

# Health Care Price Transparency

Opportunities to Lower Costs and Improve  
Competition

Christopher M. Whaley

*Testimony of Christopher M. Whaley presented before the United States Senate Special Committee on Aging  
on hospital costs and transparency within the commercial market on July 11, 2024*

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Before the Special Committee on Aging  
United States Senate

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Chairman Casey, Ranking Member Braun, and members of the committee, thank you for the opportunity to testify today. My name is Christopher Whaley. I am an associate professor of Health Policy at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). My research focuses on health care price transparency, the impacts of evolving health care markets, and studying employer and purchaser innovations that are enabled by price transparency information.

In the United States, employers and purchasers of health care play a significant role in shaping the U.S. healthcare system. Employers provide health insurance for over 160 million Americans—the largest source of health insurance in the United States.<sup>1</sup> In most cases, employers select employee plan offerings and thus determine the types of health plans available to their employees and their families. Employers also play a critical role in financing the U.S. healthcare system. Collectively, employer-sponsored insurance accounts for approximately \$1.4 trillion in health care spending.<sup>2</sup> The average premium for an employer-sponsored family health insurance plan is now nearly \$24,000.<sup>1</sup> As health care spending has increased over the last two decades, employers have reduced wages for workers.<sup>3,4,5,6</sup>

Particularly for lower-income households, rising health care costs for employer-sponsored insurance create financial burdens when receiving care, which can limit access to care. Because health benefits are financed from wages, employers have both a legal and moral obligation to be responsible fiduciaries when they purchase health benefits on behalf of their employees.

Unfortunately, many employers face challenges purchasing affordable health care coverage that provides real value for their workers, as more often than not they are having to make decisions while blind to prices for services in the marketplace. Many employers cannot access plan claims data, limiting their ability to monitor prices negotiated on their behalf and prudently design plan offerings. Furthermore, even when employers can access comparative cost information, they far too often face consolidated provider markets with limited access to lower-price, high-quality providers. The combination of a lack of price transparency and health care consolidation has made fulfilling their fiduciary obligations challenging for even the most engaged employers and purchasers.

My testimony today will focus on why making price information transparent is critical for addressing health care affordability and ensuring efficient health care markets. I will make three main points:

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<sup>1</sup> 2023 Employer Health Benefits Survey. KFF. Published October 18, 2023. Accessed July 8, 2024. <https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey>

<sup>2</sup> Centers for Medicare & Medicaid Services. Historical | CMS. [www.cms.gov](http://www.cms.gov). Published December 13, 2023. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical>

<sup>3</sup> Arnold D, Whaley CM. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. RAND Corporation; 2020. [https://www.rand.org/pubs/working\\_papers/WRA621-2.html](https://www.rand.org/pubs/working_papers/WRA621-2.html)

<sup>4</sup> Baicker K, Chandra A. The Labor Market Effects of Rising Health Insurance Premiums. *Journal of Labor Economics*. 2006;24(3):609-634. doi:10.1086/505049

<sup>5</sup> Brot-Goldberg Z, Cooper Z, Craig SV, Klarnet LR, Lurie I, Miller CL. Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers. Published online June 2024. doi:10.3386/w32613

<sup>6</sup> Anand, Priyanka. 2017. “Health insurance costs and employee compensation: Evidence from the national compensation survey.” *Health Economics*, 26(12): 1601–1616.

1. Health care prices in the United States are high and variable and are driven by provider consolidation and market power, and those high prices are not linked to increases in quality.
2. Rather than placing the responsibility of navigating the US healthcare system on patients, effective price transparency can be a hub that enables impactful programs and policies developed by employers and policymakers that improve access to lower-priced, high-quality providers and ensure health market competition.
3. There are potential steps Congress and the federal government could consider to increase both transparency on prices and ownership structure in health care markets and enable price transparency to reach its cost-containment potential.

## U.S. Health Care Prices are High and Variable

The United States leads the world in health care spending, largely due to high prices.<sup>7</sup> Prices also vary considerably, both within and across markets. Several studies document substantial variation in U.S. health care prices. My recent research shows employer and private insurance prices for hospital care average 254 percent of Medicare. However, prices are below 200 percent of Medicare in states like Arkansas, Iowa, and Michigan, but over 300 percent of Medicare in states West Virginia, Florida, and Georgia.<sup>8</sup> In addition, both Medicare and commercial insurers pay roughly twice as much for common services, such as laboratory tests, diagnostic imaging services, and outpatient surgeries, performed in hospital-based settings than non-hospital sites of care.<sup>9</sup>

High and variable health care prices are often not linked to quality and are driven by provider consolidation and market power. Over the last two decades, U.S. health care provider markets have experienced three main types of consolidation. The first involves “horizontal” consolidation, primarily driven by hospital and health system acquisition of other hospitals. U.S. health care markets have seen over 2,000 hospital mergers. Hospital mergers lead to meaningful increases in prices, without improvements in quality.<sup>10,11</sup> The second form of consolidation involves “vertical” consolidation, where large entities, primarily hospitals and health systems, acquire intermediaries, primarily physician practices. Over the last decade, the share of U.S. physicians employed by a hospital or health system has approximately doubled. Currently, over half of U.S. physicians are employed by a hospital or health system. Driven by “site-of-care” payment differentials in both Medicare and commercial payment rates, this form of consolidation changes referral patterns for many “downstream” services,

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<sup>7</sup> Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. It’s The Prices, Stupid: Why The United States Is So Different From Other Countries. *Health Affairs*. 2003;22(3):89-105. doi:<https://doi.org/10.1377/hlthaff.22.3.89>

<sup>8</sup> Whaley CM, Kerber R, Wang D, Kofner A, Briscoe B. Prices Paid to Hospitals by Private Health Plans: Findings from Round 5 of an Employer-Led Transparency Initiative. RAND Corporation; 2024. Accessed July 8, 2024. [https://www.rand.org/pubs/research\\_reports/RRA1144-2.html](https://www.rand.org/pubs/research_reports/RRA1144-2.html)

<sup>9</sup> Robinson J, Whaley C, Dhruva S. Prices and Complications in Hospital-Based and Freestanding Surgery Centers. *The American Journal of Managed Care*. 2024;30:179-184. Accessed July 8, 2024. <https://www.ajmc.com/view/prices-and-complications-in-hospital-based-and-freestanding-surgery-centers>

<sup>10</sup> Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured. *Q J Econ*. Published online 2018. doi:10.1093/qje/qjy020

<sup>11</sup> Liu JL, Levinson ZM, Zhou A, Zhao X, Nguyen P, Qureshi N. Environmental Scan on Consolidation Trends and Impacts in Health Care Markets. RAND Corporation; 2022. Accessed January 19, 2024. [https://www.rand.org/pubs/research\\_reports/RRA1820-1.html](https://www.rand.org/pubs/research_reports/RRA1820-1.html)

thereby increasing both Medicare and commercial spending.<sup>12,13</sup> A more recent form of vertical integration involves insurers directly acquiring both physician practices and other types of providers.<sup>14</sup> Particularly for Medicare Advantage populations, this form of consolidation raises concerns about access to care and payment gaming.<sup>15</sup> Finally, the latest wave of health care consolidation is driven by private equity, which owns a growing share of U.S. physician practices. Studies show private equity acquisition leads to price increases without commensurate gains in access or quality. Importantly, these models of consolidation disadvantage the healthcare workforce, with physicians and nurses receiving lower pay following consolidation.<sup>16,17</sup>

While high and variable prices directly impact those with commercial insurance, they also have important implications for aging Americans. First, many over-65 individuals receive private insurance, most commonly from current or former employers, and are thus impacted by high and variable prices. Second, numerous studies show the health impacts of high healthcare costs for patients in the form of reductions in high-value and necessary care.<sup>1-7</sup> For the under-65 population to age healthily, it is critical that they have access to affordable health care. Finally, high and differential prices drive health care consolidation, which erodes access to and quality of care for Medicare beneficiaries.<sup>18,19, 20</sup>

## What is the role of price transparency in addressing rising health care costs?

Due to the high and variable nature of U.S. health care prices, improving price transparency has been a potential policy option for several years. Early price transparency models relied on patient-driven use through

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<sup>12</sup> Whaley C, Paul DRL, Perkins J. Addressing Site-of-Care Payment Differentials in the United States Health Care System. Brown University School of Public Health; 2024. Accessed July 8, 2024.

<https://cahpr.sph.brown.edu/sites/default/files/documents/Site%20Neutral%20Payment%20Policy%20Brief-2.pdf>

<sup>13</sup> Richards MR, Seward JA, Whaley CM. Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *Journal of Health Economics*. 2022;81:102569. doi:<https://doi.org/10.1016/j.jhealeco.2021.102569>

<sup>14</sup> Zhao X, Richards MR, Damberg CL, Whaley CM. Market Landscape and Insurer-Provider Integration: The Case of Ambulatory Surgery Centers. *Health affairs scholar*. 2024;2(6). doi:<https://doi.org/10.1093/haschl/qxae081>

<sup>15</sup> Rooke-Ley H, Shah S, Fuse EC. Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All. *New England Journal of Medicine*. Published online July 6, 2024. doi:<https://doi.org/10.1056/nejmp2405438>

<sup>16</sup> Prager E, Schmitt M. Employer Consolidation and Wages: Evidence from Hospitals. *American Economic Review*. 2021;111(2):397-427. doi:<https://doi.org/10.1257/aer.20190690>

<sup>17</sup> Whaley CM, Arnold DR, Gross N, Jena AB. Physician Compensation In Physician-Owned And Hospital-Owned Practices. *Health Affairs*. 2021;40(12):1865-1874. doi:<https://doi.org/10.1377/hlthaff.2021.01007>

<sup>18</sup> Beaulieu ND, Dafny LS, Landon BE, Dalton JB, Kuye I, McWilliams JM. Changes in Quality of Care after Hospital Mergers and Acquisitions. *New England Journal of Medicine*. 2020;382(1):51-59. doi:<https://doi.org/10.1056/nejmsa1901383>

<sup>19</sup> Levin JS, Komanduri S, Whaley C. Association Between Hospital-Physician Vertical Integration and Medication Adherence Rates. *Health Services Research*. Published online October 22, 2022. doi:<https://doi.org/10.1111/1475-6773.14090>

<sup>20</sup> Whaley CM, Zhao X, Richards M, Damberg CL. Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration. *Health Affairs*. 2021;40(5):702-709. doi:<https://doi.org/10.1377/hlthaff.2020.01006>

apps and online tools.<sup>21</sup> Despite initial promise, these models had little success.<sup>22,23</sup> Relying on patients to navigate the complexities of the U.S. healthcare system with even the best price transparency tools is a challenging task.<sup>24</sup> However, the lack of usable price transparency limits the ability of researchers to understand health care markets, entrepreneurs from adding competition to healthcare markets, and regulators from monitoring market conduct and competition. Rather than placing the responsibility of navigating the US healthcare system on patients, effective price transparency can be a hub that enables impactful programs and policies. Several employers and purchasers have used price transparency to redesign benefits.

### *Example 1: California Public Employees Retirement Systems (CalPERS)*

The California Public Employees Retirement System (CalPERS), which provides health benefits to approximately 1.4 million individuals, recognized the wide variation in prices within their network that was not tied to clinical outcomes. Rather than implementing a punitive high-deductible plan, they worked in conjunction with their labor representatives to design a steerage program that uses financial incentives to encourage the use of lower-priced providers and non-hospital providers. Across several services, this program reduced spending by approximately 20 percent and improved care quality.<sup>25,26,27</sup>

### *Example 2: State of Oregon Hospital Reimbursement Caps and All-Payer Claims Database*

A similar example comes from the State of Oregon. Recognizing the wide variation in hospital prices, Oregon passed legislation that caps the prices of hospital care at 200 percent of the Medicare rates for Oregon's public employees and educators. My colleagues have demonstrated that this program led to over \$100 million in savings in the first two years of the program, without impacts on the quality of care or the provider workforce.<sup>28</sup> If adopted among other states, we estimate that this model could reduce public employee spending by approximately \$7 billion, which could be used to increase public employee pay or returned to taxpayers, and nearly \$90 billion if expanded to the broader commercial market. Oregon also invested in an all-payer claims database, which allows state authorities to monitor price and spending trends.

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<sup>21</sup> Whaley C, Chafen Schneider J, Pinkard S, et al. Association Between Availability of Health Service Prices and Payments for These Services. *Journal of the American Medical Association*. Published online October 22, 2014.

<sup>22</sup> Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA*. 2016;315(17):1874-1881. doi:10.1001/jama.2016.4288

<sup>23</sup> Desai S, Hatfield LA, Hicks AL, et al. Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees. *Health Affairs*. 2017;36(8):1401-1407. doi:10.1377/hlthaff.2016.1636

<sup>24</sup> Chernew M, Cooper Z, Hallock EL, Scott Morton F. Physician agency, consumerism, and the consumption of lower-limb MRI scans. *J Health Econ*. 2021;76:102427. doi:10.1016/j.jhealeco.2021.102427

<sup>25</sup> Robinson JC, Brown TT. Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery. *Health Affairs*. 2013;32(8):1392-1397. doi:https://doi.org/10.1377/hlthaff.2013.0188

<sup>26</sup> Robinson JC, Brown TT, Whaley C, Finlayson E. Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications. *JAMA Internal Medicine*. 2015;175(11):1783. doi:https://doi.org/10.1001/jamainternmed.2015.4588

<sup>27</sup> Robinson JC, Brown TT, Whaley C. Reference Pricing Changes The “Choice Architecture” Of Health Care For Consumers. *Health Affairs*. 2017;36(3):524-530. doi:https://doi.org/10.1377/hlthaff.2016.1256

<sup>28</sup> Murray RC, Brown ZY, Miller S, Norton EC, Ryan AM. Hospital Facility Prices Declined As A Result Of Oregon’s Hospital Payment Cap. *Health Affairs*. 2024;43(3):424-432. doi:https://doi.org/10.1377/hlthaff.2023.01021

### *Example 3: 32BJ Health Fund - Private-Sector Adoption of Innovations*

These innovations are also being adopted by private-sector organizations. In one notable example, the 32BJ Health Fund, which provides health benefits to approximately 200,000 service workers, reviewed its claims data and realized some providers had exceptionally high prices. After several attempts at negotiation, 32BJ excluded a single hospital from its network. This decision saved the Health Fund approximately \$100 million per year, which it returned to its workers in the form of the largest worker pay increase in its history and a \$3,000 bonus for each member.<sup>29</sup>

### *Example 4: Indiana employers using data to push for policy changes*

Another example comes from employers in the state of Indiana. Through the Employer's Forum of Indiana, we worked with Indiana employers to analyze their claims data and found they were paying some of the highest prices in the country.<sup>30</sup> In addition to using price transparency data to monitor prices negotiated on their behalf and to inform both benefit design and purchasing decisions, Indiana employers pushed for legislation that limits facility fees and adds additional transparency to Indiana health care markets.<sup>31</sup> These efforts use price transparency data to add oversight into an opaque market and inform policies that improve market competition.

These are notable examples and there are many more entrepreneurs and innovators that are using price transparency data to develop similar programs that steer patients to lower-priced providers,<sup>32</sup> modernize payment methods in ways that align incentives between patients, providers, and payers,<sup>33</sup> and add competition to health care markets.

While these policies and programs are designed to fit the needs of each group's market and population, a common theme is that each group relied on price and network data, most commonly from medical claims data, to innovate. These organizations also take seriously their responsibilities as health care purchasing fiduciaries. These types of models are critical to ensure affordable access to high-quality providers across the aging lifecycle.

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<sup>29</sup> SEIU 32BJ Healthcare Savings Case Study. PatientRightsAdvocate.org. Accessed July 8, 2024. <https://www.patientrightsadvocate.org/seiu-32bj-healthcare-savings-case-study>

<sup>30</sup> Abelson R. Many Hospitals Charge Double or Even Triple What Medicare Would Pay. The New York Times. <https://www.nytimes.com/2019/05/09/health/hospitals-prices-medicare.html>. Published May 9, 2019.

<sup>31</sup> Mathews AW. These Employers Took On Healthcare Costs, and the Fight Got Nasty. WSJ. Published September 28, 2023. <https://www.wsj.com/health/healthcare/these-employers-took-on-healthcare-costs-and-the-fight-got-nasty-54674114>

<sup>32</sup> Whaley CM, Vu L, Sood N, Chernew ME, Metcalfe L, Mehrotra A. Paying Patients To Switch: Impact Of A Rewards Program On Choice Of Providers, Prices, And Utilization. *Health Affairs*. 2019;38(3):440-447. doi:<https://doi.org/10.1377/hlthaff.2018.05068>

<sup>33</sup> Whaley CM, Dankert C, Richards M, Bravata D. An Employer-Provider Direct Payment Program Is Associated With Lower Episode Costs. *Health Affairs*. 2021;40(3):445-452. doi:<https://doi.org/10.1377/hlthaff.2020.01488>

## What more can be done to enable price transparency to reach its cost containment potential?

In recognition of the importance of price transparency, recent federal policies have sought to expand access to price transparency information. On January 1, 2021, requirements for hospitals to negotiate their prices for all items and services went into effect.<sup>34</sup> Following that, on July 1, 2022, a federal rule went into effect that requires health plans to disclose the negotiated prices they pay physicians and facilities for each item they provide, known as Transparency-in-Coverage (TiC) data.<sup>35</sup> Both of these policies greatly expand health care price transparency.

While there have been some concerns with the implementation of the rules, there have been significant positives to each. The insurer-posted (TiC) data provides the most comprehensive view of U.S. health care prices currently available. There were initial concerns about the TiC data usability, but researchers, including myself, have been able to use data to measure price variation. Entrepreneurs are also using these data to improve benefit design innovations.

While these data are important, they, like most things, can also be improved. There are several steps Congress and the federal government could consider to increase price transparency in health care markets and enable price transparency to reach its full cost-containment potential.

### *Increase compliance enforcement and standardization of hospital-posted price transparency data*

The hospital-posted price transparency data represent an initial step into expanding access to price transparency. However, compliance with requirements to post negotiated rates for 300 shoppable services could have been better, largely due to more enforcement. While recent enforcement has increased, compliance still needs to improve, with estimates suggesting that only 16 to 35 percent of hospitals are fully compliant.<sup>36,37</sup> Other studies find strategic non-compliance is related to a hospital's market environment.<sup>38</sup> Even among complying hospitals, data formats, reported services, and price measurements vary widely. To ensure that these data are useful for informing policy decisions, it is important for CMS to enforce compliance and standardize data submission.

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<sup>34</sup> Department of Health and Human Services. 45 CFR Part 180. Published November 27, 2019. <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180#180.40>

<sup>35</sup> FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49.; 2021. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>

<sup>36</sup> MRF Tracker. Turquoise Health. Accessed July 8, 2024. [https://turquoise.health/mrf\\_tracker](https://turquoise.health/mrf_tracker)

<sup>37</sup> Patient Rights Advocate. Sixth Semi-Annual Hospital Price Transparency Report February 2024. Patient Rights Advocate; 2024. <https://www.patientrightsvocate.org/semi-annual-report-feb2024>

<sup>38</sup> Mittler JN, Abraham JM, Robbins J, Song PH. To be or not to be compliant? Hospitals' initial strategic responses to the federal price transparency rule. Health Services Research. Published online November 6, 2023. doi:<https://doi.org/10.1111/1475-6773.14252>

### *Reduce the duplicative prices and prices for providers that do not perform listed services from the TiC data and centralize data posting*

The TiC data include many duplicative prices and prices for providers that do not perform listed services. These features greatly inflate the size of the TiC data, reducing its applicability and accuracy. Second, the TiC data are completely updated on a monthly basis, which further adds barriers to data use. To further improve this innovative resource, CMS could require insurers to only post prices for providers with submitted claims for a given procedure. CMS could also limit monthly updates to new or changed prices, rather than a complete data refresh.

Additionally, the TiC data are currently hosted individually by plans and insurers. CMS could centralize TiC data by acting as a central hub for hosting these data. The data are also currently posted in non-standard data formats, which contributes to inflated data size. CMS could use common modern database technologies to allow a broad set of users to access the data and substantially reduce data size and complexity without losing any valuable data.

### *Require a centralized national database to enhance transparency of provider ownership and control*

While existing transparency efforts primarily focus on prices, provider ownership and affiliation arrangements are often complex and opaque. Existing data resources do not adequately track ownership structure, limiting appropriate measurement of consolidation activities and policies to guard against adverse impacts of consolidation.<sup>39</sup> Researchers, and importantly, policymakers, lack comprehensive data on who owns or controls health care entities and physician practices. Many provider organizations are organized through complex corporate structures that obscure the identity of the owner or control entity and prevent accountability.<sup>40</sup> Patients often have little information on their physician's actual employer. As a result, estimates of both the extent and impacts of consolidation are limited and incomplete. Ownership transparency could be improved by requiring provider organizations to report not just direct ownership but also management, joint venture, and related arrangements. Developing a centralized national database to enhance the transparency of provider ownership and control will allow for a more complete understanding of the true extent and effects of consolidation in US health care markets, including changes in prices, utilization, and quality of care.

### *Ensure that self-funded purchasers have access to data on price, utilization, and quality*

While these efforts have been primarily focused on expanding access to publicly-available price transparency data, many employers and self-funded purchasers rely on medical claims data to measure prices, track quality, and ensure access to efficient providers. Yet, many employers and purchasers face barriers in accessing their medical and pharmacy claims data. The 2021 Consolidated Appropriations Act (CAA) removes many restrictive and anti-competitive clauses from plan contracts, but does not ensure that self-funded

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<sup>39</sup> The Perils Of PECOS: Using Medicare Administrative Data To Answer Important Policy Questions About Health Care Markets. Forefront Group. Published online January 7, 2021. doi:<https://doi.org/10.1377/forefront.20201222.615286>

<sup>40</sup> Hearing on Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing Economic Resiliency. Published online 2024. <https://www.judiciary.senate.gov/committee-activity/hearings/strengthening-us-economic-leadership-the-role-of-competition-in-enhancing-economic-resiliency>

purchasers have access to their claims data.<sup>41</sup> As a result, many employers have had to sue to get access to their own data.<sup>42</sup> It is important that purchasers have access to data on price, utilization, and quality that these data provide. Proposed bipartisan legislation codifies access to these data, which are necessary for self-funded plans to be responsible fiduciaries and monitor prices negotiated on their behalf.<sup>43</sup>

## Conclusion

Health care prices in the United States are high, variable, and opaque. High prices are both a cause and a consequence of health care consolidation, which has left many communities with a single provider system and worsened access to high-quality care. Arguably, the most significant bipartisan federal agreement in recent years has centered on enhancing transparency in healthcare pricing. In combination with expanded insight into provider ownership and management, broadened transparency can help employers and health care purchasers fulfill their fiduciary obligations to provide access to high-quality and affordable care. It also aids regulators and policymakers in overseeing healthcare market competitiveness and ensuring patient access to high-quality, cost-effective care. While not a cure-all for the U.S. healthcare system, given the widespread impact on all individuals navigating the healthcare system, these initiatives enjoy substantial public backing. To accomplish these goals, Congress can improve the existing Transparency-in-Coverage policies that provide substantial insight into US health care prices, ensure transparent reporting of provider ownership and management, and codify self-funded employer and purchaser access to their claims data.

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<sup>41</sup> Consolidated Appropriations Act, 2021 (CAA) | CMS.

[www.cms.gov.https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-cao](https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-cao)

<sup>42</sup> Kraft Heinz Co. Employee Benefits Administration Board, et al., v. Aetna Life Insurance Company, 2:23-cv-00317, District Court, E.D. Texas, June 30, 2023, <https://www.versanconsulting.com/post/kraft-heinz-co-employee-benefits-administration-board-et-al-v-aetna-life-insurance-company>; Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts, 66 F.4th 307 (1st Cir. 2023), April 25, 2023, <https://casetext.com/case/mass-laborers-health-welfare-fund-v-blue-cross-blue-shield-of-mass-1>; Owens & Minor, Inc. and Owens & Minor Flexible Benefits Plan v. Anthem Health Plans of Virginia, Inc., 3:23-cv-00115, February 13, 2023, [https://www.millerchevalier.com/sites/default/files/resources/General\\_Alerts/2023-02-13\\_Owens-v-Anthem\\_Complaint.pdf](https://www.millerchevalier.com/sites/default/files/resources/General_Alerts/2023-02-13_Owens-v-Anthem_Complaint.pdf); Bricklayers, Craftworkers, Sheet Metal Workers Unions v. Elevance, 3:22-cv01541-VLB, December 5, 2022, <https://www.documentcloud.org/documents/23378734-bricklayers-craftworkers-sheet-metal-workers-unions-v-elevance>.

<sup>43</sup> 118th Congress . S.3548 - Health Care Prices Revealed and Information to Consumers Explained Transparency Act. <https://www.congress.gov/bill/118th-congress/senate-bill/3548/all-info>