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Before the House Energy and Commerce Health Subcommittee

"Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency"

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Chairs Guthrie and Griffith, Ranking Members Pallone and DeGette, members of the Committee, thank you for the opportunity to testify at this critical hearing focused on solutions to improve health care affordability by ensuring greater transparency across many dimensions of the health care system: pricing, data reporting, ownership structure, insurance coverage decisions, and more.

My name is Sophia Tripoli, and I am the senior director of health policy at Families USA, the longtime national, non-partisan voice for health care consumers. For 45 years, Families USA has been working to achieve our vision of a nation where the best health and health care are equally accessible and affordable to all.

Across the country, America's families are sounding the alarm: the cost of health care is too high, the system is too complex, and relief is desperately needed.[1] An estimated 72.2 million—or nearly one in three[2]—American adults did not seek needed care in the past three months due to cost.[3] When people in the U.S. do seek care, they are burdened with unmanageable costs and often forced to choose between basic necessities, such as housing and food, or paying their health care bills.[4] Now, over 40% of U.S. adults—an estimated 100 million people—face medical debt they may never be able to pay off.[5]

Improved transparency is a key piece to solving the affordability puzzle: you cannot appropriately shop for, negotiate, or regulate what you cannot see.[6] Strengthening price transparency, ensuring more oversight of health industry ownership structures, mergers and acquisitions, and allowing more transparency into Medicare Advantage (MA) and other insurer revenue, claims and encounter data, are all in service of reining in the corporate capture of our health care system that is driving high-cost and low-quality care. **In particular, Families USA strongly supports H.R. 5582, Patients Deserve Price Tags, as well as discussion draft legislation**

before the Committee today that would require mandatory reporting with respect to certain health-related ownership information.

It is important to note that transparency is a necessary but not sufficient step toward delivering meaningful and lasting health care affordability. Ultimately, this Committee should push even further to advance legislation that directly takes on the worst health industry abuses and enact commonsense bipartisan reforms that drive foundational shifts to the way we pay for and deliver health care in this country.[7]

You have the support of the American public as you work to address these issues. Nearly 9 in 10 Americans agree that our country is paying too much for the quality of health care we receive, and nearly half of adults in that same poll said that their most recent health care experience was not worth the cost.[8] The majority of Americans now rate the quality of health care as subpar, giving it a letter grade of a C+.[9]

Polling from Families USA and Hart Research Associates shows that lowering health care costs is the top priority for Americans across demographics, even surpassing concerns related to housing, jobs, crime, and immigration.[10] It should come as no surprise then that over 9 in 10 voters think it is important that Congress and the President act to lower health care costs to reduce stress on family budgets, bring down the cost of living, and to make health care more affordable and accessible to millions of families around the country.[11]

Lack of Transparency Provides Cover to Medical Monopolies and their Unjustifiably High Prices

Importantly, America's health care affordability crisis stems from inflated, and irrationally variable prices across a wide range of health care goods and services, particularly for hospital care and prescription drugs[12]. For example, the price of Humira — a drug used to treat arthritis — is more than four times as expensive in our country as in the United Kingdom and almost twice as

expensive as in Germany.[13] The average price of a hospital-based MRI in the United States is $1,475,[14] while that same scan costs $503 in Switzerland and $215 in Australia.[15]

Prices for the exact same service vary widely, sometimes even within a single hospital system:

- A colonoscopy at the University of Mississippi Medical Center in Mississippi can range from $782 to $2,144 depending on insurance.[16]
- At Aurora St. Luke's Medical Center in Wisconsin, an MRI costs between $1,093 and $4,029 depending on level of insurance.[17]
- The price of an MRI at Mass General Hospital in Boston Massachusetts ranged from $830 to $4,200, depending on the insurance carrier.[18]
- Across the country, the average price for a knee replacement ranges from $21,976 in Tucson, Arizona to $60,000 in Sacramento, California.[19]

What's more, **health care is one of the only markets in the U.S. economy in which consumers are blind to the price of a service until they receive a bill *after* the services are delivered.[20]** Consumers and employers, who are the ultimate purchasers of health care, have limited insight into the prices of health care goods and services. For the majority of Americans (66%) who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans based on who has more market power.[21] These health care prices, often referred to as the negotiated rate, are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[22]

These exorbitant, opaque, and unjustifiable prices are largely due to trends in health care industry consolidation across the U.S. that have eliminated healthy competition and allowed

monopolistic pricing to flourish.[23] Consolidation allows providers, insurers, and other sectors of the health care industry to amass a disproportionate share of market power to set prices, prevent data from flowing and limit provider networks.[24] The result of excessive provider market power is that health care prices are neither value-driven nor equitable.[25] These high prices have no relationship to health care quality and in many cases, the quality of care goes down following a merger or an acquisition.[26] **Unveiling what is currently opaque in our health care system and addressing the impact of consolidation on health care prices is a fundamental step toward controlling health care costs and creating a more fair, equitable, and sustainable system.**

Consolidation Flourishes Under a System that Lacks Transparency, and Patients Pay the Price

Rapid and pervasive consolidation within health care markets since the late 1990s has led to the highly concentrated market power that defines the U.S. health care system today.[27] As it stands, 90 percent of metropolitan statistical areas have highly concentrated hospital markets, 65 percent of those areas have highly concentrated specialist physician markets, and 57 percent have highly concentrated insurer markets.[28]

Importantly, most health care consolidation has not resulted in reduced costs through economies of scale, improved care coordination or quality oversight as industry proponents have argued.[29] In fact, the evidence overwhelmingly confirms that consolidation has produced exploitative markets that drive high prices and costs, without improving the quality of care.[30]

<u>Hospital System Consolidation Drives High Health Prices</u>

Growing and unchecked consolidation in the hospital sector is a major driver of higher health costs, and has allowed corporate health systems to buy up hospitals and physician practices that dominate local markets — and then leverage that power to raise prices and maximize service

volume.[31] **Over the last 25 years, unchecked hospital consolidation has driven up hospital prices by over 220%**.[32]

Recent analysis by Families USA found that a handful of corporate hospital systems in each state now control most of American hospital care.[33] In 42 states and the District of Columbia, just five or fewer health systems in each state controlled at least half of all hospital care in 2023.[34] In nearly half of all states, just three systems controlled the majority of care that year. This level of consolidation gives major hospitals the ability to set prices with no meaningful competition or accountability.[35]

Our analysis confirms that large hospital systems use their market power to charge far more than the Medicare rate, the only national, evidence-backed standard for fair pricing.[36] From 2018 to 2023:

- The 15 largest systems in the country charged on average 2.82 times what Medicare paid for the exact same services.
- Those big systems also raked in an average of more than $22 million in net income per hospital per year.
- No state was spared. Average commercial hospital prices in every state were higher than what Medicare paid for the same services, with average commercial prices in each state ranging from 157% to 365% of the Medicare rate. The most expensive states — Colorado, Florida, Georgia, New Mexico, South Carolina, West Virginia and Wisconsin — had average hospital prices ranging from 320% to 365% of the Medicare rate for the same services.

The biggest systems also earned the most. Individual hospitals owned by a health system generated nearly 10 times more in annual net income ($27.7 million) than independent hospitals

not owned by a health system ($3.0 million). Rural independent hospitals generated the lowest average net income ($2.3 million).

Particularly large and expensive systems from our analysis include the following:

- HCA Healthcare, the largest for-profit health system in the United States, operated 158 hospitals from 2018-2023 across 20 states, charged an average of 339% of the Medicare rate for hospital services, and generated $70.3 million in annual net income per hospital.
- CommonSpirit Health, a Catholic health system that is currently the largest nonprofit hospital system in the country, operated 140 hospitals in our sample across 17 states, charged an average of 306% of the Medicare rate for hospital services, and generated $17.4 million in annual net income per hospital.

High hospital prices have resulted in a 320% increase in family health insurance premiums since 2000.[37] Moreover, these high hospital prices come directly out of workers' paychecks in the form of higher premiums and out-of-pocket health care costs, which have resulted in nearly $1 trillion in lost workers' wages since 2012.[38] As a direct result, Americans are increasingly struggling to manage rising health care expenses and are fearful of what a medical emergency could mean for their finances.[39]

Consolidation and Vertical Integration Provide Inflated Payments to Private Insurers and Medicare Advantage Plans

Over the last 60 years, the role of health insurers and the business of health insurance has changed dramatically.[40] What started as a system of independent local health plans with a mission to provide high-quality, affordable health care to communities has radically shifted into a multitrillion-dollar industry in which large health insurance corporations are laser focused on increasing their revenues and profits while doing everything they can to minimize their costs and

expenditures.[41,42,43] Insurers who sell Medicare Advantage (MA) plans are no exception, adopting a core business model that leverages the MA program to maximize Medicare payments from the federal government while minimizing the costs they incur for providing care to older adults.[44] As a result, insurers make nearly double the profit per enrollee in the MA market than they do in the commercial market, draining our nation's federal health care resources.[45]

A key strategy of large insurance corporations is to manipulate the Medicare payment system to secure inflated payments from Medicare, including through the systematic upcoding of patient diagnoses that often do not reflect the actual care that beneficiaries receive, all while restricting patient access to care through the use of narrow provider networks and prior authorization to reduce insurers' health care spending.[46] MA insurers can pocket a growing portion of those inflated payments as profits, while using the remaining portion to offer low-value benefits that sound attractive to persuade Medicare patients to enroll in their plans.[47] This business model is costly and wasteful for the federal government and bad for the health and well-being of our nation's older adults.[48]

Dramatic consolidation in Medicare Advantage, between health insurers (horizontal integration) as well as between insurers and health care provider groups and other health care entities (vertical integration), has resulted in nearly 80% of the Medicare Advantage market being controlled by just five large insurance corporations: UnitedHealthcare, Humana, CVS Health/Aetna, Elevance Health (formerly Anthem) and Kaiser Permanente.[49] As of 2024, nearly all Medicare beneficiaries (95%) lived in counties with highly concentrated MA markets.[50] This means that while beneficiaries may seemingly have access to more MA plan choices, these plans are mostly controlled by the same five dominant health insurer parent companies, limiting meaningful plan choices for beneficiaries.[51] This unchecked consolidation undermines healthy competition

and allows MA insurers to focus on minimizing their costs and expenditures to the detriment of improving health care quality, making care delivery more efficient, or lowering premiums and offering more benefits.[52]

Unchecked consolidation in the MA market has also allowed insurers to subvert medical loss ratio (MLR) requirements, one of the few tools policymakers have to ensure taxpayer dollars are spent on patient care rather than insurer profits, marketing or executive salaries.[53] Plans that directly employ providers can more easily game medical loss ratio requirements. MLR requirements are critical patient protections put in place under the Affordable Care Act to ensure the majority of premium dollars (85%) are spent on health-related expenses and not an insurance company's administrative costs or profits.[54] However, because provider practices are not subject to MLR requirements, once a plan acquires a provider group, the insurance plan can then pay those providers above market rates and report that amount as a medical cost even though those payments ultimately result in additional profit for the parent company beyond what the MLR requirement would otherwise allow.[55] By making medical spending look higher on paper, MA plans can continue to meet MLR requirements while diverting a larger and larger share of their Medicare payments toward their profit margins and away from patient care.[56] In fact, some estimates suggest that vertically integrated plans could be spending as little as 70% of their premium dollars on patient care.[57]

Private Equity's Role in Destabilizing the Health Care Delivery System

Widespread consolidation across the health care system has been compounded by the growing role of private equity (PE) firms over the last decade. Once largely uninvolved in the U.S. health care system, PE firms are increasingly purchasing and reselling a variety of health care provider organizations in order to make short term profit, largely to the detriment of the financial

well-being of those providers and ultimately to health care access and affordability in a community.[58] In 2020, health care became the second largest sector for private equity investment, accounting for 18 percent of all reported deals, up from 12 percent in 2010.[59] Private equity investors spent more than $750 billion on health care acquisitions between 2010 and 2019.[60]

The business model of private equity firms is fundamentally misaligned with ensuring that our nation's families have the high-quality, affordable, and equitable health care they need and deserve. PE firms often apply a very short-term profit driven business model (a three-to-seven-year period) to their investment strategy, characterized by buying a health care entity that is struggling financially or offers short-term growth potential, investing in it, saddling it with debt, and then selling their stake to generate profit.[61]

Further, recent studies show that PE ownership is associated with a number of harmful health care impacts, including but not limited to:

- Decreases in health care quality and patient safety: PE owned hospitals experience a 25% increase in hospital-acquired conditions, including a 27% increase in patient falls and an almost 38% increase in infections.[62] Researchers say that these outcomes may be partially due to "decreased staffing, changes in operator technique, poorer clinician experience," among other potential causes;[63]
- Increases in health care prices and charge-to-cost ratios:[64] PE owned hospitals charge $400 more per inpatient day on average compared to non-PE owned hospitals;[65] and
- Increased out-of-network costs due to PE firms buying up specialty physician staffing firms.[66]

High Health Prices Impact Not Just Patients, But Also Taxpayers and the Economy

High and rising health care costs not only threaten the health and financial security of patients and their families but are also a critical problem for the federal government, state governments, and taxpayers. National health expenditures (NHE), which includes both public and private spending on health care, have grown from $27.1 billion in 1960 to *$5.3 trillion* in 2024.[67] Relative to the size of the economy, NHE grew from 5% of gross domestic product (GDP) in 1960 to 17.4% in 2022.[68] The largest proportion of this spending is on hospital care, which accounts for a 31 percent share at a whopping $1.6 trillion annually.[69]

And the situation is expected to get much worse with NHE projected to climb to $8.5 trillion by 2033, and high and rising health care costs projected to continue to grow faster than the economy, hitting over 20% of GDP by 2033.[70] That means over a fifth of our economy will be spent on health care. This far outpaces what similarly situated countries spend on health care: On a per capita basis, the U.S. spent $14,775 in 2024 – over $4,000 more per person than any other peer nation.[71]

High Prices are Unrelated to Health Care Quality and Health Outcomes

What makes the extraordinarily high cost of health care particularly egregious is that spending has no relationship to the quality of care or health outcomes. The U.S. has some of the worst health outcomes and lowest levels of access to care compared with other Organization for Economic Co-operation and Development (OECD) countries.[72] One of the best indicators for the quality of a health care system is avoidable mortality — the measure of preventable and treatable deaths that could be avoided with timely and effective interventions. The U.S. has substantially higher avoidable mortality than the average of other OECD countries in 2025. In the U.S., the number of preventable deaths was 217 per 100,000 people, compared with 145 per 100,000

people in OECD countries on average.[73] The number of treatable deaths in the U.S. was 95 per 100,000 people, compared with OECD's average of 77 per 100,000 people.[74] In other words, despite the fact that hospital and physician care account for half of U.S. health care spending,[75] the system fails to provide timely and effective interventions to save Americans' lives.

In fact, sometimes hospital care makes people sicker. On any given day, 1 in 31 hospital patients have at least one healthcare associated infection.[76] Our health care system also has worse health outcomes than other advanced countries as evidenced by having among the lowest life expectancy, the highest rates of infant mortality and among the highest rates of maternal mortality compared with other industrialized nations.[77]

In many cases, consolidation itself is directly associated with reductions in health care quality.[78] For instance, one study found that mortality risk among heart attack patients is significantly higher in more concentrated hospital markets.[79] On top of that, consolidation often leads to reduced geographic access to needed providers, which can contribute to longer travel times and serious health consequences, particularly for rural communities.[80] For example, rural hospitals that merge with larger hospital systems are more likely to eliminate key service lines in primary care, maternal and neonatal health, surgery, mental health, and substance use disorder services post-merger, significantly reducing access to critical health care services and threatening the health and well-being of rural communities.[81] Moreover, increasing the distance to the nearest site of health care can result in people living in all types of communities not getting the care they need due to a lack of transportation or the time needed to get there, disproportionally affecting the elderly, racially and ethnically marginalized groups, those with low incomes, and people with disabilities.[82]

Congress Should Fix our Broken System and the Financial Incentives to Get Bigger, Not Better

It does not have to be this way. We know what the major drivers of high and irrational health care prices are, and we know how to fix them. This committee has previously examined the lack of transparency and competition in our health care system and the roles of large hospital systems, insurers, and drug companies in driving rising costs. In the 118th Congress, the Committee worked with colleagues in the House of Representatives to pass the *Lower Costs, More Transparency Act of 2023*, which would have made crucial progress by codifying and strengthening price transparency rules, expanding site neutral payments, and advancing billing transparency, among other reforms. While that bill never made it to the Senate floor, some of its key provisions have since been passed into law and advanced by the administration. Yet much more is needed to meaningfully address the root causes driving unaffordable American health care. **Congress must waste no more time in taking on the health care industry's anticompetitive behaviors and the misaligned incentives that are driving up costs for families in order to provide real relief to the American people.**

To that end, we support today's discussion and consideration of legislation that aims to pull back the curtain on opaque health industry behavior and begin to remedy some of our most obvious health system failings.

Strengthen Price Transparency

Unveiling prices is a critical step towards achieving truly affordable health care, improved health, and more competitive health care markets across the U.S. health care system. Price transparency pulls back the curtain on prices so that policymakers, researchers, employers, and consumers can see how irrational health care prices have become and take action to rein in pricing abuses.[83] Furthermore, unveiling prices can specifically inform where the highest and most

irrational prices are occurring in the health care system, so policymakers can implement targeted policy solutions to bring down the cost of health care.[84]

The American public is in broad agreement about the need for action on price transparency. Polling shows that a large majority (95%) of the public say it is important for Congress to pass a law to make health care costs more transparent to patients, including 60% who call this a top priority.[85]

In fact, consumer advocates have long sought transparency in health care prices. Following years of consumer advocacy, the Center for Medicare and Medicaid Services (CMS) finalized the Hospital Price Transparency Rule and the Transparency in Coverage Rule, which require hospitals and insurers respectively to disclose health pricing information, including their negotiated rates, and to provide consumer-friendly online tools to allow consumers to compare prices and estimate out-of-pocket costs.[86] But many large hospital corporations have bucked the federal requirements and are actively working to keep their prices hidden.[87]

The committee should take action to ensure that all Americans, and particularly older Americans who heavily rely on the health care system, should be able to know the price of health care services at a hospital or health care facility *before* they receive care.

H.R. 5582, the Patients Deserve Price Tags Act, is strong, bipartisan legislation that would make meaningful progress in price transparency by making clear, without any exception, that all hospitals and insurers are required to post the underlying price of health care services, in dollars and cents and in a machine readable and consumer-friendly format. Most importantly, this bill builds upon previous price transparency efforts by:

- **Codifying and strengthening hospital price transparency and Transparency in Coverage requirements.**
    - Requires negotiated rates (standard charges) in dollars and cents
    - Expands requirements to imaging centers, diagnostic lab tests, ambulatory surgical centers, and drugs covered by health plans
    - Requires the secretary to establish a uniform format
    - Establishes monetary penalties and penalties for consistent non-compliance
    - Explicitly bars the Secretary from waiving penalties
- **Building on the No Surprises Act (NSA) Advanced Explanation of Benefits (AEOB) requirements** by requiring insurers to provide patients an updated explanation of benefits within 30 days of a provider billing an insurer for the service after such service was delivered.
- **Establishing that a health care provider or facility must include an itemized bill** of the cost of each reasonably expected item or services provided to the patient no later than 30 days after the provider or facility received final payment on the service from a third party.

We urge the Committee to advance the *Patients Deserve Price Tags Act* without delay.

Also under consideration today, the ***Lower Costs, More Transparency Act of 2026,*** unfortunately misses the mark. While we appreciate the bill's stated objective of improving price transparency, the bill undercuts this shared bipartisan goal by backtracking on key provisions in the same-named 2023 legislation passed by the House. As written, the bill would codify the status quo that enables hospital systems to continue to undermine the intent of the price transparency regulation by allowing the Secretary of Health and Human Services to waive requirements to publish negotiated rates in dollars and cents. For these reasons, **Families USA would have to**

oppose the discussion draft of this bill as written, and we encourage the Committee to amend this provision before advancing this legislation. Further, the bill lacks the strong consumer guardrails included in H.R. 5582, making it the less preferable approach to delivering meaningful up-front prices and price transparency for health care consumers.

Lastly, under consideration is proposed legislation ***H.R. ___, [To amend title XXVII of the Public Health Service Act to require hospitals to post prices on the walls]*** that requires every hospital to publicly post discounted cash prices on their hospital walls. This bill also misses the mark in achieving meaningful price transparency, and only serves to waste hospital administrative resources and divert hospitals' attention away from meaningful efforts to provide consumers with up-front pricing information.

Ensure Transparency in Ownership

Additionally, we urge the Committee to improve transparency around ownership interests of health care corporations, such as private equity.

H.R. ___, [To amend title XI of the Social Security Act to require mandatory reporting with respect to certain health-related ownership information] is discussion draft legislation that would strengthen oversight efforts and enable policymakers to better understand increasingly consolidated health care markets and the corporate interests that drive them.

This bill would allow critical insight into business structures of large health care entities, including data on mergers, acquisitions, and ownership changes for the previous 1-year period; parent company ownership; hospital average debt-to-earning ratios; and in the case of a nonprofit hospital or entity: capital gains investments and taxes paid on gains from such investments.

Without insight into ownership structures and how profits from health systems are ultimately being funneled, regulators find it very difficult to conduct appropriate oversight over health care transactions that do not meet federal thresholds for Federal Trade Commission (FTC) review, and therefore are not subject to the scrutiny needed to determine the impact on market dynamics including on health care access, costs and quality. Ownership transparency is the first step in being able to rein in the role of private equity firms and other health care corporations, including their ability to purchase health systems to drive profits through upcoding, surprise billing, and other questionable business practices. **We are strongly in support of this bill and urge the Committee to advance it for consideration on the House floor.**

Bolster Transparency in Medicare Advantage and the Private Insurance Market

Unveiling opaque behaviors and machinations of Medicare Advantage plans and other private insurers is essential to ensuring our seniors and future generations have access to the health and financial well-being they deserve.

Policymakers should prioritize strengthening Medicare Advantage encounter data to reform MA payment — shifting from risk adjusting payments based on documented diagnoses to those based on validated services delivered, conditions treated, and other high quality, less gameable data, that accounts for the true differences in health care costs between healthier and sicker populations. A major flaw of the current system is that it increases payments to plans with patient populations that appear sicker on paper, incentivizing them to document high volumes of diagnoses that too often are unconnected to actual care or patient acuity in order to receive significant overpayments.[88] Encounter data offers a more complete picture of patient interactions and can serve as a critical validator — identifying where documented diagnoses fail to correspond

to services rendered.[89] Although MA plans are already required to submit encounter data to CMS, incomplete submissions have undermined payment reform efforts.[90] Stronger CMS enforcement is needed to ensure encounter data files are complete and current.

Encounter data is equally critical for understanding the misuse of prior authorization and the marketing of supplemental benefits in MA. Transparency is the foundation of effective program oversight — it enables targeted policy solutions to lower costs for Medicare and beneficiaries, remove unnecessary barriers to care, reform prior authorization to improve efficiency, and eliminate prior authorization for services with little clinical value. The discussion draft legislation under consideration, ***H.R. ___, [To amend title XVIII of the Social Security Act to require the inclusion of certain information in Medicare Advantage encounter data]***, would expand what data MA plans must submit to CMS, which would increase transparency on cost-sharing and allowed amounts. Families USA supports this proposal as written and urges the committee to go further by establishing comprehensive metrics to evaluate encounter data completeness overall, and impose financial penalties on plans that fail to keep their data complete and up-to-date.

Additional discussion draft legislation before this committee, ***H.R. ___, [To amend title XVIII of the Social Security Act to limit the compensation that may be paid to agents and brokers by Medicare Advantage organizations]***, would address perverse financial incentives in MA by limiting compensation that agents and brokers receive for enrolling individuals in MA plans — including protections against steering beneficiaries toward plans based on these financial arrangements rather than patient need. Families USA supports capping agent and broker compensation and believes it is essential to ensuring these entities are not exploiting their trusted role in the enrollment process.

Families USA also seeks more insight into how plans are spending dollars, and into plan usage of prior authorization and denials, which are all important for both public accountability and the ability of consumers to compare plan options. ***H.R. ___, [To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to require the displaying of claim denial rates]***, would improve understanding of which plans are requiring prior authorization most frequently, which services are most often subject to them, and how often prior authorization requests are eventually approved. ***H.R. ___, [To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments]***, would improve health insurer accountability through publishing of overhead costs and claim payments. Private plans are already required to submit this information to HHS, but new transparency provisions, combined with requiring Medicare Advantage plans to publicly report this information, would provide meaningful insight into MA payments.

H.R. 9117, the Clear Healthcare Expense Cost Knowledge (CHECK) Act, is also a critical step in ensuring better oversight of third party entities that work with MA and other private insurers, including third-party administrators, pharmacy benefit managers, and prior authorization organizations. By requiring providers, insurers, and third party administrators to make health care information, including prices and payments, available to more actors in the system, including patients and their insurers, this bill would make meaningful progress toward creating real transparency in what services patients are receiving and what they're being charged for those services. In particular, the prohibition on collections actions for providers and facilities that do not

clearly communicate the prices for their care ahead of time is very helpful for holding patients harmless for hospitals' and providers' poor communication.

Congress has the Power to Fix our Broken System – And Families Can't Afford to Wait

Over the last year there has been growing bipartisan momentum in Congress to advance policies that improve health care system transparency, end pricing abuses, and deliver on promises to make health care more affordable. Congress has a clear and immediate opportunity to put the needs of families ahead of the demands of corporate greed. And people all across the country are desperately awaiting action.

Consider the story of Danielle from West Virginia, whose son's pediatrician's practice was taken over by the state's largest hospital system in 2024:

> *Shortly after the ownership change, a routine case of strep throat brought them in for a throat swab and prescription. After a short visit, Danielle paid her copay and left. Weeks later, she received a bill for more than $500. When she called the hospital billing office, she was told one charge was the doctor's fee and the other was a "clinic fee" for using that facility. No one explained what that facility fee covered, why it existed, or why it doubled the cost of the visit.*
>
> *A few months later she found herself once again strapped with unexpected and unexplained charges after her son's annual wellness visit, a visit she assumed would be fully covered. Yet she received a bill for more than $1,200: $175 for the physician fee, fifty cents for albuterol, $700 for a breathing treatment her son did himself, and another $300- $400 for the facility fee.*

Danielle appealed the charges and eventually the hospital removed the facility fee for that visit, calling it her "first offense." What troubles her most is the lack of transparency, and how easily families can be blindsided: "Hospitals don't post the fees, they don't tell you what they're for, and they can change them at any time." She worries that as hospital systems grow larger, families in rural and low-income areas will suffer: "They're buying up everything. If every place around here charges a facility fee, how are families supposed to afford basic care?"

Consider too the story of Jessica from Arizona, who needed endoscopy and colonoscopy procedures to identify the cause of gastrointestinal bleeding, a potentially life-threatening condition:

With a history of cancer, Jessica knows all too well that every delay in care matters. But as someone who lives paycheck to paycheck, she also knows she can't afford to schedule a procedure unless she knows she can pay for it. "I have to make decisions based on what I can financially afford," she said. "And I don't have time to be wasting."

When she inquired about her options, Jessica was told she needed to contact her insurer, who advised her to search for a stand-alone facility to avoid additional hospital or facility fees. She tried to shop around, contacting ambulatory surgery centers, tracking down which doctors operated at which facilities, and calling her insurer to compare prices. The burden of navigating the system fell entirely on her. "It's time and energy I shouldn't have to spend," she said. And what's worse, she hit the same wall again and

again. "They hit me with the most ridiculous thing, saying 'We can't give you a cost estimate.'"

Even after identifying a potentially affordable ambulatory surgery center, Jessica still could not obtain a specific price. She was told she would need to establish care with a new doctor, secure referrals, and undergo preliminary testing before receiving an estimate. "I still don't have a price. I don't have a ballpark idea," she said. "So again, I have to prolong this to try to get the cash to be in a financially good place to do it."

The American People Want Action

We urge the House Energy and Commerce Committee to advance an agenda that prioritizes health care affordability for American families and holds corporate health systems accountable for charging excessive prices. Many of the solutions being discussed today have strong support[91] from the public:

- Strengthening hospital and health plan price transparency by requiring all hospitals and health plans to disclose their negotiated rates in dollars and cents with no exception. (91% of Americans support)
- Requiring Medicare Advantage insurers to submit high-quality and complete encounter data to promote meaningful transparency in the Medicare Advantage program so that CMS, lawmakers, and the public understand to what extent Medicare Advantage insurers are delivering affordable, high-value care. (82% of Americans support)
- Requiring greater transparency around the role of private equity and corporate ownership in health care to ensure all Americans, including those in rural communities, have access to the health care they need at a price they can afford. (83% of Americans support)

- Reducing conflicts of interest among health plans that employ their own providers by strengthening ownership transparency and medical loss ratio (MLR) requirements to prevent plans from subverting MLR rules and diverting health care dollars to increase profits at the expense of paying for lifesaving health care.[92] (80% of Americans support)

Additionally, the below pro-consumer reforms to the health care system are proven solutions that would put money back in people's pockets, are overwhelmingly popular with voters across the political spectrum,[93] and have strong bipartisan support: and have strong bipartisan support:

- Prohibiting health systems from charging Medicare more for the same procedure if performed at a hospital facility instead of a doctor's office, saving an estimated $157 billion over 10 years.[94] (84% of voters support)
- Establishing a limit on the maximum price or the price growth rate of hospital services as a percentage of the Medicare rate to prevent hospitals from charging exorbitantly high prices, as seen in Indiana and Vermont.[95] (64% of voters support)
- Prohibiting anticompetitive contracting terms including between providers and insurers such as "all-or-nothing," "anti-steering," and "anti-tiering" clauses in provider and insurer contracts and noncompete clauses in employee contracts that limit patient access to alternative sources of higher-quality, lower-cost care, saving $3.2 billion to $194 billion over 10 years.[96] (78% of voters support)
- Ensuring better integrity around tax-exempt status for nonprofit hospitals that are exploiting rules to evade meeting their obligation under federal law to provide meaningful health improvements to the communities they serve and making health care unaffordable for America's families and patients.[97] (78% of voters support)

- Preserve and strengthen protections against surprise medical bills by requiring more transparency into the No Surprises Act independent dispute resolution process, including ownership structures of independent dispute resolution entities, to ensure payment determinations are made in the best interests of patients and taxpayers.[98] (88% of voters support)[99]

Beyond these immediate steps, policymakers should focus on a broader redesign of the economic incentives of the health care sector to align with consumers and families. Ultimately, policy solutions should reorient health care payment and delivery to the goal that we all have — improved health for ourselves and our families that is affordable and economically sustainable.

Thank you again for holding this hearing today and for your leadership in addressing the challenges posed to consumers by our health care system's lack of transparency and affordability. Congress should seize this momentum to cut costs, not care, by immediately implementing common sense policies that hold health corporations accountable for abusive health care prices and make health care more affordable for everyone: patients, workers, and taxpayers alike. The journey to fully transform our health care system is long, but Congress holds the power to take the next critical steps. Families USA stands ready to support you in this essential and urgently needed work.

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