and Physician Consolidation and Its Impact on the Federal Budget* (May 23, 2024), www.cbo.gov/publication/60279.

2. Charles Gray, Abby E. Alpert, and Neeraj Sood, *Disadvantaging Rivals: Vertical Integration in the Pharmaceutical Market*, Working Paper 31536 (National Bureau of Economic Research, August 2023), www.nber.org/papers/w31536.

3. Medicare Payment Advisory Commission, "Assessing Postsale Rebates for Prescription Drugs in Medicare Part D," Chapter 2 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2023), https://tinyurl.com/2z34jy3v.

they experienced payment reductions from public payers. In CBO's assessment, the preponderance of the research evidence suggests that hospitals do not engage in cost shifting.[4] Therefore, in CBO's view, expanding Medicare's use of site-neutral payments (in which the payment for a service does not vary by the setting where the service is provided) would not increase the prices paid by commercial insurers.

Question. Would you briefly elaborate on the current level of federal health spending in the United States, growth projections over the next ten years, and why this is unsustainable from a federal budgetary perspective?

Answer. As a share of the nation's economic output, net federal subsidies for health insurance are projected to grow from 7.1 percent of gross domestic product (GDP) in 2024 to 8.5 percent in 2034.[5] That increase in federal subsidies contributes to budget deficits and to a rise in federal debt held by the public relative to GDP. The deficit in 2034 is projected to equal 6.9 percent of GDP—substantially more than the 3.7 percent of GDP that deficits have averaged over the past 50 years.[6] The historically large deficits and debt that CBO projects for the next 10 years reflect a fiscal trajectory for the United States that is unsustainable and poses increasing budgetary risks over time.[7]

Question. Given that CBO has acknowledged that increased consolidation in health care markets increased federal spending, how has CBO built the current and expected trends in health care consolidation into the CBO baseline for health care program spending?

Answer. CBO bases its baseline projections for Medicare, Medicaid, employment-based coverage, and nongroup coverage on projections of enrollment and federal subsidies per enrollee. CBO expects that the trend of increasing consolidation in health care markets will continue. That trend is implicitly reflected in the projected growth of federal subsidies per enrollee, rather than being broken out as an explicit factor in CBO's baseline.

Representative Ferguson's Questions About Pharmacy Benefit Managers and Anticompetitive Behavior

Question. Looking at just United's PBM operation, if PBM customers are the health plans but PBMs own the health plans—or vice versa—how can United assure that PBM practices can be properly monitored or regulated to ensure they're delivering value for patients?

Answer. Vertical integration among insurers, pharmacy benefit managers, and pharmacies can make it more difficult for regulators to monitor some of their activities, particularly when the regulators operate under rules that do not anticipate that those entities can be vertically integrated.[8] For example, in Medicare Part D, pharmacy markups are included as drug costs in plans' bids (estimates of what it would cost them to provide Part D benefits), whereas profits retained by plans' sponsors are reported separately. Higher price markups by pharmacies can translate directly to larger federal subsidies for a plan's sponsor. A plan or PBM that is separate from a pharmacy has a financial incentive to negotiate the lowest possible markups with that pharmacy. But for a vertically integrated entity, pharmacy markups are a source of revenues as well as costs.

Question. Doesn't this vertical integration incentivize PBMs and plans to generate profits for each entity if health plans are the customers they sell to but they also own them? How does that marketplace incentivize these entities to direct savings for patients?

Answer. CBO expects that if insurance and PBM services are provided by different companies, those separate lines of business will generally both need to be profitable to be sustained. A vertically integrated entity, by contrast,

4. Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* (January 2022), www.cbo.gov/publication/57422.

5. Congressional Budget Office, *Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections* (June 2024), https://tinyurl.com/884awjzy.

6. Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2024 to 2034* (June 2024), www.cbo.gov/publication/60039.

7. For more information about the risks posed by perpetually rising federal debt, see Congressional Budget Office, *The Economic Effects of Waiting to Stabilize Federal Debt* (April 2022), pp. 2–3, www.cbo.gov/publication/57867.

8. Department of Health and Human Services, Office of Inspector General, *CMS Should Strengthen Its Prescription Drug Event Guidance to Clarify Reporting of Sponsor Margin for Medicare Part D Bids*, Report A-03-17-00001 (November 2021), https://tinyurl.com/3pvz3scr.

could focus on the combined profits of its insurance and PBM businesses, which might not entail maximizing the profitability of each line of business individually. The incentive to deliver value and lower costs for patients is greater when competition between their potential insurers, some of whom may own PBMs, is greater.

Question. Is it possible that United and its PBM, Optum Rx, have inflated drug costs for its Medicaid program by engaging in spread pricing—or creating and pocketing a difference between dispensing fees that PBMs pay pharmacies and the higher rate they bill to state Medicaid programs?

Answer. The Louisiana attorney general has alleged that Optum Rx and United Healthcare engaged in spread pricing in Louisiana's Medicaid program. That allegation is the subject of ongoing litigation, and CBO has no information about the facts of that case. More generally, the use of spread pricing by PBMs in state Medicaid programs is subject to state laws. CBO expects that spread pricing does occur in some states where it is permitted.

PBMs have several possible ways to be compensated for the services they provide to their clients. The degree to which restricting spread pricing would reduce total costs to state Medicaid programs and managed care organizations is unclear, because PBMs could recover lost revenues through other fees.

Question. Reports highlight bipartisan support to investigate what seems to be anti-competitive behavior in the healthcare insurance industry. This is one of the few issues that Democrats and Republicans at the federal and state level can all agree on; don't you agree anti-competitive behavior should be addressed?

Answer. CBO does not make policy recommendations. If anticompetitive behavior among insurers was addressed in a way that reduced consolidation, the incentives for insurers to pass on savings to patients would probably increase. Insurers' bargaining power with providers would probably be reduced—decreasing the amount of savings that could be passed on.[9] Research literature suggests that most health insurance markets in the United States are highly concentrated. For example, a 2023 report by the American Medical Association about commercial markets in metropolitan statistical areas (MSAs) found that 73 percent of MSA-level markets were highly concentrated.[10] Moreover, in 90 percent of MSA-level markets, at least one insurer had a commercial market share of 30 percent or more. And in 48 percent of MSA-level markets, a single insurer had a commercial market share of at least 50 percent.

Question. Since PBMs own their own specialty pharmacies, might this explain why PBMs conveniently neglect negotiating competitive costs on medicines that are disproportionately dispensed at pharmacies they own?

Answer. Although evidence is inconclusive, there are some indications that vertically integrated pharmacies are paid higher prices than other pharmacies for the same drugs. For example, MedPAC examined the prices that four PBMs in Medicare Part D paid for six categories of drugs and compared those prices according to whether the PBM was vertically integrated with the pharmacy and with the plan's sponsor.[11] In most cases, the study found that vertically integrated pharmacies were paid the highest prices, although the authors could not account for payments made by pharmacies after the point of sale. One possible reason for the study's finding is that price markups by pharmacies can be a more attractive revenue generator for a vertically integrated entity than profits retained by the plan's sponsor or the PBM. Regardless of whether common ownership led PBMs to pay higher prices to integrated pharmacies, CBO expects that PBMs would face the same incentive to negotiate rebates from drug manufacturers.

Question. Do you think that markets with more PBM competition and less vertical integration would have experienced less disruption in health system operations in the wake of the cyberattack?

9. Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review*, vol. 102, no. 2 (April 2012), pp. 1161–1185, http://dx.doi.org/10.1257/aer.102.2.1161.

10. American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2023 Update* (2023), https://tinyurl.com/kytajc9m.

11. Medicare Payment Advisory Commission, "Assessing Postsale Rebates for Prescription Drugs in Medicare Part D," Chapter 2 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2023), https://tinyurl.com/2z34jy3v.

Answer. CBO has not assessed whether a different market structure would be more or less vulnerable to cybercrime and is not aware of evidence on that subject.

Question. We know more and more often UnitedHealth Group pays providers electronically rather than by check. We also have heard from providers that those electronic payments require a fee—which looks a lot like a kickback. This sort of arrangement has been publicly linked to Change Healthcare. Another payment processor owned by United, VPay, says in its marketing materials that insurers can "make money on every virtual card transaction." It seems to me that United is financially squeezing independent physician practices from every direction—EFT fees, lower reimbursement rates, network exclusions, increased prior authorizations, coverage denials—thus beating them into submission so United can then buy their practice and expand its physician networks. How possibly is this good for patients?

Answer. Through its subsidiaries, UnitedHealth Group owns and operates several electronic funds transfer (EFT) services that are marketed to both health insurance issuers and providers. Examples include Change Healthcare, VPay, and Optum Pay. ProPublica has reported that those EFT service providers deduct and retain a percentage of the transfer amount from a provider's reimbursement and that 60 percent of medical practices report being compelled to accept EFT transfers with associated fees.[12] CBO has very little information about EFT fees and their impact on patients. The agency is seeking data sources that would allow it to analyze the extent to which providers are being charged EFT fees and the size of those fees.

Minimum medical loss ratios (MLRs) could motivate insurers to align vertically with EFT service providers and impose EFT fees. MLRs, which are applied to many types of health insurance, are intended to limit insurers' administrative costs and profits relative to the costs of the claims they pay for medical care and prescription drugs. From the perspective of a health care provider, paying EFT fees is similar to receiving a smaller reimbursement. From the perspective of an insurer that is vertically integrated with an EFT service provider, imposing EFT fees can be beneficial. In MLR calculations, EFT fees are included as claims costs, which helps the integrated entity comply with MLR regulations while effectively lowering reimbursements to providers. CBO has not assessed other possible motivations for the imposition of EFT fees.

Representative Yakym's Questions About Contract Pharmaceutical Manufacturers and Pharmacy Benefit Managers

Question. There are multiple pharmaceutical contract manufacturers across the U.S. How do these manufacturers play a role in ensuring patients have access to necessary treatments? How could acquisitions of large pharmaceutical contract manufacturers impact drug manufacturing as a whole?

Answer. CBO has not assessed how acquisitions of pharmaceutical contract manufacturers (third parties hired to manufacture drugs for pharmaceutical companies) affect drug production.

Question. There are various policies being considered related to Pharmacy Benefit Managers (PBMs) including delinking, transparency, etc. In CBO's modeling, what generates the greatest budget impact—delinking itself, or enhanced transparency and fee enforcement?

Answer. CBO expects that prescription drug spending would be reduced in some cases if payers (employers and insurers) had more complete information about the operations of their PBM, including the net drug prices the PBM negotiates with drug manufacturers and pharmacies. In general, CBO's approach to estimating the effects of PBM price transparency depends on the parties receiving additional information, the extent to which they could obtain similar information under current law, and CBO's assessment of how useful the additional information would be to its recipient. Additional information disclosed by PBMs would enable some employers to select an insurer, PBM, or drug benefit that better met its particular needs. In some cases, that change could result in lower drug spending and budgetary savings.

Small employers are generally the least informed about the operations of their contracted PBM or about the net prices PBMs pay for drugs. As a result, mandated

12. Cezary Podkul, "The Hidden Fee Costing Doctors Millions Every Year," *ProPublica* (August 14, 2023), https://tinyurl.com/bdhuhhff.

disclosure of information would have the greatest potential benefits for those employers. There would be less potential for savings in Medicare Part D, for two reasons. First, PBMs are already required by law to disclose more information to sponsors of Part D plans. Second, most people covered by Part D are enrolled in plans whose sponsors are vertically integrated with PBMs.[13]

A delinking provision would limit the compensation that manufacturers pay PBMs to bona fide service fees and would prohibit any linkage between such compensation and drug prices. CBO expects that in the commercial market, a delinking policy would be less likely to be effective without a transparency policy, because a PBM could work around the delinking policy more easily if it was not required to report information on net prices and fees to employers. The converse would also be true: The information disclosed to a payer under a PBM transparency policy would be more useful if payments from manufacturers to PBMs were delinked from drug prices or spending.

In Part D, any compensation paid by manufacturers to PBMs other than bona fide service fees must be disclosed and passed on to plans' sponsors along with manufacturers' rebates. Enhanced enforcement of that rule could lead to more accurate reporting, which would increase the amount of fees passed on to plans' sponsors. That increase would reduce bid amounts for plans' expected benefit payments, which in turn would reduce spending in Part D.

13. Medicare Payment Advisory Commission, "Assessing Postsale Rebates for Prescription Drugs in Medicare Part D," Chapter 2 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2023), pp. 91–92, https://tinyurl.com/2z34jy3v.