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6 LOWERING HEALTH CARE COSTS FOR ALL AMERICANS:

7 EXAMINING POLICIES TO INCREASE HEALTH CARE TRANSPARENCY

8 WEDNESDAY, JUNE 10, 2026

9 House of Representatives,

10 Subcommittee on Health,

11 Committee on Energy and Commerce,

12 Washington, D.C.

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16 The subcommittee met, pursuant to call, at 10:15 a.m. in
17 Room 2123 of the Rayburn House Office Building, Hon. Morgan
18 Griffith [chairman of the subcommittee] presiding.

19 Present: Representatives Griffith, Harshbarger,
20 Bilirakis, Joyce, Balderson, Miller-Meeks, Cammack, James,
21 Bentz, Houchin, Langworthy, Guthrie (ex officio); DeGette,
22 Ruiz, Dingell, Kelly, Barragan, Schrier, Trahan, Veasey,
23 Fletcher, Ocasio-Cortez, Auchincloss, Landsman, and Pallone
24 (ex officio).

25 Staff Present: Ansley Boylan, Director of Operations;
26 Jessica Donlon, General Counsel; Sydney Greene, Director of
27 Finance and Logistics; Jay Gulshen, Chief Counsel; Annabelle

28 Huffman, Policy Analyst; Megan Jackson, Staff Director; AT
29 Johnson, Special Advisor; Jonathan Kupperman, Professional
30 Staff Member; Madeline Martinez, Staff Assistant; Claire
31 Richey, Clerk; Chris Sarley, Member Services/Stakeholder
32 Director; Timothy Trimble, Staff Assistant; Matt VanHyfte,
33 Communications Director; Katie West, Press Secretary; Nick
34 Wooldridge, Professional Staff Member; Jordan Antwi, Minority
35 Intern; Ruth Campos, Minority Intern; Keegan Cardman,
36 Minority Staff Assistant; Tiffany Guarascio, Minority Staff
37 Director; Saha Khaterzai, Minority Professional Staff Member;
38 Una Lee, Minority Chief Counsel; Brendan Lopez, Minority
39 Press Assistant; and Hannah Treger, Minority Staff Assistant.
40

41 *Mr. Griffith. The subcommittee will come to order.

42 The chair recognizes himself for five minutes for an
43 opening statement, and we will let the witnesses come in.

44 [Pause.]

45 *Mr. Griffith. I had to run from another committee, so
46 -- yes, all right.

47 Today's hearing will examine ways we can work to improve
48 health care price transparency.

49 Health care affordability has long been a priority for
50 this committee and congressional Republicans. Building on
51 the foundation established by President Trump's transparency
52 initiatives, we have focused on policies that increase
53 competition, expand consumer choice, reduce regulatory
54 burdens, and strengthen transparency throughout the health
55 care system.

56 While there is no single solution to addressing rising
57 health care costs, empowering Americans with better
58 information and transparency data remains a critical step
59 toward a more efficient, accountable, and affordable health
60 care landscape.

61 For too long, patients, families, and employers have
62 faced a health system where the cost of care is often
63 unclear, sometimes even unclear after the care is delivered.
64 As we have seen throughout our affordability series, health
65 care pricing, medical bills, and coverage information can be

66 complex and opaque. But it does not have to be that way.
67 Greater transparency is essential to creating a more
68 consumer-driven marketplace, where patients have the tools
69 needed to make more informed care decisions.

70 When patients have a better understanding of the costs
71 associated with medical treatments, procedures, and services,
72 they are better positioned to compare options, seek high-
73 value care, and avoid unexpected medical bills. Increased
74 transparency is also critical to bringing health care
75 disruptors into the marketplace and promoting competition
76 amongst insurers and providers, where we continue to see
77 consolidation that contributes to higher health care costs.
78 It is important that we strive to foster a health system that
79 not only delivers high-quality care at a more affordable
80 cost, but also increases accountability across the sector.
81 This Administration, both in President Trump's first term and
82 this current term, has prioritized bringing more transparency
83 to health care.

84 Some of the proposals today build off the transparency
85 work that President Trump has implemented through regulatory
86 pathways, meaning a different administration can come in and
87 change or reverse course on those pathways. That is why
88 codification -- codification -- is so important, as it aims
89 to allow for a more standardized format and implementation of
90 rules for hospitals and insurers to follow.

91 During this hearing we will explore a range of
92 legislative proposals aimed at strengthening transparency
93 requirements and providing patients with up-front, clear
94 information about health care prices.

95 One of the bills we will consider is an updated version
96 of the Lower Cost, More Transparency Act, which was led by
97 former Chairwoman Cathy McMorris Rodgers, and passed the
98 House on the floor back in 2023. The bill aims to increase
99 price transparency throughout the health care system,
100 including hospitals, ambulatory surgical centers, and
101 clinical labs and imaging testing.

102 Additionally, some of the proposals today look at ways
103 we can empower the Centers for Medicare and Medicaid
104 Services, or CMS, with the tools they need to improve price
105 transparency data and accountability.

106 Further, we look at ways participants can be more fully
107 informed, as one of the discussion drafts requires Medicare
108 Advantage and commercial health plans to publicly post their
109 prior authorization data so individuals can view the plans'
110 approval and denial rates for health claims.

111 Another bill we will discuss is H.R. 5582, the Patients
112 Deserve Price Tags Act, championed by Representative John
113 James from Michigan. This bill takes a slightly different
114 approach compared to the Lower Cost, More Transparency Act,
115 but shares the same goal of bringing more transparency into

116 the marketplace.

117 I am proud of this subcommittee's commitment to working
118 to lower health care costs for all Americans, and I am eager
119 to examine these proposals so we can continue to look for
120 ways to make health care more affordable and more
121 transparent.

122 I thank the witnesses for being here today, and I look
123 forward to the discussion our committee will have.

124 [The prepared statement of Mr. Griffith follows:]

125

126 *****COMMITTEE INSERT*****

127

128 *Mr. Griffith. With that, I now yield back, and I now
129 recognize the ranking member, Representative DeGette, for her
130 five minutes for an opening statement.

131 Ms. DeGette.

132 *Ms. DeGette. Thank you, Mr. Chairman. Chairman, we
133 both agree that health care is too expensive and too complex.
134 Looking after your health, finding a doctor who takes your
135 insurance, scheduling, figuring out exactly what it is going
136 to cost you, and figuring out how to pay for it is difficult
137 at best, if not impossible.

138 Now, I have long supported price and policy transparency
139 throughout the health system, and I look forward to bringing
140 more of it. We need transparency to inform policy next steps
141 and to help researchers to understand exactly how prices got
142 so out of control, and how we are going to work together to
143 bring them down. Sunlight, as they say, is the best
144 disinfectant. And on that we all agree.

145 So I would like to have a little sunlight on H.R. 1,
146 which was passed last summer, which I always call the big,
147 bad bill. Last year, when we were considering the bill, my
148 Democratic colleagues and I warned that it would result in
149 sick people losing their health care and more uninsured
150 Americans. In particular, we warned that the new paperwork
151 requirements would simply add red tape for people who need
152 health care. The majority said that that was an

153 exaggeration. They accused us of engaging in scare tactics,
154 and they even called us liars.

155 I would -- for example, on June 22 in 2025, a piece from
156 the New York Post which Chairman Guthrie wrote said -- and by
157 the way, Mr. Chairman, I believe that you thought this --
158 "You are exempt if you are medically frail, which includes
159 anyone who is blind, disabled, battling a chronic substance
160 use disorder, or living with a serious and complex medical
161 condition like cancer.'" Okay, so this is what the chairman
162 said to the New York Post after the bill passed.

163 But then, when you look at the rule implementing the
164 chairman and Donald Trump's bill, it specifically states in
165 section 435.554(c)5(I) that, "We considered including
166 specific conditions within our definition of 'serious or
167 complex medical condition,' including human immunosuppressive
168 virus and acquired immunosuppressive virus, HIV AIDS, end
169 stage renal disease, cancer, and sickle cell disease. But we
170 do not believe it is reasonable to categorically consider
171 conditions as serious or complex without factoring in
172 criteria such as the severity of the condition.'" In other
173 words, if you just have cancer, you still are subject to
174 this.

175 And I would like to add unanimous consent to enter this
176 newspaper article into the record, Mr. Chairman.

177 *Mr. Griffith. And the date is June 22?

178 *Ms. DeGette. June 22, 2025.

179 *Mr. Griffith. Without objection, so ordered.

180 [The information follows:]

181

182 *****COMMITTEE INSERT*****

183

184 *Ms. DeGette. Thanks. Now, so this is just all to the
185 point. We saw this coming. We warned of it. We implored
186 the majority not to go forward with this disastrous policy.
187 And the results are clear: the implementation of the big,
188 bad bill contradicts how this majority attempted to sell it
189 to the American people, and sick people, the ones I just
190 mentioned, are going to be -- and more -- are going to be
191 kicked off of care as a result.

192 So just remember, though, these paperwork requirements
193 were never intended to make people healthier. What happened
194 was these cuts to Medicaid were made to give tax hand-outs to
195 the wealthiest Americans and corporations. So they had to
196 find the offset by cutting Medicaid which cares for health
197 care for poor and working Americans. And this really ignores
198 the reality that health care should not be a reward for
199 working, but a prerequisite to being stable and productive
200 and healthy so you can work.

201 Now, so this year, since the majority passed through the
202 big, bad bill and didn't work with us to expand the enhanced
203 ACA subsidies, more Americans are losing insurance and they
204 are seeing their costs go up. Eighty percent of returning
205 marketplace enrollees say they are seeing higher costs this
206 year; fifty-one percent say these costs are "a lot higher."
207 And critically, as of March, 37 percent of marketplace
208 enrollees were cutting back on necessities like food to

209 afford health insurance. And I talked to some of the
210 insurance companies; they said that enrollment is way, way
211 off this year.

212 And so Mr. Chairman, I agree with you. We need to pass
213 legislation relating to transparency. But we need to sit
214 down and work in a bipartisan way about how we can get
215 affordable health care for all Americans, not just a few. I
216 yield back.

217 *Mr. Griffith. The gentlelady yields back. I now
218 recognize the chairman of the full committee, Chairman
219 Guthrie, for his five minutes for an opening statement.

220 *The Chair. Thank you, Chairman Griffith. Thank you
221 for holding this hearing today, and thank you for all of our
222 witnesses being here.

223 And today we are -- the hearing will examine several
224 health care transparency policies and build on this
225 committee's many years of bipartisan work to bring greater
226 transparency to the sector, and we are continuing the
227 committee's work this year to tackle health care
228 affordability for the American people. Again, the
229 committee's work this year to tackle it.

230 We will also consider legislation to build on the Trump
231 Administration's historic price transparency regulations by
232 codifying a framework for hospital and insurer price
233 transparency. These policies will help provide actionable

234 pricing information to patients and employers, empowering
235 them with the tools they need to get high-quality care at the
236 best price. This will ultimately bolster competition and
237 improve American health care and affordability for American
238 people.

239 Further, today's hearing will include newer policies
240 taking action on President Trump's great health care plan.
241 We will consider how to address concerns we have heard from
242 patients and from providers about the burdens created by
243 prior authorization, and for improving transparency of
244 insurers' overhead costs. By providing this information to
245 the American people in a consumer-friendly way, these
246 policies can help consumers better shop for their health care
247 plans that will increase competition in the marketplace.

248 We will also consider a discussion draft that brings
249 pricing information directly to patients when they are
250 seeking care by requiring hospitals to publicly post on their
251 walls the discounted cash price of shoppable services,
252 enabling consumers to make informed choices about where to
253 lower -- where to find lower-cost care.

254 As I noted, this committee has a long track record of
255 working in a bipartisan way to bring greater transparency to
256 the health care system, shining a light on the cost of health
257 care while equipping American patients and employers with the
258 tools they need to lower health care costs. It was in this

259 committee over three years ago when Congress had our first
260 hearing working on price transparency legislation. Today's
261 hearing will continue our leadership on this critical work to
262 empower patients by improving health care transparency.

263 [The prepared statement of The Chair follows:]

264

265 *****COMMITTEE INSERT*****

266

267 *The Chair. I thank the witnesses for being here, and I
268 will yield back.

269 *Mr. Griffith. The gentleman yields back. I now
270 recognize the ranking member of the full committee, Mr.
271 Pallone, for his five minutes for an opening statement.

272 *Mr. Pallone. Thank you, Mr. Chairman.

273 Almost a year after passage of the Republicans' big,
274 ugly bill, health care prices are skyrocketing, hospitals and
275 clinics are closing, and health care workers are being laid
276 off. Over 20 million Americans saw their health care
277 premiums skyrocket at the beginning of this year because of
278 Republicans' failure to extend the premium tax credits. And
279 Republicans' big, ugly bill cut Americans' health care by
280 more than \$1 trillion, and families across the country are
281 facing the brunt of this health care crisis.

282 Now, doubling down on this chaos, just last week the
283 Trump Administration issued a rule that will intentionally
284 result in more people losing access to health care when they
285 need it most. And to make -- make no mistake, this is by
286 design and what congressional Republicans voted for. People
287 with devastating illnesses including those with cancer,
288 Parkinson's, and HIV will be forced to prove over and over
289 again that they are, in fact, too sick to work in order to
290 maintain their health care. And undoubtedly, for many, this
291 will be a burdensome and complex reporting scheme that is

292 impossible to navigate when they need the care most and, for
293 states, a costly and inefficient mandate that will only
294 result in fewer people having access to care.

295 In fact, according to the American Cancer Society, these
296 new restrictions are, and I quote, "unreasonably harsh and
297 will be life-threatening for cancer patients.'" And it could
298 even get worse as Republicans are considering another budget
299 reconciliation bill that would strip health care away from
300 even more Americans than their big, ugly bill.

301 Fortunately, today we are considering bills that will
302 actually improve Americans' health care by bringing more
303 transparency to the health care system. And I want to thank
304 the chair for recognizing the importance of this transparency
305 effort. I heard Chairman Guthrie talk about the link between
306 transparency and competition. And I agree they are linked,
307 but it may be necessary also to create more competition even
308 with increased transparency because, if you know -- as we
309 know, the monopolization with regard to hospitals and so many
310 health care interests exists and is getting worse as well.
311 So let's not forget that in order to create -- in order to
312 use transparency more effectively as many of these bills
313 will, we have to also look at the competitive environment to
314 make sure it truly is competitive.

315 We will also discuss a bill that would codify existing
316 requirements for both hospitals and insurers to make health

317 care pricing more transparent by requiring price information
318 to be displayed publicly and in a standardized format. And
319 lack of transparency into health care prices makes it
320 difficult for consumers to make informed decisions, and it
321 also makes it challenging for employers to negotiate more
322 competitive prices. This bill represents work that this
323 committee has been undertaking for several congresses and
324 that I worked on with the previous chair of this committee,
325 Chair Rodgers, and I look forward to our discussion on this
326 bill today.

327 We will also discuss a bill that will bring more
328 transparency to hospital ownership by requiring hospitals and
329 physician practices to disclose ownership data, including for
330 entities owned by private equity firms and venture capital
331 firms. And I am very concerned that private equity firms
332 investing in health care are driving up health care costs for
333 consumers while also reducing the quality of care for
334 patients. Recent studies have shown consumers receiving care
335 at hospitals acquired by private equity saw an increase in
336 their out-of-pocket costs. Billions of dollars are being
337 invested into the health care system by private equity firms,
338 many with unclear ownership structures. And our health care
339 infrastructure is becoming increasingly unstable because of
340 it.

341 According to the private equity Stockholder Project, at

342 least 20 percent of health care companies that filed for
343 bankruptcy in 2023 were owned by private equity firms.
344 Policymakers and regulators need better visibility into these
345 ownership structures, and this legislation gives us that
346 visibility.

347 We will also discuss bills to increase transparency in
348 the Medicare Advantage program to improve care. More seniors
349 with Medicare are now enrolled in MA plans than traditional
350 Medicare. But there is limited data to conduct oversight and
351 ensure that the program is providing good value. And I am
352 also concerned by reports of some MA plans' misuse of prior
353 authorization requirements, and the harmful impact these
354 practices have on seniors accessing timely care.

355 And we will also consider a bill that would increase
356 transparency and accountability of broken compensation in the
357 MA market. While agents and brokers can play an important
358 role in helping seniors enroll in Medicare, they deserve
359 access to unbiased and accurate information about coverage
360 options that best serve their individual needs. And it is
361 critical that we increase transparency and accountability of
362 broker compensation in order to protect Medicare
363 beneficiaries.

364 So I look forward to the discussion today. We can't
365 have a comprehensive conversation about addressing health
366 care affordability without acknowledging the ongoing harm of

367 the Republicans' big, ugly bill. And I also hope that their
368 efforts to try to improve -- or expand, I guess I should say
369 -- the big, ugly bill, hopefully they come to naught for the
370 sake of our health care system.

371 [The prepared statement of Mr. Pallone follows:]

372

373 *****COMMITTEE INSERT*****

374

375 *Mr. Pallone. And with that, Mr. Chairman, I yield
376 back.

377 *Mr. Griffith. The gentleman yields back. We now
378 conclude with opening statements. The chair would like to
379 remind members that, pursuant to committee rules, all
380 members' opening statements will be made a part of the
381 record.

382 We want to thank our witnesses for taking their time to
383 testify before our subcommittee today. Although it is not
384 the practice of this subcommittee to swear in witnesses, I
385 would remind our witnesses that knowingly and willfully
386 making a material false statements to the legislative branch
387 is against the law under title 18, section 1001 of the United
388 States Code.

389 You will have the opportunity to give an opening
390 statement followed by questions from members.

391 Our witnesses today are Ms. Carol Skenes, who is the
392 chief of staff at Turquoise Health.

393 We also have Mr. Shawn Gremminger, who is president and
394 chief executive officer for National Alliance of Healthcare
395 Purchaser Coalitions.

396 Mr. Benedic Ippolito is senior fellow at the American
397 Enterprise Institute.

398 Dr. Christopher Whaley is the associate director of the
399 Center for Advanced Health Policy through Research and

400 associate professor of health services policy and practice at
401 Brown University School of Public Health.

402 And Ms. Sophia Tripoli, who is the senior director of
403 health policy at Families USA.

404 Per committee custom, each witness will have the
405 opportunity for a five-minute opening statement, followed by
406 a round of questions from the members. The light on the
407 timer in front of you will turn from green to yellow when you
408 have one minute left.

409 I now recognize Ms. Carol Skenes for her five minutes to
410 give an opening statement.

411 Welcome.

412

413 STATEMENT OF CAROL SKENES, CHIEF OF STAFF, TURQUOISE HEALTH;
414 SHAWN GREMMINGER, PRESIDENT AND CHIEF EXECUTIVE OFFICER,
415 NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS; BENEDIC
416 IPPOLITO, PH.D., SENIOR FELLOW, AMERICAN ENTERPRISE
417 INSTITUTE; CHRISTOPHER WHALEY, PH.D., ASSOCIATE DIRECTOR OF
418 THE CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH AND
419 ASSOCIATE PROFESSOR OF HEALTH SERVICES, POLICY AND PRACTICE,
420 BROWN UNIVERSITY SCHOOL OF PUBLIC HEALTH; AND SOPHIA TRIPOLI,
421 MPH, SENIOR DIRECTOR OF HEALTH POLICY, FAMILIES USA

422

423 STATEMENT OF CAROL SKENES

424

425 *Ms. Skenes. Chairman Griffith and Guthrie and
426 distinguished members of the subcommittee, thank you for the
427 opportunity to be a witness today. My name is Carol Skenes,
428 and I am chief of staff at Turquoise, a health care pricing
429 and transparency platform that partners with more than 300
430 hospitals, payers, employers, life sciences organizations,
431 and researchers to make price transparency data useful,
432 reliable, and actionable.

433 I want to start with a simple observation: the
434 transparency framework this subcommittee helped build is
435 making an impact.

436 When hospitals were first required to post machine-
437 readable files in 2021, initial observations were that the

438 data would be too complex or incomplete to use. When payers
439 followed in 2022, the files were so large that many doubted
440 whether anyone could even parse them.

441 We have come a long way since then, between iterative
442 final rules and improved file quality. And at Turquoise we
443 see industry stakeholders, regulators, and consumers deriving
444 value from price transparency data every day. The
445 transparency rules are creating competitive pressure and we
446 see it in the market. Payers and providers are negotiating
447 rates with more clarity and efficiency. Self-insured
448 employers have better ownership of their fiduciary
449 responsibilities by using price transparency data to find
450 savings opportunities and shop smarter within their existing
451 networks.

452 But MRF data alone does not answer the question patients
453 and employers actually ask: How much is this going to cost
454 me? Answering that question requires solving four problems:
455 first, bundling individual billing codes into complete open
456 license procedure packages; second, integrating benefits data
457 so cost calculators reflect what a specific patient actually
458 owes; third, improving data quality because today there are
459 known yet solvable gaps in the MRF data; and lastly,
460 targeting administrative waste in the health care transaction
461 in areas besides pricing data. These include prior
462 authorization, simplified modular contracts, and streamlined

463 claims processing.

464 Turquoise has built more than 400 open license standard
465 service packages specifically to bridge that gap. And in
466 February we partnered with New York City to launch the first
467 consumer price comparison tool in the country powered by MRF
468 data. It reached 83,000 users in days. A colonoscopy in New
469 York City ranges from \$500 to 9,000, depending on a number of
470 factors including which patient -- which door a patient
471 chooses to walk through. And for the first time, patients
472 can see the range before they walk through any specific door.

473 Scaling that nationally requires Congress to act. We
474 urge this subcommittee to pass legislation that aligns with
475 current final rules. Bills such as the Lower Cost, More
476 Transparency Act and the Patients Deserve Price Tag Act --
477 Price Tags Act have the opportunity to codify the existing
478 MRF requirements in statute, extend them to non-hospital
479 providers, mandate drug price reporting, self-pay and stop-
480 loss rate disclosure, and establish uniform schema standards.
481 Any such legislation should ensure that when prices cannot be
482 expressed as fixed dollar values, the underlying formulas,
483 algorithms, and contractual methodologies used to determine
484 payment amounts are disclosed as well.

485 And beyond price, we ask Congress to also support
486 process transparency. Open standards can reduce prior
487 authorization burden, cut claims denials, and eliminate the

488 administrative waste that consumes nearly \$0.25 of every
489 health care dollar. Any system supporting process
490 transparency should be consumer friendly and open license.

491 The patient demand is ever present, and open AI reports
492 two million health insurance pricing and benefits questions
493 to ChatGPT every week, most of which occur outside of working
494 hours, and they allow patients to use plain language to ask
495 common questions. We have entered a new before-and-after era
496 of consumer activation and engagement with price
497 transparency. Before, when the original final rules and laws
498 were passed, our best bet was patient estimate tools and
499 patient education. Now AI has given us both an accelerant
500 and a new era because it lowers the barrier to entry for
501 consumers in an incredibly meaningful way.

502 The data is ready, and innovators like the team here at
503 Turquoise are ready. So now, more than ever, we are at a
504 critical moment where AI-enabled technology can give patients
505 and employers the chance to utilize new tools for
506 understanding the cost of care. Our hope is that today we
507 can discuss the legislative framework necessary to keep that
508 momentum going.

509 Thank you again for the opportunity to speak with you.
510 I welcome your questions.

511 [The prepared statement of Ms. Skenes follows:]

512

513 *****COMMITTEE INSERT*****

514

515 *Mr. Griffith. Thank you very much. I now recognize
516 Mr. Shawn Gremminger for his five minutes for an opening
517 statement.

518

519 STATEMENT OF SHAWN GREMMINGER

520

521 *Mr. Gremminger. Thank you, Mr. Chairman, Ranking
522 Member DeGette, and members of the subcommittee. Thank you
523 for the opportunity to speak on behalf of America's employers
524 and health care purchasers. I am Shawn Gremminger, president
525 and CEO of the National Alliance of Healthcare Purchaser
526 Coalitions. We are a national trade association representing
527 nearly -- more than 400 regional employer purchaser
528 coalitions around the country.

529 Our member coalitions represent employers of every size,
530 from Fortune 500 companies to small businesses to public
531 entities providing health care coverage to roughly 90 million
532 Americans. These are the employers who write the checks, and
533 I am here to tell you what they are getting in return is not
534 acceptable.

535 The problem is simple, even if the solution is hard.
536 Health care costs continue to outpace wages and inflation. A
537 family health plan now approaches \$30,000 per year, and
538 health care inflation is rising at the fastest pace in at
539 least 15 years. Every dollar consumed by rising health care

540 costs is a dollar not going to wages, retirement, or business
541 growth.

542 What makes this especially maddening is that higher
543 prices don't mean better care. In my written comments I
544 highlight the lack of connection between costs and quality by
545 hospitals in Virginia and Colorado. In the Commonwealth, my
546 home state, the highest-priced hospital with more than 200
547 beds has negotiated rates at 327 percent of Medicare. It has
548 a two-star quality rating by CMS. Just 50 miles away, the
549 lowest-priced hospital in the state with more than 200 beds
550 has rates less than 200 percent of Medicare and boasts a 5-
551 star quality rating. Employers are often paying more and
552 getting less.

553 And as we know, and has been discussed already, the
554 system is deliberately opaque. Five years after the Federal
555 price transparency rules took effect, less than half of
556 hospitals are fully compliant, though the stats depend on who
557 you ask. When the data does exist, it is often too
558 inconsistent and poorly standardized, and it takes an army of
559 data engineers just to make it usable, though I agree with
560 Ms. Skenes that the transparency rules have made -- provided
561 meaningful improvements over the previous regime.

562 But here is what I find most troubling. Many employers
563 can't even access their own claims data. In our 2025 survey
564 of more than 300 purchasers, 42 percent said their vendors

565 refused to provide complete data access. More than half of
566 smaller employers said they simply can't get it. Employers
567 are all paying the claims. They are bearing the financial
568 risk, and someone else is deciding whether or not they get to
569 see their bill. When employers do have access to their
570 claims, the results speak for themselves. They are far more
571 likely to implement direct contracting, centers of
572 excellence, site of care programs that reduce costs and
573 improve outcomes. Data access isn't just a compliance issue.
574 It drives real, measurable savings.

575 So what do we need from Congress? Among the bills the
576 committee has before it, I want to focus on the Patients
577 Deserve Price Tags Act, particularly section seven, which
578 establishes once and for all that plan sponsors have a right
579 to their own claims and encounter data. This should not be
580 controversial. Employers fund these plans. They have
581 fiduciary obligations to their workers. They need this
582 information to do their jobs.

583 The legislation also codifies and strengthens the
584 hospital and price transparency rules, requires disclosures
585 of how prices are actually calculated, and creates meaningful
586 enforcement mechanisms. It is the most comprehensive
587 transparency bill before this body.

588 I should note that we also support provisions from the
589 CHECK Act; the Lower Cost, More Transparency Act; and others.

590 But none go far enough without the employer access data
591 provisions in section seven.

592 I also want to be clear about something: transparency
593 alone will not solve this problem. In markets dominated by
594 one, two, or three health systems, employers may gain
595 visibility into prices but still have no leverage to
596 negotiate. Transparency is necessary, but it is not
597 sufficient. This committee should also pursue site neutral
598 payment policies, restrictions on facility fees, and
599 prohibitions on anti-competitive contracting practices that
600 lock employers into over-priced networks.

601 And in the most consolidated markets policymakers should
602 seriously consider reference-based pricing benchmarks tied to
603 Medicare. States as diverse as Indiana, Vermont, Montana,
604 and Washington have already gone in this direction. These
605 are not radical policies. They are rational responses to
606 failed markets.

607 Finally, I want to leave you with this. A poll
608 conducted just last month by the United States of Care found
609 that more than 7 in 10 Americans believe health care costs
610 are unaffordable, and nearly half have faced financial
611 pressure from medical bills in the past two years. Sixty-
612 nine percent of people believe Congress should act, including
613 majorities of both Democrats and Republicans. The public's
614 frustration matches what employers feel every day.

615 The diagnosis is not in dispute. What we need now is
616 the will to act. If we do not give employers the tools to
617 bring costs under control, the commercial market will buckle.
618 And what replaces it will almost certainly be worse for
619 American workers and their families. The moment for action
620 is now. Thank you very much.

621 [The prepared statement of Mr. Gremminger follows:]

622

623 *****COMMITTEE INSERT*****

624

625 *Mr. Griffith. The gentleman yields back. I now
626 recognize Dr. Benedic Ippolito for his five-minute opening
627 statement.

628

629 STATEMENT OF BENEDIC IPPOLITO

630

631 *Dr. Ippolito. Thanks very much, Chairman Griffith and
632 Ranking Member DeGette, members of the committee. My name is
633 Benedic Ippolito. I am an economist at the American
634 Enterprise Institute. I am also an incoming commissioner at
635 MedPAC, and I believe that obliges me to say that these are
636 my views and, of course, not theirs.

637 Many -- not all, but many -- of the challenges that
638 health care markets face stem from a -- directly or
639 indirectly from a lack of transparency. Either you have
640 market actors who have to make decisions without all the
641 relevant information in front of them or you have
642 policymakers like yourselves who are tasked with regulating
643 or overseeing markets, yet you don't have all the relevant
644 information to do so. And so today I think you are
645 considering several bills that illustrate the broad potential
646 value of transparency. There is many of them, so I am just
647 going to focus on a couple that I think are notable.

648 I will start by saying, first, one of the most important
649 ways that individuals influence health care markets is by the

650 way they choose their insurance plan. When they do that they
651 make these trade-offs between premiums and various measures
652 of generosity on those plans. How broad is the network? How
653 low is the cost sharing? Which hospitals are in and which
654 hospitals are out? All right?

655 When you are in a well-functioning market, those
656 decisions reflect their preferences and they direct insurers
657 how to design their markets, and they influence hospitals and
658 other market actors. If they are making those decisions
659 without relevant information, there is no reason to think
660 that the outcomes we observe actually reflect their
661 preferences.

662 So I really like the provision to start publishing
663 greater information about prior authorization rates, denial
664 rates, things of that nature. That is clearly something that
665 consumers value. We see it in surveys. I am sure you hear
666 about it in your offices. It is also something that is
667 opaque and it varies a lot across insurers. And so what you
668 have are people or their employers picking between plans
669 where there is big variation in this measure, and yet they
670 can't readily observe it. So that strikes me as a very good
671 idea.

672 Second, I appreciate the proposal to increase reporting
673 of ownership and merger information. This has been a sort of
674 consistent frustration. As health care markets have evolved,

675 we have seen a greater share of consolidation come in the
676 form of serial acquisitions that are too small to require
677 reporting to antitrust agencies or other regulators. That
678 means that we have got a lot of sort of stealth consolidation
679 that occurs, particularly in markets like the physician
680 market. This is a tactic that you often see private equity
681 firms employ. It is very difficult to tell policymakers what
682 you should do about this if we don't really have a good
683 handle on what that consolidation looks like and what the
684 effects of it are. And so efforts to increase reporting of
685 ownership, transactions, and update that every year seem like
686 a very good idea to me.

687 I will conclude with one, I guess, maybe a little bit
688 more nuanced point. The committee is considering increasing
689 transparency into broker fees in the MA program and
690 considering restrictions on how large those fees can be. I
691 just want to flag that that does come with some
692 complications. Trying to regulate financial transactions
693 between private entities can be fraught. The bill includes a
694 laundry list of fees that are included and tried to be
695 captured in this limit. You know, it is transactions,
696 payments, gifts, reimbursements for costs, all sorts of
697 things that illustrates how hard it is to sort of encompass
698 all potential transactions. I just highlight that it is
699 possible that includes everything. It is equally possible

700 that we are going to find creative work-arounds and that
701 limit isn't really going to bind.

702 I also want to say that I think that provision -- I
703 don't want to tell anyone what they think, but it strikes me
704 that that really reflects a question about Medicare Advantage
705 and how those payments work in the program. If you think
706 those payments are too high or you think those payments are
707 otherwise inappropriate in some form, that seems to me to be
708 the underlying issue. That is what is giving these plans a
709 big incentive to pay large fees to brokers to encourage
710 enrollment in those plans. And so it strikes me that the
711 more direct thing to do is address the Medicare Advantage
712 program directly. That will come with important trade-offs.
713 You will hear about those trade-offs from your constituents,
714 but it strikes me that that is worth confronting directly
715 rather than trying to do it through sort of broker fee
716 restrictions and things like that.

717 That said, I think this strikes me as a constructive
718 effort to improve transparency in the health care market. It
719 reflects the broad value that transparency can have for
720 consumers and for policymakers. And so I thank you for
721 having me, and I look forward to questions.

722 [The prepared statement of Dr. Ippolito follows:]

723

724 *****COMMITTEE INSERT*****

725

726 *Mr. Griffith. The gentleman yields back. I now
727 recognize Dr. Christopher Whaley for his five-minute opening
728 statement.

729

730 STATEMENT OF CHRISTOPHER WHALEY

731

732 *Dr. Whaley. Thank you. Chairmen Guthrie and Griffin
733 (sic), Ranking Members Pallone and DeGette, and members of
734 the subcommittee, thank you for the opportunity to testify
735 today. My name is Christopher Whaley. I am a health
736 economist and an associate professor at the Brown University
737 School of Public Health. My research focuses on health care
738 costs, price transparency, and the impacts of market
739 consolidation on the employer-sponsored and Medicare markets.

740 Today I want to make three core points: first, health
741 care prices are high and, I think, broken; second,
742 transparency in both price and organizational structure is a
743 necessary foundation to improve health care affordability;
744 and finally, the bills before you this morning would take
745 steps, I believe, to directly address the gaps that matter
746 the most.

747 The United States leads the world in health care
748 spending. High spending is driven by price, not by sicker
749 patients or better care. For a family of four with employer-
750 sponsored insurance coverage, premiums are projected to

751 exceed \$37,000 per year. My work shows that private
752 insurance hospital prices average 254 percent of what
753 Medicare pays nationally. But in some states like West
754 Virginia, Florida, and Georgia, prices exceed 300 percent of
755 what Medicare pays.

756 Critically, these high prices are not linked to better
757 quality. Several studies show that higher-priced hospitals
758 and providers do not provide better quality of care.
759 Instead, a major driver of high prices is consolidation.
760 Over the last two decades roughly 2,000 hospital mergers have
761 produced massive health system conglomerates, increasing
762 prices with no quality improvement.

763 Beyond hospitals, over half of U.S. physicians are now
764 employed by a hospital or health care system, and private
765 equity firms have deployed nearly \$1 trillion into health
766 care markets over the last decade. These new ownership
767 models remain deeply opaque to patients, employers, and
768 regulators alike.

769 To improve the affordability of the U.S. health care
770 system, I think it is critical for Congress and policymakers
771 to improve both price and organizational transparency. And I
772 want to make one thing clear. Transparency by itself is not
773 a cure-all for the U.S. health care system. Patient-facing
774 price tools have largely not changed shopping behavior, and
775 health care is far too complex for that alone. But I think

776 transparency is foundational for everyone else who needs to
777 act, whether it is employers negotiating on behalf of their
778 workers, researchers studying health care market dynamics
779 such as myself, states designing price reforms, and Federal
780 regulators overseeing the Medicare program.

781 I think transparency is already working. Transparency
782 data has allowed researchers like myself to document several
783 things, including private equity-affiliated, physician-
784 charged prices that are 6 to 10 percent higher than prices
785 that independent doctors charge.

786 In addition, Medicare Advantage plans pay less than half
787 what commercial plans pay negotiated by the very same
788 insurer.

789 And finally, prices at ambulatory surgical centers are
790 approximately 36 percent lower than hospitals in the same
791 county, providing what I think is rigorous evidence for site
792 neutral payment reforms.

793 Transparency data has also provided the evidence base
794 for Oregon's hospital payment limits which saved over \$100
795 million in 2 years with no harm to quality or the workforce.
796 Purchasers like the 32BJ Health Fund have used their own
797 claims data to generate \$100 million in annual savings, money
798 that went back directly to the workers in the largest pay
799 increase in their union's history.

800 To further these innovations and to fully understand the

801 evolving U.S. health care ecosystem, I think it is critical
802 for Congress to continue their existing efforts. As I
803 discuss in more detail in my written testimony, the bills the
804 subcommittee is considering have the potential to address
805 some of the most consequential gaps in our current
806 transparency framework.

807 First, the Lower Cost, More Transparency Act and the
808 Patients Deserve Price Tags Act would strengthen price
809 disclosure and ensure that employers can actually access
810 their own claims data, data that third-party administrators
811 currently withhold, despite clear fiduciary obligations that
812 employers and purchasers have.

813 I want to emphasize the importance of ensuring that
814 employers have access to their own claims data, which is
815 critical for them to fulfill their fiduciary obligations.
816 The CHECK Act would extend those protections to itemized
817 billing, and limit excuses about gap clauses and other
818 provisions for not sharing data. And likewise, the ownership
819 transparency data would create the national database we need
820 to track organizational changes.

821 And finally, the Medicare Advantage bills would bring
822 long-overdue accountability to broker compensation and the MA
823 encounter data. Both areas are where my colleagues and I
824 have documented serious problems. My colleagues found in a
825 recent study that over \$10 billion in payments to MA brokers

826 from MA plans per year, raising what I think are concerns
827 that the advice that Medicare Advantage beneficiaries use to
828 select their plans might be conflicted by broker payments.

829 In conclusion, Congress can help bring transparency into
830 the increasingly complex U.S. health care system, which I
831 think will benefit patients, employers, and policymakers.

832 Thank you, and I look forward to your questions.

833 [The prepared statement of Dr. Whaley follows:]

834

835 *****COMMITTEE INSERT*****

836

837 *Mrs. Harshbarger. [Presiding.] The gentleman yields
838 back, and I will now recognize Ms. Sophia Tripoli for her
839 five minutes of testimony.

840

841 STATEMENT OF SOPHIA TRIPOLI

842

843 *Ms. Tripoli. Thank you. Chairmen Guthrie and
844 Griffith, Ranking Members Pallone and DeGette, and members of
845 the committee, thank you for the opportunity to testify. My
846 name is Sophia Tripoli, and I lead health policy at Families
847 USA, the long-time voice for health care consumers.

848 I want to start with a near universal truth: health
849 care affordability is the top issue for voters across the
850 country, and 91 percent of Americans, including conservative
851 Republicans and progressive Democrats, want Congress to lower
852 their health care costs.

853 A big part of why costs are out of control is because
854 the system has been operating in the shadows, and the
855 institutions profiting as a result have fought hard to keep
856 it that way. For decades hospitals, health plans, and drug
857 companies have been allowed to quietly take over entire
858 sectors of the American health care system, consolidating
859 markets to drive up prices, aggressively billing patients,
860 denying access to care, and hiding all of it behind layers of
861 complexity designed to keep patients and lawmakers in the

862 dark while maximizing their profits.

863 It may be tempting to chop this up to just a broken
864 system or to scapegoat vulnerable populations as the reason
865 why health care costs too much. But that is a false
866 representation of what is actually occurring. The U.S.
867 health care system is working very well, but just not for us.
868 While families struggle to afford the care they need,
869 corporate consolidation and health care is accelerating.
870 Insurers grow larger and more dominant. Hospital systems
871 consolidate into powerful regional monopolies that charge any
872 price they want. Private equity has moved aggressively into
873 care delivery, and drug companies still block lower-cost
874 generic drugs from entering the market, while drastically
875 increasing drug prices almost entirely unchecked.

876 Consider the example of CommonSpirit Health, the
877 nation's largest non-profit health system, which owns 158
878 hospitals and more than 2,000 health care centers across 21
879 states. They charge more than 3 times what Medicare pays for
880 the exact same hospital services, generating \$17 million in
881 net income per hospital per year.

882 Or take the Medicare Advantage program, where 33 million
883 of our nation's seniors get their care. Just 5 health
884 insurance giants now control 80 percent of the market, where
885 insurers abuse the billing system by making enrollees appear
886 sicker than they are to generate higher payments for

887 Medicare. This upcoding costs the Medicare program \$40
888 billion each year.

889 Or take that nearly 60 percent of doctors say their
890 patients were delayed needed care because of prior
891 authorization. These are symptoms of a sickness spreading,
892 the corporate capture of our health care system, all
893 facilitated by a complete lack of transparency.

894 Nowhere is this more alarming than in the case of
895 hospitals. Over the last 25 years unchecked hospital
896 consolidation has driven up prices by over 220 percent,
897 costing hard-working Americans nearly \$1 trillion in lost
898 wages since 2012. Private equity has compounded the damage,
899 becoming one of the largest investors in health care delivery
900 over the past decade. PE firms increasingly buy up small
901 health care providers in order to skirt antitrust oversight
902 and enforcement, all while driving up prices and worsening
903 access and outcomes for patients.

904 For too long health care corporations have been allowed
905 to set prices in secret, hide their ownership structures
906 behind layers of shell entities, and operate with almost no
907 accountability. American families are not bargaining chips
908 to be traded in the backroom deals between corporate giants
909 and their lobbyists, and this Congress has the power and
910 responsibility to end that game. This is why this hearing is
911 so important. Our health care system is in desperate need of

912 transparency of prices, ownership status, care denials,
913 coding abuses, and the bad behavior of brokers and agents.

914 Transparency is essential to any meaningful effort to
915 hold corporate health systems accountable. Just ask Jessica,
916 an Arizona resident who waited months for a cancer screening
917 she can't get a price on. Jessica needed a procedure to
918 investigate her GI bleeding. With her history of cancer,
919 every delay matters. Jessica lives paycheck to paycheck and
920 cannot afford a big medical bill, so she spent weeks calling
921 surgery centers, tracking down her doctors, calling her
922 insurers to find out how much the procedure would cost her,
923 all while her bleeding worsened. No one she talked to could
924 give her an answer. Jessica told us, "I still don't have a
925 price, so I have to keep waiting."

926 This is a system designed to protect corporate greed at
927 the expense of people like Jessica and families across the
928 country. Congress should advance meaningful proposals such
929 as the Patients Deserve Price Tags Act, mandatory ownership
930 transparency, displaying care denials, the CHECK Act,
931 improving MA encounter data and MLR transparency, limiting
932 agent and broker compensation in MA, and other reforms.
933 These are practical, bipartisan solutions that are long
934 overdue.

935 As I wrap, I want to make one more point: as critical
936 as transparency is -- and we desperately need it -- it will

937 not be nearly enough to lower health care costs. It is an
938 essential step, but not sufficient to solve the American
939 affordability crisis. We implore you to ensure greater
940 transparency in the system and to advance bold solutions that
941 will fundamentally lower prices and bring down the cost of
942 care.

943 Thank you, and I look forward to your questions.

944 [The prepared statement of Ms. Tripoli follows:]

945

946 *****COMMITTEE INSERT*****

947

948 *Mrs. Harshbarger. Thank you. Now we will begin
949 questioning, and I would ask that members not begin a new
950 question to our witnesses as their five minutes expire. I
951 would encourage members to submit written questions for the
952 record. And I now recognize myself for five minutes.

953 Dr. Whaley, your testimony notes that commercial
954 hospital prices now average roughly 254 percent of Medicare
955 nationally, with some states exceeding 300 percent of
956 Medicare. So can you explain what is driving up those
957 extreme price differences between markets, and whether
958 consolidation is a primary factor?

959 *Dr. Whaley. Sure. So nationally, hospital prices
960 average 250 percent of Medicare, and we see wide variation in
961 what hospitals charge patients with commercial insurance.
962 And what is really driving those prices is not due to
963 difference in quality, not due to differences in, say, cost
964 shifting, but a key driver is consolidation, where we have
965 seen tremendous mergers and acquisitions within the hospital.

966 *Mrs. Harshbarger. Yes, exactly. And I would like to
967 enter into the record an article from The Associated Press
968 dated June 9, 2026 highlighting the Trump Administration's
969 recent actions to ensure hospitals are complying with
970 hospital price transparency rules and making available
971 information about the prices they are charging to consumers.

972 So without objection, so ordered.

973 [The information follows:]

974

975 *****COMMITTEE INSERT*****

976

977 *Mrs. Harshbarger. You know, it talks about they have
978 warned more than 500 hospitals that are failing to provide
979 the public with basic pricing information.

980 So I will continue with you, Dr. Whaley. Your testimony
981 highlights significant payment differences between hospitals,
982 outpatient departments, and ambulatory surgical centers for
983 the exact same services. And as somebody who supports
984 preserving access to independent, community-based care, you
985 know, my worry is that current payment incentives are pushing
986 more care into higher-cost hospital-owned settings. Do you
987 believe greater transparency around site of service pricing
988 could help slow consolidation and encourage lower-cost,
989 community-based care options, sir?

990 *Dr. Whaley. Sir I do. I certainly think that --

991 *Mrs. Harshbarger. Yes.

992 *Dr. Whaley. -- transparency around site of care, as
993 well as site neutral payment policies can help narrow those
994 gaps.

995 *Mrs. Harshbarger. Great. Dr. Ippolito, in your
996 testimony you discuss the importance of ownership
997 transparency, and how complex ownership structures can
998 obscure consolidation trends. We don't know who owns who.
999 So it is difficult for policymakers and regulators to even
1000 understand who actually owns health care delivery assets in a
1001 local market. So would better ownership reporting from (sic)

1002 Congress and antitrust regulators identify anticompetitive
1003 behavior earlier, before communities lose independent
1004 providers?

1005 *Dr. Whaley. Yes, I think so.

1006 *Mrs. Harshbarger. Well, that is good. I have got
1007 another question for you, sir. I think most Americans would
1008 be shocked to learn how little visibility patients have into
1009 claim denial rates and utilization management practices
1010 before enrolling in a plan. You mentioned that in your
1011 testimony. It is unbelievable when the only way you know it
1012 is when you get denied or when you are required to get a
1013 prior approval. Do you believe consumers would make
1014 different plan choices -- and even, you know, private
1015 entities and health sponsors -- if denial rates and prior
1016 authorization practices were presented clearly and uniformly
1017 during the enrollment phase?

1018 *Dr. Whaley. They certainly might. There is a trade-
1019 off. You trade off lower premiums for more, you know,
1020 oversight of services that you get. Let's let consumers
1021 choose what they prefer.

1022 *Mrs. Harshbarger. Yes.

1023 *Dr. Whaley. I think that is the right way to do it.
1024 Transparency seems perfect for that.

1025 *Mrs. Harshbarger. I am all about that, exactly,
1026 because if you work in the health care industry, even as a

1027 pharmacist, and you are looking at these claims that are
1028 denied or these prescriptions, it is unbelievable what -- the
1029 process you have to go through. You have to have a dedicated
1030 person to do all these things. But if the plan sponsor knew
1031 ahead of time that this was going to cost their company
1032 money, I think they would make a different choice.

1033 And it would also put market pressure on insurers to
1034 change their behavior. Don't you think?

1035 *Dr. Whaley. Yes. The whole point is that the insurer
1036 should be offering what customers actually want. This is an
1037 important amenity that they should be evaluating that
1038 decision on, yes.

1039 *Mrs. Harshbarger. Yes, and, you know, I think
1040 Americans increasingly feel like health care pricing operates
1041 in a black box where nobody knows the price, nobody
1042 understands the billing. And patients, they don't have any
1043 leverage.

1044 Ms. Tripoli, you said it. You have got patients who
1045 don't -- they can't get surgery because they don't know how
1046 much it is going to cost. If Congress could enact just one
1047 transparency reform this year that would most directly lower
1048 health care costs for patients and employers, what would it
1049 be?

1050 Quickly, Ms. Skenes.

1051 *Ms. Skenes. Increased price and process transparency

1052 across the board.

1053 *Mrs. Harshbarger. Mr. Gremminger?

1054 *Mr. Gremminger. It would be section seven of the
1055 Patients Deserve Price Tags Act.

1056 *Mrs. Harshbarger. Dr. Ippolito?

1057 *Dr. Ippolito. Data on ownership structures.

1058 *Mrs. Harshbarger. Dr. Whaley?

1059 *Dr. Whaley. I think the Patients Deserve Price Tags
1060 Act.

1061 *Mrs. Harshbarger. Ms. Tripoli?

1062 *Ms. Tripoli. I agree, Patients Deserve Price Tags Act.

1063 *Mrs. Harshbarger. Okay. Well, with that I yield back
1064 and now I recognize the ranking member, Representative
1065 DeGette, for her five minutes.

1066 *Ms. DeGette. Thank you, Madam Chair. Well, I think it
1067 is great to hear all of our witnesses here today saying that
1068 addressing transparency and consolidation are really
1069 important towards beginning to understand the high prices of
1070 health care. And I was just recently at a conference with
1071 Dr. Ippolito where he explained in greater depth about his
1072 views on this, and the -- it was a bipartisan attendance at
1073 this conference and there was a lot of bipartisan agreement.
1074 So that was great.

1075 But what I want to talk about is how transparency -- and
1076 also addressing consolidation could be first steps, but they

1077 are not the solution to the problem of high health care
1078 costs. So Dr. Whaley, I want to start with you. With
1079 additional transparency -- I am going to give you an example
1080 -- do you think people would shop for MRIs in the same way
1081 they shop for cars? There is transparency. The MRI over
1082 here costs this and costs that over there.

1083 *Dr. Whaley. Yes, as currently constructed, patients
1084 probably have a hard time shopping for MRIs the same way they
1085 do as a car.

1086 *Ms. DeGette. Do you think they would if we had more
1087 transparency?

1088 *Dr. Whaley. It would help somewhat, but it wouldn't
1089 move us all the way there.

1090 *Ms. DeGette. And why not?

1091 *Dr. Whaley. One of the things that my research has
1092 shown is that when patients get even something we think is
1093 simple, like an MRI, it is not just their choice; it is the
1094 choice of the physician referring them. And if you are, say,
1095 a physician who works for a hospital system or a private
1096 equity company, then they have incentives to refer you to a
1097 higher-priced provider, despite what the patient might want.

1098 *Ms. DeGette. Right. So just because we have
1099 transparency doesn't necessarily mean the patient is going to
1100 get the cheapest MRI or, by the way, that the cost savings
1101 will inure to the patient.

1102 *Dr. Whaley. Exactly.

1103 *Ms. DeGette. So who would really use the information
1104 that we would get from new transparency requirements?

1105 *Dr. Whaley. I think it is important for employers like
1106 -- such as the ones that Mr. Gremminger represents when they
1107 are designing networks, even upstream of the patients, to
1108 ensure that they have access to efficient providers who have
1109 lower costs or negotiate better prices.

1110 I think it is also very important for regulators,
1111 research assessors myself to use this type of data to
1112 understand the impacts of consolidation and design policy.

1113 *Ms. DeGette. So it is really a good data point for
1114 everybody, but it doesn't necessarily mean it is going to
1115 solve the pricing issue.

1116 *Dr. Whaley. I think if it is used in ways to inform
1117 benefit design and to design networks and audit the plans
1118 that -- or the prices that insurers negotiate on behalf of
1119 employers, that can certainly help.

1120 *Ms. DeGette. Yes, okay. So Ms. Tripoli, do you think
1121 that transparency in and of itself would bring prices down
1122 for the health care consumers?

1123 *Ms. Tripoli. I think I agree with Dr. Whaley that
1124 price transparency is absolutely essential in terms of
1125 unveiling how high and variable prices are so that we can
1126 target where there is low-value care and high-value care

1127 occurring in the health care system. There might be some
1128 cases where consumers can shop in certain circumstances and
1129 actually find a lower-cost service. But for the reasons that
1130 Dr. Whaley outlined, I agree it is most useful for employers
1131 to negotiate a better deal for workers and for themselves, as
1132 well as for researchers to help continue to study the
1133 markets.

1134 *Ms. DeGette. So what would the next steps be if
1135 Congress were to enact transparency legislation?

1136 *Ms. Tripoli. I mean, I think once we -- first of all,
1137 please enact the transparency legislation. It is desperately
1138 needed, as a number of bills are under -- on discussion for
1139 today are also needed.

1140 And then we would have to have a really serious
1141 conversation on how do we directly intervene more directly on
1142 prices, site neutral payments, addressing the anticompetitive
1143 marketing practices -- contracting practices, and even, I
1144 would say at this point, some sort of intervention on the
1145 growth of hospital prices in particular will more directly
1146 bring down prices and lower health care costs for consumers.

1147 *Ms. DeGette. Right. So just the -- what I am trying
1148 to get at is just the transparency, it helps open it up and
1149 see better what is happening.

1150 *Ms. Tripoli. Correct.

1151 *Ms. DeGette. But it doesn't necessarily in and of

1152 itself bring down prices.

1153 *Ms. Tripoli. Correct.

1154 *Ms. DeGette. Okay. So I look forward, Madam Chair, to
1155 working with you and all of our colleagues, because I do
1156 think this first step is something that we can do. But we
1157 need to be clear: we need to go further.

1158 And I yield back.

1159 *Mrs. Harshbarger. Thank you. The ranking member
1160 yields back and I now recognize the chairman of the full
1161 committee, Representative Guthrie, for his five minutes.

1162 *The Chair. Thank you. This is to Mr. Gremminger.

1163 The price transparency rules that we have now have been
1164 in effect for several years now, and we have seen updates
1165 made over time to improve the usability of this data for
1166 consumers and employers. Can you give us an example of how
1167 employers in your organization have leveraged these tools to
1168 lower costs for employees?

1169 And how would codifying price transparency frameworks
1170 strengthen these requirements?

1171 *Mr. Gremminger. Thank you for the question, Mr.
1172 Chairman. So we have -- I would point to just a couple of
1173 quick things.

1174 First, the Purchaser Business Group on Health. One of
1175 our members did a data demonstration project where they
1176 married claims data that employers have access to with the

1177 price transparency data as provided through Turquoise, and
1178 found that they were able to significantly better understand
1179 what they were paying, understand what plan designs would
1180 make a difference in terms of their ability to lower costs.

1181 What we have seen in the research that we have done in
1182 terms of researching with our employers, employers that have
1183 better access to data, both through the public -- publicly
1184 available price transparency, data transparency and coverage
1185 rule, et cetera, and their own claims data is they are more
1186 likely to engage in more innovative plan designs including
1187 tiered networks, where you would say we are going to try to
1188 drive people to lower-cost, higher-quality settings; narrow
1189 networks, where we are going to say we are going to exclude
1190 high-cost or over-priced places; working with centers of
1191 excellence.

1192 Codifying these rules, I think, will mean that providers
1193 will be more likely, first of all, to comply -- we have seen
1194 not full compliance -- but also more likely to lean in on
1195 this as a real reality of the future.

1196 *The Chair. Thanks. You know, and the things that we
1197 do here -- Congress is trying to be -- we want to be -- make
1198 it for the consumer, for the patient, to be friendly for
1199 them. And so there was a particular provision where rebates
1200 go to the customer. That is where the rebates go, to the
1201 customer, because we want the benefit to go to the consumer.

1202 Well, there was an insurance company -- insurance
1203 business that we had before us a few months back that created
1204 a group purchasing organization that was the customer. And
1205 so if you are going to buy their insurance, you have to join
1206 their group purchasing organizations. Guess where the rebate
1207 went? To the group purchasing organization. And so what it
1208 seems to me is every time we try to really tackle it so the
1209 American people benefit, it just seems to pop up somewhere
1210 else, and the coverage is somewhere else.

1211 And so that is what we are trying to get at, is make it
1212 transparent so people can make informed decisions. And I
1213 like what my friend from Colorado talked about with somebody
1214 out shopping for MRIs. You know, most people get their
1215 health insurance through their employer. So if you are -- so
1216 if every individual went out and shopped like that, that
1217 would be very, very beneficial, and we want to give them the
1218 information to be able to do that. But if employers shop
1219 like that, it would really make a big difference when our
1220 major, major employers have lots of covered lives.

1221 Can -- and when you talk to them -- that is what is
1222 frustrating. You will talk to CEOs of the, you know, Fortune
1223 50 (sic) companies. As a matter of fact, I think even Jamie
1224 Dimon, who is a financial person or had the most
1225 sophisticated financial group around him tried to get a
1226 handle on the information around his -- their employees'

1227 insurance and finally gave up because they said we couldn't
1228 get to this, too opaque and not clear.

1229 *Mr. Gremminger. Yes, sir.

1230 *The Chair. And I think it is that way for a reason.
1231 Then you have group purchasing organizations show up in
1232 Switzerland. That is where the money is going. That is what
1233 happened.

1234 And so what do you -- what do your employees need? We
1235 know that there are groups that buy pharmaceuticals at a
1236 discounted price and sell full price to employer plans. And
1237 so what do your employers need to say we really just need to
1238 sit down and -- I talked to somebody in the automotive
1239 industry, my family's automotive business, and said if we had
1240 a 700 percent markup on a product we sold you, what would you
1241 do? And he said, we would fire your buyer -- you would fire
1242 a buyer and then tell us what is the deal, what are you doing
1243 to get that kind of a markup. But there are some medicines
1244 that have that kind of a markup when you check the discounted
1245 price of what they are paying. What do you really need for
1246 your employers to be able to sit down with their insurance
1247 company and say, I am getting a bad deal?

1248 *Mr. Gremminger. Yes, I think -- I mean, two things,
1249 particularly in the pharmaceutical side, but really also on
1250 the medical benefit. Having access to your own claims data
1251 so you know exactly what you are paying -- not just what you

1252 should be paying, but literally what you have paid -- is
1253 extremely helpful, because then you know whether or not you
1254 are getting a bad deal. Otherwise, you are just sort of
1255 guessing.

1256 And then you need competition, right? You need to have
1257 multiple choices so that you can change direction. If you
1258 have just one or two dominant hospital systems in an area, or
1259 if you only have just a couple of big PBMs that you are
1260 having to negotiate with, you may be just trading one bad
1261 deal for another bad deal. What really is going to make a
1262 difference is employers actually having both the transparency
1263 and the greater competition to be able to shop.

1264 *The Chair. There appear to be disruptors coming. I
1265 think the information and the -- making it transparent means
1266 that they will come into the business place. But we have one
1267 in Ohio that said you can go to any doctor that you want to,
1268 and here is the number we will pay, and if you can get it
1269 cheaper you get the money so that the patient has some skin
1270 in the game on it. They get to keep money if they get it
1271 cheaper than what is listed, but they can't get on the
1272 marketplace because they don't have a network.

1273 *Mr. Gremminger. Right.

1274 *The Chair. And -- but the network is every doctor in
1275 Ohio, but that is not a sufficient network. And -- which is
1276 frustrating when we do things like that that prevent people

1277 from being disruptors. And that is what we need, disruptors
1278 to bring lower price and better quality and better care. So
1279 when I say "disruptors," that is what I mean.

1280 I will yield back.

1281 *Mrs. Harshbarger. The gentleman yields back and I now
1282 recognize the ranking member of the full committee,
1283 Representative Pallone.

1284 *Mr. Pallone. Thank you, Madam Chair.

1285 About half of Americans have reported difficulty
1286 affording health care, and too many families have to delay or
1287 forgo necessary care due to rising costs. Meanwhile, health
1288 care consolidation and private equities' increased role in
1289 our health care system is driving up the prices of health
1290 care services for families. So I am concerned about the
1291 growing influence of private equity and its impact on costs
1292 and patient care and health outcomes. I have three
1293 questions, and I am going to ask each person to maybe spend a
1294 minute or so in answering the question. Let me start with
1295 Dr. Whaley.

1296 In your testimony you discussed how private equity firms
1297 have been driving consolidation. Could you briefly, in a
1298 minute or so, discuss how private equity arrangements can
1299 impact health care costs and patient access to care, if you
1300 will?

1301 *Dr. Whaley. Sure, I think there are two main ways. So

1302 the first is the roll-up strategy, if you will, where a
1303 private equity slowly accumulates market power within a given
1304 market in a way that each individual transaction evades
1305 regulatory scrutiny, but cumulatively leaves the private
1306 equity company with lots of bargaining power that they can
1307 use to negotiate higher prices. And we have seen in our own
1308 work that that leads to considerably higher prices.

1309 The second way is what happens to the firm that they
1310 acquire. And in many cases they either saddle the firm with
1311 bad debt, engage what is often referred to as a sale
1312 leaseback, or charge high and excessive management fees that
1313 allow the private equity company to make money off the firm.

1314 *Mr. Pallone. All right, thank you. Then let me go to
1315 Ms. Tripoli.

1316 Can you discuss the impact of private equity
1317 acquisitions on our overall health care system?

1318 *Ms. Tripoli. Absolutely. I mean, I think private
1319 equity, by definition, is incompatible with making sure that
1320 patients have health care they need at a price that they can
1321 afford. The whole business model is you come in, you buy up
1322 the competition, you cut off service lines so you get -- you
1323 remove access to care. You increase prices, you lay off
1324 workers, you make the business look profitable in the short
1325 term, you saddle them with bad debt.

1326 And we know that the result of private equity in the

1327 markets, they are increasing competition, they are driving up
1328 prices, reducing access to care. And many of the private
1329 equity or venture capital-backed health care institutions
1330 have much worse quality, higher fall rates for seniors. So
1331 we know that it is higher-cost care and lower-quality care
1332 for the American people.

1333 *Mr. Pallone. No, I appreciate that and what you say
1334 certainly makes sense. There is a lot of evidence that
1335 private equity investments in health care result in price
1336 increases for families without -- and also reduce the quality
1337 of care. But despite billions of dollars being invested into
1338 the health care system by these private equity firms, the
1339 ownership arrangements remain totally opaque to patients and
1340 policymakers and regulators. That is part of the problem.
1341 So let me go back to Dr. Whaley.

1342 Can you briefly elaborate why transparency in the
1343 ownership structure is important?

1344 What kind of data elements would be helpful for
1345 hospitals and providers to disclose regarding ownership?

1346 And this goes back to my thing is, you know, all for
1347 transparency, but if there is no competition what is the
1348 point? But if you could, answer that with regard to the data
1349 or some suggestions.

1350 *Dr. Whaley. Most of these transactions are incredibly
1351 opaque, which makes it hard for researchers, policymakers,

1352 and patients to know who employs a given doctor. And I think
1353 it is critical that we have transparency around these efforts
1354 to actually make sure that we are monitoring these markets
1355 and ensuring competition. And we have seen several examples
1356 of this at the state level, where they actually require, I
1357 think, meaningful ownership disclosure.

1358 *Mr. Pallone. No, I agree and I appreciate it. I just
1359 think that transparency is important. Without transparent
1360 ownership data, health care consolidation is going to
1361 continue unchecked.

1362 I mean, you know, in my state we have basically two
1363 large systems now -- I mean, a few others, but there is not
1364 really -- you know, the competition is not really there
1365 anymore, in my opinion. And given the impact of health care
1366 costs and patient outcomes, I mean, policymakers and
1367 regulators need to -- better visibility into the ownership
1368 structure.

1369 And I support, obviously, efforts to strengthen price
1370 transparency, but we are not going to be able to achieve it
1371 without ownership transparency. I mean, that is the key. So
1372 thank you. I appreciate the comments from both of you.

1373 I yield back, Mr. Chair, now.

1374 *Mr. Griffith. [Presiding.] Thank you. The gentleman
1375 yields back, and I appreciate my vice chair taking over while
1376 I had to go to another committee where my vote was needed.

1377 So I do apologize to the witnesses and the members as well.

1378 There you go.

1379 So now I will begin my questioning. I yield to myself
1380 the five minutes that I am allotted.

1381 Let's try to get things straightened out, Ms. Skenes,
1382 for folks back home. Can you briefly explain how hospital
1383 prices are set with all the different insurance plans that
1384 individuals have, and if these are the prices that the
1385 hospitals post?

1386 *Ms. Skenes. Yes, thank you for the question. A number
1387 of different ways through negotiated rates that may be
1388 straight-forward dollar values, something like a case rate,
1389 or based on a specific fee schedule. And then you get into
1390 more nuanced options. Maybe it is a percentage based on the
1391 claim-specific total charge or a per diem rate, depending on
1392 the number of days the patient is in the hospital. Then
1393 there is additional exceptions for high-acuity care known as
1394 stop loss or outlier clauses.

1395 All of these percentages of Medicare, you know,
1396 percentages of statewide fee schedules, any number of these
1397 -- one, two, or all of them -- could exist in these payer-
1398 provider-negotiated rate contracts. And so what you see in
1399 the files is both a list of the charges, but also those
1400 negotiated rates.

1401 So, you know, for a consumer, the ability to download

1402 that information and understand meaningfully what does that
1403 mean based on your own cost sharing amount is quite
1404 difficult. That is a high barrier to entry.

1405 *Mr. Griffith. So there is not a standard price that
1406 each hospital insurance company plans start their
1407 negotiations from. Or is there a price they start from and
1408 then they negotiate from there?

1409 *Ms. Skenes. Yes, there is typically -- particularly if
1410 the hospital is already in network with the payer, they will
1411 renegotiate based off of the rates that are currently in
1412 existence, and that is a lot of what the rate data has been
1413 used for, is understanding what a fair rate is in comparison
1414 to the market, whether it is in the state or maybe it is
1415 other hospitals that offer similar treatment options. That
1416 is where their ability is to look for what the appropriate
1417 rate is for the services.

1418 *Mr. Griffith. And I think you have already answered
1419 that it is -- that makes it -- all of the different things
1420 that go on makes it difficult for hospitals to post these
1421 prices because of the variables. Is that accurate?

1422 *Ms. Skenes. Most of them are posting the rates. And
1423 the challenge then for groups like us and like Mr. Gremminger
1424 shared is taking that information, which is accurate at that
1425 granular level, and then translating that into so what does
1426 it mean for an employer who is looking for care? What does

1427 it mean for a patient who is looking for care? And that is
1428 where I think that translation layer of taking something that
1429 is inherently machine readable and making it more consumer-
1430 friendly, particularly if the underlying data is accurate,
1431 which we are seeing, then we have a better chance of helping
1432 patients understand what it costs.

1433 *Mr. Griffith. So what we need to do is get that
1434 standard price out there so then people can have some idea.

1435 Now, I just have to bring this up and my team back here
1436 is rolling their eyes because we have talked about it before.
1437 I pulled into the gas station at Raphine, Virginia. There is
1438 about five or six of them. They have their price posted.
1439 But then there is a touch screen. And when I pulled into --
1440 this week, I chose the Shell, they had one of the lowest
1441 prices. And then they gave me, like, four or five different
1442 rewards programs I could be a part of. And I chose the
1443 Kroger program and got \$0.10 a gallon off.

1444 Can we not create something -- I know it is more
1445 complicated than the four or five options that Shell offered
1446 me as to, you know, their own program, the Kroger program
1447 that they are affiliated with, or others, but can we not,
1448 with -- and you mentioned AI in your opening statement -- can
1449 we not use AI so that me, as the consumer who is not as
1450 familiar with purchasing something that I may need in the
1451 future -- God forbid, a knee transplant or a knee replacement

1452 or something -- can we not have it so that, you know, I plug
1453 in that I am with Anthem, Blue Cross Blue Shield care and
1454 have the price pop up so I can see what is going on?

1455 *Ms. Skenes. Yes. I mean, first and foremost, Kroger
1456 doesn't exist in South Carolina, so I am jealous that you had
1457 that discount at the gas station.

1458 But secondly, I think you are exactly right.

1459 *Mr. Griffith. And they all have them, Sheetz and
1460 Circle K, I mean, I have got all kinds of memberships.

1461 *Ms. Skenes. Yes. And I think secondly, to your point,
1462 the idea is the clinical complexity that goes into all these
1463 underlying different data points tied to what is actually on
1464 a claim is not a level of information that a patient is going
1465 to have access to. You go to the gas station, you know which
1466 of the two types of gases you are going to get, and then you
1467 get to pick a rewards program.

1468 So from our perspective, the onus is on the industry to
1469 create open license and more patient-friendly service
1470 packages so they can say I need a knee replacement, I have
1471 Anthem -- that is what our consumer cost tools do -- and not
1472 go through all the machinations of what are the specific
1473 codes behind that, and making the patients just end at just I
1474 need a knee replacement, I have this insurance.

1475 *Mr. Griffith. And my time is just about up, but don't
1476 you think AI can help us with that?

1477 *Ms. Skenes. Absolutely, and --

1478 *Mr. Griffith. So we are right around the corner from
1479 being able to do this so everybody can know what is going on.
1480 I have to yield back, I apologize, and I may have questions
1481 for the record.

1482 [The information follows:]

1483

1484 *****COMMITTEE INSERT*****

1485

1486 *Ms. Skenes. Thank you.

1487 *Mr. Griffith. I now go to Dr. Ruiz for his five
1488 minutes of questioning.

1489 *Mr. Ruiz. Thank you, Mr. Chairman.

1490 The majority has called yet another hearing to present
1491 their ideas to lower costs for patients. Well, here is the
1492 thought. If you really want to make health care more
1493 affordable and more accessible for people, you don't cut \$1
1494 trillion from Medicaid. You don't impose more red tape
1495 paperwork and make sick people jump through even more hoops.
1496 And you don't negligently let the premium subsidies people
1497 rely on to afford coverage expire. You just don't.

1498 The title of this hearing boasts "lowering health care
1499 costs," but the nine bills under consideration today miss
1500 the mark. Transparency is greatly needed, but requiring
1501 hospitals and insurance companies to publicly display just
1502 how much patients are getting ripped off isn't going to stop
1503 patients from being ripped off. In fact, competition thrives
1504 when there is a choice. And in a lot of health care systems
1505 there is no choice. You have to go to the hospital that your
1506 insurance company requires you to or see the doctors that
1507 they require you to. And as an emergency physician, I can
1508 tell you that when you are in an emergency somewhere, you
1509 have no choice. You come into the emergency department, you
1510 get that MRI, that CAT scan. You are not choosing when they

1511 are trying to provide you the kind of emergency care.

1512 Publicly disclosing prices isn't going to keep safety
1513 net hospitals from shutting their doors because they can't
1514 afford the latest Republican cuts: over \$600 billion of
1515 decreased revenues to hospitals. More than 400 rural
1516 hospitals across the country are at risk of closure now,
1517 including several in the congressional district I represent.
1518 So where is the choice when your only hospital in a rural
1519 area has closed, and now you have to drive even further
1520 during an emergency? Suddenly your risk of permanent injury
1521 or death from stroke or heart attacks has skyrocketed.

1522 So we all agree that health care has become unaffordable
1523 and less accessible, but we need to dig deeper to address
1524 that growing problem, especially since it has been
1525 exacerbated by Republicans' fabricated health care crisis
1526 driven by that One Big, Beautiful Bill, better known as the
1527 big ugly law.

1528 Ms. Tripoli, which would have a more direct impact on
1529 health care access and affordability, making prices public or
1530 restoring ACA enhanced premium tax credits for millions of
1531 Americans?

1532 *Ms. Tripoli. Thank you for the question.

1533 Without question, restoring the enhanced premium tax
1534 credits would bring affordability immediately to millions of
1535 Americans who need a short-term fix.

1536 And also, price transparency is critical, as is
1537 ownership transparency, because in addition to providing out-
1538 of-pocket protection for consumers, we also have to address
1539 the root drivers of why premiums are so high in the first
1540 place.

1541 *Mr. Ruiz. So again, I liken this to the patients that
1542 come into the emergency department with multi-organ failure
1543 and a rash, right? Like, let's say a diabetic coming in in a
1544 coma. You have to treat the emergency first, and the
1545 emergency is the ACA tax credits expiring and the near
1546 trillion-dollar cuts to Medicaid. You have to deal with
1547 that. Otherwise, you are only dealing with the rash.

1548 Yes, we have to deal with the rash at some point, but
1549 you have to save the patient's life first. Okay? This
1550 hearing is about dealing with the rash and ignoring that the
1551 patient is dying because of the crisis that they created. So
1552 again, Ms. Tripoli, which would have a more direct impact on
1553 health care access and affordability, making prices public or
1554 reversing the \$1 trillion Medicaid cuts?

1555 *Ms. Tripoli. We absolutely have to reverse the
1556 trillion dollars of cuts to health care, including the
1557 disproportionate impact it has had and will continue to have
1558 on Medicaid.

1559 At the same time, we do need price transparency to
1560 address the root drivers of the affordability crisis.

1561 *Mr. Ruiz. So with the near \$1 trillion Medicaid cuts,
1562 that is going to -- and the ACA tax credits expiring, that is
1563 going to leave 15 million people uninsured. They are going
1564 to be uncompensated care. And we heard from insurance
1565 company CEOs in this hearing, in this hearing room, that the
1566 hospitals are going to renegotiate their prices to cover the
1567 uncompensated care. They are going to pay those prices, and
1568 so they are going to -- and they already have -- increase
1569 premiums for everybody.

1570 I yield back.

1571 *Mr. Griffith. The gentleman yields back. I now
1572 recognize the gentleman from Ohio, Mr. Balderson, for his
1573 five minutes of questioning.

1574 *Mr. Balderson. Thank you, Mr. Chairman, and thank you
1575 all for being here this morning -- this afternoon. My first
1576 question is for Mr. Skenes.

1577 Thank you for being here. As machine-readable files for
1578 hospital and insurance pricing have continued to improve, can
1579 you give us an example of how your company has been able to
1580 leverage this more actionable data to improve market
1581 competition and help consumers and employers shop for care?

1582 *Ms. Skenes. Thank you for the question.

1583 To your first part, that is right. We primarily see the
1584 accuracy of the data play out in the elimination of needing
1585 to go back and forth to verify what the correct rate is when

1586 payers and providers are negotiating for a fair market value
1587 rate.

1588 From an employer perspective, alongside other data sets
1589 like claims data, it allows them to see the different
1590 scenarios that their specific employee group is high
1591 utilization and, you know, essentially adding the ability to
1592 look at the price data way alongside quality data and ensure
1593 that they are upholding their fiduciary responsibilities to
1594 providing that care.

1595 And then, from a consumer perspective, I would touch
1596 just briefly on this recent boon in the way patients are
1597 engaging with AI to ask what the cost of their care is. We
1598 have started to see that feeding through, for example, with
1599 our work with New York City, where the machine-readable file
1600 data itself powers the prices that patients are receiving
1601 when they use our cost comparison tool alongside the ability
1602 to input which insurance they have so that they don't have to
1603 actually go through the files. They can see one rate, an
1604 accurate rate, and then, with the understanding of their own
1605 cost sharing, see what it costs them. The idea is then that
1606 could scale if that underlying data is accurate in AI uses,
1607 that patients will have access.

1608 *Mr. Balderson. Okay, thank you. A follow-up to that:
1609 As Congress looks to strengthen price transparency
1610 requirements, what concrete steps should we consider to

1611 improve the usability of this data?

1612 *Ms. Skenes. Thank you for the question. There is a
1613 number of things that are currently not available in the data
1614 that we think are crucial for understanding the full cost of
1615 care.

1616 The first of that is either stop loss or outlier
1617 reimbursement. This is, you know, upwards of \$100 billion
1618 worth of cost every year for patients who are extremely sick
1619 or needing high-acuity services. That is not currently a
1620 requirement in either the hospital or the payor machine-
1621 readable files. But particularly for employers, it matters
1622 significantly for understanding how to best cover their
1623 employees.

1624 There is also a gap in drug coverage reporting that
1625 would be helpful to add, and then ensuring anything
1626 specifically tied to non-dollar-value rates. So percentage-
1627 based reimbursement, algorithm-based reimbursement, we want
1628 to make sure that however that is codified in the rules that
1629 pass, that information is required, the calculus is required
1630 so that we understand the dollar value of the rate.

1631 *Mr. Balderson. All right. Thank you very much. Well
1632 done.

1633 Mr. Gremminger, as Congress looks to ways to strengthen
1634 health care price transparency, can you explain how employers
1635 are already using this data? First question.

1636 For example, how are they using it to steer employees
1637 towards higher-quality providers, pursue direct contracting
1638 arrangements, or build tiered provider networks?

1639 And what does that ultimately mean for the cost of their
1640 employers' care?

1641 *Mr. Gremminger. Thank you very much for --

1642 *Mr. Balderson. That is a bunch of questions right
1643 there, but --

1644 *Mr. Gremminger. Sure.

1645 *Mr. Balderson. -- if you can -- thank you.

1646 *Mr. Gremminger. So what we have seen in the research
1647 that we have done as we have surveyed employers is that folks
1648 that have better access to the data are, in fact, using it in
1649 meaningful ways. So I will give you one of the things you
1650 mentioned, sort of steering toward higher-quality, lower-cost
1651 providers.

1652 If you are able to look at and really be able to digest
1653 and understand the data that we come -- that comes out of
1654 Turquoise, you can see where, just within your own insurance
1655 network, which hospitals are priced lower than maybe the ones
1656 that you currently have or that you see most of your patients
1657 going to. Then you can direct patients using usually cost
1658 sharing changes to say, instead of going to hospital X for
1659 your knee replacement, we want to encourage you to go to
1660 hospital Y because we know that the negotiated prices are

1661 substantially lower.

1662 You can look and say, well, we have seen a hospital that
1663 has really high quality and relatively low cost. Let's see
1664 if we could create a center of excellence program where we
1665 actually provide, you know, meaningful direction for
1666 employees to go to that specific hospital to receive care.
1667 The end result is we are seeing lower overall trend for those
1668 employers that are able to engage in those kinds of
1669 practices.

1670 But I also want to be clear, that is sort of a marginal
1671 one or two percent, you know, trend change off of some of the
1672 highest health care trend that we are seeing in the United
1673 States today. These changes are important, but in the end
1674 being able to make those things are still somewhat at the
1675 margins.

1676 *Mr. Balderson. Okay, thank you very much.

1677 Mr. Chairman, I yield back.

1678 *Mr. Griffith. The gentleman yields back. I now
1679 recognize the gentlelady from Michigan, Mrs. Dingell, for her
1680 five minutes of questioning.

1681 *Mrs. Dingell. Thank you, Mr. Chair, and thanks to both
1682 you and Ranking Member DeGette for holding this important
1683 hearing, because health care cost transparency is really
1684 important.

1685 Patients are navigating an unreasonably complicated

1686 system and paying outrageous bills that don't seem to reflect
1687 the level of care they receive. Total health care spending
1688 and insurance premiums continue to increase at rates much
1689 faster than the economy, the rest of the economy. Families
1690 are then left to face impossible decisions between care and
1691 other household necessities.

1692 While patients struggle, major companies are buying up
1693 various entities in the health care supply chain,
1694 consolidating power, gaming our broken system to inflate
1695 costs, deny care, and pad their bottom lines. You know that
1696 this is called vertical integration. Vertical integration
1697 allows companies to enrich themselves with taxpayer money,
1698 evade laws meant to hold companies accountable. I have seen
1699 too many examples of this in recent months and, point blank,
1700 vertical integration harms patients, taxpayers, and
1701 independent doctors and pharmacists who cannot compete with
1702 massive consolidated companies.

1703 We need meaningful reforms to address this, not the
1704 half-baked plans and secret deals with drug companies that we
1705 have heard about recently, all with few substantive details
1706 that explain how they will tangibly benefit patients.

1707 So Ms. Tripoli, let me start with you. In your
1708 testimony you mentioned the need for greater transparency
1709 around health-related ownership information, which I agree
1710 with you. What gaps currently exist in oversight and

1711 reporting requirements for ownership across the health care
1712 industry?

1713 And how could stronger disclosure requirements improve
1714 accountability, patient care outcomes, and the costs for
1715 consumers?

1716 *Ms. Tripoli. Thank you so much for the question.

1717 I think, by and large, there is so much consolidation
1718 happening in the system -- horizontal, vertical integration
1719 as well. But it is essentially a giant black box. We
1720 actually don't -- we have very, very little information into
1721 these smaller transactions that are not raising to the level
1722 where they would trigger Federal oversight and antitrust
1723 enforcement and laws. And so they are flying underneath the
1724 hood. I think Dr. Ippolito called them stealth mergers and
1725 acquisitions, which -- I love that term because that is
1726 exactly what they are.

1727 So we actually need the legislative -- the discussion
1728 draft that we -- that is for today's hearing on ownership
1729 transparency, that is a piece of legislation that would help
1730 to break that wide open and give us very critical information
1731 about how these mergers and acquisitions are actually
1732 occurring, who owns the care. And then we would have much
1733 greater information at scale for Federal and state regulators
1734 to actually intervene on these health care transactions.

1735 *Mrs. Dingell. Thank you. I just -- I don't think

1736 people -- I had a sister who was hospitalized. And people
1737 don't understand that even the medical practices are being
1738 bought up by the hospital and the -- it is impacting patient
1739 care.

1740 So I would like to ask you, how does the lack of
1741 transparency surrounding ownership among all the entities
1742 impact the quality of patient care? Specifically, I mean, it
1743 is -- I can give you some examples, but I would like you to
1744 give it to me.

1745 And how does it make it easier for providers to jack up
1746 prices and for some of these corporate entities to deny care
1747 or say you don't need it, and for -- and how do patients
1748 dispute these decisions?

1749 *Ms. Tripoli. Absolutely. Because it is a black box
1750 and because we don't actually have this information, there is
1751 actually not a ton of oversight, Federal or at the state
1752 level oversight or regulation about these types of
1753 transactions, to flag them and to investigate them about
1754 whether there is going to be a benefit to the community or
1755 whether it is, in fact, just going to increase prices and
1756 reduce access to care. And in some cases, as is the case
1757 with private equity and venture-backed -- capital-backed
1758 purchases, the real estate that the facility is sitting on is
1759 more profitable than the business itself. And so they close
1760 it down and they sell it off. They can sell off the property

1761 itself.

1762 So we need the transparency data so we can know what is
1763 happening under the hood, and then we can allow Federal and
1764 state regulators to intervene and analyze what is happening
1765 in these markets and address the very deep consolidation that
1766 is occurring and driving up the cost of care.

1767 *Mrs. Dingell. So I am down to 28 seconds, so I am
1768 going to ask you in writing what more does Congress need to
1769 do to tackle the negative impacts. But not only when you
1770 talk -- when private capital are taking over, they are
1771 telling how long a doctor can spend time with, they are
1772 telling whether they can give them further care. They are
1773 making medical decisions, and people do not know that it is
1774 venture capitalists that are making medical decisions. Thank
1775 you. Thank you for your work on this.

1776 And I yield back, Mr. Chair.

1777 *Mr. Griffith. I appreciate the gentlelady yielding
1778 back and now recognize Dr. Mariannette Miller-Meeks for her
1779 five minutes.

1780 *Mrs. Miller-Meeks. Thank you very much, Mr. Chairman,
1781 for holding this extremely important hearing, and I want to
1782 thank our witnesses for being here today.

1783 Health care costs continue to place significant
1784 financial strain on American families, employers, and
1785 taxpayers. It is why I introduced and the House passed the

1786 Lower Health Care Premiums for All Americans Act to address
1787 these issues, and why one of the bills we are considering is
1788 Lower Cost, More Transparency Act of 2026, which this
1789 committee has previously passed.

1790 While patients are often encouraged to shop for care and
1791 make informed decisions, too many still lack access to clear,
1792 timely, and usable information about the cost of services. I
1793 look forward to discussing these proposals that aim to
1794 improve transparency across the health care system and
1795 strengthen accountability for providers and insurers, and,
1796 most importantly, empower consumers with the information they
1797 need to make informed choices.

1798 Dr. Ippolito, did the unaffordable care act, or
1799 Obamacare, hasten and promote consolidation and vertical
1800 integration that my colleague just mentioned?

1801 *Dr. Ippolito. I think it probably weekly encouraged it
1802 through things like coordinated care and the emphasis on
1803 that. That was seen at that time as beneficial for
1804 coordinating and improving --

1805 *Mrs. Miller-Meeks. Hospital outpatient departments.
1806 Did that increase cost of care?

1807 *Dr. Ippolito. The --

1808 *Mrs. Miller-Meeks. I mean, there are many of us who
1809 predicted that this would occur, and it has occurred in an
1810 accelerated pace and rate.

1811 Dr. Whaley and Dr. Gremminger, you each noted how
1812 employers can leverage price transparency data along with
1813 their own claims data to ultimately make health care costs
1814 more affordable for their employers. Should employers have
1815 access to covered employees' claims data to help employers to
1816 better negotiate premiums from insurance companies?

1817 *Dr. Whaley. Absolutely, and it is necessary for them
1818 to be responsible fiduciaries.

1819 *Mrs. Miller-Meeks. And how have you seen employers
1820 shift care to lower-cost settings or providers using price
1821 transparency data?

1822 *Dr. Whaley. I provide several examples of my
1823 testimony. One example comes from the 32BJ Health Fund,
1824 which used their own data to recognize that a single provider
1825 was charging prices that were excessive, and they used their
1826 own data to exclude that provider from their network, saving
1827 their plan over \$100 million.

1828 *Mrs. Miller-Meeks. And Mr. Gremminger?

1829 *Mr. Gremminger. The example that Dr. Whaley provided
1830 is an excellent one. We have seen smaller employers do
1831 similar things.

1832 There is a belief sometimes that only large employers
1833 have sort of market -- you know, are able to be market
1834 movers. But we found that in smaller locations we have even
1835 seen employers engage in sort of tiered pricing strategies in

1836 which you will say with -- keeping the open network, saying
1837 we found that this hospital is overpriced in this particular
1838 service, and we are going to use a tiered co-pay to try to
1839 drive people to a lower-cost setting that is equally high
1840 quality.

1841 *Mrs. Miller-Meeks. Ms. Skenes, as price transparency
1842 data usability and machine-readable files improve, how can
1843 innovators leverage artificial intelligence -- or I would
1844 prefer to call it augmented intelligence -- to help consumers
1845 or employers find insights from this data to lower their
1846 health care costs?

1847 *Ms. Skenes. Thank you for the question. I think it is
1848 about meeting consumers where they are, which is
1849 understanding a data set that is machine readable is
1850 inherently not where consumers are going to find the answers
1851 to their questions. So can we take it a step further and
1852 bundle all of the known clinical policies, procedures, code
1853 sets that flow into the data and the machine-readable files
1854 and create open-license bundled service packages whereby a
1855 patient can say I need an MRI, and then they can get accurate
1856 pricing data flowing into the conversation they are having
1857 with whatever AI agent of their choosing?

1858 *Mrs. Miller-Meeks. Mr. Gremminger, as a physician I
1859 have seen firsthand my arch nemesis, the challenges prior
1860 authorizations can create throughout our insurance companies,

1861 be they private or public. And today we are considering
1862 discussion drafts that would require commercial health plans
1863 to provide greater transparency into prior authorization and
1864 claim denial rates, which we know -- about 90 percent of
1865 those are approved after the first review, so -- as well as
1866 the plan's overhead cost. How would this additional data
1867 benefit the employers you represent?

1868 *Mr. Gremminger. So first I will just say we very much
1869 support the discussion draft.

1870 You know, I think the employer perspective on prior
1871 authorization utilization management is a nuanced one, right?
1872 We have seen too often where physicians may inadvertently, or
1873 potentially intentionally, prescribe drugs that are higher
1874 priced than what is otherwise necessary, or try to do
1875 services that are unnecessary and may actually be harmful to
1876 patients. That is a rarity, but we think it is important
1877 that there is actually an opportunity to say time out, let's
1878 look at something else.

1879 That being said, we do believe that the significant use
1880 of prior auth is often simply to just delay care, create
1881 float for the insurance plan, and then ultimately they are
1882 going to, 90 percent of the time, say yes. Understanding how
1883 often prior auth is being used not just by the carriers that
1884 we may be contracted with but by other carriers will then
1885 provide more information for employers to say, you know, I

1886 don't like the way that we are doing it internally, we found
1887 there is this other carrier over here, we have their data, we
1888 want to shift to them because we think that they are doing
1889 this better.

1890 *Mrs. Miller-Meeks. And/or claims denial. I will add
1891 that in, as well. Thank you very much.

1892 I yield back.

1893 *Mr. Griffith. The gentlelady yields back. I now
1894 recognize the gentlelady from California, Ms. Barragan, for
1895 her five minutes.

1896 *Ms. Barragan. Thank you, Mr. Chairman. I think this
1897 is an important hearing, and I appreciate that we are doing
1898 it today.

1899 Ms. Tripoli, do you think it is important for patients
1900 to have timely and accurate access to information about their
1901 own health and medical records?

1902 *Ms. Tripoli. Absolutely. I think one of the
1903 challenges right now in the health care system is that the
1904 data doesn't follow the patient. So you show up in the
1905 MedStar hospital system and your data sits there, but if you
1906 see a primary care doctor at the GW facility a couple of
1907 weeks later your data is in two different places. And so it
1908 makes it much more difficult for the providers to coordinate
1909 your care and make sure that they can meet your health needs.

1910 *Ms. Barragan. Do you think there is any connection or

1911 tie to that and the cost of health care or transparency?

1912 *Ms. Tripoli. I think, in general, there is absolutely
1913 a need for -- there are a lot of different areas in health
1914 care system where we need greater transparency over prices,
1915 over ownership data. We also do need a lot more work on sort
1916 of the back-end complexity of the system, making sure that
1917 there is data sharing across providers, interoperability
1918 standards so that data can flow -- with patient privacy
1919 protections, of course.

1920 All of those tools together help to streamline and
1921 improve the experience of health care system for the American
1922 people, lower health care costs, make sure they can get the
1923 care that they need.

1924 *Ms. Barragan. Do you have any idea why a -- why
1925 somebody like a doctor or a provider would not want to
1926 provide timely access to a patient, their health care file
1927 and the notes?

1928 *Ms. Tripoli. I am -- off the top of my head I am not
1929 sure. But what I do know is that there are data vendors that
1930 block data from flowing to providers. That is a business
1931 practice. That is a huge problem in terms of data access.

1932 My understanding and experience is, by and large,
1933 providers want to be able to leverage the data about their
1934 patient population to deliver the care that they need, but
1935 there might be other challenges, right, about the different

1936 data systems and -- that they are using across provider
1937 practices that make it very difficult for them to be able to
1938 do that, and I think that is an actual challenge of data
1939 sharing and interoperability of the system.

1940 *Ms. Barragan. So the reason I am asking is it -- I had
1941 an experience recently where I was trying to get access to my
1942 mother's hospice file, her medical records, to consider
1943 whether to move her to another hospice program. But for
1944 whatever reason I was told that it would take a long time if
1945 I wanted to get her medical file. But if I transferred her,
1946 the other company that would take over could get it
1947 immediately. And I have heard some theories on why that is
1948 the case.

1949 And, you know, this company called Compass is -- I
1950 wouldn't say has a stellar record, but does anybody here want
1951 to opine on why that may be the case, that it is hard for a
1952 patient to get their medical file?

1953 *Ms. Tripoli. I mean, the one thing -- and then, of
1954 course, other witnesses should respond too -- but I think the
1955 one thing, of course, is if the patient stays in that
1956 practice, that is volume that they can then bill for. So I
1957 think there is a financial incentive to keep patients with
1958 the providers that they are seeing.

1959 And there are hurdles in terms of getting providers to
1960 share data. Some of that is the complexity of the system in

1961 itself.

1962 *Ms. Barragan. Do you think that Congress should pass
1963 legislation to ensure that all Americans have access to their
1964 comprehensive digital health records in real time?

1965 *Ms. Tripoli. Absolutely.

1966 *Ms. Barragan. Well, thank you. This is National
1967 Health Data Week, and it is a week of action focused on
1968 demonstrating the power of health data to drive positive
1969 outcomes for patients. As the owners of their health care
1970 information, patients, I think, should have access, timely
1971 access to their medical records and any notes about them
1972 without unnecessary administrative or financial burdens. I
1973 can tell you I was shocked when I had heard about, oh, well,
1974 we got to go through legal and this and that, but if I give
1975 it to another hospice company right away they can get it
1976 right away.

1977 Ms. Tripoli, I want to ask you. It has been touched
1978 upon a little bit. In your testimony you point out that
1979 colonoscopy can range at the University of Mississippi
1980 Medical Center from \$782 to \$2,144, depending on insurance.
1981 And I recently heard a story about a colonoscopy procedure
1982 that was affected by differences in reimbursement across care
1983 settings. Why is it that patients sometimes pay almost three
1984 times as much for the same procedure?

1985 And how would greater price transparency help families

1986 avoid these unnecessary costs?

1987 *Ms. Tripoli. Absolutely. I mean, the biggest
1988 predictor is consolidation. These prices are set based on
1989 who has more, which institution has more market power, the
1990 hospital system or their insurer. And the reality is that
1991 the vast majority of hospital markets are highly
1992 consolidated. And so that is a major reason why we are
1993 seeing not only that prices are so high, but we see for a
1994 single service like a colonoscopy or a knee surgery,
1995 incredible variation across the country, across the state,
1996 within a particular plan.

1997 *Ms. Barragan. Great, thank you.

1998 I yield back.

1999 *Mr. Griffith. The gentlelady yields back. I now
2000 recognize the gentleman from Pennsylvania, Mr. Joyce.

2001 And if you would take -- and we are going to give you an
2002 extra 15 to 30 seconds to talk about sunscreen for a quick
2003 second.

2004 *Mr. Joyce. Well, thank you, Mr. Chairman, and thank
2005 you to this committee. I am pleased to report that -- the
2006 FDA's approval of Benzotriazole, the first new sunscreen
2007 ingredient in over 20 years in America. This came out of
2008 this committee with bipartisan support. Mr. Chairman, it
2009 shows what we can do when we work together, and I am proud,
2010 as a board certified dermatologist, to report how important

2011 new sunscreens are in preventing skin cancers, something that
2012 we have seen over the last decades, the rise in skin cancers
2013 in young individuals.

2014 Talking about working together, I would like to continue
2015 for talking about what we are doing and we are doing together
2016 with increasing transparency in health care. For far too
2017 long, patients and purchasers of insurance products have been
2018 kept in the dark about the true cost of medical care. While
2019 we have made important strides both administratively through
2020 legislation and passed in this committee, we know that much
2021 more needs to be done.

2022 In November of 2019 HHS issued rulemaking that requires
2023 hospitals to publish prices as of January 2021. Hospitals
2024 are required to publish a machine-readable file of five types
2025 of standard charges for all items and services. They are
2026 also required to create a consumer-friendly shoppable list of
2027 300 items and services, including 70 identified by CMS.

2028 While I am pleased to see data from my home state of
2029 Pennsylvania indicates that over 90 percent of Pennsylvania
2030 hospitals are in compliance with key components of this rule,
2031 a November 2024 report issued by HHS estimated that 46
2032 percent of all eligible U.S. hospitals were not complying
2033 with the HPT rule requirements. Less than 50 percent, that
2034 is unacceptable.

2035 I was further concerned to see the announcement from

2036 Secretary Kennedy and Administrator Oz that there are over
2037 500 hospitals still out of compliance. Mr. Whaley, do you
2038 feel that the current transparency requirements are
2039 sufficient and being adequately enforced to give patients an
2040 accurate view to enable them to shop effectively for care
2041 when possible?

2042 *Dr. Whaley. I think they are a good start, but not
2043 sufficient and, as you noted, not being sufficiently
2044 enforced.

2045 *Mr. Joyce. Ms. Tripoli, do you concur with that
2046 assessment? It is not an adequate amount. Do you agree?

2047 *Ms. Tripoli. Absolutely. That is why we need the
2048 codification of the legislation being considered today.

2049 *Mr. Joyce. And I think that is important legislation,
2050 again, that we can consider and implement in a bipartisan
2051 fashion.

2052 Ms. Tripoli, you also cited hospital consolidation of
2053 independent physician practices as a key driver of increasing
2054 health care costs. Would you view policies that incentivize
2055 independent practices as an important safeguard against the
2056 rising health care costs that we continue to see throughout
2057 America?

2058 *Ms. Tripoli. I think, absolutely, we want to address
2059 that incentive for big systems to buy up physician practices.
2060 The best policy solution to address that is to advance this

2061 comprehensive, site neutral payment policy.

2062 *Mr. Joyce. Mr. Whaley, in your testimony you described
2063 physician-owned hospitals showing a substantial reduction in
2064 outpatient costs when compared to their non-physician-owned
2065 counterparts. Would repealing the prohibition of physician-
2066 owned hospitals be a good initial step to stop that rising
2067 cost?

2068 *Dr. Whaley. I think it would be a good step to improve
2069 affordability and add competition.

2070 *Mr. Joyce. Finally, I am pleased to see provisions of
2071 the Seniors Timely Access to Care Act surrounding prior
2072 authorization denial rates included in this hearing today.
2073 While I urge passage of this critical legislation overall,
2074 Mr. Ippolito, can you elaborate on why public disclosure of
2075 denial rates is a benefit to the American patient?

2076 *Dr. Ippolito. Sure. I mean, surveys have shown
2077 clearly people care a lot about denial rates, they care a lot
2078 about prior authorization rates, yet they can't really
2079 observe that. So it would be a natural feature to make clear
2080 to patients when they actually choose a plan so they can tell
2081 us how much are they willing to pay to have less denials,
2082 less prior authorization.

2083 *Mr. Joyce. When you have the input from the patient,
2084 does that allow you to provide better coverage, better
2085 insight, and better education to the patient of what policies

2086 cover?

2087 *Dr. Ippolito. Well, sure. As a first order thing, it
2088 tells the insurance companies how to design plans that people
2089 actually want. And that strikes me as a first order
2090 importance.

2091 *Mr. Joyce. I think that first order of importance,
2092 that message is not lost on us here today in the committee.

2093 Mr. Chairman, I thank you for the additional time and I
2094 yield back.

2095 *Mr. Griffith. The gentleman yields back. I now
2096 recognize Ms. Kelly of Illinois for her five minutes of
2097 questioning.

2098 *Ms. Kelly. Thank you, Chair Griffith and Ranking
2099 Member DeGette, for holding today's hearing.

2100 Lowering health care costs and improving health care
2101 access for all Americans is something everyone should be able
2102 to get behind, yet this Administration has been misleading
2103 the public about their work to make health care less
2104 accessible and more expensive. A great example is passing
2105 the one big, ugly bill, taking away one trillion -- nearly
2106 one trillion in funding from Medicaid under the false
2107 narrative of fraud, waste, and abuse.

2108 Dr. Whaley, for a family weighing where to get an MRI or
2109 a lifesaving procedure, for example, the current price
2110 transparency posting can be difficult to navigate and

2111 understand what the out of costs (sic) will be. What
2112 policies would you recommend to close that gap?

2113 *Dr. Whaley. As I highlight in my testimony, it is
2114 important to not just think of price transparency as a way to
2115 inform patients making decisions, but actually how networks
2116 are designed and choices are made upstream of the patient.
2117 So the patient's, say, insurance plan or employer can
2118 actually exclude high-priced and low-quality providers from
2119 the network.

2120 *Ms. Kelly. Thank you.

2121 Ms. Tripoli, my district encompasses urban, suburban,
2122 and rural communities, and we are seeing significant
2123 financial strain on rural critical access hospitals and a
2124 loss of services in these areas. How might hospital and
2125 physician pricing transparency reforms affect rural hospitals
2126 and their patients?

2127 *Ms. Tripoli. I think price transparency, when we get
2128 it right, is a benefit to consumers across the country,
2129 including rural residents living in your district, and I
2130 think will provide a great value. I think rural hospitals
2131 should be able to comply. Many of them are.

2132 And I think the main question here is, like, if these
2133 hospitals can generate a bill and send it to a patient, then
2134 they should be able to tell us what the price is before the
2135 patient gets the care.

2136 *Ms. Kelly. And I was just saying to someone that I had
2137 -- it wasn't a rural hospital, but -- a procedure, and I
2138 didn't realize until I went there and they said, oh, you owe
2139 this amount of money right before I had the procedure. So
2140 yes, I was quite shocked.

2141 But thank you to the witnesses and for being here. But
2142 in order to improve the lives and health of all Americans, we
2143 need to build on the bipartisan work we have accomplished
2144 with the No Surprises Act and the previous iteration of the
2145 Lower Cost, More Transparency Act, not defunding, not
2146 dismantling more of the health care system, but putting
2147 people over profits is the only way forward.

2148 And I yield back. Thank you.

2149 *Mr. Griffith. The gentlelady yields back. And I now
2150 recognize the gentleman from Michigan, Mr. James, for his
2151 five minutes of questioning.

2152 *Mr. James. Well, thank you, Mr. Chairman. I
2153 appreciate you holding this hearing today, and a special
2154 thank you to our hard-working staff working on getting this
2155 to a position where we can get it to the people, getting a
2156 hearing today.

2157 Congress is not doing enough to lower the cost of health
2158 care. We can help people save money by passing my bipartisan
2159 and bicameral Patients Deserve Price Tags legislation. The
2160 idea behind this legislation is simple: it will make it

2161 easier for patients to price compare when getting medical
2162 treatment so that they can pick the lowest-cost option, just
2163 like they do in every other aspect of their lives.

2164 People drive out of their way to fill up on cheaper gas.
2165 They check different websites for the best price before
2166 making an online purchase. They price compare before buying
2167 a flight. They get an estimate before making house repairs.
2168 So why can't the people price compare before getting a
2169 medical procedure? Because it is too hard. The people are
2170 forced to blindly pay whatever it costs because hospital
2171 prices are confusing and hard to find. The system is too
2172 complicated by design. It is a confusopoly. As a result,
2173 patients end up paying hundreds of thousands of dollars more
2174 for the exact same services and the same level of care with
2175 the same billing codes.

2176 Patients Deserve Price Tags was part of a bipartisan,
2177 lower cost, more transparency legislation the House approved
2178 last term. It is not controversial. It passed the committee
2179 under suspension. The ranking member supported it, and then
2180 it passed the House 320 to 71. But the Senate, under Chuck
2181 Schumer, let the bill die. This term Senators Marshall and
2182 Hickenlooper are working on an identical version of this
2183 bill. They have 10 Democrats and 10 Republican Senators as
2184 cosponsors. That is one-fifth of the entire Senate already
2185 on board.

2186 In 2025 President Trump issued an executive order to
2187 make America healthy again, which included an April 1
2188 deadline for health care providers to comply with existing
2189 but unenforced price transparency laws. Yesterday, HHS
2190 Secretary Kennedy announced that the grace period had ended
2191 and that the Trump Administration is enforcing hospital price
2192 transparency. I applaud that leadership from the President
2193 and from the Secretary, and I applaud that action.

2194 My Patients Deserve Price Tags bill will make that
2195 change permanent and provide stronger enforcement for that
2196 mechanism for the American people. The Senate has members
2197 from both parties on board. My bill has members of both
2198 parties on board. The White House supports this. HHS and
2199 RFK, Jr. support this. Passing this bill again in the House
2200 should be a no brainer. We can and we must get this done for
2201 the American people.

2202 The great health care plan that President Trump put out
2203 in January has four main tenants: lower drug prices, lower
2204 premiums, hold big insurance companies accountable, and
2205 maximize price transparency. My price transparency act,
2206 again, is bipartisan and bicameral. This legislation
2207 bolsters each of those pillars. Patients Deserve Price Tags
2208 will lower health care costs by requiring hospitals to
2209 clearly label prices so that patients can make informed
2210 decisions about where they get treated to save money,

2211 increase quality of care.

2212 I urge the committee to pass this popular, bipartisan,
2213 bicameral bill that will lower health care costs for
2214 everyone. Thank you all for being here today.

2215 My first question is for Ms. Tripoli. From the patient
2216 perspective, what happens to a working family that cannot see
2217 the price of their care prior to receiving it?

2218 How does this opacity feed the medical debt crisis that
2219 is affecting an estimated 100 million Americans?

2220 *Ms. Tripoli. In my oral testimony and in my written
2221 testimony I shared some examples of consumers who have
2222 serious medical conditions, are living paycheck to paycheck,
2223 and needed the opportunity to shop around for certain
2224 services, and basically find -- found a dead end. They
2225 talked to insurers, to doctors, they talked to everybody, and
2226 no one could tell them how much something could cost.

2227 The result for Jessica, one of the storytellers that we
2228 share her story of, is that she had to delay her care for
2229 months, maybe even years before she was actually able to get
2230 the service, all because she couldn't find the price.

2231 *Mr. James. That is unacceptable. We have a sick care
2232 cartel problem in the country, and we have to tear down the
2233 sick care cartels to make sure that we are fighting for the
2234 people. I am excited for the support, the momentum behind
2235 this bill, and I am looking forward to getting this across

2236 the finish line.

2237 Again, Mr. Chairman, thank you for your leadership on
2238 this matter. I yield.

2239 *Mr. Griffith. The gentleman yields back. I now
2240 recognize the gentlelady from Washington, Dr. Schrier.

2241 *Ms. Schrier. Thank you, Mr. Chairman. Thank you,
2242 Ranking Member DeGette. And thank you to our witnesses for
2243 being here today.

2244 I have a constituent named Lawrence. He is from Granite
2245 Falls, Washington, which is a rural town in my district. He
2246 and his wife are super studious and diligent. And when they
2247 qualified for Medicare, they did their homework and they
2248 reviewed all the plans available to make sure that they would
2249 find the best one with the coverage that they needed. And
2250 they settled on a Humana Medicare Advantage plan, and
2251 eventually found a medical home at a clinic 40 minutes away.
2252 That is just -- when you live in a rural area, that is how
2253 far away it is. And Lawrence's doctor's clinic is owned by
2254 Optum, which is a subsidiary of UnitedHealth Group.

2255 Last year Optum announced that it would no longer be in
2256 network with Humana starting January 1 of this year, so
2257 Lawrence would not be able to see his doctor. Faced with
2258 having to either find a new provider or find new insurance,
2259 he ended up having to switch to a United Medicare Advantage
2260 plan to -- just to stay in network with his doc. Mr. Whaley,

2261 when United health insurance company and the owner of its own
2262 clinics and providers pulls Optum clinics out of competing
2263 insurance networks, how does United benefit from that?

2264 *Dr. Whaley. I think that is a clear concern of the
2265 payvider-type model, where a insurer, and particularly a
2266 Medicare Advantage insurer, can acquire a physician practice
2267 and essentially say to that physician, you could only treat
2268 my patients. And so if you are a patient on, say, a rival
2269 insurance plan, then you either have to change your doctor or
2270 lose access to your care or switch to a plan which maybe is
2271 more expensive.

2272 *Ms. Schrier. And so this behemoth just keeps growing.
2273 Like, it is already a monopoly and it becomes more of a
2274 novelty. UnitedHealth Group CEO Stephen Hemsley, when he
2275 came before this committee, he told us that United's vertical
2276 integration, the ownership of the clinics, the doctors, the
2277 pharmacy benefit managers, the pharmacy, he told us that it
2278 drives down prices. Is that true?

2279 *Dr. Whaley. We have seen no evidence that that is the
2280 case.

2281 *Ms. Schrier. Nobody else has seen evidence of that
2282 either. Thank you.

2283 This is a gigantic problem with our health care system.
2284 UnitedHealth Group is the poster child. It is a company with
2285 more than \$400 billion in annual revenue. It owns 1 in 10

2286 physicians in this country. It is the company that is the
2287 poster child, the biggest abuser of prior authorization that
2288 delays or denies care, frankly, as part of its business
2289 model. And this company is gobbling up the health care
2290 system and jacking up prices for all of us.

2291 Not only can they force beneficiaries into their own
2292 plans, they also get paid based on how sick they say a
2293 patient is, and they purposely make patients look sicker in
2294 order to pad their pockets even further. And it is a lot
2295 easier to exaggerate how sick somebody is if you own the
2296 doctor and the medical record system and the way that a
2297 problem list is generated, and add sometimes meaningless
2298 diagnoses that just sound really bad.

2299 Research shows that patients are labeled as sicker when
2300 the insurance company also owns the provider. This is the
2301 definition of a monopoly and market manipulation, and this is
2302 what consolidation looks like, and it is a huge part of what
2303 is driving up costs for patients. My constituents are sick
2304 of it, I am sick of it. I think I can speak for every doctor
2305 in Congress who is sick of it. And this committee needs to
2306 take even bolder and more meaningful steps to stop this.

2307 So Mr. Whaley and Ms. Tripoli, why is transparent
2308 ownership reporting important for health care entities?

2309 And what should this committee be doing to go further to
2310 break up UnitedHealth and other health care monopolies?

2311 *Dr. Whaley. So for the example you raised, it is very
2312 likely that the patient in your district had no idea that
2313 their doctor had been acquired by an insurance company. And
2314 likewise, the State of Washington probably didn't know. And
2315 Medicare through CMS also probably didn't know.

2316 And so if we are going to design policies to address
2317 this type of consolidation, we need to know actually who owns
2318 any individual doctor.

2319 *Ms. Schrier. So start with transparency and knowledge.
2320 Ms. Tripoli?

2321 *Ms. Tripoli. I would just add that one of the things
2322 we are also seeing in these vertically integrated plans --
2323 and UnitedHealth is a perfect example -- is that they are
2324 actually financially, like, offering bonuses to their
2325 providers to upcode to make their patients appear sicker.
2326 And there is documentation and evidence of that.

2327 And in these vertical -- this vertical integration, they
2328 are also able to pay above-market rates to their provider to
2329 the parent entities and to keep the delta so that they can
2330 actually appear on paper that they are meeting medical loss
2331 ratio requirements, but in fact they are actually subverting
2332 the Federal requirement and putting those to profits instead
2333 of to patient care.

2334 So I think some of the legislation for consideration
2335 today -- strengthening encounter data, more transparency over

2336 medical loss ratio requirements, and how plans in the MA
2337 program are spending their premium dollars -- all,
2338 incredibly, tools to help us understand what is happening as
2339 -- the effects of consolidation for better intervention.

2340 *Ms. Schrier. And then insistence that consumer dollars
2341 be spent on health care has been absolutely abused and
2342 perverted by insurance companies who are now controlling
2343 doctors.

2344 Thank you, I yield back.

2345 *Mr. Griffith. The gentlelady yields back. I now
2346 recognize the gentlelady from Florida, Mrs. Cammack, for five
2347 minutes.

2348 *Mrs. Cammack. Well, thank you, Mr. Chairman. Thank
2349 you to our witnesses for appearing before us here today.

2350 I think we are all on the same page, which is rare in
2351 Congress. Both Republicans and Democrats, we all agree the
2352 system is broken. So I think that is a great starting place
2353 for all of us here today, because I think we all agree that
2354 patients deserve to know what health care costs are before
2355 they receive care, not weeks later, not when the bill
2356 arrives.

2357 And of course, over the last several years Congress and
2358 multiple administrations have enacted transparency
2359 requirements intended to give patients, employers, and
2360 policymakers a clear picture of those costs. Yet every day

2361 Americans -- heck, colleagues on this panel here, we have all
2362 talked about this -- we still struggle to understand the
2363 prices, the coverage, and ultimately what we will owe for any
2364 procedure.

2365 Transparency, however, should not be the end goal. It
2366 is a part of it, yes, but the goal should be a more
2367 affordable, competitive, and accountable health care system,
2368 not a sick care system. As we consider additional
2369 transparency policies today, I am very interested in whether
2370 the information being disclosed is actually useful to
2371 patients and employers, and whether it helps identify the
2372 drivers of rising health care costs, and if it can empower
2373 consumers to make better decisions without adding unnecessary
2374 burdens that increase costs elsewhere.

2375 So we are going to do a quick round robin down the
2376 panel, starting with the first question, and I am going to
2377 ask you to be super brief and just give the name of the bill.
2378 Of all the proposals before us today that have been listed,
2379 which one is most likely to lower costs for patients and
2380 employers rather than simply produce more data?

2381 And I will start with you, Ms. Tripoli.

2382 *Ms. Tripoli. Patients Deserves Price Tags and
2383 ownership transparency.

2384 *Mrs. Cammack. Great.

2385 *Dr. Whaley. The Patients Deserve Price Tags Act.

2386 *Mrs. Cammack. Excellent.

2387 *Dr. Ippolito. I will take ownership transparency.

2388 *Mrs. Cammack. Okay.

2389 *Mr. Gremminger. The Patients Deserve Price Tags Act
2390 and, in particular, section seven.

2391 *Mrs. Cammack. Okay. Excellent.

2392 *Ms. Skenes. Patients Deserve Price Tags Act,
2393 specifically the element around algorithm and percentage-
2394 based reporting and machine-readable files.

2395 *Mrs. Cammack. Excellent. You guys did so good on that
2396 one. Thank you.

2397 All right, second question, around the panel again.
2398 Congress has enacted hospital transparency requirements,
2399 insurer transparency requirements, and transparency in
2400 coverage rules. Yet health care costs, they continue to
2401 rise. So from your perspective, what is the single biggest
2402 reason that transparency has not translated into greater
2403 affordability for patients and employers?

2404 *Ms. Tripoli. Transparency alone is not going to bring
2405 down prices. You also need to target high hospital prices,
2406 high drug prices.

2407 *Mrs. Cammack. Excellent.

2408 *Dr. Whaley. Employers and purchasers need access to
2409 their own claims data.

2410 *Dr. Ippolito. We have heavily subsidized purchasers

2411 buying in very consolidated markets.

2412 *Mr. Gremminger. Market consolidation and
2413 anticompetitive practices by providers and health plans.

2414 *Mrs. Cammack. Yes.

2415 *Ms. Skenes. There is a missing but necessary
2416 translation layer to take the data from those machine-
2417 readable files and get them into a more usable, palatable
2418 format for consumers and employers.

2419 *Mrs. Cammack. I have something for the record that I
2420 am going to submit on that, so hang onto that.

2421 But again, down the panel one more time. So do we have
2422 an information problem or do we have an accountability
2423 problem?

2424 *Ms. Tripoli. We have both.

2425 *Mrs. Cammack. Okay.

2426 *Dr. Whaley. I agree there is both.

2427 *Mrs. Cammack. Both? Okay.

2428 *Dr. Ippolito. Yes, both.

2429 *Mrs. Cammack. Both?

2430 *Mr. Gremminger. Sadly, I agree.

2431 *Ms. Skenes. Both.

2432 *Mrs. Cammack. Okay. The whole system sucks. Got it.
2433 Now, what information -- since you all answered "both" -- is
2434 missing that would help negotiate better prices?

2435 *Ms. Tripoli. Fundamentally, the negotiated rates, the

2436 actual price of health care, is the most important piece of
2437 information to unveil for us to know how to better regulate.

2438 *Mrs. Cammack. Okay.

2439 *Dr. Whaley. Employers and purchasers need to have data
2440 that -- on prices that are negotiated on their behalf and be
2441 held accountable for those prices.

2442 *Mrs. Cammack. Okay.

2443 *Dr. Ippolito. Yes, the most important is that
2444 employers, who are the real decision-makers in that market,
2445 have to have the information they need.

2446 *Mrs. Cammack. Okay.

2447 *Mr. Gremminger. As a guy representing employers, I
2448 agree. We need access to claims data, but we do need to be
2449 able to go further because we actually have to be purchasing
2450 in a competitive marketplace, which we don't have today.

2451 *Mrs. Cammack. Yes.

2452 *Ms. Skenes. I think there is a focus on the few data
2453 elements that are currently missing that need to be codified,
2454 so stop loss and outlier reporting. We haven't mentioned it
2455 briefly, but non-hospital entities should also be required to
2456 post their rates. Drug prescription rates, as well, and then
2457 self-pay cash prices for those non-hospital entities.

2458 *Mrs. Cammack. Excellent, and you gave me the perfect
2459 segue. In my remaining 30 seconds I want to talk about the
2460 medical loss ratio.

2461 If consumers are paying rate premiums, most of the money
2462 should be going towards patient care. That would be common
2463 sense. We know common sense is not common, particularly on
2464 Capitol Hill. But as insurers have vertically integrated and
2465 acquired PBMs, pharmacies, provider groups, and other
2466 entities throughout the health care system, concerns have
2467 been raised that companies can satisfy the medical loss ratio
2468 requirements on paper while moving money within the same
2469 corporate family.

2470 So again, down the panel, do consumers today have enough
2471 transparency to know whether their premium dollars are
2472 funding care or simply being transferred between affiliated
2473 entities? Yes? No?

2474 *Ms. Tripoli. Enough information? No, there is not
2475 enough.

2476 *Dr. Whaley. No.

2477 *Dr. Ippolito. Consumers, no.

2478 *Mr. Gremminger. Not at all.

2479 *Ms. Skenes. Consumers, no.

2480 *Mrs. Cammack. Hot damn, we got it through.

2481 All right, Mr. Chairman, I yield back.

2482 *Mr. Griffith. The gentlelady yields back. I now
2483 recognize the gentlelady from Massachusetts, Mrs. Trahan, for
2484 her five minutes.

2485 *Mrs. Trahan. Thank you, Mr. Chairman.

2486 A little over two years ago Steward Health Care declared
2487 bankruptcy. Steward was the largest private for-profit
2488 hospital chain in the country. When it collapsed, it was
2489 over \$1 billion in debt. Meanwhile, Steward executives
2490 walked away with hundreds of millions of dollars, and left
2491 communities holding the bag. Hospitals closed overnight.
2492 Patients were turned away. In the district that I represent,
2493 Nashoba Valley Medical Center closed, eliminating nearly 500
2494 jobs and leaving a health care vacuum. Emergency transport
2495 times spiked from an average of 12 minutes to nearly a half
2496 an hour.

2497 Looking back, it is clear that this wasn't bad luck. It
2498 was the predictable result of a business model designed to
2499 extract value, not deliver care, and regulators who didn't
2500 have the tools to see it coming. Dr. Whaley, why was it so
2501 difficult for regulators to identify these risks sooner?

2502 *Dr. Whaley. I think, in the case of Steward
2503 specifically, regulators in the state of Massachusetts really
2504 had no idea until it was too late, until the hospital was
2505 already under distress. And so if they knew about the
2506 agreement prior, they could have potentially regulated the
2507 transaction.

2508 And we have seen similar lessons in other states, where
2509 they are actually trying to get ahead of what might be the
2510 next Steward.

2511 *Mrs. Trahan. Thank you. Following up on that,
2512 ownership transparency is important, but only if we are
2513 connecting it to the real impacts that it has on patients.

2514 Dr. Whaley, briefly, would the transparency measures we
2515 are discussing help researchers and policymakers better link
2516 ownership models to patient outcomes, higher prices, and
2517 hospital closures?

2518 *Dr. Whaley. Absolutely.

2519 *Mrs. Trahan. It has been two years since Steward's
2520 collapse, and it is long overdue that we give regulators the
2521 tools to identify risks before communities lose essential
2522 health care providers. But the thing is, transparency can
2523 only take us so far.

2524 In Massachusetts, Steward appeared at first to be
2525 swooping in to save community hospitals that were financially
2526 under water. Destabilized by years of chronic under-
2527 investment, these facilities were struggling to keep the
2528 doors open, and that is exactly the opening predatory
2529 investors look for.

2530 Ms. Tripoli, in your experience, what are the conditions
2531 that make a hospital vulnerable to this kind of acquisition?

2532 *Ms. Tripoli. There are a variety of factors, but I
2533 think, you know, obviously, the financial status of the
2534 hospital, the volume of services that they are seeing, the
2535 payer mix are all factors.

2536 And I would just say this business practice in itself
2537 that you are referring to, right, is these are small
2538 transactions that are happening. The whole purpose of
2539 private equity in this case, their whole business model, is
2540 to target vulnerable hospitals and to target as many of them
2541 as they -- possible in the region so they can get the market
2542 control and, you know, for short-term profit, increasing the
2543 bad debt for those hospitals. So it is incompatible with
2544 making sure that you are keeping access to care that patients
2545 can afford in their communities.

2546 *Mrs. Trahan. Yes. It sounds like exactly the
2547 conditions that Democrats on this committee were sounding the
2548 alarm about as Republicans passed the big, ugly bill, the
2549 largest cut to health care spending in history, followed up
2550 by refusing to extend the ACA tax credits that families need
2551 to keep their health care coverage.

2552 In Massachusetts over 27,000 people have already dropped
2553 coverage through the Health Connector because they simply
2554 can't afford their premiums. And as coverage losses grow,
2555 hospitals face more uncompensated care while also absorbing
2556 substantial funding reductions. All that adds up to a
2557 massive destabilization of hospitals, especially safety net
2558 hospitals with the most strained margins. And they are
2559 already starting to feel the pressure.

2560 Ms. Tripoli, are you concerned that the massive cuts

2561 facing hospitals right now are creating the conditions for
2562 more Steward-like failures?

2563 *Ms. Tripoli. I think the hospitals that are most
2564 vulnerable, financially vulnerable, are these independent --
2565 particularly rural, independent hospitals, those that are not
2566 associated or affiliated with these big systems. And so they
2567 have smaller financial margins. And so when a cut happens or
2568 a change happens, they are not able to absorb the impact as
2569 well as these big systems. So those institutions, those
2570 rural independents, independent hospitals, are financially
2571 vulnerable right now.

2572 *Mrs. Trahan. Yes. So transparency is an important
2573 step, let's be honest. But what is keeping my constituents
2574 up at night isn't who owns the hospital, it is whether the
2575 care is going to be there when they need it, and it is
2576 whether their next prescription premium or co-pay is going to
2577 break the bank.

2578 So I am all for giving regulators more line of sight
2579 into health care ownership and more tools to protect
2580 patients, but we can't lose sight of the immediate challenge,
2581 which is ensuring that hospitals remain financially stable
2582 and that patients can afford care in the first place. So
2583 thank you for your testimony.

2584 And I yield back.

2585 *Mr. Griffith. The gentlelady yields back. I now

2586 recognize the gentleman from New York, Mr. Langworthy, for
2587 his five minutes.

2588 *Mr. Langworthy. Thank you very much, Mr. Chairman, and
2589 I want to thank the committee for including my legislation,
2590 H.R. 9117, the Clear Healthcare Expense Cost Knowledge, or
2591 CHECK Act, as part of today's discussion. The CHECK Act is
2592 designed to lift the veil of secrecy surrounding health care
2593 costs, giving patients clearer information, bringing hidden
2594 costs out into the open, and creating better accountability
2595 throughout the system.

2596 In every other part of our economy consumers can see
2597 prices before making a purchase. When you go to a
2598 restaurant, you get a menu. There is prices on it. When you
2599 walk through a grocery store, there is prices on every shelf.
2600 Health care should be no different. There should not be a
2601 surprise when you get a letter in the mail a month later.

2602 But with that, Ms. Tripoli, for the average patient
2603 trying to navigate the health care system today, what
2604 information is most often missing when they are trying to
2605 understand the cost of their care?

2606 *Ms. Tripoli. I think just that, the cost of their
2607 care, their out-of-pocket costs. Like, what are they
2608 actually paying out of pocket, as well as other information
2609 about what is the type of care that I am going to get from
2610 this plan when I am selecting a plan, what are the prior

2611 authorization care denial rates, what is the quality of care
2612 that I am going to get, can I see the doctor that I am
2613 currently seeing, I think those are all very challenging data
2614 points for consumers to have as they navigate the health care
2615 system.

2616 *Mr. Langworthy. Thank you. Too often patients open a
2617 bill and they are left with way more questions than answers.
2618 And one of the goals of the CHECK Act is to ensure that
2619 patients receive clear explanations of benefits and itemized
2620 medical bills so that they can better understand what they
2621 are actually being charged for, what their insurance actually
2622 covered, and what they owe.

2623 Ms. Tripoli, how important is that type of transparency
2624 for patients trying to make informed decisions about their
2625 care and their finances?

2626 *Ms. Tripoli. Very important. Having an itemized bill
2627 on the back end helps patients just to double-check, right,
2628 what their EOB and what they have been -- what they are being
2629 charged. So it is an important tool that consumers can use.

2630 But I would say that that in and of itself is not going
2631 to be sufficient. We still need broader price transparency
2632 across the system, unveil prices overall, and to bring down
2633 health care costs by directly addressing the root drivers of
2634 what is driving up premiums in the first place.

2635 *Mr. Langworthy. Yes, thank you, and I think that is

2636 exactly why this matters. When prices remain hidden
2637 throughout the system, no matter which leg of the stool
2638 within our health care system they are, it becomes much
2639 harder to understand who is being paid for what services and
2640 at what cost. And when health care costs go up, every part
2641 of the system seems to blame a different leg of the stool.
2642 And hospitals, they point to insurers. Insurers point to
2643 hospitals. PBMs point to manufacturers. Manufacturers point
2644 right back to the PBMs. And maybe everybody is right. Maybe
2645 everyone is right, and maybe they are all wrong. But the
2646 only way to know is for everyone to flip their cards over
2647 because if no one can follow the money, no one can figure out
2648 why the costs are skyrocketing to the level they are.

2649 Mr. Gremminger, the CHECK Act includes enforcement
2650 provisions intended to help ensure compliance with
2651 transparency requirements and provide employers and health
2652 plans with access to information that they are entitled to
2653 receive. From your perspective, have existing transparency
2654 requirements been consistently enforced?

2655 And how important is enforcement in ensuring that those
2656 requirements produce actual, meaningful results?

2657 *Mr. Gremminger. Thank you for the question.
2658 Unfortunately, I think they have not been consistently
2659 enforced. As we have seen, only a couple dozen hospitals
2660 have been -- had penalties against them for non-compliance

2661 with the hospital price transparency rule.

2662 I understand President Trump just suggested that they
2663 would fine up to 500 hospitals for lack of compliance. We
2664 think that stronger enforcement is necessary, and we very
2665 strongly endorse legislation to codify these rules and
2666 increase enforcement action.

2667 *Mr. Langworthy. Well, thank you very much, and I
2668 appreciate all of the witnesses' testimony here today and for
2669 this discussion. And I want to thank the committee for
2670 including my legislation, the CHECK Act, as part of today's
2671 hearing.

2672 And with that I will yield back.

2673 *Mr. Griffith. The gentleman yields back. I now
2674 recognize the gentleman from Texas, Mr. Veasey, for his five
2675 minutes of questioning.

2676 *Mr. Veasey. Thank you, Mr. Chairman. I am really glad
2677 that we are here today to talk about something that I think
2678 everyone feels that we should be discussing, and that is
2679 health care transparency. I know that everyone wants to know
2680 why we have to pay so much money for our health care.

2681 And one thing that I can tell you for sure, as much as
2682 we already pay for health care in this country, those costs
2683 are going to go up. As we all know, last year Republicans
2684 gutted nearly \$1 trillion out of the American health care
2685 system. And no matter what insurance you have, where you

2686 live, or who you are, we are all going to pay the cost for
2687 that because the money has to be made up somewhere. And
2688 hospitals, particularly rural hospitals and safety net
2689 hospitals and providers, they are all going to bear the
2690 greatest brunt of those cuts. Gutting \$1 trillion out of our
2691 health care systems means that hospitals have to figure out
2692 how they are going to absorb those levels of uncompensated
2693 care, tighter margins, growing financial pressure. And that
2694 is really where private equity comes into the conversation.

2695 Over the last two decades private equity, or PE, they
2696 have invested roughly 5 billion in 2000 -- dollars -- to more
2697 than \$100 billion in 2024. And I want to explain a -- I just
2698 really want to take a quick second to explain exactly what
2699 private equity is. These are -- the PE firms are investment
2700 partnerships that buy companies and they restructure them to
2701 increase revenue and then sell them for a profit. And
2702 usually it is between three to seven years. And this
2703 business model is centered on maximizing returns for
2704 investors.

2705 And I want to be clear, it is not always black and
2706 white. PE firms can provide capital to struggling hospitals,
2707 improve operations, manage administrative functions, and in
2708 some cases help avoid closure for these facilities. If the
2709 choice is a hospital shutting its doors or someone stepping
2710 in to keep it operating, hospitals are going to make the

2711 decision they believe keeps care available in their
2712 community. That math is not hard to understand, but we also
2713 can't ignore what the evidence tells us.

2714 Studies consistently show that private equity ownership
2715 in health care means higher prices, it means reduced
2716 staffing, it means worse patient outcomes and fewer essential
2717 services. Again, these people are in the business of making
2718 money. And some firms load hospitals up with debt, others
2719 strip assets through sale leaseback managed arrangements, and
2720 they force hospitals to pay rent on buildings they once
2721 owned. And because many of these arrangements are
2722 incredibly, incredibly opaque, patients often have no idea
2723 who actually owns the facility that they are walking into.

2724 And so as Republicans tout their health care cuts that
2725 will push more hospitals towards private investment, Congress
2726 should at least know who owns what, how these deals are
2727 structured, and what impact they are having on cost and
2728 quality. That is why I think transparency is critical. As
2729 we consider ways to improve ownership transparency, we should
2730 be reporting -- we should make these reporting requirements
2731 pose as little burden as possible to hospitals. And the last
2732 thing we should do is pile new administrative burdens onto
2733 providers that are already struggling to keep the doors open.

2734 And I wanted to ask Dr. Whaley, your research found that
2735 PE acquisitions are associated with higher provider prices,

2736 particularly when firms buy up practices within the same
2737 market. Can you explain how these roll-up strategies
2738 increase health care costs for patients?

2739 *Dr. Whaley. Sure. So prices between hospitals and
2740 physicians and insurers are typically negotiated. And the
2741 way you negotiate better prices is you just get bigger and
2742 have better negotiation power. And so what happens in many
2743 cases with private equity is there is a single transaction
2744 that might be too small to be scrutinized regulatorily, and
2745 then there is a second one that adds on top of that. And by
2746 and by, it essentially adds cumulative market power that
2747 leads to higher prices and is passed on to patients through
2748 higher out-of-pocket costs.

2749 *Mr. Veasey. Yes, wow, wow, wow. Ms. Tripoli, Families
2750 USA has raised some serious concerns about the role of PE in
2751 health care. Would you agree that hospitals facing financial
2752 distress, particularly under deep Medicaid cuts, may
2753 increasingly feel pressure to turn to PE investment just to
2754 keep their doors open?

2755 *Ms. Tripoli. It is certainly possible. And just given
2756 the fact that there is so much consolidation in the
2757 marketplace already, they are already -- vulnerable hospitals
2758 are already susceptible to that dynamic.

2759 *Mr. Veasey. Yes. Wow, wow. I also wanted to ask,
2760 would you agree that ownership transparency is the first step

2761 in understanding when private equity is stabilizing care and
2762 when it may be making health care more expensive and less
2763 safe?

2764 *Ms. Tripoli. Absolutely. Ownership transparency is
2765 critical. It is a giant black box right now. We need that
2766 data so that we can not only understand what is happening in
2767 terms of these transactions, the effects on communities, but
2768 that also so Federal and state regulators can actually
2769 intervene and evaluate and investigate these transactions
2770 before they happen.

2771 *Mr. Veasey. Yes, thank you. Thank you very much.

2772 Mr. Chairman, I yield back.

2773 *Mr. Griffith. I thank the gentleman for yielding back.
2774 I am just trying to figure out the right order here, but
2775 according to my team it is the gentleman from Ohio. Mr.
2776 Landsman is up for his five minutes of questioning.

2777 *Mr. Landsman. Thank you, Mr. Chair, and thank you all
2778 for being here.

2779 Ms. Tripoli, you talked about the corporate takeover of
2780 health care in your testimony and made a really compelling
2781 argument that part of fixing this is the transparency
2782 question or issue, meaning that if there was full
2783 transparency on benefits and costs and prior authorization,
2784 everything, that, you know, we would be able to address this
2785 as a country, as a Congress in ways that we currently aren't.

2786 The -- part of where this is playing out is Medicare
2787 Advantage. And so I wanted to get into that with you. In
2788 general, though, would you say that this corporate takeover
2789 of health care is increasing costs?

2790 *Ms. Tripoli. Yes.

2791 *Mr. Landsman. What about care? Is care getting
2792 better? Is it the same? Is it getting worse?

2793 *Ms. Tripoli. It is in some places staying stagnant,
2794 but on many key indicators it is getting worse.

2795 *Mr. Landsman. Profits, you know, are they making
2796 money?

2797 *Ms. Tripoli. Yes. These corporate institutions,
2798 whether it is plans, systems, drug companies, are making
2799 profit.

2800 *Mr. Landsman. Let's get into Medicare Advantage
2801 because the transparency piece should be much easier for us
2802 with Medicare Advantage. They are using -- it is private
2803 health insurance, correct?

2804 *Ms. Tripoli. Yes.

2805 *Mr. Landsman. Do you think, based on all your
2806 research, that everybody who enrolls understands that it is
2807 private health insurance?

2808 *Ms. Tripoli. I think there is some -- probably some
2809 level of understanding, but what that means in terms of the
2810 comparisons -- I think there is an overwhelming number of

2811 choices for seniors when they go to enroll on the Medicare
2812 Advantage side and on the traditional Medicare side. And so
2813 it is a lot to navigate through for seniors and to make a
2814 choice that is going to make sense for them.

2815 *Mr. Landsman. Do you think there is sufficient
2816 understanding as to, based on your research, what they are
2817 getting from Medicare Advantage versus what they could be
2818 getting if they actually had in -- Medicare, which is, you
2819 know, not private health insurance, it is Medicare. Do you
2820 think there is full understanding? Maybe they understand
2821 that it is private insurance, but do they understand the
2822 differences in terms of benefits, in terms of the network, in
2823 terms of pre-authorization rates? I mean, are those
2824 comparisons provided to seniors?

2825 *Ms. Tripoli. I think the comparisons provided are very
2826 challenging to navigate. Plus, if you bring in agents and
2827 brokers who have a financial incentive to steer patients and
2828 seniors into certain MA plans for their own financial gain,
2829 it complicates the issue. And so we do have many examples of
2830 seniors who think they are getting a supplemental benefit and
2831 enroll into an MA plan and get there and only find out that,
2832 in fact, that supplemental benefit doesn't exist.

2833 So it is the reason we need a lot of transparency over
2834 MA and a whole variety of data points so that consumers and
2835 seniors, when they are going to shop, they actually can make

2836 a much more informed decision and are not only steered by
2837 agents and brokers' financial incentives.

2838 *Mr. Landsman. I would think that the American people
2839 would not only understand, but expect the Federal Government
2840 to require a private insurer who is using the name
2841 "Medicare'" to provide all of the data necessary so that
2842 seniors have a full understanding of what they are buying,
2843 which is full transparency in terms of costs, full
2844 transparency in terms of benefits, what benefits actually get
2845 used versus the amount of money they are spending on the
2846 marketing of these benefits, the comparative advantage when
2847 it comes to the networks, you know, pre-authorization rates.
2848 Those kinds of things should be immediately available to
2849 seniors. That would make a big difference in terms of them
2850 deciding what is best for them, correct?

2851 *Ms. Tripoli. Correct.

2852 *Mr. Landsman. How do you think this committee -- we
2853 have -- there is a whole host of bills. What do you think
2854 the most important thing this committee should do as it
2855 relates to Medicare Advantage and this issue of transparency?

2856 *Ms. Tripoli. There is a couple of things that are
2857 being -- some of the discussion drafts -- all the discussion
2858 drafts, actually, on Medicare Advantage that are for today
2859 are -- would be incredibly important. More transparency
2860 information around care denials, better and stronger

2861 encounter data. And I would recommend including an
2862 enforcement mechanism to apply financial penalties on MA
2863 plans who don't comply with -- who are already required to
2864 report encounter data. That helps crack down on the coding
2865 abuses and helps to get to a much more sane MA payment,
2866 accurate payment system, as well as, I think, increased
2867 transparency over medical loss ratio and how MA plans are
2868 spending their premium requirements. All very important.

2869 *Mr. Landsman. Super helpful. Before I yield back, our
2870 bill, Medicare Advantage Consumer Protection Transparency
2871 Act, would require MA plans to be transparent, submit
2872 detailed information to CMS about the supplemental benefits,
2873 usage offered, usage of supplemental benefits, number of
2874 patients covered, denials, and pre-authorization requests. I
2875 think you spoke to those.

2876 With that I yield back.

2877 *Mr. Griffith. The gentleman yields back. I appreciate
2878 it and now recognize the gentleman from Florida, Mr.
2879 Bilirakis, for his five minutes of questioning.

2880 *Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate
2881 it very much.

2882 Health care affordability remains one of the biggest
2883 challenges facing patients in the State of Florida and across
2884 the country. I think all of you know that. Every year
2885 families face high premiums, higher deductibles, and higher

2886 out-of-pocket costs, while employers struggle to keep
2887 coverage affordable for their workers. At the same time, our
2888 health care system has become increasingly complex. Patients
2889 often have little visibility into the cost of care before
2890 they receive it, and employers often lack access to the
2891 information they need to evaluate the cost and quality of the
2892 coverage they provide. I think we can all agree on that.

2893 These challenges can be especially difficult for
2894 communities like those I represent in Florida, Florida's 12th
2895 congressional district, which includes the nature coast and
2896 the Tampa Bay area as well. Again, as health care markets
2897 become more concentrated, patients in suburban and rural
2898 communities can face fewer choices, higher costs, and greater
2899 challenges accessing care to home -- close to home. It is a
2900 big issue, the transportation issue. It is a huge issue in
2901 Florida.

2902 At the same time, independent physicians, community
2903 providers, and smaller health care facilities often struggle
2904 to compete against larger systems. For Congress to address
2905 these challenges effectively, we need a clear understanding
2906 of how prices are set, how health care markets are changing,
2907 and how those changes affect affordability and access to
2908 care.

2909 So I want to thank all the presenters today, and thank
2910 you, Mr. Chairman, for holding this hearing, and I have a

2911 question for Dr. Whaley.

2912 Your testimony notes that higher prices are often not
2913 associated with better-quality outcomes. If quality is not
2914 the primary driver, what factors are contributing to higher
2915 prices in many markets, sir?

2916 *Dr. Whaley. We know that prices are high and variable
2917 and are not linked to quality or not linked to things like
2918 cost shifting. But instead, a key contributor is
2919 consolidation and market power.

2920 *Mr. Bilirakis. Yes, okay. The follow-up is, how can
2921 more transparent pricing information help employers direct
2922 their employees toward high-quality, lower-cost providers?

2923 And do you have any examples you can share from your
2924 research where employers have been able to leverage this
2925 data?

2926 *Dr. Whaley. One example comes from the 32BJ Health
2927 Fund, which was able to get access to their own claims data.
2928 And when they looked at their data, they realized that there
2929 was one hospital network that was particularly and
2930 excessively higher priced. And so they used their data and
2931 actually decided to exclude that hospital and favor other
2932 hospitals in their market. And as a result, they saved \$100
2933 million, which they passed on to their workers and their
2934 families.

2935 *Mr. Bilirakis. Thank you. The next question is for

2936 Mr. Gremminger -- I hope I got that right.

2937 Your testimony notes that many employers lack access to
2938 complete information about the health plans they fund. And
2939 the question is, what barriers are preventing employers from
2940 obtaining that information?

2941 *Mr. Gremminger. Thank you very much, Congressman. You
2942 got the name right.

2943 In general, what we see is that the health plans
2944 themselves or their TPAs just simply refuse to provide
2945 access. Or, if they do, they will often put up other
2946 significant barriers. They will say, we can only provide
2947 kind of a higher level of access at sort of an aggregate
2948 level, or we are going to charge you a substantial amount of
2949 money if you want to have full access to your own claims
2950 data. Rarely is it just a straight-up no, it is often a, you
2951 know, here is what we can provide and if you want to pay more
2952 or you want to sue us, we will provide more than that. This
2953 is why we are so supportive of the Patients Deserve Price
2954 Tags Act, because we think it would finally get rid of the
2955 game that employers have -- themselves having to play.

2956 *Mr. Bilirakis. Oh, very good.

2957 Mr. Chairman, I will yield back. Thank you.

2958 *Mr. Griffith. The gentleman yields back. Now I
2959 recognize the gentlelady from New York, Ms. Ocasio-Cortez,
2960 for her five minutes of questioning.

2961 *Ms. Ocasio-Cortez. Thank you so much, Madam Chairman
2962 (sic). Just one moment. Okay, thank you.

2963 I also want to thank the committee leadership for
2964 including my bill in today's hearing as well. And I want to
2965 talk about an aspect of Medicare Advantage today that we
2966 actually haven't focused on much this Congress, and that is
2967 on the agents and brokers who sell Medicare Advantage plans.

2968 Now, Dr. Whaley, when someone turns 65 they are often
2969 inundated with all sorts of information about the different
2970 Medicare Advantage plans available to them, correct?

2971 *Dr. Whaley. That is correct.

2972 *Ms. Ocasio-Cortez. And so people -- I mean, you turn
2973 on daytime television, and you have got all these
2974 celebrities, you have got Joe Namath and William Shatner
2975 talking to you about Medicare Advantage plans. You get lots
2976 of mail. People really start getting tons of marketing about
2977 these plans.

2978 And because of the money, the amount of money that these
2979 for-profit insurers invest in marketing, many people don't
2980 understand -- to my colleague from Ohio's point -- that
2981 Medicare Advantage is not Medicare. It is corporate, for-
2982 profit managed insurance. Correct?

2983 *Dr. Whaley. Correct.

2984 *Ms. Ocasio-Cortez. Now, Dr. Whaley, if I am turning 65
2985 and I don't know the difference between Medicare and Medicare

2986 Advantage, I am faced with sorting through dozens of these
2987 plans and marketing. And that is where we encounter this
2988 issue of agents and brokers. Dr. Whaley, in theory, agents
2989 and brokers work with everyday people enrolling in a Medicare
2990 plan that are there to help them pick the best plan for their
2991 health. Right?

2992 *Dr. Whaley. I --

2993 *Ms. Ocasio-Cortez. Ostensibly.

2994 *Dr. Whaley. I think that is how we would like it to
2995 work.

2996 *Ms. Ocasio-Cortez. Ostensibly, that is how it is
2997 supposed to be set up. What gets complicated is that the
2998 agents and brokers are paid by the health insurers for
2999 enrolling individuals in specific plans. That means that
3000 their decision-making could potentially be clouded by
3001 compensation offered by these for-profit health insurers.

3002 And in fact, some of these individual companies -- say
3003 you have a Blue Cross Blue Shield Medicare Advantage Plan or
3004 any other kind of company -- UnitedHealthcare-managed MA
3005 plan. They often will provide these kinds of kickbacks to
3006 the brokers that enroll people in their preferred plan.
3007 Right?

3008 *Dr. Whaley. That is correct.

3009 *Ms. Ocasio-Cortez. And what are some examples of the
3010 compensation provided to these agents and brokers when they

3011 enroll individuals in any given Medicare Advantage plan?

3012 *Dr. Whaley. They can include direct fees of up to
3013 hundreds of dollars, or they can include things like
3014 conferences and ski trips and all that type of stuff.

3015 *Ms. Ocasio-Cortez. So, like, trips you said. And
3016 almost -- it is almost like a back-door commission type of
3017 setup, right?

3018 *Dr. Whaley. I think that is a good assessment.

3019 *Ms. Ocasio-Cortez. And so you are supposed to have the
3020 agents and brokers that are talking to your mom or your
3021 grandparent saying, we would like to enroll -- we think this
3022 plan is what is best for you. But what that person doesn't
3023 know is that UnitedHealthcare is saying, we will give you a
3024 vacation if you enroll people in our plan, or we will give
3025 you a couple of extra hundred dollars if you enroll someone
3026 in a Blue Cross Blue Shield, or a United plan, or any other
3027 number of plans.

3028 And in your testimony you stated that agents and brokers
3029 have received \$10 billion in this kind of compensation in
3030 2022 alone, right?

3031 *Dr. Whaley. That is correct.

3032 *Ms. Ocasio-Cortez. That is \$10 billion in taxpayer
3033 money that is being -- a lot of it is being funneled through
3034 these corporations, and so that is money that is not going to
3035 care. It is going to perks and trips to Boca and financial

3036 incentives for brokers to enroll people out of traditional
3037 Medicare and into for-profit Medicare Advantage plans. That
3038 is almost 3 times -- 10 billion is almost 3 times what they
3039 were compensated in 2014. So not only is this amount a lot,
3040 it is exploding.

3041 And Dr. Whaley, they actually aren't fiduciaries either,
3042 these agents and brokers, so they have no obligation to the
3043 people that they are allegedly supposed to help. Correct?

3044 *Dr. Whaley. Unfortunately, that is correct.

3045 *Ms. Ocasio-Cortez. So I have a sensible piece of
3046 legislation that would make a lot -- and I know there are a
3047 lot of good agents and brokers out there, but from a policy-
3048 making perspective we shouldn't be relying on people to just
3049 do the right thing. We do have compensation today that -- or
3050 rather, legislation today that limits and redefines what
3051 those caps are so that we can introduce some accountability
3052 into this system. And I hope we can have some bipartisan
3053 agreement on that. Thank you.

3054 *Mr. Griffith. The gentlelady yields back. I now
3055 recognize the gentlelady from Indiana, Mrs. Houchin, for her
3056 five minutes.

3057 *Mrs. Houchin. Thank you, Mr. Chairman.

3058 This hearing advances an important part of the
3059 subcommittee's ongoing effort to improve health care
3060 affordability and empower patients to make informed

3061 decisions. And the diagnosis hasn't changed: prices are
3062 high, widely variable, and not connected to quality.

3063 In most markets consumers can compare prices before
3064 making purchases, but in health care that information remains
3065 opaque, difficult to access, and even harder to understand.
3066 Hospital prices have outpaced inflation by more than double
3067 over the last decade -- two decades. And as big systems have
3068 consolidated, independent physicians have been squeezed,
3069 their reimbursements haven't kept pace with the cost of
3070 running a practice. So they sell to larger systems, reducing
3071 competition in the marketplace and causing prices to go up
3072 yet again.

3073 Now, transparency is not the whole answer. Every
3074 witness here agrees on that, I would think. But the
3075 precondition of transparency is connected to every other
3076 issue and every other answer. You cannot have a competitive
3077 market when one side of the table can hide the price. That
3078 is why legislation like the Patients Deserve Price Tags Act
3079 is so important. Transparency only works if it is complete,
3080 accurate, and enforceable. By requiring hospitals, insurers,
3081 and other health care entities to publicly disclose pricing
3082 information in a standardized format and by imposing
3083 consequences for those who fail to comply, this bill would
3084 help hold industry participants accountable while giving
3085 patients the information they need to make informed decisions

3086 about their care.

3087 This legislation ensures that transparency requirements
3088 are not mere suggestions, but enforceable obligations that
3089 bring greater accountability to the health care marketplace,
3090 and I would like to thank my colleague, Congressman John
3091 James, for his work on the bill.

3092 We spend a lot of energy asking hospitals to post their
3093 prices, and rightly so. But the plan a family chooses is one
3094 of the most consequential decisions that they make, and they
3095 often make it blindly and make it blind to how aggressively
3096 the plan denies care or uses prior authorization. The drafts
3097 before us would require insurers and Medicare Advantage plans
3098 to disclose their denial rates, appeal outcomes, and
3099 turnaround times.

3100 My first question is for Dr. Ippolito. From a market
3101 design standpoint, why does that information matter, and what
3102 happens to a plan's incentives when enrollees can finally see
3103 it?

3104 *Dr. Ippolito. Well, it is a measure of generosity,
3105 just like how many hospitals are in the network, which
3106 hospitals are in the network, how high is the cost sharing.
3107 All of those things matter to patients.

3108 We have seen surveys where patients are very clear.
3109 They care a lot about prior authorization and denials. But
3110 if it is not observable to them, they can't signal their

3111 preferences to insurers. They can't direct them to design
3112 the plans they want. So it seems first order to me.

3113 *Mrs. Houchin. Thank you. And you have cautioned that
3114 reporting requirements should be kept as simple as possible,
3115 something like an above-average, average, below-average
3116 rating so people can easily understand it. Could you walk us
3117 through what that useful, plain language might look like for
3118 disclosure versus just a kind of data dump that complies but
3119 doesn't really tell patients anything?

3120 *Dr. Ippolito. Yes. One of the lessons we have had
3121 over time is that consumers, they do respond very, very
3122 clearly to price signals, but they do it much better when
3123 they have relatively straightforward signals. When we have a
3124 choice to go in network versus out of network, we all tend to
3125 go in network because it is cheaper. When we have a choice
3126 between a brand drug and a generic drug, the vast majority of
3127 us pick the brand -- or the generic drug because it is much
3128 cheaper, right? It is the exact same concept. Keep it
3129 simple, and people respond to the incentives.

3130 *Mrs. Houchin. And simplification would be important
3131 because we wouldn't want to have transparency that they might
3132 just throw all the data at us and then we are still in the
3133 dark in terms of our ability to understand what is in -- what
3134 we are looking at?

3135 *Dr. Ippolito. Yes, I still have some confidence that a

3136 third party could deal with that and --

3137 *Mrs. Houchin. Got it.

3138 *Dr. Ippolito. -- and simplify it for us, but it would
3139 be much better, just from the get-go, do it the best way
3140 possible.

3141 *Mrs. Houchin. As simple as possible.

3142 Dr. -- or Mr. Gremminger, your members are the employers
3143 footing the bill. The draft would make insurers publish how
3144 much of every premium dollar actually goes to care versus
3145 overhead and retained profit. From where you sit, would that
3146 change which carriers employers would be willing to buy from?

3147 *Mr. Gremminger. Yes, I think it would. And I love the
3148 legislation.

3149 You know, there is a lot of things that go into a
3150 decision that employers will make about which plan they are
3151 going to choose to use: you know, overall coverage, quality
3152 of the employers, how much we are paying in premiums. But I
3153 think it is really critical for us to know, effectively, just
3154 how competitive is this organization and how much of the
3155 money is just going to overhead that we don't know about.

3156 *Mrs. Houchin. Thank you. This seems pretty common
3157 sense to me, but I do appreciate your thoughts and your
3158 engagement on the issue. I look forward to continuing to
3159 working with all of you as we hopefully move this legislation
3160 forward.

3161 Thank you, I yield back.

3162 *Mr. Griffith. The gentlelady yields back. I now
3163 recognize the gentleman from Massachusetts, Mr. Auchincloss,
3164 for his five minutes of questioning.

3165 *Mr. Auchincloss. Thank you, Chairman. This question,
3166 actually, anybody can take it.

3167 I didn't see any mention in the testimony about NADAC
3168 reporting, National Average Drug Acquisition Cost reporting.
3169 But if we are going to get traction on transparency for drug
3170 pricing, particularly for reimbursement to pharmacists and
3171 for co-pays for patients, we have got to understand what the
3172 actual cost of goods sold is. And right now NADAC reporting
3173 for pharmacies is voluntary, it is inconsistent, subject to
3174 games being played.

3175 And, you know, I have got legislation under the
3176 Pharmacists Fight Back Act, and there has been other examples
3177 of bipartisan legislation to make NADAC reporting mandatory
3178 and also to broaden its scope so that we actually just
3179 understand what the actual acquisition cost is of these
3180 drugs. Do any of you want to speak on the importance of
3181 NADAC reporting?

3182 Mr. Gremminger.

3183 *Mr. Gremminger. Thank you very much, Congressman. I
3184 am a big fan of NADAC as a benchmark. As you all -- as you
3185 know, most of the other benchmarks that are available out

3186 there -- WAC, average sales price, et cetera -- are highly
3187 gameable. NADAC you can game, but it is actually based on a
3188 survey of sort of what a sort of unleveraged pharmacy is able
3189 to buy a drug for.

3190 Just as we heard earlier, you know, the way in which
3191 hospital prices are negotiated is highly variable. And so
3192 the kind of output is very difficult to understand, how we
3193 got there. The same thing very much occurs on the --

3194 *Mr. Auchincloss. Yes.

3195 *Mr. Gremminger. -- on the drug side. I love the idea
3196 of getting to a standard place. I think NADAC is the right
3197 place for --

3198 *Mr. Auchincloss. Minnesota recently promulgated some
3199 rules on NADAC reporting, which I think are probably the most
3200 expansive of any of the 50 states. This is very wonky, so I
3201 don't expect -- if you don't have any comments, that is fine.
3202 But does anybody want to talk about whether Minnesota could
3203 be a basis for a national law?

3204 Ms. Skenes, I think you had comments.

3205 *Ms. Skenes. Yes, thank you for the question.

3206 I think, in general, the stance at Turquoise is, if the
3207 data is available, let's grab it and analyze it and see what
3208 additional transparency can be gleaned from it. There is a
3209 lack of information around prescription drug pricing and
3210 transparency, so any of that, you know, even if it is one

3211 state, then we can start there and expand accordingly.

3212 *Mr. Auchincloss. Yes. Anybody -- does anyone have
3213 specific comments on Minnesota?

3214 Well, we are talking about transparency and simplicity,
3215 and -- is an important element of health care. So I have got
3216 to talk about 340B, maybe the least transparent, least simple
3217 element of our drug pricing system. And, you know, there has
3218 been a lot of light and heat on this, partly because of the
3219 proposed rebate program from the Administration and because
3220 of discussions here in Congress, both House and Senate, on
3221 what can be done.

3222 Mr. Gremminger, do you -- and I will let others, as well
3223 -- want to comment on how we should be thinking about the
3224 340B program?

3225 *Mr. Gremminger. As you know, I have a lot to say about
3226 this program. But I will say, just as it relates to the
3227 rebate program -- and it actually highly relates to what is
3228 going on in this hearing. Employers have a difficult time
3229 accessing their own claims data right now.

3230 *Mr. Auchincloss. Yes.

3231 *Mr. Gremminger. We have almost no ability to
3232 understand the degree to which 340B is impacting us. In
3233 part, we -- whenever a drug is sold through 340B, we lose
3234 access to the rebates, the discounts that we would otherwise
3235 get. The cost of that is significant, and yet it is almost

3236 impossible for an employer to track.

3237 *Mr. Auchincloss. Yes.

3238 *Mr. Gremminger. The rebate model or similar
3239 legislation would enable employers to finally understand what
3240 is going on and then try to create plan design to mitigate
3241 the impact.

3242 *Mr. Auchincloss. Dr. Whaley?

3243 *Dr. Whaley. My own research shows that if you are a
3244 cancer patient who gets care at a 340B hospital, the markup
3245 on your drugs is almost 700 percent. And so while I think
3246 it, you know, is appropriate for hospitals to get revenue, I
3247 think it is a very open and challenging question of whether
3248 or not cancer patients should be the ones essentially
3249 financing the hospital.

3250 *Mr. Auchincloss. Yes. We have talked a lot about
3251 transparency and simplicity for prices, which -- agreed. I
3252 think it is also increasingly just as salient to my
3253 constituents is about process and, in particular, prior
3254 authorization. In addition to not understanding how a bill
3255 came, also not understanding why you are being denied care is
3256 immensely frustrating for people.

3257 And I would just highlight -- I don't have a question
3258 based on this, but I would highlight that not included in
3259 these bills is really strong bipartisan prior auth
3260 legislation being -- that has been proposed by my colleague,

3261 Suzan DelBene from the State of Washington. I myself am
3262 going to be putting forward prior authorization legislation
3263 for MCOs and Medicare Part D.

3264 But people really deserve electronic, in real-time,
3265 evidence-based human-in-the-loop accountable prior auth
3266 decisions. Because right now the single biggest use of AI in
3267 health care that I can see is basically insurance companies
3268 playing games with it to deny care. And that would be such a
3269 disappointing outcome from what could, I think, be a helpful
3270 technology. But right now it is being used for revenue cycle
3271 management. We have got to change that arc.

3272 I yield back.

3273 *Mr. Griffith. The gentleman yields back. Now I
3274 recognize the gentlelady from Texas, Mrs. Fletcher, for her
3275 five minutes of questioning.

3276 *Mrs. Fletcher. Well, thank you, Mr. Chairman, and
3277 thank you to our witnesses. This has been a very useful
3278 hearing, and I think we have covered a lot of ground here.
3279 And it is a hugely important topic, something that I hear
3280 about from my constituents all the time. And you have heard,
3281 I think, a lot of bipartisan agreement today, as there has
3282 been on this topic for a long time. So I do hope that we can
3283 move forward on some of the thoughtful recommendations and
3284 ideas that we have heard not only today, but over the last
3285 several years.

3286 And as this hearing comes to a close, I just -- I do
3287 want to take a minute to bring it back to where we started,
3288 which is we are in a health care affordability crisis. And
3289 transparency is a part of the answer, but it isn't all of the
3290 answer. And I so appreciated the comments from Mr.
3291 Auchincloss just now about prior authorizations. That is
3292 something I hear from my constituents, both the physicians
3293 and the patients.

3294 I represent a lot of physicians. I represent Houston
3295 and have the district right outside the Texas Medical Center,
3296 so I have a lot of physicians I represent who are so
3297 frustrated that they can't give the patients the care they
3298 need, and they spend so much of their time trying to get
3299 authorization for the care they know their patients need
3300 through insurance companies. And I think it is this overall
3301 transparency.

3302 We had a conversation just the other day about the
3303 challenges and kind of the shorthand of Medicare for all,
3304 which, of course, is just the payer side of the equation.
3305 And there is so much else that we don't understand. And I
3306 think it is a shorthand for health care for all. Everyone
3307 should have access to affordable health care, and they should
3308 be able to get the care they need and understand the costs,
3309 the rationale, the coverage options that they have. So the
3310 conversation about Medicare Advantage is also hugely

3311 important.

3312 But as we know, health care costs continue to go up,
3313 even with all of these good legislative ideas. And we cannot
3314 ignore the fact that a huge part of the reason these health
3315 care costs are going up is because this is an ecosystem. And
3316 the decisions that this Congress has made in the last year,
3317 year-and-a-half to drastically cut funding for Medicaid,
3318 which -- the estimates are that 10 million Americans are
3319 going to lose health care coverage because of those cuts --
3320 but also the elimination of the tax credits relating to the
3321 Affordable Care Act's Enhanced Premium Tax Credit program.

3322 In my district that was 125 000 people who were relying
3323 on those tax credits, and so they are facing increased costs.
3324 They are getting worse plans for more money and less coverage
3325 because they can't afford their health care. And it is
3326 estimated that that is more than four million Americans that
3327 are going to be in that situation. And they don't even cover
3328 -- those numbers don't cover the people who are forced to
3329 change their plans because they are all becoming more
3330 unaffordable.

3331 I know too, hearing from the folks who work in our
3332 hospitals in Texas, where we already have the highest
3333 uninsured rate in the country, as I am sure you all know,
3334 that those rates are going up even more, and that our
3335 hospitals are seeing an increased number of uninsured

3336 patients, and that is increasing their uncompensated care
3337 costs. All of this is an ecosystem, and what decisions we
3338 make in one area affect decisions in another. And so as we
3339 work to address costs and transparency, we also have to
3340 address what is driving up costs. And it is just one piece
3341 of it. And so I do think it is critically important. I feel
3342 like we have heard a lot of really interesting and important
3343 testimony today.

3344 And so, Ms. Tripoli, I just want to end the hearing and
3345 my time with you with a question. If you -- I know you have
3346 answered a lot of questions already today, but if you could,
3347 just answer whether there is anything you feel like we didn't
3348 touch on in the hearing today about how health care consumers
3349 that you work with and your organization works with have been
3350 impacted by these health care cuts, if there is anything that
3351 we haven't covered in this hearing today that you think is
3352 important for us to know, or any -- most salient points you
3353 just want to make sure that we have clarity on as we end this
3354 hearing.

3355 *Ms. Tripoli. Thank you. I mean, I would say, first
3356 and foremost, consistent with what we have talked about today
3357 is that there is a suite of legislation, a discussion draft
3358 in discussion today, much of it which should move forward and
3359 is an important step in addressing the affordability crisis.
3360 Not sufficient, but a majorly important step.

3361 Second, in terms of the cuts, we know that the cuts --
3362 obviously, the trillion dollars of health care cuts in
3363 Medicaid are having an incredible harm on people. Up to 10
3364 million people are likely to lose coverage. We just saw an
3365 interim final rule come out from the Administration just a
3366 couple of weeks ago going even further than H.R. 1, putting
3367 paperwork upon paperwork for beneficiaries to maintain their
3368 Medicaid coverage.

3369 And we are now going to see -- we are already seeing the
3370 effects of what happened with the expiration of the Enhanced
3371 Premium Tax Credits: over a million people less enrolled
3372 this year than last year because those tax credits did
3373 expire. And as new -- the final data comes out over the next
3374 -- over the summer, we expect to see that much, much higher.

3375 So this is and there are -- there is significant harm
3376 that is ongoing and that we will continue to see this year
3377 from the H.R. 1 bill that was enacted last year, as well as
3378 the failure to extend the premium tax credits.

3379 *Mrs. Fletcher. Thank you, Ms. Tripoli.

3380 And with that, I have gone over my time so I thank you,
3381 Mr. Chairman, for allowing me to ask that final question as
3382 we close the hearing. Thank you, and I yield back.

3383 *Mr. Griffith. The gentlelady yields back, and that
3384 concludes our time of questions.

3385 I would ask unanimous consent to insert into the record

3386 the documents included on the staff hearing document list.

3387 Without objection, so ordered.

3388 [The information follows:]

3389

3390 *****COMMITTEE INSERT*****

3391

3392 *Mr. Griffith. I would like to thank all of our
3393 witnesses once again for being here today.

3394 Members may have additional written questions for you.
3395 I will remind members they have 10 business days to submit
3396 questions for the record, and I ask the witnesses to respond
3397 to those questions promptly. Members should submit their
3398 questions by the close of business on Friday, June 26.

3399 Without objection, the subcommittee is adjourned.

3400 [Whereupon, at 12:59 p.m., the subcommittee was
3401 adjourned.]