

Senate Committee on Health, Education, Labor and Pensions

United States Senate

**Making Healthcare Affordable Again Part 2: Perspectives from Employers, Patients,
and Providers**

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Introduction

Chairman Cassidy, thank you for the opportunity to testify today on health care affordability and the possible areas of reform.

The United States health care system is in a deepening affordability crisis. Patients are paying more, employers are paying more, taxpayers are paying more, and too many Americans are finding that health care is harder to access, more bureaucratic to navigate, and increasingly disconnected from the physician-patient relationship. The core problem is not simply that care is expensive. The core problem is that federal policy has allowed the health care marketplace to consolidate, distort prices, and reward institutional power over patient-centered care.

If I could boil the root cause down to one word, it would be 'consolidation'. Hospitals have merged into dominant regional systems. Insurers have vertically integrated with pharmacy benefit managers, pharmacies, and even physician groups. At the same time, independent community-based practices — including community oncology practices — are being pushed out of the market by payment rules, administrative burdens, and reimbursement

structures that favor large systems. Research has consistently shown that consolidation raises prices, limits patient choice, and does not reliably improve quality or outcomes. [1] [2] [3]

This is especially clear in cancer care. Independent community oncology practices deliver high-quality care close to where patients live and work. But when these practices close or are acquired, patients are often shifted into hospital outpatient departments, where the same drugs and services can cost far more. Studies have found that hospital acquisition of physician practices increases prices and spending, and that vertical integration in oncology has shifted care toward higher-cost sites. [4] [5] [6]

The first area of reform is to address hospital consolidation. Congress should implement site-neutral payment reform so that Medicare pays the same amount for the same service, regardless of whether it is delivered in a hospital outpatient department or an independent physician office. Current policy too often pays more because of ownership, not because of clinical complexity. The Congressional Budget Office has estimated that broader site-neutral payment reform could save \$156.9 billion over ten years. [7] That is real money for taxpayers, employers, and patients.

Congress should also reform the 340B Drug Pricing Program. The program was created to support safety-net care, but it has grown far beyond its original purpose. CBO found that 340B drug spending grew from \$6.6 billion in 2010 to \$43.9 billion in 2021, and HRSA reported that 340B purchases reached \$81.4 billion in 2024. [8] [9] Yet hospitals are not required to pass 340B savings directly to patients, and evidence has raised serious concerns that 340B revenue can fuel hospital expansion, acquisition of physician practices, and migration of cancer care into more expensive hospital settings. [10] [11] Congress should require transparency, clear patient eligibility standards, charity care obligations, and safeguards so that 340B benefits patients in need rather than financing consolidation.

Second, Congress must address insurer and PBM consolidation. The largest PBMs are no longer neutral administrators. They are part of vertically integrated conglomerates that own insurers, specialty pharmacies, mail-order pharmacies, and other health care assets. The FTC has found that the largest PBMs wield significant power over drug access and reimbursement, and that the top three PBMs process roughly 80 percent of U.S. prescriptions. [12] [13] This market power lets PBMs design formularies, steer patients to affiliated pharmacies, impose prior authorization, and use reimbursement practices that squeeze independent pharmacies and physician practices.

For patients with cancer, these practices can delay or deny treatment. IQVIA has documented growing oncology access barriers, including formulary exclusions and payer rejections that delay initiation of therapy. [14] Treatment delays are not harmless; a systematic review in BMJ found that cancer treatment delays are associated with increased mortality. [15] Congress should require PBM transparency, prohibit spread pricing and patient steering, delink PBM compensation from drug prices, prevent mandatory use of affiliated pharmacies, and ensure that prior authorization decisions in cancer care are timely and reviewed by physicians with the appropriate specialty expertise.

Third, Congress must fix physician reimbursement and address workforce shortages. Medicare physician payment has failed to keep pace with inflation and practice costs. The AMA has documented that inflation-adjusted Medicare physician payment has declined substantially since 2001. [16] Meanwhile, the Association of American Medical Colleges projects a physician shortage of up to 86,000 physicians by 2036. [17] In oncology, demand is projected to grow as the population ages and cancer survivorship increases. If independent practices cannot remain viable, patients will face longer wait times, longer travel distances, and higher-cost care.

The Community Oncology Alliance also recommends tying physician payment updates to the Medicare Economic Index, eliminating unnecessary sequestration pressure on independent practices, supporting value-based models that work for physician practices, expanding Medicare-supported residency positions, and creating incentives for physicians and nurses to serve rural and underserved communities. These reforms are not about protecting providers for their own sake. They are about protecting patient access.

Fourth, Congress must ensure access to oncology therapies. Patients are facing rising drug costs, shortages of generic sterile injectables, instability in the biosimilar market, and unintended consequences from Medicare drug price negotiation under the Inflation Reduction Act. Generic sterile injectables are essential cancer medicines, yet drug shortages can delay care, force substitutions, and increase costs. ASPE has reported that drug shortages increase consumer costs, and ASHP has found that many drugs in shortage are low-cost generics. [18] [19]

Congress should stabilize the generic sterile injectable supply chain, exempt vulnerable low-cost products from policies that worsen shortages, reward reliable manufacturing, and protect biosimilar access from rebate-driven formulary restrictions. Congress should also pass technical corrections to the IRA so independent practices are not placed in the middle of price negotiations between manufacturers and Medicare. Avalere has estimated that Medicare Part B negotiation could significantly reduce physician add-on payments for drugs, with particularly serious implications for oncology practices. [20]

Fifth, Congress must modernize outdated CMS Medicare policies. Medicare’s siloed payment system too often increases costs and accelerates consolidation rather than supporting efficient, community-based care. CMMI models must be evaluated honestly to determine whether they reduce cost for all, improve quality, and support the practices willing to participate. Congress should also immediately protect the ability of community oncology practices to deliver oral cancer drugs to patients through medically integrated dispensing, including by mail, courier, caregiver, or family member when clinically appropriate. Current restrictions can be especially harmful for elderly, rural, and very sick patients. [21] [22]

Conclusion

The affordability crisis is not inevitable. It is the result of policy choices. Congress can choose a different path: site-neutral payment, real 340B accountability, PBM transparency, physician payment stability, workforce investment, drug shortage reform, IRA technical fixes, and Medicare modernization.

Patients do not experience health care policy in silos. They experience it as a bill they cannot pay, a prescription they cannot afford, a treatment delayed by prior authorization, or a local practice that has closed. My testimony here today offers a practical roadmap to restore competition, lower costs, and protect access to care close to home.

I urge this Committee and Congress to act now — not to protect institutions, but to protect patients.

Thank you.

Citation Appendix

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