



Testimony of Shawn F. Gremminger, MPP
President and CEO

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

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

June 10, 2026

National Alliance of Healthcare Purchaser Coalitions
1015 18th Street NW, Suite 705
Washington, DC 20036

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee:

Thank you for the opportunity to offer the perspective of America’s employers and healthcare purchasers on the vital necessity to improve transparency in the commercial healthcare market. I am President and CEO of the National Alliance of Healthcare Purchaser Coalitions, a trade association representing roughly 45 regional employer and purchaser coalitions around the country. Our member coalitions directly represent employers and purchasers of all shapes and sizes – from jumbo employers in the Fortune 500 to public entities like cities, counties, and states, to Taft-Hartly labor trust funds, to small businesses. Together, National Alliance coalitions’ members provide healthcare coverage to roughly 90 million people – a majority of people who receive employer-sponsored insurance.

Context – High and Rising Costs, Variable Quality, and Deep Opacity

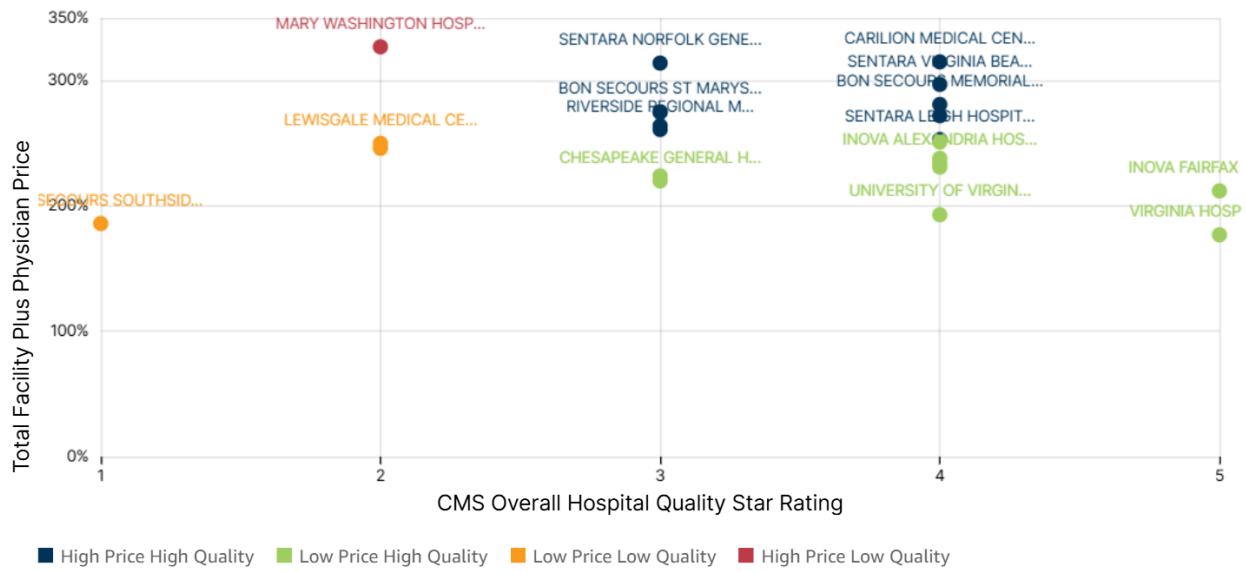
American employers, workers, and families face a healthcare system with persistently high and rapidly rising costs, uneven quality, and a lack of meaningful market transparency. Healthcare spending continue to outpace wage growth and inflation, putting increasing pressure on employers that sponsor coverage and on the employees and dependents who rely on it.¹ Research has also shown that higher prices do not consistently mean higher quality.² Patients and purchasers routinely encounter situations in which providers charging dramatically different prices deliver comparable – or in some cases inferior – quality. That gap between price and value would be concerning in any market. In healthcare, it is compounded by a level of opacity that makes informed purchasing extraordinarily difficult.

The figures below – comparing negotiated in-network prices for hospitals in Virginia and Colorado with a commonly used quality metric – are indicative of the lack of correlation between cost and quality across the United States.

¹ Fiscal Policy Institute: *The Healthcare Affordability Agenda Part I: The Economic Toll of Rising Private Health Insurance Costs*, 2026: <https://fiscalpolicy.org/the-healthcare-affordability-agenda-i>

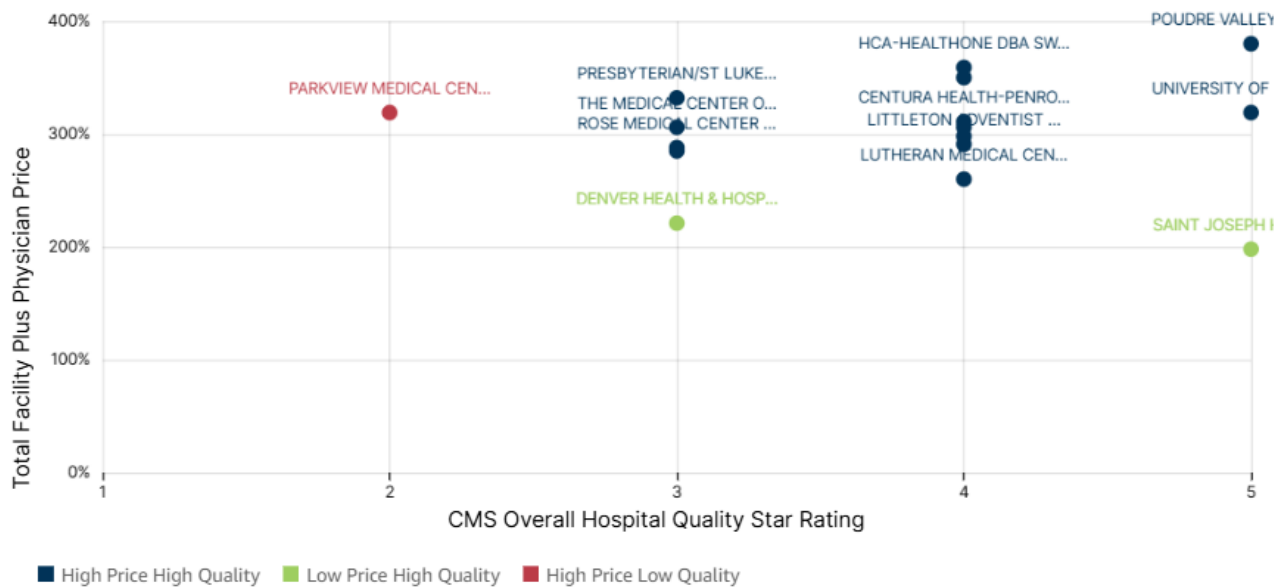
² Annals of Internal Medicine: *The Association Between Health Care Quality and Cost A Systematic Review*, 2013: <https://pmc.ncbi.nlm.nih.gov/articles/PMC4863949/>

Figure 1 – Hospital Cost and Quality Comparison in Virginia³



Notes: The highest-priced hospital in the Commonwealth with more than 200 beds is Mary Washington Hospital in Fredericksburg. Its total negotiated prices (physician + facility) equal 327% of Medicare. Mary Washington received 2 stars on CMS’ overall quality star rating system. The lowest-priced hospital with more than 200 beds is Virginia Hospital System in Arlington. VHA’s prices are just 177% of Medicare, and the hospital received 5 stars from CMS.

Figure 2 – Cost and Quality Comparison in Colorado



³ Sage Transparency: <https://dashboard.sagetransparency.org/>

Notes: Colorado's relative hospital prices are among the highest in the country, but the lack of correlation between cost and quality is similar. Among hospitals with more than 200 beds, Parkview Medical Center in Pueblo has the poorest CMS quality rating in the state with just 2 stars. Its average negotiated prices are 319% of Medicare, just above the state's average, but far higher than the national average of 253% of Medicare. The highest priced hospital in the state – Poudre Valley Hospital – boasts a five-star rating from CMS but is one of the most expensive hospitals in the country with prices at 380% of Medicare. St. Joseph Hospital in Denver manages to provide high quality (five-star CMS rating) at commercial prices that are 198% of Medicare, below the national average.

The National Alliance and its member coalitions believe transparency is a foundational requirement for a more competitive and value-driven healthcare system. It is clear that employers, patients, and plan sponsors cannot effectively manage healthcare spending when the prices negotiated between providers and payers are hidden from view and often unknown until after care is delivered.

Current Landscape: Challenges with Public Reporting, Uneven Access to Claims Data

Five years after the federal Hospital Price Transparency (HPT) and Transparency in Coverage (TiC) rules took effect, compliance and data quality still remain significant challenges. Independent audits by Patient Rights Advocate have consistently found that most hospitals fail to fully comply with federal transparency requirements.⁴ Their most recent nationwide review found that only about one-fifth of hospitals were fully compliant, with many institutions either omitting negotiated rates, failing technical file requirements, or providing incomplete payer-specific pricing information.

The Purchaser Business Group on Health's (PBGH) Health Care Data Demonstration Project revealed a second challenge: even when transparency data are available, it is often difficult or impossible to use.⁵ PBGH, a National Alliance member, found that machine-readable files routinely contain inconsistent provider identifiers, non-standardized coding, duplicative records, missing fields, and contract terms that vary widely across payers and providers. Extracting meaningful price information required extensive data engineering and validation before any analysis could occur. In some markets, prices could not be reliably compared across hospitals because negotiated rates were reported using different methodologies or lacked sufficient contextual information. Despite these obstacles, the demonstration ultimately showed that the data can provide value when properly standardized and analyzed, allowing employers to identify

⁴ PatientRightsAdvocate.org, *7th Semi-Annual Hospital Price Transparency Compliance Report, 2024*:

<https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024>

⁵ Purchaser Business Group on Health (PBGH), *Leveraging Health Care Price Transparency: Findings from the Health Care Data Demonstration Project, 2026*: <https://www.pbgh.org/wp-content/uploads/2026/04/Leveraging-Health-Care-Price-Transparency-Final-April-2026.pdf>

unwarranted price variation, evaluate network performance, and benchmark provider prices. Their project demonstrates that transparency policy must go beyond simple data publication requirements to focus on data quality, standardization, accessibility, and usability.

What Employers and Purchasers Really Want: Visibility, Control, Choices, Value

Each year, our organization publishes the Pulse of the Purchaser survey and the 2025 survey included responses from more than 300 purchasers across our coalitions' membership. It found that most employer benefits leaders (52%) see lack of transparency as a significant threat to affordability for their organizations.⁶

A significant portion of survey respondents reported challenges in accessing their own claims data. Two-fifths (42%) reported that vendors refused to provide complete access to all data fields, and one-third (33%) said they do not have complete access. The issue is particularly acute among smaller employers as more than half of those with fewer than 1,000 employees said they cannot obtain complete access to their claims data.

For those that can access their claims data, nearly three-quarters use it to analyze usage patterns, conduct cost analyses, and engage in fiduciary oversight and cost containment.⁷ Notably, there was a clear correlation between employers with access to their own claims data and taking high-value actions to reduce costs and increase quality.

Employers want control over plan design and purchasing strategies, supported by access to accurate claims, encounter, and pricing data. And they want meaningful choices so that healthcare decisions can be guided by information about cost, quality, and outcomes rather than by guesswork or opaque contracting arrangements.

Ultimately, purchasers are pursuing value, not just lower prices. Employers recognize that the least expensive care is not always the best care, so they are focused on identifying providers and delivery systems that consistently produce better outcomes at a reasonable cost. Transparency is the foundation of a healthcare system that rewards competition based on cost and quality, rather than information asymmetry.

What Transparency Enables – Smarter Purchasing and Lower Spending

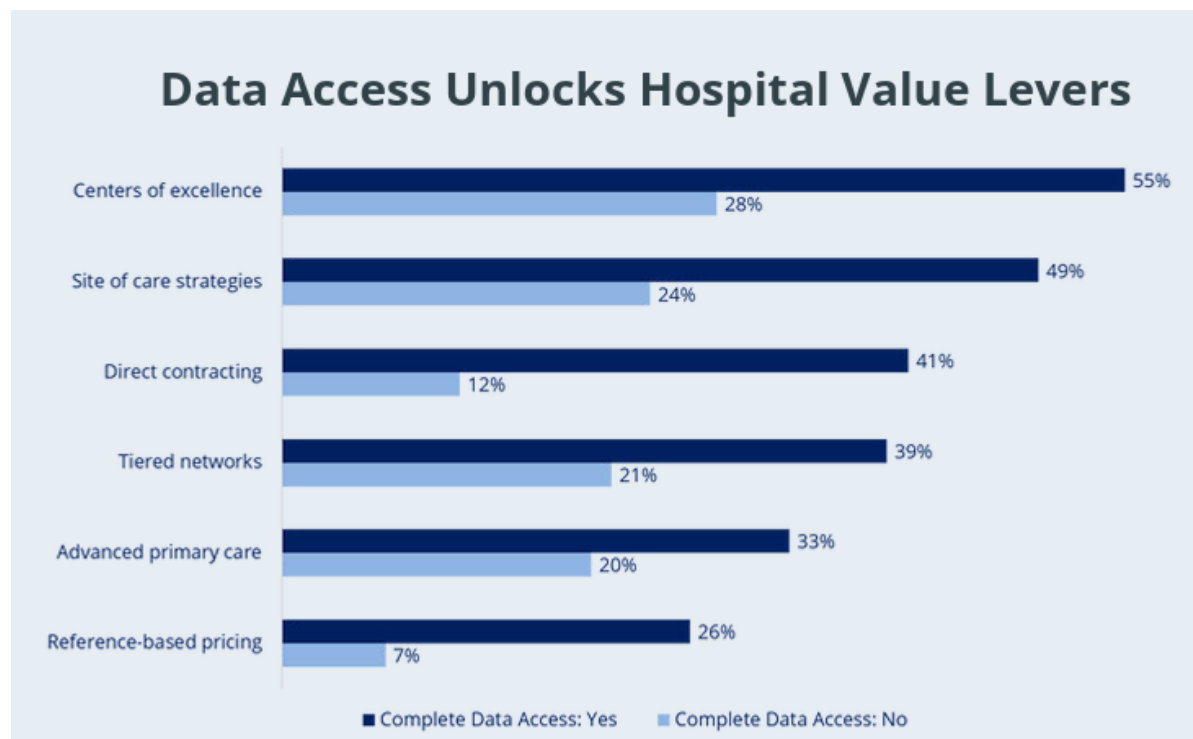
Full and timely access to their own healthcare claims and encounter data gives employers the ability to become informed purchasers rather than passive payers. Access to complete claims data enables employers to identify high-cost drivers, measure price variation, assess the effectiveness of benefit designs, and compare costs and quality across providers. It also allows

⁶ National Alliance of Healthcare Purchaser Coalitions, *2025 Pulse of the Purchaser Annual Survey, 2025*: <https://www.nationalalliancehealth.org/wp-content/uploads/Pulse-of-the-Purchaser-2025-Annual-Survey.pdf>

⁷ (ibid)

plan sponsors to verify that contractual commitments are being honored and to exercise their fiduciary responsibilities with greater confidence.

Figure 3 – Correlation of Access to Data and High-Value Strategies⁸



Notes: Employers with complete claims data access are far more likely to deploy high-value hospital strategies, especially direct contracting (+29 pts), centers of excellence (+27 pts), and site of-care redirection (+25 pts). Meaningful gaps also appear for reference-based pricing (+19 pts) and tiered networks (+18 pts). From the 2025 Pulse of the Purchaser survey.

As important, access to claims data empowers employers to take concrete actions that improve affordability and value for employees and their families. Employers can design benefits that steer patients toward high-quality, lower-cost providers, implement centers-of-excellence programs, pursue reference-based pricing strategies, evaluate alternative payment models, and hold healthcare partners accountable for performance. Claims data transparency also helps employers identify disparities in quality, utilization, and outcomes that would otherwise remain hidden.

One example of a new effort intended to support these goals is Peterson Health Analytics. The National Alliance is partnering with this new initiative that will combine hospital and health plan price transparency data, employers' own claims data, and independent quality and safety ratings so that employers can better benchmark spending and assess the value of the care

⁸ (ibid)

available in their markets. Importantly, this model aims to provide a more comprehensive and independent view of healthcare cost and quality than employers have traditionally had access to, helping them make more informed purchasing decisions.

Perspectives on Legislation Before the Subcommittee

We appreciate the committee's interest in pursuing varied paths toward greater transparency in the healthcare marketplace. My comments focus on legislation affecting the commercial market, as the National Alliance does not focus on Medicare or Medicare Advantage plans.

H.R. 5582, Patients Deserve Price Tags

Among the transparency proposals before Congress, the *Patients Deserve Price Tags Act* stands out for reinforcing a basic but often unmet principle: employer access to healthcare data is essential for the effective management of self-funded health plans. Section 7 of the legislation builds upon the transparency foundations established in the Consolidated Appropriations Act of 2020 by making clear that plan sponsors are entitled to timely access to claims, encounter, and related health plan data necessary to fulfill their fiduciary obligations. Employers pay the claims, assume the financial risk, and are ultimately responsible for stewarding healthcare resources on behalf of workers and their families. Yet the current healthcare marketplace is often structured in ways that limit access – through delays, contractual restrictions, or opaque data practices imposed by third-party administrators, carriers, and other intermediaries. This bill would help correct that imbalance by establishing that plan sponsors have a right to the information they need to understand, evaluate and manage the benefits they fund.

This clarity is essential. Employers cannot control costs or meet their fiduciary responsibilities when information about their own healthcare spending can be withheld or restricted. The *Patients Deserve Price Tags Act* would establish once and for all that the data belongs to the plan and that those entrusted with managing employee health benefits have the right to access it.

Beyond Section 7's critical provisions expanding employer access to group health plan data, the legislation strengthens and codifies the HPT and TiC rules, which require hospitals, ambulatory surgery centers, imaging centers, laboratories, and health plans to disclose actual negotiated prices in standardized, consumer-friendly formats. It also requires disclosure of the underlying formulas, methodologies, and contractual terms used to determine reimbursement rates, ensuring that purchasers can understand not only the final price but how that price was established. By making these requirements statutory rather than purely regulatory, the bill provides greater durability and consistency for employers seeking long-term transparency reforms.

The legislation also strengthens accountability and usability. Health plans and providers would be subject to enhanced auditing, executive attestation requirements, and stronger enforcement

mechanisms to improve the accuracy and completeness of reported data. The bill further expands patient-facing protections through clearer cost-estimation tools, more detailed explanations of benefits, and standardized billing information that helps consumers understand what was provided, what was paid, and what they owe. Taken together, these reforms move the healthcare system closer to a basic standard that exists in virtually every other sector of the economy: consumers and purchasers should be able to know the price of a service before making a purchasing decision.

H.R. 9117, Clear Healthcare Expense Cost Knowledge (CHECK) Act of 2026

The National Alliance supports many of the transparency and market reform provisions included in H.R. 9117, particularly those that strengthen hospital and payer price disclosure, improve data standardization, and enhance enforcement mechanisms. These elements are consistent with our longstanding commitment to advancing a more functional healthcare marketplace for employers and their families. However, we cannot support H.R. 9117 as freestanding legislation because it omits several critical components of the broader *Patients Deserve Price Tags Act* framework – most notably Section 7. Without these provisions, the bill falls short of ensuring that transparency translates into usable information for fiduciaries responsible for managing healthcare costs on behalf of workers and their families, limiting its effectiveness as a comprehensive reform.

Lower Costs, More Transparency Act

The National Alliance supports the intent and core provisions of the *Lower Costs, More Transparency Act*, particularly its efforts to strengthen price transparency requirements, improve consistency in reporting, and enhance enforcement across hospitals and health plans. These reforms align with our priorities of creating a more accountable and functional healthcare marketplace for employers and the patients they cover. However, we view the legislation as less comprehensive than the *Patients Deserve Price Tags Act*, especially with respect to employer access to actionable claims and plan-level data.

Discussion Drafts

H.R. _____, [To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments]

While we have not formally taken a position on this discussion draft, we believe requiring health insurers to publicly disclose how premium revenue is allocated between claims payments, administrative overhead, and retained profit would rebalance the information asymmetry that favors insurers over employers and purchasers. This bill would provide employers with the standardized, comparable data they need to select higher-value carriers and challenge unjustified premium increases.

H.R. _____, [To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to require the displaying of claim denial rates.]

As above, the National Alliance has not formally taken a position on this discussion draft, but we support its implicit intent. Employers want prior authorization to result in less friction for plan members, quicker decisions by health plans, and clear guidance to patients and clinicians when a procedure or therapeutic is denied. Yet it is critical that prior authorization and utilization management be retained as an effective tool to reduce unnecessary and overpriced care. This bill appears to advance that balance by requiring insurers to publicly disclose plan-level denial rates, appeal outcomes, and decision turnaround times, giving the employers and purchasers additional information to evaluate whether their carrier is deploying prior authorization as a genuine clinical management tool or as a systematic barrier to care.

H.R. _____, [To amend title XI of the Social Security Act to require mandatory reporting with respect to certain health-related ownership information.]

We support the ownership transparency included in this discussion draft. Employers and purchasers cannot make sound network and contracting decisions when the ownership structures behind hospitals, physician practices, and ambulatory facilities are opaque. Particularly given the rise of private equity purchasers in the healthcare sector, this bill would provide greater clarity to employers by requiring institutional providers to annually disclose ownership structures, parent companies, merger activity, and debt levels. With this information, employers could negotiate with greater awareness of who actually controls the providers across the table, and advocate where consolidation is harming the market.

The Limits of Transparency – Prices Will Not Fall Though Transparency Alone

The National Alliance strongly supports transparency because it is a foundational prerequisite for a more competitive and accountable healthcare marketplace. However, transparency alone is not sufficient. In many communities across the country, employers and families face healthcare markets that are highly concentrated, with one, two, or three dominant health systems controlling a substantial share of available services. In such markets, purchasers may gain visibility into prices yet still have limited ability to negotiate or exert meaningful competitive pressure.

We strongly urge the Committee to pursue additional reforms that promote a more level and competitive marketplace. These include:

- Site-neutral payment policies that eliminate unjustified payment differences for the same service based solely on where it is delivered.
- Restrictions on facility fees that increase costs without improvements in quality or patient outcomes.

- Prohibition of anticompetitive contracting practices that limit purchaser choice, restrict steering to higher-value providers, impede the development of innovative benefit designs, or otherwise insulate dominant market participants from competitive forces.

Finally, given the evidently never-ending increases in hospital prices, policymakers should consider more direct approaches to protecting patients and employers from excessive prices. One such approach is the use of reference-based pricing methodologies that establish reasonable payment benchmarks tied to a percentage of Medicare rates. While some on the committee might object to reference-based caps as “price setting” by the government, states as diverse as Indiana and Vermont have enacted similar proposals. An equally diverse set of states in the Pacific Northwest – Montana, Oregon, and Washington – have enacted policies to limit hospital prices for state employee health plans based on Medicare benchmarks.

Reference-based pricing may serve as an important safeguard in markets where provider consolidation has created pricing power that is disconnected from quality or underlying costs. The National Alliance believes that healthcare purchasers deserve both transparency and meaningful policy tools to ensure that healthcare markets deliver value.

Call to Action: The Moment of Truth

The challenge before us is no longer one of diagnosis. It is one of action. Healthcare costs continue to rise at rates that outpace wages and economic growth, placing increasing strain on employers, workers, and their families. For many employers, annual healthcare cost increases are consuming resources that could otherwise be invested in wages, retirement benefits, workforce development, or business growth. For employees, rising costs are eroding household budgets and creating difficult tradeoffs. Price transparency is not a complete affordability strategy, but it is an essential and long-overdue down payment on one. Policymakers cannot effectively address healthcare affordability without first ensuring that purchasers, patients, and regulators can see how prices are set, where costs are rising, and whether those costs are justified by improvements in quality or outcomes.

The subcommittee may wonder whether the public shares employers’ sense of urgency on healthcare affordability. An April 2026 poll commissioned by United States of Care Action provides a clear answer. More than seven in 10 respondents agreed that healthcare costs are unaffordable for individuals and families, and nearly half (49%) said they experienced at least one financial pressure related to a medical bill – such as contact from a credit agency or taking out a loan – in the past two years.⁹ Astoundingly, one in five (21%) adults currently have bills that are past due or that they are unable to pay. The public’s diagnosis of the problem aligns closely with what employers experience: 53% of respondents believe hospitals charge more

⁹ United States of Care, *Affordable Health Care is Out of Reach for People*, 2026: <https://unitedstatesofcare.org/public-opinion-poll-affordability-april-2026/>

than they need to, a view that holds across all political affiliations. Nearly seven in 10 (69%) believe Congress should act to ensure affordable healthcare, even if that means regulating healthcare companies, including majorities of both self-described Democrats and Republicans.

I cannot overemphasize the level of concern I have for the future of employer-sponsored healthcare in the United States. The word “unsustainable” is overused in today’s lexicon. However, with the cost of coverage for a family approaching \$30,000 annually and healthcare inflation rising at its fastest pace in at least 15 years, the word appears apt. Unless policymakers give employers the tools they need to bring costs under control, we fear the commercial market will falter and be replaced by a system that is likely much worse for America’s working families.