

WRITTEN STATEMENT OF TURQUOISE HEALTH

Before the

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON ENERGY AND COMMERCE

Hearing:

“Lowering Health Care Costs for All Americans:

Examining Policies to Increase Health Care Transparency”

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Prepared by:

Carol Skenes

Chief of Staff, Turquoise Health

ONE-PAGE SUMMARY

Turquoise Health is in strong support of the Subcommittee's ongoing work to advance healthcare price transparency and lower costs for all Americans. We offer the following key points:

- Machine-readable files (MRFs) represent the most important public infrastructure investment in healthcare transparency. The data is real, voluminous, and actionable, and is already producing measurable market competition and price convergence.
- The data exists in part to deliver patients upfront, personalized cost estimates, but getting from raw MRF data to a patient-facing price requires solving difficult technical challenges around standardization, bundling, and benefit integration. Turquoise has built supporting infrastructure through Standard Service Packages (SSPs) and patient cost tools.
- Congress should act to close remaining gaps by passing and strengthening federal price transparency legislation, such as the Lower Costs, More Transparency Act of 2026 or the Patients Deserve Price Tags Act. Priority objectives include codifying MRF and stop-loss requirements in statute and extending those requirements to non-hospital providers.
- The Publicly Accountable, Transparent, Interoperable, Efficient, Nonproprietary Transaction Standard (PATIENTS) Framework offers Congress a practical blueprint for both price and process transparency. It focuses on cutting administrative waste from prior authorization, claims adjudication, and contract administration.
- The public wants clear, upfront prices. OpenAI reports that ChatGPT receives two million questions per week about health insurance pricing and benefits¹. Turquoise's consumer platform tripled in engagement between late 2025 and 2026. Congress can help accelerate the AI-enabled transparent consumer experience of the future.

FULL WRITTEN STATEMENT

I. INTRODUCTION

Chairmen Guthrie and Griffith, and distinguished Members of the Subcommittee on Health, thank you for the opportunity to submit testimony in connection with the hearing titled “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency.”

Turquoise Health (Turquoise) is a healthcare pricing and transparency platform founded in 2020 with a mission to eliminate the financial complexity of healthcare. We partner with more than 300 health systems, payers, employers, and life sciences organizations to make sense of MRFs, contracts, and compliance requirements. Our platform supports negotiations and out-of-network pricing for providers and payers, creates hundreds of compliant MRFs and patient estimate tools (PETs) for hospitals and payers, and delivers patient-facing cost comparison tools that give consumers real, personalized price estimates before their appointments. For example, in February 2026, we launched the New York City Health Care Price Comparison Tool with the NYC Department of Health, reaching 83,000 users in its first days.

We are strong supporters of the federal price transparency framework, including the Hospital Price Transparency Final Rule, the Transparency in Coverage (TiC) Final Rule, and the No Surprises Act. These policies collectively represent the most significant investment in healthcare pricing infrastructure in American history. We are grateful for the Subcommittee’s bipartisan commitment to building on them, and the unlocked data is real, vast, and market-changing. But patient-facing transparency has not yet fully arrived, and this Committee, alongside future rulemaking and innovative partners, has an opportunity to close that gap.

Our testimony addresses three themes: (1) what the existing MRF infrastructure has accomplished and why it matters; (2) what it takes to turn raw MRF data into genuine payer, provider, employer, life sciences, and consumer transparency; and (3) concrete legislative and regulatory steps Congress should take next.

II. THE EVIDENCE IS CLEAR: MACHINE-READABLE FILES ARE WORKING

When the Hospital Price Transparency Final Rule took effect in January 2021, requiring hospitals to publicly post their negotiated rates with commercial insurers, skeptics questioned whether the data would be useful. When the TIC Final Rule followed in July 2022, requiring health plans to publish MRFs, the sheer size of those files led to slow parsing and rate confusion. In those early days, it was not uncommon for one major payer's table of contents file alone to be 12 gigabytes compressed. For Turquoise, that reality translates into a monthly ingestion process of up to 300 terabytes of MRF data..

Despite early challenges; however, the data is real and is producing results. Turquoise's independent research, published in a 2024 white paper, analyzed commercially negotiated rates at over 200 hospitals across the ten largest U.S. metropolitan areas, examining 37 common healthcare services from December 2021 through June 2024². The findings are striking:

- Prices are converging. High rates declined by 6.3% annually; low rates increased by 3.4% annually.
- Price convergence was observed in 82.8% of the markets examined.

- Outpatient services showed greater convergence than inpatient services, suggesting that more frequent and more standardized purchasing decisions drive faster market discipline.

In the market, this data is already generating value across the healthcare system. Recor Medical, a medical device company, used Turquoise's facility-level contracted rate data to reopen stalled provider conversations and prioritize market access strategy for a newly FDA-approved therapy³. Self-insured employers who access our data have an average identified savings opportunity of 27% across 500 common healthcare services simply by shopping smarter across existing networks.

The MRF infrastructure has also produced more competitive negotiations. When payers and providers can both see what rates look like across a market, they negotiate based on publicly-available prices, not opacity. For example, MRF data reveals that prices for the same service in the same geographic area can vary by thousands of dollars, depending on an employer's insurance carrier. That data, which was previously not available to employers, brokers, or the wider audience outside of a negotiation, equips employers to make smarter purchasing decisions and creates competitive pressure for payers and providers to deliver high quality clinical outcomes and fair prices.

According to our Hospital MRF Tracker, nearly 95% of hospitals are posting files⁴. The majority of hospitals have adopted the latest file version requirements that went into effect on April 1, 2026, and 72% have adopted both the text file posting standards introduced in 2024 and the newest 2026 schema. Required schema standards dramatically improved data quality and accessibility. Progress on the payer side, while more complex given the volume and variety of data, is also accelerating: Turquoise has assigned transparency scores to 97 payers, and 94% of

payers' files are "highly parsable," meaning they can be automatically ingested and processed⁵. National carriers including Cigna, UnitedHealthcare, and Aetna adopted the new TiC schema required as of February 2, 2026 (Version 2.0 schema), driving significant improvements in file structure, network name adoption, and data consistency. Those improvements make the files easier to parse and ultimately more useful toward accomplishing the goal of consumers and employers' ability to attach the rates to clear provider and plan identifiers.

The conclusion is straightforward: the MRF framework is functioning as intended and is beginning to deliver market benefits. The policy infrastructure Congress and The Departments have built deserves continued support, investment, and strengthening.

III. THE GAP BETWEEN MRF DATA AND PATIENT-FACING PRICES

Despite the progress, MRF data alone does not answer the question patients actually ask: "How much is this going to cost me?" Closing that gap requires solving three distinct technical challenges that existing rules have not yet fully addressed.

A. Code-Level Rates Are Not Consumer Prices

MRFs publish rates at the level of individual billing codes, but many healthcare encounters involve multiple codes. For example, a surgical procedure may involve a facility fee, anesthesia, professional fees, supplies, and follow-up. Some portion of those codes, and not often any single line item, determines what an insurance company would reimburse the provider. Only then, once cost sharing is factored in, will the patient learn what amount is actually owed. Presenting a patient with a list of proprietary CPT or DRG codes and their reported MRF rates is not transparency in any meaningful sense.

Turquoise developed Standard Service Packages (SSPs) specifically to solve this problem. SSPs are open license templates that bundle all the clinical codes, services, and fees associated with a healthcare procedure into a single, claim-like package. Developed by analyzing historical claims data and validated against real encounter patterns, SSPs range from simple services like X-rays to complex encounters like deliveries. Our library currently contains more than 400 SSPs, and each is designed to be locally customizable, consumer-friendly, and “claim-like” in form, meaning a price generated from an SSP reflects what a patient can actually expect to receive as a bill.

Because SSPs are published under an open license, any innovator, health system, payer, or state government can use them to build patient-facing tools without paying licensing fees or accepting proprietary constraints. This open license approach is essential to make consumer price transparency scalably accessible.

B. Benefit Integration Is Required for Meaningful Estimates

Even a well-constructed service bundle price is not useful to an insured patient unless it accounts for individual plan design. A patient with a high-deductible health plan who has met 80% of their deductible may expect to pay a vastly different amount as compared to a patient on the same plan who has met 0%. Meaningful price estimates require real-time integration with benefit accumulators that track a patient’s deductible, out-of-pocket maximum, co-insurance, and co-pay obligations.

Both Advanced Explanations of Benefits (AEOBs) and the convened Good Faith Estimates (GFEs) required by the No Surprises Act were designed to deliver exactly this kind of personalized, all-inclusive estimate. The regulatory machinery to deliver these tools exists, and a

framework like PATIENTS, discussed further in this statement, can work alongside that regulatory machinery to create accurate and scalable cost tools. Turquoise supports establishing firm enforcement dates for AEOBs and convened GFEs, because until those estimates are reliably delivered, patients remain without the binding upfront pricing they were promised.

C. Data Quality Challenges Require Ongoing Regulatory Attention

MRF data, while vastly improved since 2021, continues to exhibit known quality issues that limit maximum usefulness and can mislead consumers and researchers. Turquoise's analysis of payer MRFs found that 28% of payers have more than 50% conflicting rates (meaning multiple dollar values are associated with a single line item), making it impossible to determine which is accurate. Outlier rates, such as a \$0.01 rate for an organ transplant, appear in virtually every file. And network name configurations are often inconsistent or misleading, particularly as payers transition to the new TiC Version 2.0 schema.

These are solvable problems. CMS can address conflicting rates by creating a designated field to identify the specific location of a rate. Regulators can close reporting gaps by adding stop-loss reimbursement data and outlier rate fields to MRF schemas. Turquoise submitted a public comment in strong support of key provisions of CMS's TiC proposed rule, including network-specific files, quarterly data refreshes, a mandatory table of contents file, utilization data, and improved plausibility standards for rate reporting. If the proposed rule is finalized, files would be leaner, more organized, and more useful. Each of those improvements move the industry one step closer towards one trustworthy negotiated rate reported for each clinical code.

IV. THE NYC HEALTH CARE PRICE COMPARISON TOOL: A MODEL FOR WHAT IS POSSIBLE

In February 2026, Turquoise partnered with the New York City Department of Health to launch the NYC Health Care Price Comparison Tool⁶. The tool is the first consumer-facing, all-inclusive price comparison tool in the country powered directly by MRF and cost sharing data. The tool allows New York City residents to search for a healthcare procedure, compare prices across hospitals and ambulatory surgery centers, and calculate their expected out-of-pocket costs based on their specific insurance benefits and accumulators before scheduling an appointment.

The tool reached 83,000 initial users within days of launch. A colonoscopy in New York City costs anywhere from \$500 to \$9,000 depending solely on which door a patient walks through. For the first time, patients can see that variation before making a choice.

The NYC tool demonstrates the full arc from raw MRF data to consumer value: Turquoise's technology ingests, standardizes, and quality-checks hospital and payer MRF data; our SSPs bundle individual codes into complete procedure packages; our benefit integration engine applies real-time eligibility data to personalize the estimate; and a plain-language consumer interface delivers the result. The technology stack is not theoretical. It is live, in use, and in working order.

The lesson of New York City is that price transparency can and should work for patients. The data exists. The technology exists. But scaling this model nationally requires regulatory and legislative action to mandate the standards, enforce the deadlines, and keep the underlying architecture open.

V. THE PATIENTS FRAMEWORK: A BLUEPRINT FOR PRICE AND PROCESS TRANSPARENCY

Healthcare's transparency challenge is inseparable from its administrative complexity challenge. The United States spends nearly 25% of all healthcare dollars on administrative costs, the largest single contributor to excess spending in the system⁷. That waste is the predictable result of a fragmented ecosystem of proprietary billing systems, incompatible payment rails, and opaque contract structures that evolved piecemeal over decades.

Turquoise has developed the Publicly Accountable, Transparent, Interoperable, Efficient, Nonproprietary Transaction Standard (PATIENTS) Framework as a practical blueprint for healthcare administrative reform⁸. PATIENTS seeks to replace the patchwork of proprietary systems between health plans, providers, and intermediaries with unified, open license standards focused on patient outcomes and upfront clarity. The framework addresses both price and process transparency.

A. Price Transparency Components

The price transparency components of the PATIENTS Framework form the foundation for consumer-facing cost tools and a waste-free healthcare transaction based on a cleaner, simpler interaction between providers, payers, and patients. They include:

- **Standard Computable Provider-Group Purchaser Contract:** a standardized, machine-readable contract format that enables automated rate retrieval, comparison, and compliance, replacing the bespoke, paper-intensive contract structures that make rate verification slow and error-prone.

- **400+ Open License Shoppable Service SSPs:** the procedure bundles described above, available to any developer or health system without licensing fees, forming a common vocabulary for what healthcare services cost.
- **x12 and FHIR Crosswalk for AEOBs and Convened GFEs:** technical mappings that allow the existing claims transaction infrastructure (x12) and modern interoperability standards (FHIR) to work together to produce binding upfront estimates.
- **In development:** a Universal Clinical Coverage Library and Standard Plan Design and Benefits Mapping that would allow coverage determinations to be made in real time before a service is rendered.

B. Process Transparency: Cutting Administrative Waste

Price transparency tells patients what care will cost. Process transparency determines how efficiently and predictably care gets authorized, billed, and paid. Today, the gap between those two realities imposes enormous costs on the entire system, creating confusion and misaligned incentives.

Prior authorization is among the most visible symptoms of process opacity. Providers spend billions of hours each year navigating payer-specific authorization requirements that vary by plan, network, service type, and clinical context. There is no standard language for what requires authorization, no standard format for submitting requests, and no standard timeline for receiving decisions. The result is friction that delays care, burns clinical staff time, and drives administrative costs that have nothing to do with clinical quality. A framework built on open license, standardized coverage rules, such as the Universal Clinical Coverage Library in

development under PATIENTS, would give providers, payers, and patients a shared, computable understanding of what is covered before a service is scheduled, reducing the authorization burden at its source.

Claims administration is a parallel problem. The U.S. healthcare system processes billions of claims each year through a tangle of proprietary formats, payer-specific editing rules, and adjudication logic that is largely invisible to stakeholders. Claim denials and subsequent appeals consume valuable resources on both sides of the transaction. The standard computable contract and benefits mapping components of the PATIENTS Framework address this directly. When both parties to a transaction share a machine-readable understanding of the contracted rates, covered services, and applicable plan rules, the space for administrative disagreement shrinks dramatically thanks to fewer denials and faster payment. These outcomes lower administrative costs for everyone.

The PATIENTS Framework's approach to process transparency is grounded in the same open license principle that governs its price transparency components. Proprietary administrative systems for prior authorization, eligibility verification, or claims submission create dependency and cost without adding clinical value. Open standards, by contrast, allow competition on service quality and clinical outcomes rather than on administrative lock-in. This is the model that has driven efficiency in every other sector of the economy that has successfully digitized its core transactions, from banking to airline reservations to supply chain logistics. Healthcare is overdue.

The PATIENTS Framework is aligned with CMS's own Health Technology Ecosystem initiative, and Congress can reinforce this direction by prioritizing open license standards in any

legislation addressing price and process transparency. Fragmented standards that lock service bundles, coverage rules, or claims logic behind proprietary walls obfuscate the market and perpetuate the administrative burden that is pricing care out of reach for millions of Americans.

VI. CONSUMER DEMAND IS REAL AND GROWING

Perhaps the most important signal for this Committee is the evidence of consumer demand.

OpenAI has reported that ChatGPT receives two million questions per week about health insurance pricing and benefits. Why is the demand so high? These new interfaces don't require patients to understand the complicated language of insurance benefits and medical billing.

Patients can use plain language to ask common questions about the cost of care and get relevant responses back. This crosses the engagement chasm that has historically plagued early iterations of PETs and price comparison interfaces.

Turquoise's consumer platform engagement also tripled between late 2025 and early 2026. A new wave of consumer-first applications for plan selection, price comparison, and point-of-service cost estimation is emerging across the industry, driven by the combination of improved MRF data and rising consumer expectation.

Patients are looking for AI-enabled healthcare advice and cost information, despite the challenges posed by the archaic revenue cycle. They want to know what their care will cost before they commit to it. The regulatory and legislative framework to deliver that information is largely in place and innovator development is occurring even faster with new AI capabilities.

What remains is the final push: standardize service bundles as open license infrastructure, finalize the TiC proposed rule, extend reporting obligations to cover the remaining data blind

spots such as stop-loss rates and cash-pay prices for non-hospital settings, and pass federal legislation that locks these gains into statute.

VII. LEGISLATIVE AND REGULATORY RECOMMENDATIONS

Based on our experience processing and using MRF data at scale, Turquoise offers the following specific recommendations to the Subcommittee:

A. Pass and Strengthen Federal Price Transparency Legislation

The existing MRF framework rests on agency rulemaking that can be modified, delayed, or rescinded without congressional action. To ensure that the gains of the last five years are durable, Congress should codify the core MRF requirements in statute. Several bills currently before Congress provide a strong foundation for this work, including the Lower Costs, More Transparency Act of 2026 and the Patients Deserve Price Tags Act. Turquoise urges the Subcommittee to advance legislation that achieves the following objectives:

- **Codify MRF requirements in federal statute.** Hospital and payer MRF obligations should be grounded in law, not solely in rulemaking, to ensure their permanence and provide a stable foundation for the innovation ecosystem that has grown up around them.
- **Extend MRF requirements to non-hospital entities.** Physician groups, ambulatory surgery centers, imaging centers, laboratories, and other non-hospital providers are not currently required to post MRFs. Patients seeking care in these settings, which are often lower-cost alternatives to hospital outpatient departments, are reliant on innovators pulling relevant rates from TiC pricing data. Legislation should close this gap.

- **Mandate the inclusion of self-pay rates.** Hospital MRFs include cash-pay rates, but payer MRFs do not. Any patient without insurance, or any patient whose out-of-pocket costs exceed the cash-pay rate, deserves to know what the uninsured price is at every type of provider, including non-hospital providers. In conjunction with the point above, Federal provider legislation should require self-pay rate disclosure universally, across all provider types.
- **Mandate the inclusion of stop-loss and outlier rates.** High-acuity, high-cost claims represent a relatively small share of total healthcare encounters but a disproportionately large share of total spend, particularly for self-insured employers, for whom a single catastrophic case can reshape an entire plan year. Yet stop-loss reimbursement rates and outlier payments remain known blind spots in the current MRF framework. Neither hospitals nor payers are currently required to include stop-loss thresholds or outlier payment structures in MRFs, and both lack any standardized field for optionally reporting these figures in the status quo. The result is that the cases that matter most financially are precisely the ones for which the transparency data is most incomplete. Congress should include stop-loss reporting in future rulemaking and direct CMS to require that both hospital and payer MRFs include designated fields for stop-loss thresholds, outlier payment triggers, and outlier rate amounts, using standardized definitions applied consistently across all filers. This would give employers, researchers, and regulators a complete picture of what healthcare actually costs at the extremes and close the gap that currently makes high-cost care the least transparent reimbursement category.
- **Establish uniform schema requirements.** The value of MRF data depends in part on comparability. The regulated hospital and payer MRF frameworks are taking the right

steps to minimize schema variations that create barriers to automated analysis. Federal legislation should be in lockstep with the current CMS-led schema requirements to establish and maintain uniform schema standards that are not administratively burdensome to providers and payers. The standards should come with mandatory adoption timelines that make data from hospitals, non-hospital entities, and payers reliably comparable, consistently formatted, and machine-processable without custom engineering for every source.

B. Support Open License Service Bundle Standards

Service bundles that group clinical codes to reflect complete healthcare encounters are the essential link between MRF data and consumer prices. Congress should consider partnering with innovators building open license service bundle methodology that can be used to generate patient cost estimates, available to any developer working alongside providers, payers, state governments, and employers, without royalty or licensing restriction. This prevents proprietary lock-in and ensures that patient-facing price comparisons reflect uniform underlying definitions.

C. Invest in MRF Data Quality and Enforcement Infrastructure

The value of the MRF framework depends on the quality of the data it produces. Congress should support CMS in developing automated quality-checking infrastructure, expanding enforcement of hospital transparency requirements, and creating clear enforcement and remediation pathways for payers with persistent data quality issues such as conflicting rates and implausible rate outliers. State-level enforcement efforts, which are beginning to emerge, should be encouraged and supported with federal coordination.

VIII. CONCLUSION

Healthcare is one of the few major purchases Americans are expected to make without knowing the price in advance. That is not an inherent feature of the system. It is the legacy of decades of opacity that federal policy has been systematically dismantling. The Hospital Price Transparency Rule, the TiC Rule, the No Surprises Act, and the emerging AEOB and GFE frameworks represent a coherent, evidence-based architecture for consumer price transparency.

Turquoise exists because we believe that closing the remaining gap between the data that exists in MRFs and the plain-language, personalized, binding price that a patient deserves before their appointment is both technically achievable and critically important. We have built the technology to do it, and AI will only speed the technology up. The question is whether the regulatory and legislative framework will keep pace and continue this positive momentum.

We urge this Subcommittee to pass durable federal price transparency legislation, mandate open license service bundle standards, strengthen MRF quality requirements, and invest in the process transparency reforms that will finally eliminate the administrative friction at the heart of America's healthcare cost problem.

Thank you for the opportunity to submit this testimony. Turquoise stands ready to assist the Subcommittee with data, analysis, or technical expertise as this important work continues.

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Prepared by:

Carol Skenes

Chief of Staff, Turquoise Health

carol@turquoise.health

Turquoise.health

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Footnotes

¹<https://cdn.openai.com/pdf/2cb29276-68cd-4ec6-a5f4-c01c5e7a36e9/OpenAI-AI-as-a-Healthcare-Ally-Jan-2026.pdf>

²<https://turquoise.health/resources/reports/is-price-transparency-helping-white-paper>

³<https://turquoise.health/resources/case-studies/recor-medical-reimbursement-data-renal-denervation>

⁴https://turquoise.health/mrf_tracker

⁵<https://turquoise.health/transparency-scores/>

⁶<https://pricecomparison.health.cityofnewyork.us/nyc-health/>

⁷<https://hmpi.org/2024/11/19/applying-precedents-thinking-to-the-intractable-problem-of-transaction-costs-in-healthcare/>

⁸<https://open.forpatients.health/docs/getting-started/introduction>