Addressing Health Care Affordability Through Transparency

Evidence on What Works and Areas for Further Congressional Action

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Testimony of Christopher M. Whaley before the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health on June 10, 2026

CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.
[2]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairmen Guthrie and Griffith, Ranking Members Pallone and DeGette, and members of the subcommittee. Thank you for the opportunity to testify today on the role health care price transparency can play in lowering costs for employers and patients, and the policy options available to strengthen it.

My name is Christopher Whaley. I am an associate professor of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on how to reduce health care costs, the role of price transparency, and the impacts of evolving health care markets, particularly on the employer-sponsored insurance market and the Medicare program. The remarks I deliver today are in my personal capacity as an expert on U.S. health care markets and are informed by several recent studies from my colleagues and me examining hospitals, market consolidation, and price growth.

My remarks today highlight the importance of transparency in US health care markets. Today, I will focus on three core areas:

1. The challenges of high and variable health care prices that are not linked to quality;
2. How both price and organizational transparency can address these challenges; and
3. Policy options Congress could consider to improve transparency for patients, providers, employers, policymakers, and the research community.

Over the last two decades, the US health care system has grown increasingly complex. A lack of transparency around both price and organizational structure limits the ability of patients to attempt to navigate the insurance and delivery systems, employers from fulfilling their fiduciary responsibilities, researchers from studying evolving health care markets, and regulators from ensuring competitive market environments. To improve the affordability of the US healthcare system, it is critical for Congress and policymakers to improve both price and organizational transparency.

The Problem: U.S. Health Care Prices Are High, Variable, and Opaque, and Not Linked to Quality

The U.S. leads the world in health care spending. High US health spending is driven by prices, particularly for those with commercial insurance.[3,4] Prices for health care services, particularly hospital care, have outpaced nearly all other industries and sectors over the last two decades. Driven by rising prices, health care affordability is a key concern, particularly for the nearly 200 million individuals with commercial insurance. For a family of four with employer-sponsored insurance, the average annual health

[3] Anderson, Gerard F., Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." *Health Affairs* 22, no. 3 (2003): 89–105. https://doi.org/10.1377/hlthaff.22.3.89.

[4] Anderson, Gerard F., Peter Hussey, and Varduhi Petrosyan. "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt." *Health Affairs* 38, no. 1 (2019): 87–95. https://doi.org/10.1377/hlthaff.2018.05144.

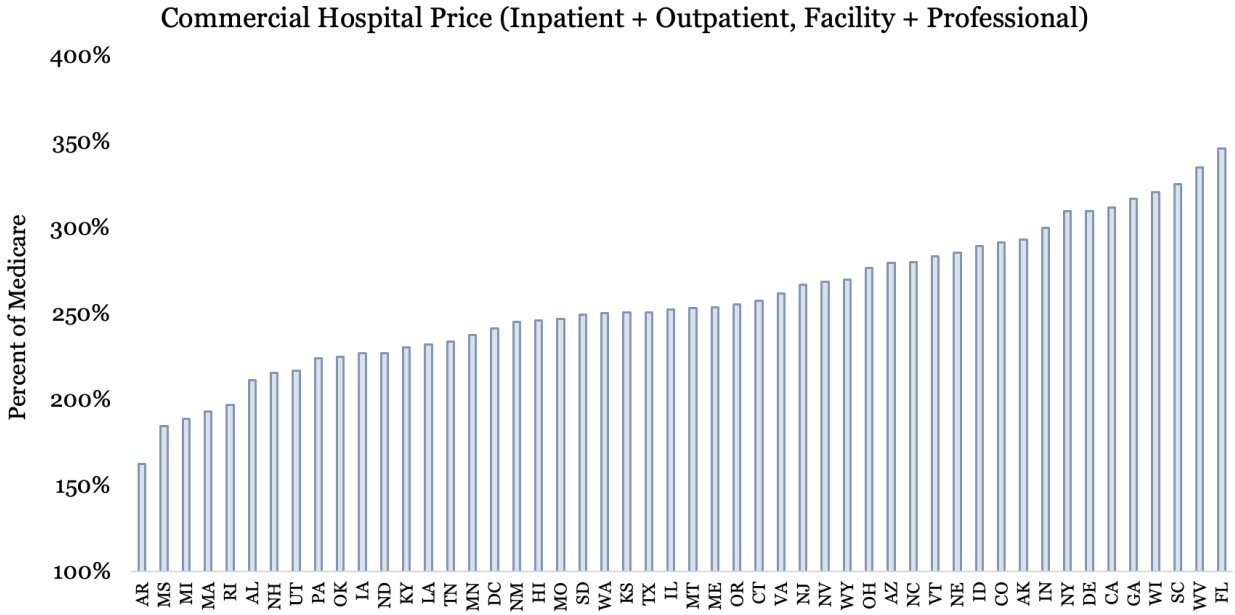
insurance premium is projected to exceed $37,000 in 2026.[5] As health care costs have risen, employers have reduced wages to compensate, creating a direct financial burden on workers, particularly lower-income households.

Health care prices are high and variable, and not linked to quality

Unlike in many other markets, high and variable health care prices are not consistently linked to improved quality. As highlighted in Figure 1, among hospital services, my research shows private insurer prices average 254% of Medicare nationally, ranging from below 200% in states like Arkansas, Iowa, and Michigan to over 300% in states like West Virginia, Florida, and Georgia.[6] At the same time, high and variable prices demonstrate minimal link to better quality of care or greater access to patients.[7,8,9] High and variable commercial insurance prices are also not due to "cost-shifting" or differences in payments by public payers. Yet, these price differences were not always the case. Commercial insurance and Medicare payment rates were once similar, and as recently as 1996, commercial insurers paid hospital rates that averaged just 106 percent of Medicare's corresponding reimbursement levels.[10]

[5] Bell, Deana, Jason Clarkson, Brent Jensen, et al. *2026 Milliman Medical Index*. Milliman, 2026. https://www milliman.com/en/insight/2026-milliman-medical-index.
[6] Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscombe. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative*. 2024. https://www rand.org/pubs/research_reports/RRA1144-2-v2 html.
[7] Cooper, Zack, Joseph J. Doyle Jr., John A. Graves, and Jonathan Gruber. 2022. "Do Higher-Priced Hospitals Deliver Higher-Quality Care?" NBER Working Paper 29809.
[8] Beaulieu, Nancy D., Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams. 2020. "Changes in Quality of Care after Hospital Mergers and Acquisitions." New England Journal of Medicine 382 (1): 51–59.
[9] Crespin, Daniel J., and Christopher Whaley. 2023. "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality." Health Services Research 58 (1): 91–100.
[10] Selden, Thomas M., Zeynal Karaca, Patricia Keenan, Chapin White, and Richard Kronick. 2015. "The Growing Difference between Public and Private Payment Rates for Inpatient Hospital Care." Health Affairs 34 (12): 2147–50.

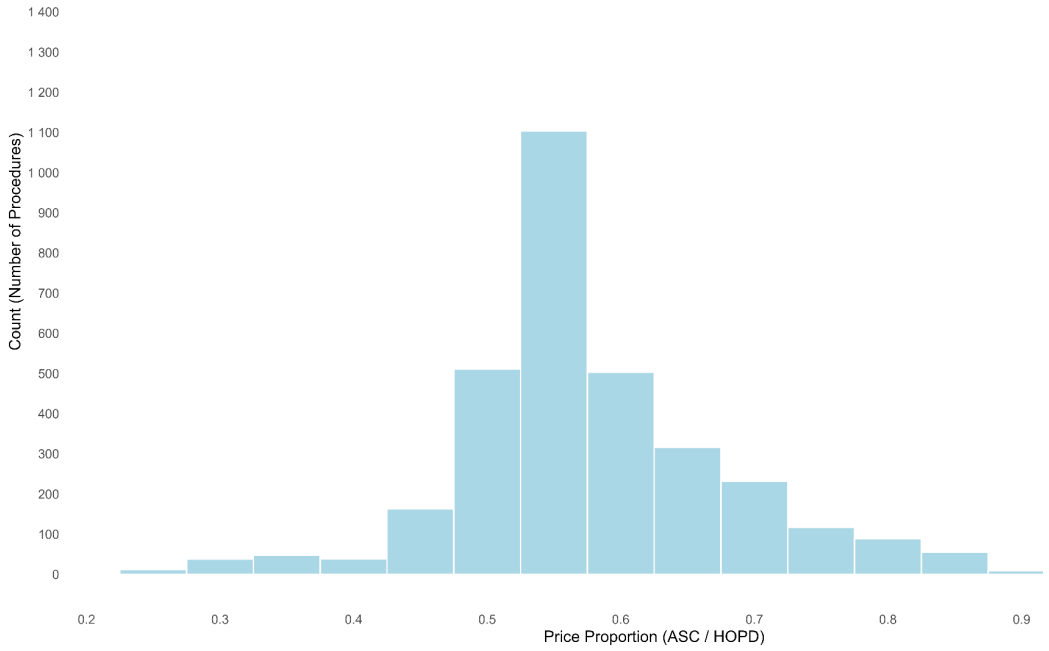
Figure 1: State-Level Variation in Commercial Insurance Prices for Hospital Care, Relative to Medicare



At the same time, prices vary considerably across comparable care delivery settings. For example, both Medicare and commercial insurers pay roughly twice as much for services performed in hospital-based settings compared to non-hospital sites of care. Figure 2 below shows the range of differences in Medicare reimbursement rates for outpatient surgical services between ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs). Medicare payment rates are commonly half when the same outpatient procedure is performed in an ASC, despite better performance in non-hospital settings.[11] These site-of-care payment differences encourage health care consolidation, including by health systems and private equity firms.

[11] Robinson, James C., Christopher M. Whaley, and Sanket Dhruva. "Prices and Complications in Hospital-Based and Freestanding Surgery Centers." *The American Journal of Managed Care* 30, no. 4 (2024): 179–84. https://doi.org/10.37765/ajmc.2024.89529.

Figure 2: Medicare Payment Differences Between Services Performed in Ambulatory Surgical Centers and Hospital Outpatient Departments[12]



Source: Analysis of Medicare outpatient price lookup data, https://www.medicare.gov/procedure-price-lookup/.
Note: The horizontal axis shows the proportion of the facility fee in an ambulatory surgical center (ASC) in proportion to a hospital outpatient department (HOPD). The vertical axis shows the number of procedures with this proportion, based on a sample of 3,410 common outpatient procedures.

Provider consolidation is a key driver of high prices

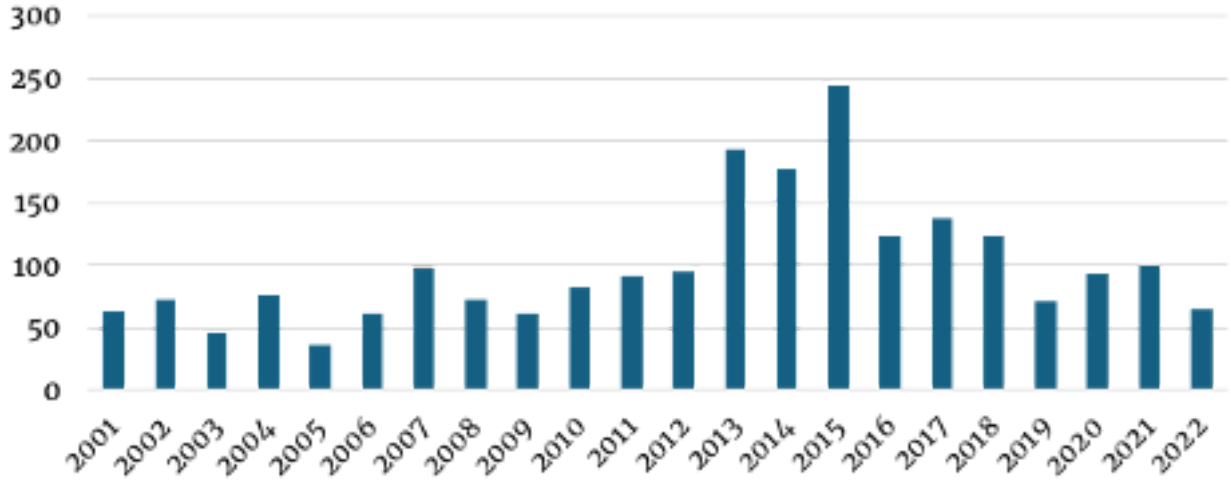
Rising health care prices are influenced and shaped by growing consolidation in the US health care sector. US health care consolidation largely takes three forms:

Horizontal consolidation*:* The organization of both hospitals and insurers has been drastically reshaped by horizontal consolidation over the past few decades. Insurance companies have merged into a small number of dominant firms and are now dominated by the five large "BUCAH" insurers. Collectively, these firms control 80 percent of US commercial health insurance.[13] Partly in response to insurance consolidation, since 2000, approximately 2,000 hospital mergers have led to the emergence of health system conglomerates (Figure 3) and the ten largest hospital systems now account for 22 percent of all hospital beds. Nearly all US hospital markets exceed the concentration thresholds used by the Department of Justice and Federal Trade Commission to identify consolidated markets.[14] Numerous studies link

[12] Richards, Michael R., and Christopher M. Whaley. 2026. "The Current Era of Health Care Consolidation." Journal of Economic Perspectives 40 (2): 93–116. DOI: 10.1257/jep.20251472
[13] Richards and Whaley, "The Current Era of Health Care Consolidation."
[14] Fulton, Brent D. 2017. "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses." Health Affairs 36 (9): 1530–38.

increased hospital market power to higher prices, with post-merger price increases ranging from six percent to over 20 percent.[15,16,17] Importantly, the quality of care does not improve following hospital mergers, and in many cases, it gets worse.[18,19] Hospitals also shift resources to higher-margin commercially insured patients at the expense of Medicare and Medicaid patients, particularly with respect to lower-margin services such as labor and delivery care, harming the viability of safety net and rural hospitals.[20,21,22]

Figure 3: Annual Number of U.S. Hospital Mergers



Source: Analysis of American Hospital Association data

Vertical consolidation of physician practices: Beyond horizontal mergers, hospitals and health systems have also aggressively acquired a growing share of physician practices in recent years. The share of US physicians employed by a hospital or health system has increased by over 40 percent since 2016. This

[15] Gaynor, Martin, Kate Ho, and Robert J. Town. 2015. "The Industrial Organization of Health-Care Markets." Journal of Economic Literature 53 (2): 235–84.
[16] Liu, Jodi L., Zachary M. Levinson, Annetta Zhou, Xiaoxi Zhao, PhuongGiang Nguyen, and Nabeel Qureshi. 2022. Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. RAND Corporation.
[17] Andreyeva, Elena, Atul Gupta, Catherine Ishitani, Malgorzata Sylwestrzak, and Benjamin Ukert. 2024. "The Corporatization of Independent Hospitals." Journal of Political Economy Microeconomics 2 (3): 602–63.
[18] Gaynor, Martin. 2006. "What Do We Know about Competition and Quality in Health Care Markets?" NBER Working Paper 12301.
[19] Beaulieu, Nancy D., Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams. 2020. "Changes in Quality of Care after Hospital Mergers and Acquisitions." New England Journal of Medicine 382 (1): 51–59.
[20] Desai, Sunita M., Prianca Padmanabhan, Alan Z. Chen, Ashley Lewis, and Sherry A. Glied. 2023. "Hospital Concentration and Low-Income Populations: Evidence from New York State Medicaid." Journal of Health Economics 90: 102770.
[21] Arnold, Daniel, Nandita Radhakrishnan, and Christopher Whaley. 2025. "Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization." Preprint, SSRN. http://dx.doi.org/10.2139/ssrn.5265291.
[22] Dranove, David, Martin Gaynor, and Eilidh Geddes. 2025. "Expecting Harm? The Impact of Rural Hospital Acquisitions on Maternal Health Care." NBER Working Paper 34159.

trend is prevalent across all physician specialties,[23,24] and the American Medical Association estimates that over half of US physicians are vertically integrated. As a result, most physicians are employees, rather than owners of their own medical practice firms. This rapid re-transformation of the organizational structure of practice environments has fundamentally changed how US physicians operate.

This ubiquitous rise of vertically integrated physician groups is largely due to financial incentives for exercising greater control over physician referrals, especially when these referral decisions impact the flow of patients and revenues to hospital settings. These incentives are most directly related to site-of-care payment differentials, which are both a cause and a consequence of physician vertical integration. Large difference in payments based on site creates an arbitrage opportunity that directly incentivizes consolidation, in order to redirect or recapture referrals. Directing necessary physician referrals to hospitals and health systems can be a way for these organizations to exploit the opportunities for higher payment for otherwise identical care. My own studies show how this dynamic can both increase health care spending, as well as create access barriers for patients.[25,26,27]

New financing models and corporatization: New models of provider ownership and management, characterized fundamentally by the aggressive entry of new financial actors into the care delivery ecosystem, also threaten affordability and quality. Led predominantly by private equity firms and insurance companies, these entities are driving the integration of previously distinct health care sectors at a scale and velocity that traditional providers lack the capital to achieve independently. Critically, these novel ownership arrangements remain largely opaque, rendering them far less observable to both health care consumers and policymakers than the traditional, horizontal hospital mergers of prior decades.

While private equity has participated in health care markets for several decades—most notably punctuated by the historic 2006 leveraged buyout of the HCA hospital chain[28]—the sheer magnitude of recent capital deployment necessitates rigorous congressional scrutiny.[29] Between 2013 and 2023 alone, private equity

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[23] Nikpay, Sayeh S., Michael R. Richards, and David Penson. 2018. "Hospital-Physician Consolidation Accelerated in the Past Decade in Cardiology, Oncology." Health Affairs 37 (7): 1123–27.
[24] Whaley, Christopher M., Daniel R. Arnold, Nate Gross, and Anupam B. Jena. 2021. "Physician Compensation in Physician-Owned and Hospital-Owned Practices." Health Affairs 40 (12): 1865–74.
[25] Richards, Michael R., Jonathan A. Seward, and Christopher M. Whaley. 2022. "Treatment Consolidation after Vertical Integration: Evidence from Outpatient Procedure Markets." Journal of Health Economics 81 (January): 102569. https://doi.org/10.1016/j.jhealeco.2021.102569.
[26] Whaley, Christopher M., and Xiaoxi Zhao. 2024. "The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics." Journal of Public Economics 238 (October): 105175. https://doi.org/10.1016/j.jpubeco.2024.105175.
[27] Whaley, Christopher M., Xiaoxi Zhao, Michael Richards, and Cheryl L. Damberg. 2021. "Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration." Health Affairs 40 (5): 702–9. https://doi.org/10.1377/hlthaff.2020.01006.
[28] Richards, Michael R., Jonathan A. Seward, and Christopher M. Whaley. 2022. "Treatment Consolidation after Vertical Integration: Evidence from Outpatient Procedure Markets." Journal of Health Economics 81 (January): 102569. https://doi.org/10.1016/j.jhealeco.2021.102569.
[29] Grassley, Chuck. *Private Equity in Health Care Shown to Harm Patients, Degrade Care and Drive Hospital Closures*. January 7, 2025. https://www.grassley.senate.gov/news/news-releases/private-equity-in-health-care-shown-to-harm-patients-degrade-care-and-drive-hospital-closures.

firms deployed an estimated $800 billion to acquire a diverse portfolio of health care providers.[30] At the same time, insurers have also expanded into acquiring physician practices as a way of expanding a "payvider" footprint.[31] This new organizational form raises concerns that plan ownership may influence provider referral patterns, treatment of rival insurer patients, and enable increased Medicare Advantage risk coding.[32] This unprecedented influx of capital has systematically altered the ownership structure of hospitals, physician practices, nursing facilities, and ambulatory surgical centers across the nation.

Several studies link the surge in private equity investment to adverse downstream consequences for both patients and purchasers. Across multiple care delivery settings, studies consistently find that private equity acquisitions lead to increases in provider prices.[33,34,35] These effects are particularly pronounced when investment firms execute "roll-up" strategies—systematically purchasing and consolidating previously fragmented independent practices within a specific geographic market. By accumulating market concentration, these firms successfully maximize their negotiating leverage against commercial payers, driving up health care costs structurally rather than through improvements in clinical quality.[36]

Opacity compounds these problems: Across all forms of consolidation, an underlying theme is the lack of transparent information, both on prices as well as more fundamental insights into organizational structure. Until recently, commercial insurance prices have been largely hidden or protected as "trade secrets" from patients, employers, researchers, and regulators.[37] Even though they provide health insurance for 160 million Americans and have a fiduciary responsibility to ensure plan resources are used efficiently, most employers cannot access their own plan claims data, preventing them from monitoring prices negotiated on their behalf. This lack of plan data exists despite the 2021 Consolidated Appropriations Act's prohibition on gag clauses in health plan contracts. These restrictions limit the ability of employers to be informed purchasers and to ensure access to affordable health care for their workforce.

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[30] Singh, Yashaswini, Megha Reddy, Irene Papanicolas, and Richard Scheffler. "Private Equity Investments in Health Care in OECD Countries: An Exploratory Analysis." *Health Economics, Policy and Law*, January 28, 2026, 1–28. https://doi.org/10.1017/S1744133125100352.

[31] Rooke-Ley, Hayden, Soleil Shah, and Erin C. Fuse Brown. "Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All." *New England Journal of Medicine* 391, no. 2 (2024): 97–99. https://doi.org/10.1056/NEJMp2405438.

[32] Jeffrey Marr, Christopher M. Whaley, and Xiaoxi Zhao. *From Payer to Provider: Impacts of Insurer Vertical Expansion into Physician Services*. April 14, 2026. https://doi.org/10.26300/9XTE-NH94.

[33] Borsa, Alexander, Geronimo Bejarano, Moriah Ellen, and Joseph Dov Bruch. "Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review." *BMJ* 382 (July 2023): e075244. https://doi.org/10.1136/bmj-2023-075244.

[34] Whaley, Christopher, Yashaswini Singh, Erin C. Fuse Brown, Megha Reddy, Jared Perkins, and Hayden Rooke-Ley. *Addressing Healthcare Consolidation in the U.S.: Potential Policy Options for a Competitive and Transparent Future*. 2024. https://doi.org/10.26300/T614-PW72.

[35] Fuse Brown, Erin C., Yashaswini Singh, and Christopher Whaley. *Policy Options to Address the Growth of Private Equity Among U.S. Physician Practices*. 2024. https://doi.org/10.26300/69VX-GZ50.

[36] Asil, Aslihan, Paulo Ramos, Amanda Starc, and Thomas G. Wollmann. 2024. "Painful Bargaining: Evidence from Anesthesia Rollups." NBER Working Paper 33217.

[37] Whaley, Christopher and Erin Fuse Brown. "Comments on the Request for Information (RFI) on building upon and strengthening the Employee Retirement Income and Security Act of 1974 (ERISA)." Committee on Education and the Workforce, March 15 2024, https://drive.google.com/file/d/1RZlOZLOXhCdk1-CPNj7-l8CUxe2cD_iz/view

At the same time, provider ownership structures are complex, opaque, and systematically undercounted, making consolidation difficult to measure and address.[38] The opacity of emerging organizational structures limits the ability of CMS to appropriately monitor and regulate the Medicare program. It also limits the ability of patients to know who their doctor works for and ensure their clinical care is independent of undue financial incentives.

How Price Transparency Can Address High Prices

While not the entire solution, price transparency is important for the performance of the US health care system

Current price transparency efforts have had only modest benefits for individual patients, who, even if they find actual prices, must still navigate a complex medical and billing system to determine true out-of-pocket costs.[39,40,41] On net, patient-focused price transparency tools have not led to savings.[42,43] However, developing policies to improve health care affordability requires information on provider prices. Historically, health care prices have been notoriously opaque to those that pay the bills—employers, consumers, and both state and federal governments. Many commercial payers consider price information to be a trade secret, and gag clauses commonly prohibit disclosure of the prices paid to providers. Research shows that consumers do not often effectively use price transparency to shop for care, in part due to the complexities of the US health care system. In addition, the lack of transparent, usable price information hinders the ability: of researchers to understand competition dynamics and the impacts on cost and quality, of entrepreneurs to develop new benefit design innovations to help control spending, and of policymakers to oversee market conduct and design solutions to protect competition.

Importantly, price transparency should not be seen as the end goal in and of itself, but rather as a tool to drive innovations and competition. Existing transparency data has already generated substantial insights into pricing dynamics, market power, consolidation effects, and cross-market pricing differentials that would otherwise be impossible to observe.

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[38] Singh, Yashaswini, and Erin Fuse Brown. "The Missing Piece In Health Care Transparency: Ownership Transparency." September 22, 2023. https://doi.org/10.1377/forefront.20230921.886842.
[39] Whaley, Christopher. "Health Care Price Transparency: Opportunities to Improve Affordability and Data Effectiveness," before the House Committee on Ways and Means, 118th Cong. (2023) https://www.rand.org/content/dam/rand/pubs/testimonies/CTA2700/CTA2767-1/RAND_CTA2767-1.pdf
[40] Whaley, Christopher, and Austin Frakt. "If Patients Don't Use Available Health Service Pricing Information, Is Transparency Still Important?" *AMA Journal of Ethics* 24, no. 11 (2022): E1056-1062. https://doi.org/10.1001/amajethics.2022.1056.
[41] Mehrotra, Ateev, Michael E. Chernew, and Anna D. Sinaiko. "Promise and Reality of Price Transparency." *New England Journal of Medicine* 378, no. 14 (2018): 1348–54. https://doi.org/10.1056/NEJMhpr1715229.
[42] Desai, Sunita, Laura A. Hatfield, Andrew L. Hicks, et al. "Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees." *Health Affairs* 36, no. 8 (2017): 1401–7. https://doi.org/10.1377/hlthaff.2016.1636.
[43] Desai, Sunita, Laura A. Hatfield, Andrew L. Hicks, Michael E. Chernew, and Ateev Mehrotra. "Association Between Availability of a Price Transparency Tool and Outpatient Spending." *JAMA* 315, no. 17 (2016): 1874. https://doi.org/10.1001/jama.2016.4288.

What transparency has already revealed

Despite the lack of evidence that price transparency drives consumer behavior, price transparency data has had meaningful impacts and allowed for researchers to develop insights into the performance of the US health care system. Several of the insights from price transparency data include:

- Hospitals with for-profit ownership, system affiliation, or location in concentrated markets negotiate higher commercial prices.[44]
- Physician-owned hospitals are associated with 18% lower negotiated prices for common outpatient procedures compared to non-physician-owned hospitals.[45]
- Commercial facility fees at ambulatory surgical centers are approximately 36% lower than at hospitals in the same county, providing rigorous evidence for site-neutral payment reform.[46]
- Insurers with the largest local market share negotiate the lowest rates, 31% lower for lab tests, 24% for radiology, compared to smaller insurers.[47]
- Medicare Advantage prices are less than half of commercial prices negotiated by the same insurer for the same hospital,[48] a within-insurer differential now documented because of transparency data
- Across specialties, PE firms charge prices that are 6% to 10% higher than independent physicians, while hospitals charge prices that are 11% to 20% higher.[49,50]

Continued access to transparent information on prices and ownership structure is critical to our understanding of the evolving US health care ecosystem. These findings directly inform evidence-based policymaking, including site-neutral payment reform, MA oversight, and antitrust review of consolidation.

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[44] Wang Y, Meiselbach MK, Cox JS, Anderson GF, Bai G. "The Relationships Among Cash Prices, Negotiated Rates, And Chargemaster Prices For Shoppable Hospital Services." Health Aff (Millwood). Apr 2023;42(4):516-525. 10.1377/hlthaff.2022.00977

[45] Wang Y, Plummer E, Wang Y, Cram P, Bai G. "Comparison of Commercial Negotiated Price and Cash Price Between Physician-Owned Hospitals and Other Hospitals in the Same Hospital Referral Region." JAMA Netw Open. Jun 01 2023;6(6):e2319980. 10.1001/jamanetworkopen.2023.19980

[46] Wang Y, Wang Y, Plummer E, Chernew ME, Anderson G, Bai G. "Facility Fees for Colonoscopy Procedures at Hospitals and Ambulatory Surgery Centers." *JAMA Health Forum.* Dec 01 2023;4(12):e234025. 10.1001/jamahealthforum.2023.4025

[47] Wang Y, Meiselbach MK, Xu J, Bai G, Anderson G. "Do Insurers With Greater Market Power Negotiate Consistently Lower Prices for Hospital Care? Evidence From Hospital Price Transparency Data." *Medical Care Research and Review*. 2024;81(1):78-84. 10.1177/10775587231193475

[48] Meiselbach, Mark Katz, Yang Wang, Jianhui Xu, Ge Bai, and Gerard F. Anderson. "Hospital Prices For Commercial Plans Are Twice Those For Medicare Advantage Plans When Negotiated By The Same Insurer." *Health Affairs* 42, no. 8 (2023): 1110–18. https://doi.org/10.1377/hlthaff.2023.00039.

[49] Philips, Alexander P., Nandita Radhakrishnan, Christopher M. Whaley, and Yashaswini Singh. "Hospital- And Private Equity–Affiliated Specialty Physicians Negotiate Higher Prices Than Independent Physicians." *Health Affairs* 44, no. 10 (2025): 1226–34. https://doi.org/10.1377/hlthaff.2025.00493.

[50] Singh, Yashaswini, Nandita Radhakrishnan, Loren Adler, and Christopher Whaley. "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications." *JAMA Health Forum* 6, no. 1 (2025): e244935. https://doi.org/10.1001/jamahealthforum.2024.4935.

How Employers, Researchers, Purchasers, and States Have Used Transparency to Lower Costs

Several organizations have successfully used price transparency data, including their own claims data, to inform benefit design and purchasing decisions. Additionally, states have recently used price transparency data to inform state policies around health care markets.

CalPERS (California Public Employees' Retirement System)

The California Public Employees Retirement System (CalPERS) is the nation's largest public pension fund that provides health benefits to approximately 1.4 million people. CalPERS recognized that the wide variation in prices within their network was not tied to clinical outcomes, and worked with their labor representatives to lower costs. Rather than implementing a punitive high-deductible plan, they designed a patient steering program that uses financial incentives to encourage patients to use lower-priced and non-hospital providers. This program was shown to reduce spending by approximately 20 percent and improve care quality.[51,52,53]

State of Oregon Hospital Reimbursement Caps

A similar example comes from the State of Oregon. Recognizing the wide variation in hospital prices, Oregon passed legislation that caps the prices of hospital care at 200 percent of the Medicare rates for Oregon's public employees and educators. CAHPR-affiliated research found that this program led to over $100 million in savings in the first two years of the program, without impacting the quality of care or the provider workforce.[54] We estimate that nationwide adoption of this model could reduce public employee spending by approximately $7 billion, creating opportunities to increase public employee pay or return savings to taxpayers. If extended to the broader commercial market, the model could yield nearly $90 billion in total savings. Oregon has also invested in an all-payer claims database, which allows state authorities to monitor price and spending trends.

32BJ Health Fund

Private-sector organizations are also adopting these innovations. One example is 32BJ, a local branch of the Service Employees International Union (SEIU). Through its Health Fund, which provides benefits to approximately 200,000 service workers in the mid-Atlantic region, 32BJ analyzed claims data and identified providers charging exceptionally high prices. After unsuccessful negotiations to reduce costs,

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[51] Robinson, James C., and Timothy T. Brown. “Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery.” *Health Affairs* 32, no. 8 (2013): 1392–97. https://doi.org/10.1377/hlthaff.2013.0188.

[52] Robinson, James C., Timothy T. Brown, Christopher Whaley, and Emily Finlayson. “Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications.” *JAMA Internal Medicine* 175, no. 11 (2015): 1783. https://doi.org/10.1001/jamainternmed.2015.4588.

[53] Robinson, James C., Timothy T. Brown, and Christopher Whaley. “Reference Pricing Changes The ‘Choice Architecture’ Of Health Care For Consumers.” *Health Affairs* 36, no. 3 (2017): 524–30. https://doi.org/10.1377/hlthaff.2016.1256.

[54] Murray, Roslyn C., Zach Y. Brown, Sarah Miller, Edward C. Norton, and Andrew M. Ryan. “Hospital Facility Prices Declined As A Result Of Oregon’s Hospital Payment Cap.” *Health Affairs* 43, no. 3 (2024): 424–32. https://doi.org/10.1377/hlthaff.2023.01021.

the Health Fund removed one high-priced hospital from its network. This decision generated roughly $100 million in annual savings, which were returned to workers through the largest pay increase in the union's history, along with a $3,000 bonus for each member.[55]

Indiana Employer Coalition

A similar example can be found in Indiana. Through the Employers' Forum of Indiana, we worked with employers to examine their claims data and found that they were paying some of the highest health care prices in the nation.[56] We leveraged price transparency data to evaluate negotiated rates, inform benefit design, and strengthen purchasing decisions. These insights also helped drive legislative efforts to limit facility fees and improve transparency across Indiana's health care markets.[57] Collectively, these initiatives illustrate how price transparency can improve market oversight and support reforms that promote competition and affordability.

While these are notable examples, there are many more entrepreneurs and innovators using price transparency data to develop similar programs. These models steer patients to lower-priced providers,[58] increase competition in health care markets, and modernize payment methods to align incentives between patients, providers, and payers.[59]

The specifics of these policies and programs were designed to fit the needs of each group's market and population. However, each of these groups leveraged price and network data, most commonly from medical claims data, to innovate. These organizations took seriously their fiduciary responsibility to efficiently steward health care spending. Models like these are critical to maintaining affordable access to high-quality providers across the lifespan.

State reference-based pricing policies

Price transparency, including data from all-payer claims databases, are currently being used to inform several state policies around commercial insurance health care prices. Building off of the CalPERS' experience, Montana and Washington limited hospital prices for their public employee health plans to 235% and 200% of Medicare, respectively, resulting in substantial financial savings.[60] Indiana and Vermont have used their own states' data to expand this model to limit hospital prices across *all*

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[55] SEIU 32BJ Healthcare Savings Case Study. Patient Rights Advocate. https://www.patientrightsadvocate.org/seiu-32bj-healthcare-savings-case-study

[56] Abelson, Reed. "Many Hospitals Charge Double or Even Triple What Medicare Would Pay." *The New York Times*, May 9, 2019. https://www.nytimes.com/2019/05/09/health/hospitals-prices-medicare.html.

[57] Wilde Mathews, Anna. "These Employers Took On Healthcare Costs, and the Fight Got Nasty." *The Wall Street Journal*, September 28, 2023. https://www.wsj.com/health/healthcare/these-employers-took-on-healthcare-costs-and-the-fight-got-nasty-54674114.

[58] Whaley, Christopher M., Lan Vu, Neeraj Sood, Michael E. Chernew, Leanne Metcalfe, and Ateev Mehrotra. "Paying Patients To Switch: Impact Of A Rewards Program On Choice Of Providers, Prices, And Utilization." *Health Affairs* 38, no. 3 (2019): 440–47. https://doi.org/10.1377/hlthaff.2018.05068.

[59] Whaley, Christopher M., Christoph Dankert, Michael Richards, and Dena Bravata. "An Employer-Provider Direct Payment Program Is Associated With Lower Episode Costs." *Health Affairs* 40, no. 3 (2021): 445–52. https://doi.org/10.1377/hlthaff.2020.01488.

[60] Murray, Roslyn C., Andrew M. Ryan, and Christopher M. Whaley. "Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented." *Health Affairs* 44, no. 12 (2025): 1482–89. https://doi.org/10.1377/hlthaff.2025.00682.

commercial insurance plans (Hostert et al. 2025). Similar policies are under consideration in other states, including in Delaware, where reference-based price caps have passed the state's Senate chamber this session. States have largely elected to set prices by using " reference-based pricing" as a percentage of Medicare rates because rates are administratively determined to approximate the break-even point for efficient providers and are publicly available (MedPAC 2023). In these policies, states use data on their own markets to design an appropriate and transparent limit to health care prices.

Policy Options to Improve Health Care Price and Organizational Transparency

Improve and enforce Transparency-in-Coverage (TiC) data

In recognition of the importance of price transparency, recent federal policies have sought to expand access to price transparency information. On January 1, 2021, requirements for hospitals to post negotiated prices for select "shoppable" procedures and services went into effect.[61] Following that, on July 1, 2022, a federal rule went into effect that requires health plans to disclose the negotiated prices they pay physicians and facilities for each item they provide, known as Transparency-in-Coverage (TiC) data.[62] Both of these policies greatly expand health care price transparency.

While there have been some concerns with the implementation of the rules, there have been significant positives to each. The insurer-posted TiC data provides the most comprehensive view of U.S. health care prices currently available. While there are continued concerns about the TiC data usability, researchers, including myself, have been able to use data to measure price variation and contract structure. Entrepreneurs are also using these data to improve benefit design innovations. While these data are important, they can also be improved. There are several steps Congress and the federal government could consider to increase price transparency in health care markets and enable this policy to reach its full cost-containment potential.

To improve the TiC data, Congress and federal policymakers can consider the following:

- *Reduce duplication and improve usability*: TiC data currently includes duplicative prices and prices for services that providers do not perform, inflating file size and limiting utility. CMS should require insurers to post prices only for procedures with a history of submitted claims.
- *Limit files to networks vs. plan sponsors*: To further reduce data size, the TiC data should only require posting at the carrier's network level, rather than including duplicate network files for each plan sponsor that uses that network.
- *Limit unnecessary monthly updates*: Rather than complete monthly refreshes, CMS should require updates only when prices change.

[61] Department of Health and Human Services. 45 CFR Part 180. Published November 27, 2019. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180#180.40

[62] Centers for Medicare & Medicaid Services. "FAQS about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49." August 20, 2021. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.

- *Centralize data posting*: CMS should act as a central hub for TiC data, reducing fragmentation, standardizing formats, and substantially expanding accessibility for researchers, employers, and policymakers.
- *Strengthen enforcement*: Only approximately one-fifth of hospitals are currently fully compliant with price transparency requirements.[63] Automated compliance enforcement in 2023 showed that consistent, persistent enforcement works. Congress should codify and expand these efforts, including through increased penalties as proposed in the Hospital Transparency Compliance Enforcement Act. At the same time, Congress should also ensure full insurer compliance with TiC reporting.
- *Ensure full reporting of contracted prices:* Many contracts are paid on an imputed basis (e.g., percent of charges, and per-diem), rather than direct fee-for-service. In such cases, insurers should either post the derived payment amount or the necessary information to fully calculate the payment amounts.

Develop a centralized national database of provider ownership and control

In addition to improving transparency around health care prices, it is critical to improve transparency around ownership and managerial control. TiC data do not contain information on the growing complexity of US health care delivery organizations. The US health care system has grown in complexity over the last two decades. Many ownership and management relationships are convoluted, opaque, and have the potential for conflicts-of-interest. In my opinion, ownership patterns in the health care sector often seem constructed to offer a shield from regulatory scrutiny. It is critical that patients know who their doctor works for so that they can be sure the care advice they receive is independent. At the same time, it is critical for CMS to improve transparency into the organization of the delivery and insurance system to appropriately monitor and govern the Medicare program.

While provider ownership should be reported to the Centers for Medicare & Medicaid Services through the Provider Enrollment, Chain and Ownership System (PECOS) data, observed reporting is often incomplete. In particular, PECOS data do not capture "management services organization (MSO)" arrangements, joint ventures, and other affiliation arrangements prevalent in emergent forms of consolidation, including private equity or insurer-led deals (US Government Accountability Office 2025). While these arrangements may not entail formal ownership, they can nonetheless provide operational control and facilitate consolidation. Thus, the current data systems do not adequately track provider ownership, affiliation, joint venture, or management arrangements, preventing accurate measurement of consolidation and its effects on prices, quality, and access.

Additionally, many private equity transactions and vertical physician acquisitions are too small to require notice to antitrust authorities under the Hart-Scott-Rodino Act.[64,65] In many cases, proprietary databases

[63] Patient Rights Advocate. *The Interim Semi-Annual Hospital Price Transparency Report*. 2025. https://www.patientrightsadvocate.org/interim-semi-annual-hospital-price-transparency-report.
[64] Wollmann, Thomas G. 2020. "How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare." NBER Working Paper 27274. https://www.nber.org/system/files/working_papers/w27274/w27274.pdf
[65] Capps, Cory, David Dranove, and Christopher Ody. "Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene." *Health Affairs* 36, no. 9 (2017): 1556–63. https://doi.org/10.1377/hlthaff.2017.0054.

attempt to close this gap, but these can cost tens of thousands of dollars and often produce inconsistent results. For example, one set of researchers identified 45 PE-acquired gastroenterology practices in a given period while another identified 160 using different data.[66]

In my opinion, the ownership transparency provision in the bills under consideration today—and specifically the bill to require mandatory reporting of health-related ownership information—directly addresses this gap and is critical for effectively monitoring the Medicare system. Congress should require provider organizations to report full ownership, management, joint venture, and related arrangements, creating a centralized, publicly accessible national database.

In addition to these policy goals, I believe the following ways to improve transparency into the US health care system can improve health care affordability and quality:

Codifying Employer and Self-Funded Purchaser Access to Claims Data

A parallel failure of transparency persists in the employer-sponsored market. While Section 201 of Consolidated Appropriations Act of 2021 banned restrictive contract "gag" clauses that prevent employer plans from accessing their claims data, it did not fully guarantee unrestricted data access for plan sponsors.[67] Despite fiduciary obligations to ensure plan dollars are used with the sole purpose of efficiently providing benefits,[68,6970] many employers currently face resistance from their third party administrators (TPAs) who delay or limit access to the data in part because the CAA 2021 only penalizes the employer plan (and not its TPA) for noncompliance. As a result, TPAs have little incentive to comply.[71] TPAs argue they are not ERISA fiduciaries and that their upstream contracts with health care providers, including negotiated prices, are proprietary.[72] This lack of data directly impedes employer plans' ability to monitor the prices negotiated on their behalf, evaluate network performance, and, crucially, fulfill their fiduciary obligations under ERISA.

The current market environment has forced several employers to initiate litigation simply to obtain their own plan data from third-party administrators. The proposed bipartisan legislation to codify this access is a necessary intervention to correct this market failure and should be advanced to ensure purchasers have the data required to function as informed purchasers.

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[66] Singh and Fuse Brown, "The Missing Piece In Health Care Transparency: Ownership Transparency."
[67] U.S. Congress, House, *Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong., (2020) https://www.congress.gov/bill/116th-congress/house-bill/133/text
[68] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 201, 134 Stat. 1182 (2020), https://www.govinfo.gov/app/details/PLAW-116publ260.
[69] Whaley and Fuse Brown, "Comments on the Request for Information (RFI) on building upon and strengthening the Employee Retirement Income and Security Act of 1974 (ERISA)."
[70] U.S. Department of Labor. *Fiduciary Responsibilities*. n.d. https://www.dol.gov/general/topic/retirement/fiduciaryresp.
[71] Handorf, Karen, Christine Monahan, and Kennah Watts. "The 'Patients Deserve Price Tags' Act Would Empower Employers With Information—Is That Enough?" *Center on Health Insurance Reforms, Georgetown University*, October 30, 2025. https://chir.georgetown.edu/the-patients-deserve-price-tags-act-would-empower-employers-with-information-is-that-enough/.
[72] Handorf et al., "The 'Patients Deserve Price Tags' Act Would Empower Employers With Information—Is That Enough?"

Addressing Medicare Advantage Broker Compensation

Recent research from my CAHPR colleagues finds a rapid increase in costs to MA brokers. Annual payments more than doubled between 2014 and 2022, rising from approximately $3.9 billion to nearly $10 billion.[73] The scope of these payments raises the concern that brokers may be unduly steering patients to MA plans from which they receive payments, rather than the plans most appropriate for a given beneficiary. Importantly, 44% of first-time MA enrollees use a broker to navigate their plan selection. Consistent with these concerns, renewal payments, rather than new enrollments, drove 74% of all broker commissions. Brokers are largely being compensated not for assisting beneficiaries in making active, high-value coverage decisions, but rather for simply maintaining existing enrollments. The bill currently before this Subcommittee, which seeks to strictly limit MA broker compensation, directly addresses this potential for conflicts of interest in MA plan enrollment. The bill would also take meaningful steps toward transparency. It would require MA organizations to report enrollment-linked broker compensation data at the individual beneficiary level, with that data housed in the Chronic Conditions Data Warehouse. This would enable researchers and policymakers to better track how broker incentives shape enrollment patterns. The bill further requires the Secretary to make broker compensation information publicly available.

Consideration of Legislative Proposals Before the Subcommittee

Given the significance of these issues to health care system performance, the legislative proposals before this Subcommittee represent a range of evidence-based, comprehensive approaches to addressing the structural transparency gaps outlined above. These bills include:

- **The Lower Costs, More Transparency Act of 2026:** This legislation builds on the version introduced in the 118th Congress by codifying and strengthening existing price and billing transparency mandates, including requirements for hospitals, insurers, and pharmacy benefit managers to disclose cost information to patients and employers.
- **The Patients Deserve Price Tags Act (H.R. 5582):** This bill strengthens and expands existing federal hospital price transparency requirements by extending disclosure obligations to clinical diagnostic laboratories, imaging centers, and ambulatory surgical centers. The bill also requires actual dollar-and-cents pricing, rather than estimates, and it significantly increases financial penalties for noncompliant hospitals and insurers. The bill would also amend ERISA to require third party administrators and pharmacy benefit managers to disclose claims data and fees to employer-based plans. CAHPR research has consistently found that wide and persistent price variation across hospitals cannot be addressed without robust, standardized, and enforceable disclosure requirements.
- **Clear Healthcare Expense Cost Knowledge Act of 2026 (H.R. 9117):** This legislation is designed to increase transparency throughout the healthcare system, empower patients with clear information about their medical costs, and hold healthcare middlemen accountable for hidden fees and opaque billing practices. The bill addresses three complementary transparency gaps: giving employers greater visibility into healthcare spending, strengthening oversight of pharmacy benefit managers and third-party administrators, and requiring providers to furnish detailed itemized bills

[73] Meyers, David J., Jay Shroff, Jeffrey Marr, Em Balkan, Andrew M. Ryan, and Amal N. Trivedi. "Trends in Broker Enrollment and Spending in Medicare Advantage." *JAMA Internal Medicine*, ahead of print, May 18, 2026. https://doi.org/10.1001/jamainternmed.2026.0864.

before seeking payment or pursuing collections—a provision with direct implications for patients navigating complex billing systems.

- **MA Encounter Data Legislation:** Improved MA encounter data is foundational for researchers and policymakers seeking to understand how MA plans negotiate prices, manage utilization, and engage in risk coding practices. CAHPR research on insurer-provider vertical integration, including UnitedHealthcare's physician acquisitions, found that coding intensity increased significantly post-acquisition with no corresponding improvement in patient outcomes, generating an estimated $265 million in additional federal MA spending in 2022 alone. Without complete and reliable encounter data, the full scope of these dynamics remains opaque to researchers, policymakers, and the public**.**
- **MA Broker Compensation Legislation:** CAHPR research finding that Medicare Advantage broker spending reached $10.1 billion has raised serious questions about whether compensation structures are steering beneficiaries toward plans that serve broker financial interests rather than patient needs. Legislative action is particularly warranted given that a federal court vacated CMS's 2024 rule designed to align broker compensation with beneficiary health needs, leaving the agency with limited regulatory tools to address these practices administratively.
- **Ownership Transparency Legislation:** The absence of comprehensive, standardized ownership data makes it extraordinarily difficult to assess how private equity and consolidated health systems influence pricing and care delivery. CAHPR and others have documented this as a critical gap in the current transparency framework. States including Massachusetts and Indiana have moved to fill this void legislatively. Federal action would establish a national floor and enable the kind of systematic, cross-market research needed to inform durable policy solutions.

Conclusion

Health care prices in the United States are high, variable, and opaque. Prices are not consistently linked to quality, and they are in part driven by consolidation and corporatization of the US health care sector. While price transparency is not a panacea for the totality of the U.S. health care system's dysfunction, it is a foundational prerequisite. Critically, it is important to build off of existing price transparency requirements by improving the transparency of evolving organizational structures. Both forms of transparency can improve the abilities of patients, employers, researchers, and policymakers to navigate and improve the US health care system. I believe that the legislation currently before this Subcommittee presents a highly meaningful opportunity to simultaneously advance transparency regarding prices, provider ownership, and market dynamics.