Testimony for House Committee on Energy and Commerce Hearing

Wednesday, March 18, 2026

Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

Elizabeth Mitchell
President and CEO
Purchaser Business Group on Health
Oakland, California

Opening Statement

Chairman Guthrie, Chairman Griffith, Ranking Member Pallone, Ranking Member DeGette, and members of the House Energy and Commerce Committee: thank you for the opportunity to testify today and share the experiences of large, self-insured employers and public purchasers* of health care as they seek to reduce health care costs, improve quality, and increase access and affordability for their employees.

Over 180 million Americans receive health insurance coverage through employers,[1] and they rely on the commercial market to ensure care is affordable and high quality. That is increasingly difficult. Soaring costs can quickly turn a medical emergency into a financial disaster. Affordability for American workers is reaching a crisis point.

My name is Elizabeth Mitchell. I am the President and CEO of the Purchaser Business Group on Health, or PBGH. We are a nonprofit coalition of large, self-insured employers and public purchasers that spend over $350 billion annually purchasing health care for 21 million Americans. PBGH facilitates employer-led innovation in the commercial market. For nearly 40 years, we have worked directly with purchasers and health care practices to improve quality and affordability through active purchasing strategies and actions.

Our members have implemented employer-led innovations that deliver real results – from HMO purchasing that reduced premiums by more than nine percent, [2] to advanced primary care initiatives that saved hundreds of millions of dollars and avoided tens of thousands of hospital admissions, [3] to some of the nation's earliest Centers of Excellence programs that dramatically improved outcomes while cutting total costs of care.[4] More recently, we have worked to combine price, quality, safety, and claims data to support value-based purchasing.[5] In short, we know what it takes to deliver high-value care, and we appreciate this Committee's leadership on affordability.

* Throughout this testimony, "purchasers" is used to refer collectively to public and private employers as well as non-employer purchasers of health care (e.g., Taft-Hartly benefit funds, state health plans, and state exchanges).

However, while employers and public purchasers are leading the way on innovation, policy intervention is necessary to address anticompetitive business practices and restore a functional market. The health care industry has been largely unresponsive to the concerns of employers and patients, erecting barriers to access and affordability, and stymieing efforts to innovate. When this happens, American businesses, American workers, and their families are the ones left holding the bill.[6]

But there is good news: we know what works. Evidenced-based strategies can improve care while lowering costs – if they are scaled and supported. Based on the experience among our members, we urge Congress to focus on three priorities:

First, ensure meaningful price and quality transparency so purchasers and patients can make informed decisions.

Second, redirect resources to underfunded yet high-value care areas including primary care, maternity care, and mental health care; and

Third, stop anticompetitive business practices enabled by consolidation and strengthen policies, such as site-neutral payment and anti-competitive contracting reform, that restore competition and accountability.

Employers have demonstrated they are prepared to confront the health care cost crisis – but they cannot do this work alone**.** By advancing these reforms, Congress can directly improve affordability and quality for more than half the country through market-based solutions.

Thank you for the opportunity to testify today and for the Committee's leadership on health care affordability. We look forward to working with Congress to advance transparency, competition, and market-based solutions that lower costs and improve care for American families.

The Dual Problem of Affordability and Quality

Health care affordability is a crisis felt acutely by our nation's working families and employers alike. When PBGH surveyed C-suite business executives five years ago with the Kaiser Family Foundation, 87% believed the cost of providing health benefits would become unsustainable in the next 5 – 10 years.[7] Even more surprising, over 90% of these private sector executives supported action from the Federal government to address pricing. Leading actuaries recently reported the annual cost to provide health care to an American family has risen an average of 6.1% per year for 20 years, to over $35,000 last year.[8] The rate of cost growth has only accelerated in recent years with many of our members experiencing double digit increases since 2023. Employers have held out hope that health system leaders would responsibly manage care and costs but rather than acknowledge and address the health care affordability crisis, industry actors are exacerbating it.

Today, PBGH members consistently list "affordability" as their top health care concern, as they confront double digit increases in their total health care costs. Sadly, for patients, these stark increases have no commensurate increase in care quality, are associated with diminishing access, and are accompanied by an utter lack of responsiveness from health insurers, PBMs,[*] hospitals, and health systems to employers' concerns.[9] Our members consistently report that these cost increases are <u>not</u> explained by increases in care utilization or acuity in their population – and independent research supports this firsthand experience.[10]

So, if access is worse and quality has not improved, what is driving double digit cost increases? Many cost increases are driven by expanding administrative fees from health plans and pharmacy benefit managers ("PBMs"), point solutions, private equity and other non-clinical expenses. Those are important but are the focus of other hearings. But many of the biggest cost increases are driven by hospitals and health systems and can be addressed today. Top cost growth drivers reported by PBGH members in a survey include:

- Physician-Administered Drugs
- High-cost Claims
- Emergency Room Visits
- Inpatient Hospital Admissions
- Outpatient Facility Care

These top cost growth drivers are enabled and amplified through consolidation, which began with an "aggressive wave" of hospital mergers in the 1990s and has only intensified over the last two decades,[11] with over 1,150 acute-care hospital mergers between 2002 and 2020.[12] Furthermore, consolidation has led to price increases not *only* in the top cost growth categories, but across all services provided at consolidated health systems.[13]

Rather than investing to improve preventive health through robust primary care to avoid hospitalizations, some health systems are incentivized to maximize revenue from ER

[*] PBGH thanks Congress for its recent historic reforms to PBMs in CAA 2026. The additional transparency for purchasers that will result from these reforms, paired with the actions of the Department of Labor in its proposed rule on PBM fee disclosure, will enable employers to radically improve their PBM relationships and lower drug costs.

utilization, high-cost hospital admissions, and hospital-administered drugs despite the availability of high-value alternative sites-of-care and generic options that could save patients tens of thousands of dollars.[14] Even procedures or treatments that would have been deemed high-cost at $100k several years ago are more than doubling in price to $350 - 500k with no change in patient acuity. Hospital prices have increased even when acuity has not.

The fee for service ("FFS") model is alive and well and driving business decisions. Consolidation and anticompetitive practices are protecting health systems from competition and an innovation mindset that is present in virtually every other market. Many hospitals and provider groups insist they need more money to transition away from fee for service to more 'value based' care models. After nearly two decades 'value based care' remains largely elusive with few providers taking on real risk or achieving meaningful results.[15]

A healthy market requires competition, but in health care, consolidation often means many hospitals and other providers are owned by the same system and alternatives don't exist. This market share is used to cement anticompetitive contracting practices like anti-tiering and anti-steering clauses prohibit employers from removing a high-cost, low-quality provider from a network or incentivizing employees to visit high-value providers. Even the largest employers in the world often have inadequate leverage to overcome these terms and consolidation means they have few alternatives when they do.[16]

The relentless march of increasing costs and flat or decreasing quality for our health care system is exacerbated by consolidated provider markets,[17] incentives that put profits over patient outcomes, administrative burdens that add to cost and not care, and other market perversions that have rendered our health care delivery system largely unresponsive to the needs of those it is intended to serve: patients and the purchasers who want to pay a fair price for the best outcomes.[18] Even the largest employers often do not have market power to address all of the varied and complex incentives that prevent us from reducing health care costs.[19]

Our members are particularly concerned about health system consolidation, which allows hospitals and affiliated providers to raise prices and resist both public and private efforts to rein in the resulting cost growth.[20] Employers have very limited recourse if they want access to care for their employees.

By buying up nearby independent facilities, large health systems can leverage needed access to certain specialties like maternity care or care in rural areas to command high prices across the system. This was exemplified in the case against Sutter Health, in which Sutter withheld access to maternity care unless employers contracted with their entire system. Sutter settled out of court but returned over $500 million to employers and unions – suggesting significant overcharging.[21] Although this was one health system in one region, it suggests this is a common and widespread practice across the U.S. with corresponding widespread overcharging.

Consolidation is not just among hospitals and health systems. This committee has already addressed health plans in its first hearing on affordability in January,[22] but they too deserve further scrutiny. Employers have traditionally relied on health plans to effectively negotiate lower costs on their behalf. However, rather than serve employers, some actors in the insurance industry are now vertically integrated behemoths with tendrils in virtually every aspect of the health care system –

including ownership of health care providers. New arrangements between health plans, TPAs, PBMs, and providers often mean that they have joined forces. A report from July 2025 profiling UnitedHealth Group enumerated its 2,700 subsidiaries throughout the insurance, pharmacy, clinical, data, technology, and consulting industries.[23] In 2023, UnitedHealth Group alone employed or was affiliated with over 90,000 doctors nationwide – or 10% U.S. physician workforce.[24] In these cases, health plans and health systems both benefit when health care costs increase and are increasingly partnering from mutually beneficial relationships – all at the expense of employers and patients.[25]

Purchasers' Role in U.S. Health Care

The interests of self-insured employers are aligned with employees. ERISA designates employers as fiduciaries [26] who must exercise the "highest standard [of care] known to the law" and who must act in the "sole interest" of their employees when making health care purchasing decisions.[27] This responsibility requires them to provide high-quality benefits "at only reasonable expense." [28, 29] Public purchasers, too, are often subject to fiduciary standards that are substantially similar to ERISA.[30] Aside from purchasers, no other entity in the industry consistently owes fiduciary duty and loyalty to the health care consumer nor do they have the clear incentive to ensure a healthy and productive workforce.

Despite rising costs, employers remain committed to driving accountability and affordability and ensuring their employees and families have access to high-quality care. While employers increasingly understand that their traditional partners may not have aligned interests, employers continue to drive innovation with encouraging results of better access, better outcomes, and lower costs.

Purchaser-Driven Innovations

Direct Primary Care / Directly Contracted Advanced Primary Care

Investment in primary care continues to demonstrate the unusual opportunity to lower costs through providing more care. Research has proven that robust primary care systems can lower overall health care utilization, decrease rates of disease and mortality, increase the use of preventive services, and avoid unnecessary ER visits and hospitalizations – enabling a health care system that truly promotes patient health and reduces costs.[31]

PBGH members have consistently advocated for and demonstrated commitment to wide availability of primary care.[32] However, primary care in the US is chronically underfunded. While primary care accounts for 55% of visits in the U.S., it receives only 4 - 7% of health care dollars, on average.[33] Despite this undervaluation, evidence shows that even basic primary care results in improved health outcomes and lower costs. For example, one PBGH member reports that plan members with a primary care physician have total costs of care that are 31% less on a risk-adjusted basis than those members without one. Risk-adjusted costs associated with

several chronic conditions are 25 - 49% lower. Another independent study shows that patients receiving routine primary care have 62% lower total medical and pharmaceutical costs.[34]

However, robust ***advanced*** primary care ("APC") offers even greater benefits.[35] Another PBGH member conducted a study of its primary care pilot project, which showed that team-based, highly coordinated primary care reduced health care costs by 20% and improved patient outcomes while increasing employee productivity by 56%.[36] While all primary care is good, the availability of robust APC, with integrated behavioral health and referral pathways to high-value specialists, has dramatically better results over traditional primary care in terms of access, outcomes, and affordability. This is why PBGH has invested heavily in defining and promoting APC models that redirect existing health care spending to high-quality, evidence-based care while holding total cost flat.

PBGH started its first primary care improvement initiative in 2012 through our California Quality Collaborative ("CQC").[*] From 2015 - 2019, a CMS-funded multi-stakeholder quality program helped avoid nearly 50,000 hospital bed days, reduced emergency room utilization and generated about $186 million in total savings.[37] Based on our success with the CMS demonstration project, PBGH worked with our purchaser members to reach consensus on a shared definition of advanced primary care, select priority measures, define optimal payment models, and enable improved access.[38] In addition to working with health plans to scale this approach, we have established innovative regional direct contracting relationships with primary care clinicians to deliver high-quality advanced primary care.

In January 2022, PBGH launched the Advanced Primary Care Measurement Pilot,[39] which brought together six health plans [40] and four large purchasers in California –Covered California, California Public Employees' Retirement System ("CalPERS"), eBay, and San Francisco Health Services System – to test our advanced primary care measures [41] for practice-level performance at the state level. The pilot, which concluded in 2023, is a great example of ways to ease the administrative burden on providers, as it relies on common measures and existing data aggregated across purchasers and health plans to provide a more complete picture of practice performance.

The experience gained in the pilot is already being used by purchasers and health plans in both the public and private sectors to better connect patients to practices delivering the best primary care in the market and incentivize improvement for other providers, thereby increasing the availability of advanced primary care.[42] In April 2024, PBGH launched the PBGH Care Excellence Program to identify high quality advanced primary care practices that meet employer standards by leveraging learnings from the pilot, clinical guidance, best practice, and employer input.[43] In September 2024, PBGH announced the first clinics that achieved the PBGH Care Excellence Award.[44]

Despite the impressive improvements in clinical outcomes and costs, PBGH has been unsuccessful in convincing health plans outside of those APC-participants in California to adopt or scale the APC model and the corresponding payment changes required. Despite requests

[*] **Note**: This program was *not* a direct contract and did not involve purchasers. It did, however, provide valuable insights for purchasers to use in later defining the type of advanced primary care they wanted to purchase.

from employers, many health plans have declined to make needed investments in primary care, often citing the challenges of changing contracts and reallocating funding from hospitals. To overcome these barriers, PBGH and others are now facilitating employers easily arranging direct contracts with identified APC practices to offer their employees and families the highest standard of advanced primary care. PBGH is also advocating for policies that support primary care and reinvestment of health care dollars toward primary care.[45]

PBGH has numerous examples of self-insured employer members directly contracting with APC practices and achieving better care and reduced costs. There have also been significant improvements in needed access to care. This is in part due to payment changes that self-insured employers make to both pay more and pay differently for APC,[*] allowing practices to redesign care for whole-person health. In exchange for higher and more flexible payment, APC practices agree to meet key outcome and access standards for employers and their workforce. With adequate participation, practices can scale this model to make better care available for everyone in their communities.

Given these results and the potential savings and care improvements from scaling this strategy, PBGH sincerely thanks Congress for facilitating Direct Primary Care ("DPC") in H.R. 1,[46] and strongly urges policymakers to continue facilitating DPC and direct contracting in health care, generally. To that end, we encourage Congress to work with the Administration to clarify their intent that employers can provide first dollar coverage for DPC services (i.e. that they can pay for employees' DPC below the deductible in a high-deductible health plan without compromising the employee's HSA eligibility).[†]

Supporting quality primary care is a solution we should all be able to agree on.

Direct Contracting, Centers of Excellence, and High-Quality Specialists

PBGH members do and will pay for high-value care with quantified outcomes. We have stellar examples of bold innovations driven by our employer members to buy high quality care. For example, one PBGH member has created a Centers of Excellence ("COE") program for high-quality, low-cost surgeons for joint replacements, bariatric surgery, and spine surgery – all costly procedures. This member has created tiers of "preferred" and "non-preferred" hospitals to encourage members to seek care at the high-quality, lower-cost facilities in exchange for waiving member copays and providing free transportation to and from surgery. This member cites saving ~ $80 million dollars since 2019 from deploying this COE model.

Another PBGH member has leveraged multiple years of longitudinal quality data on maternity care services to develop a high-performance OBGYN network of the top 10 best performing providers in the employer's plan. The high-quality providers in this network have a C-section

[*] It is well-established that the fee-for-service model is unable to appropriately compensate primary care physicians for their services, and that prospective, flexible payment models are required.

[†] PBGH recently submitted a comment letter to the Treasury / IRS and co-organized a joint letter as well, which each ask Treasury / IRS to issue such clarifying guidance in their implementation of H.R. 1.

rate that is less than half the rate observed in non-participating providers (22% vs. 46%). This employer built a tiered plan design that steers members directly to the highest-quality care. Because C-sections, for this employer, are 8 times as costly as normal deliveries, this is not only a win in terms of patient outcomes, but financially as well.

PBGH has other examples of COEs and high-performance networks saving significant costs on care while improving quality for patients. The Employers Centers of Excellence Network ("ECEN") – which was managed by PBGH for many years on behalf of our members – demonstrated meaningful improvements in patient outcomes and health care costs.[47] ECEN set high quality standards, vetted and selected the best providers and facilities in the country for specific procedures, and encouraged employees to use these COEs for needed care.

The ECEN program showed it is possible to save money by reducing unnecessary services while improving outcomes and patient experience. Even when factoring in travel expenses and waived co-pays, the negotiated bundled payments for surgical procedures performed by COEs cost considerably less, on average, than what employers paid for these services in the traditional model. The cost equation improved even further, since these high-quality procedures produced quality outcomes that mitigated costly readmissions and infections. Much of the cost reduction came from avoiding unnecessary procedures, with top-performing surgeons using evidence-based medicine to determine surgical appropriateness. Although the ECEN program was sunset in 2021, many employers continue to achieve significant savings and better outcomes on specialty care through Centers of Excellence strategies. Leading employers are now combining Advanced Primary Care and COE strategies to ensure top quality primary and specialty care. This often challenges health systems referral relationships but ensures care quality and cost are prioritized over ownership or other business incentives.

PBGH members continue to participate in existing direct contracting relationships and to form new ones that increase care accessibility and affordability for employees:

- One PBGH member has offered employees in certain regions of the U.S. access to health care services through direct contract arrangements between the company and large, integrated health systems that have resulted in significant savings for both the company and its employees. These direct contracts are structured around achieving the triple aim of (1) improving quality, (2) enhancing the member experience, and (3) lowering costs. The company, also, has directly contracted for primary care – first in a pilot for employees in Mesa, AZ, then in St. Louis, MO and the Puget Sound area, and soon in San Antonio, TX and North Charleston, SC.[48]

- Another PBGH member, recently announced a landmark direct contract with Northwell Direct, establishing access for 170,000 plan members with significantly lower co-pays, cost-growth guarantees, and projected savings of 20% - or $46 million – in 2026.[49] The Fund more recently announced a direct contract with Mount Sinai Health System,[50] likewise enabling continued access to care for 100,000 plan members after Anthem failed to reach contract terms with the health system in early March 2026.[51]

- Another PBGH member has a direct contract with a large and innovative health system. Recently, this member was able to leverage the Hospital Price Transparency ("HPT") and Transparency in Coverage ("TiC") price transparency data to validate that the directly negotiated prices in their direct contracts with this health system were indeed competitive with the health system's network-contracted rates.

When employers contract directly for care with high-quality providers that are willing to meet the high standards they set, as fiduciaries, for their employee population, all parties benefit. The patient benefits from high quality health care at a price that is far more affordable to them. As required by fiduciary standards, the employer pays a fair price for high-quality medical services and has full transparency in the experience and the quality of what they are purchasing. And the provider benefits from reduced administrative burden, less overhead, and complete clarity on what they will be paid.

Choosing High-Value Hospital Systems

Inpatient and outpatient hospital care is the largest category of health care spending for employer-sponsored health plans, representing between 45 – 55% of total costs.[52] Outpatient facility care, in particular, has been identified as a leading driver of cost-growth.[53] This is due in part to the uptick in acquisitions of independent physician groups (who make referral decisions) by large, well-resourced health systems and hospitals.[54]

One of PBGH's members, facing unsustainably high costs from a particular hospital in their area and an unwillingness by the hospital to reduce costs, was forced to make the difficult decision to remove this high-priced hospital from their network.[55] Removing this one hospital has saved this purchaser an estimated $120 million over four years. Put differently, eliminating a *single* hospital that priced their services unreasonably high has reduced this member's total annual health care spending by 2%. In a functioning market, providers can set their own prices but buyers must be able to choose not to do business with hospitals that will not meet their terms. In this case, the decision to exclude an unwilling partner benefits all plan participants.

As hospital prices continue to rise at a rate far greater than the rate of inflation (or any other factor of the economy),[56] purchasers will increasingly face difficult choices about whether to exclude egregiously priced providers from their network. While once very difficult, identification of these outlier providers has been made much easier in recent years due to the price transparency data made available under the HPT and TiC rules.

Changing Payment Models

It has been established for many years that a primary barrier to improved quality and affordability is the Fee-For-Service ("FFS") system. FFS incentives maximize treatments and tests, and limit clinician autonomy, time with patients, and ability to optimize care. FFS rewards expensive and fragmented care rather than enabling holistic preventive care that benefits patients and reduces spending.[57] Despite a decade of work by CMS/CMMI, Health Care Payment

Learning & Action Network ("HCP-LAN"), and the Payment Model Technical Advisory Committee ("PTAC") developing alternative payment models to change these incentives, such payment models have not scaled and have not been widely deployed by health plans that are still reliant on legacy claims systems. Many clinicians continue to name payment as a primary barrier to improved care delivery.[58]

Employers have sought to overcome these barriers to pay more flexibly for primary care, to pay more and differently for undervalued services like doulas and maternity care, and to shore up rural clinics and hospitals who may not have the volume required to succeed in FFS. Many PBGH members have led innovative payment strategies including direct payment or bundled payments for maternal health services and capitated payments for advanced primary care with integrated behavioral health care. Too often, employers need to carve this out from their health plan contract in order to implement these models with provider partners. In some cases, new independent TPAs with more flexible business models are entering the market and are more willing to implement these changes,[59] but in some cases employers must find alternative ways to administer these programs. In this area, employer and provider interests are well-aligned – but without a willing administrative partner, scaling has remained challenging.

Leveraging Price Transparency Data

We applaud Congress and the Administration for requiring hospitals and health plans to publish their prices – something the industry has resisted for many years.[*] PBGH and our purchaser members have been at the forefront of using the data made available under the HPT and TiC rules – with a first-of-its-kind Data Demonstration Project.[60] In January 2025, PBGH announced the first deployment of this initiative, which aggregated deidentified claims and demographic data from five large employers and public purchasers across 10 regional markets. These datasets were analyzed in concert with the TiC and HPT price transparency data as well as independent sources of provider quality scores at the physician-level and safety metrics at the hospital-level.

This Transparency Data Demonstration Project has proven the price transparency data is interpretable, usable, and actionable. It has delivered on the promise of transparency that Congress intended: remarkable insights for purchasers on how the prices they pay compare to the market and what network selection, benefit design, and direct contracting opportunities exist. It is noteworthy that health plans and benefits consultants did ***not*** share this data with employers previously and have not leveraged the data to seek savings for their employer customers. However, this work required philanthropic funding from the Peterson Center on Healthcare because current market incentives do not support reducing health care costs on behalf of employers and patients, and the data as it exists today is massive and messy. Furthermore, the price transparency data must be paired with quality and claims data to make it actionable for employers. The findings also enable purchasers to meet their fiduciary

[*] Not only did the industry sue the Administration over the price transparency rules (hospital suit / PBM suit), but hospitals have resisted both cost containment policies and quality/safety transparency, as shown in two prominent examples within the last several months, and many hospitals *still* remain noncompliant with the HPT rule more than 5 years after it went into effect (See PBGH's July 2025 RFI Response on the Hospital Price Transparency Rule).

requirements, which were enhanced by Congress under the Consolidated Appropriations Act of 2021 ("CAA 2021"), by enabling them to provide higher-quality, competitively priced health care benefits to employees and families.

Use cases for the price transparency data include but are not limited to:

- Determining what fair prices for health care are in the commercial market and benchmarking one's own costs and quality against other networks in the market.

- Identifying Centers of Excellence, building high performance networks, steering employees to low cost, quality providers, and direct contracting with providers.

- Holding existing partners accountable for competitive prices/rates, performance guarantees, and full compliance with the TiC price transparency rule.

The results of this first iteration of PBGH's demonstration project were released to the public on September 24, 2025,[61] and a final report was published on October 6, 2025.[62] Some of the project's findings demonstrate and reaffirm the inconsistency of provider pricing and the complete lack of correlation between price and quality:

Finding #1: There is No Correlation with Price and Safety or Quality Overall

In the Seattle area, when comparing the % of a normalized Medicare rate, the price is consistently higher for the hospital with a C safety grade

Payer Data
Payer Transparency Data
Market Data Summary

Provider Name	Leapfrog Safety Grade	Aetna Choice POS II FIP	Aetna Choice POS II FOP	Premera Blue Cross Heritage FIP	Premera Blue Cross Heritage FOP	Regence BCBS Regence Preferred FIP	Regence BCBS Regence Preferred FOP	Cigna Cigna OAP FIP	Cigna Cigna OAP FOP	United UHC Choice Plus FIP	United UHC Choice Plus FOP
Cascade Valley Hospital	D	n/a	305%	293%	427%	234%	440%	n/a	n/a	137%	424%
Evergreenhealth Medical Center	A	232%	318%	228%	226%	238%	309%	235%	566%	259%	n/a
Fred Hutchinson Cancer Center	n/a	n/a	548%	n/a	524%	n/a	589%	n/a	n/a	n/a	n/a
Harborview Medical Center	C	n/a	641%	459%	143%	357%	635%	n/a	n/a	649%	n/a
Multicare Auburn Medical Center	B	417%	475%	317%	406%	351%	456%	295%	491%	384%	554%
Multicare Covington Medical Center	A	417%	475%	317%	406%	351%	456%	296%	491%	384%	554%
Multicare Good Samaritan Hospital	C	417%	421%	317%	406%	351%	456%	296%	491%	384%	n/a
MultiCare Mary Bridge Children's Hospital	n/a	869%	760%	364%	541%	386%	675%	189%	n/a	322%	n/a
MultiCare Tacoma General Hospital	B	417%	477%	317%	406%	351%	456%	295%	491%	384%	n/a
Overlake Hospital Medical Center	B	275%	382%	269%	263%	301%	340%	261%	521%	268%	n/a
Providence Regional Medical Center Everett	C	391%	452%	432%	254%	387%	415%	462%	589%	392%	n/a
Seattle Children's Hospital	n/a	n/a	630%	n/a	593%	n/a	807%	n/a	440%	n/a	n/a
St. Anne Hospital	A	387%	609%	207%	275%	370%	364%	290%	274%	394%	485%
St. Francis Hospital	B	427%	499%	326%	300%	370%	364%	290%	274%	387%	411%
St. Joseph Medical Center	A	427%	504%	326%	270%	370%	364%	290%	274%	387%	411%
Swedish Cherry Hill Campus	C	636%	428%	419%	348%	506%	472%	425%	401%	448%	n/a
Swedish Edmonds Hospital	B	295%	249%	376%	302%	252%	343%	391%	576%	n/a	n/a
Swedish Issaquah	B	n/a	215%	321%	272%	285%	347%	424%	506%	459%	463%
Swedish Medical Center	A	636%	396%	419%	348%	506%	472%	419%	401%	448%	446%
University of Washington Medical Center - Montlake	C	309%	312%	302%	338%	286%	484%	227%	371%	311%	346%
Valley Medical Center	D	251%	524%	251%	306%	263%	352%	167%	518%	278%	417%
Virginia Mason Medical Center	A	381%	417%	330%	293%	346%	415%	412%	378%	370%	n/a

The Leapfrog Hospital Safety Grade Program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors.
For more information visit www.hospitalsafetygrade.org

In St. Louis, MO hospitals, the price to deliver a baby (DRG 807, obstetric delivery without other procedures or complications) is not correlated to a hospital's Leapfrog Safety Grade

		Payer-Posted TiC Data				
Facility	Leapfrog Safety Grade	Aetna Choice POS II	Anthem PPO	Anthem Blue Access Choice	Cigna OAP	UHC Choice Plus
Mercy Hospital St. Louis	B	$8,297	$12,311	$7,902	$7,415	$8,488
Missouri Baptist Medical Center	B	n/a	$7,006	$6,618	n/a	$8,869
St. Luke's Hospital	C	n/a	$9,866	$7,461	$6,045	$5,642
Mercy Hospital South	A	n/a	$10,464	$7,902	$6,874	$8,488
Progress West Hospital	B		$7,006	$6,618	n/a	$8,869
Barnes-Jewish Hospital	C	$8,292	$10,106	$9,067	n/a	$8,973
SSM Health St. Joseph Hospital - Lake Saint Louis	C	$5,540	$8,463	$6,371	$7,929	$7,521
Anderson Hospital	B	$4,497	$6,926	$6,926	$5,206	$5,618
HSHS St. Elizabeth's Hospital	B	$9,545	n/a	n/a	$6,534	$8,472

Despite hospital having "C" Safety Grades, some hospitals are able to negotiate a higher rate

Finding #2: Prices for the Same Services Vary Significantly Within the Same Hospital

In St. Louis, the same uncomplicated obstetric delivery code (DRG 807) can vary by up to 66% between carriers

		Payer-Posted TiC Data				
Facility	Leapfrog Safety Grade	Aetna Choice POS II	Anthem PPO	Anthem Blue Access Choice	Cigna OAP	UHC Choice Plus
Mercy Hospital St. Louis	B	$8,297	$12,311	66 %	$7,415	$8,488
Missouri Baptist Medical Center	B	n/a	$7,006	$6,618	n/a	$8,869
St. Luke's Hospital	C	n/a	$9,866	$7,461	23% $6,045	$5,642
Mercy Hospital South	A	n/a	$10,464	$7,902	$6,874	$8,488

Health insurer consolidation and increased market share seems to drive up health care prices rather than what is intuitive (the opposite)

Example: *Anthem (Elevance) has 46% of the PPO market share in St. Louis compared to Cigna at 23%,* yet Cigna has better negotiated rates compared to different network options for Anthem*

* Guardado and Kane (2025) "Competition in Health Insurance: A Comprehensive Study of U.S. Markets" *American Medical Association* [Link]

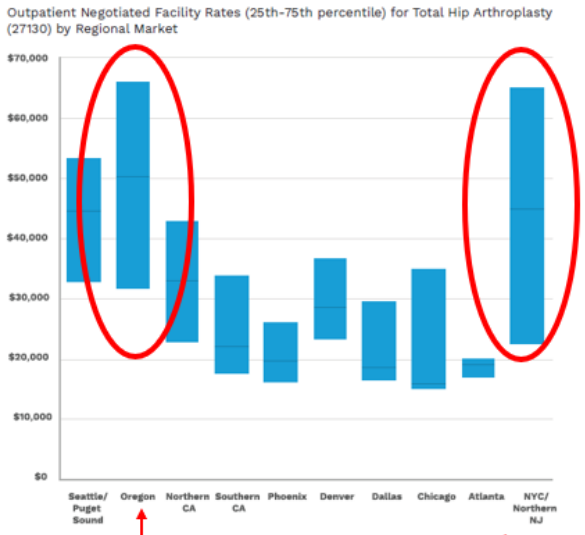
In Denver, CO at University Hospital, the rates reported for one carrier is close to 2x the rate of others in the market for emergency room visits of the same medical complexity

	Payer-Posted TiC Data			
HCPCS	Aetna Choice POS II	Anthem High Performance	Cigna PPO	UHC Choice Plus
99281	$491	$360	$811	$566
99282	$955	$840	$811	$1,541
99283	$1,670	$1,650	$1,713	$2,250
99284	$3,226	$2,250	~2x	$4,375
99285	$5,805	$3,150		$6,069

Nothing should justify this level of price variation in price for the same service, at the same hospital

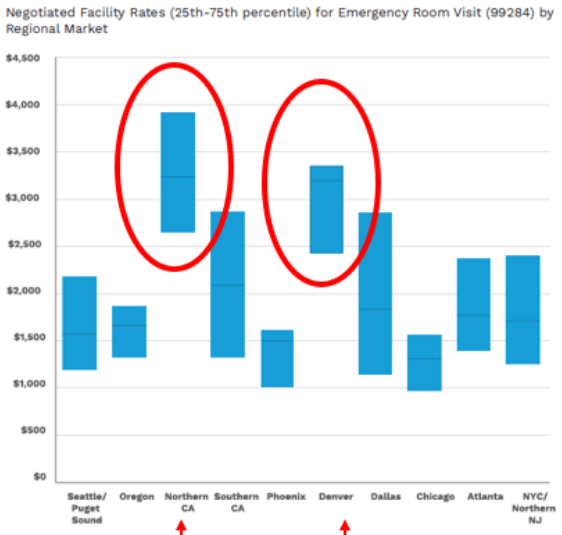
Finding #3: Regional Price Variation is Not Consistent and Defies Economic Logic

Figure 7. Payer Submitted TiC Files Show Higher Median Rates in Oregon for Total Hip Replacements (27130)



Hip replacements prices are highest in Oregon and New York area

Figure 8. Payer Submitted TiC Files Show Higher Median Rates in Northern California and Denver for Emergency Room Visits (99284)



Whereas, Emergency Room visits are highest in Northern California and Denver

Finding #4: Hospital Drug Pricing Data Also Shows Extreme Variation

One hospital in Oregon charges more than $20,000 more for dose of a medication (Ocrevus/ocrelizumab used for Multiple Sclerosis, **J 2350**) due to difference in a patients' insurance plan.

Payer-Posted TiC Data			
Facility	Regence Preferred	Cigna OAP	Providence
Hospitals			
OHSU Hospital And Clinics	$112	$83	$75
Providence St. Vincent Medical Center	$60	$56	$65

× 600 units (typical dose)

Payer-Posted TiC Data		
Regence Preferred	Cigna OAP	Providence
$67,146	$49,890	$44,814
36,150	$33,846	$38,898

A 50% price increase means a $22,332 price difference between health insurers

Finding #5: Price for Routine Services Varies Widely Based Only Upon Site-of-Care

Median prices for colonoscopy in Atlanta, GA show more than 5× cost different depending on where a procedure is performed.

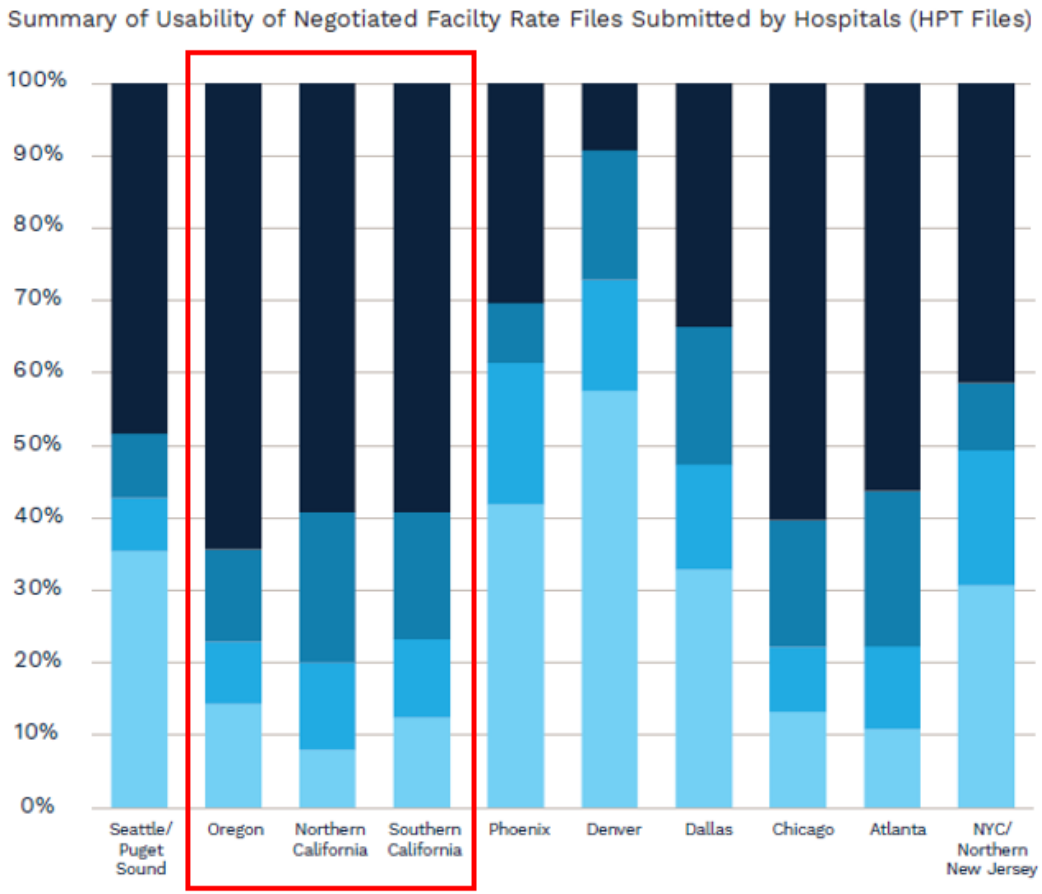
Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

		Payer Transparency Data - Outpatient Facility					
HCPCS	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
43239	Egd biopsy single/multiple	102	$847	$2,950	$3,761	$5,021	$6,915
45378	Diagnostic colonoscopy	93	$1,240	$3,073	$4,184	$5,063	$6,915
45380	Colonoscopy and biopsy	105	$1,240	$3,161	$4,184	$5,063	$9,036
45385	Colonoscopy w/lesion removal	105	$1,240	$3,227	$4,184	$5,063	$9,036

More than 5× differential

		Payer Transparency Data - Ambulatory Surgical Center					
HCPCS	**Description**	**Record Count**	**Minimum**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**Maximum**
43239	Egd biopsy single/multiple	461	$420	$583	$725	$905	$4,573
45378	Diagnostic colonoscopy	465	$420	$582	$725	$875	$4,573
45380	Colonoscopy and biopsy	423	$505	$670	$800	$935	$4,573
45385	Colonoscopy w/lesion removal	428	$524	$673	$800	$935	$4,573

Finding #6: Hospital Price Transparency Data Usability Still Highly Variable



There are some regions of the country, like Oregon and California, where hospitals are mostly not reporting usable data, though this is a national issue.

Challenges Persisting from the Health Care Industry

Consolidation, Anticompetitive Business Practices, and Unintended Policy Consequences Have Rendered Health Care Increasingly Inaccessible and Unaffordable

The staggering amount of horizontal and vertical consolidation that has occurred within the health care industry over the last two decades has allowed the health care industry to amass huge amounts of unchecked market power to raise prices.

Over a 36-year history, PBGH and our members have directly experienced the impact of increased provider consolidation and market power and the resulting anticompetitive practices and high prices. For example, PBGH played a catalyzing role in the landmark antitrust case against Sutter Health,[63] which highlighted the anticompetitive practices and monopolistic business practices employed by Sutter Health given its extreme market-dominant position in Northern California. Sutter's profits from commercially insured patients averaged over $1.5 billion annually, representing a 43% higher margin than in the previous decade. Additionally, average hospital inpatient procedures in Northern California cost $223,278 compared to $131,586 in Southern California.[64]

Although the Sutter case's settlement terms included 10 years of injunctive relief from anticompetitive practices by the health system for purchasers in Northern California, anticompetitive contracting practices by health systems in provider-insurer contracts still exist across the country. Health systems and hospitals routinely include anti-tiering, anti-steering, and all-or-nothing clauses in their contracts with insurers, to which self-insured employers are bound.[65] For their part, health insurers and TPAs include most-favored nation clauses in their agreements with providers and – either in their agreements with purchasers or their provider network agreements[*] – include anticompetitive restrictions on:

- Purchasers directly contracting outside of the insurer's network,
- Purchasers directly negotiating lower prices with in-network providers,
- Purchasers fully accessing their deidentified health care claims data or being able to share it with business associates (which Congress made impermissible in Section 201 of the Consolidated Appropriations Act, 2021).[66]
- Purchasers steering their plan members to lower-cost, higher-quality (or both) health care providers through benefit design or incentives.
- Purchasers removing high-cost, low-quality (or unsafe) providers from their network.

[*] It is sometimes unclear whether these prohibitions are driven by the health insurer / TPA, the health care provider(s), or both. In any case, the net anticompetitive effect is the same.

These barriers have obstructed PBGH members' ability to consistently provide high-quality, affordable health care to their employees. These contractual restrictions allow consolidated health systems and insurers to capitalize on their market power and raise the costs of health care with no gain in services or quality.[67]

Congress has recently shown interest in addressing anticompetitive practices,[68] which limit purchasers' ability to innovate, lower health care prices by purchasing care differently, and use the price transparency data from the HPT and TiC rules. We appreciate that transparent information and fair rules alone will not change the trajectory of U.S. health care – and that purchasers will need to leverage these changes for better results. If purchasers are given the tools, data, and information they need to make informed decisions, they have demonstrated they are prepared and willing to hold their partners accountable and exercise their health care purchasing power wisely.

Congress can also combat consolidation by reducing the policy incentives that are driving further consolidation (or allowing already-consolidation entities to extract higher prices) in health care markets. A prominent example is reforming site dependent payments. The bipartisan "Site-based Invoicing and Transparency Enhancement Act" (SITE Act, S. 1869), introduced a site neutral legislative framework in 2024. PBGH has long been a proponent of site-neutral payment reforms in the Medicare program,[69] which would reduce incentives for provider consolidation and would support site-neutral payment innovation in purchaser contracting.[70,*]

PBGH takes an interest in Medicare's payment policies, and the extent to which they may be distorting health care markets, for two reasons:

1. **Direct**: Medicare's payment policies, in many ways, provide a model for the payment policies of private health insurers – carrying direct implication for health care prices in the commercial market [71] which are already high.[72]

2. **Indirect**: When Medicare payment policies incidentally discriminate against independent, freestanding physician offices, this incentivizes further health care consolidation,[73] which is well-documented to allow providers to charge higher prices in the commercial market without commensurate gains in quality of care.[74]

PBGH supported the Administration's inclusion of site neutral payment reforms for drug administration services performed in hospital outpatient departments ("HOPDs"),[75] and supports further site-neutral action from policymakers for medical services where there is no clinical benefit to performing the service in a hospital outpatient setting.

[*] The medical billing reforms included in Section 6225 of the CAA 2026 for the Medicare program may, also, increase transparency into the site-of-service of care and accelerate site-neutral payments in the commercial market. PBGH's members are interested and actively pursuing this strategy through our Purchaser-Driven Contracting project.

Unintended Consequences and Provider Abuse of the No Surprises Act

While the No Surprises Act ("NSA") has largely succeeded in shielding patients from balance billing, it has failed to contain costs for purchasers as CBO originally projected.[76] One analysis places the additional total cost to the health care system from 2022 to 2024 at $5 billion, with less than half that comprised of actual payment amounts to providers.[77] The NSA statute was intended to anchor out-of-network payments to the "Qualified Payment Amount ("QPA") – generally the median in-network rate – thereby preventing surprise billing from becoming a backdoor mechanism for price inflation. In practice, however, arbitration outcomes from the independent dispute resolution ("IDR") process have routinely exceeded in-network benchmarks, driving higher prices for the commercial market. Analyses of federal IDR data show that arbitration utilization has resulted in millions of disputes initiated (almost all by providers) and with payment determinations frequently multiple times the QPA.[78] As a result, costs that were once constrained through network contracting are increasingly being reset through arbitration, undermining the NSA's cost-containment intent.

The IDR process has emerged as the NSA's most significant design flaw. Congress envisioned IDR as a narrow, last-resort mechanism, yet the data released to-date shows it has become a provider reimbursement strategy, with providers prevailing in approximately 80–85 percent of cases.[79] Furthermore, evidence increasingly makes clear that a subset of providers are actively exploiting the NSA and IDR process to extract higher payments from commercial health plans.[80] The result is a system that is administratively burdensome, slow to resolve disputes, and structurally biased toward higher payment outcomes – costs that are borne almost entirely by purchasers and ultimately patients in the form of higher premiums.

Lastly, there is simply far too little transparency into the IDR process, which limits purchasers' ability to manage the arbitration process (within their plan) and understand how its costs directly and indirectly affect their health plan. Some of our members – frustrated by the lack of transparency and agency they have in the NSA's IDR process – have resorted to handling the arbitration process in-house.[81] The flaws with the IDR process have increased administrative burden and costs for employers without achieving Congressional intent.

Upcoding

Provider upcoding is a growing driver of health care affordability challenges in the commercial market.[82] In fact, a study published in 2024 using data from 2011 – 2019 found that upcoding in hospital billing led to price increases that were higher in the commercial market than in public programs ($5.8 billion vs. $4.6 billion in Medicare and $1.8 billion in Medicaid).[83] Another study in 2025 found that from 2018 – 2023, visits coded at higher complexity levels increased across all outpatient settings, including emergency departments, urgent care centers, and physician offices.[84]

Because employer-sponsored plans often rely on negotiated rates tied to billing codes and severity levels, inflated coding directly raises allowed amounts, employer premiums, and employee cost sharing without delivering additional clinical value. Purchasers often lack transparency into coding patterns across health systems, making it difficult to identify inappropriate variation.

Health Care Industry Leadership Challenges

Policymakers, employers, and patients have historically relied on health care industry leaders, executives, and boards to manage their costs as stewards of public and private resources (as the case warrants). Given the persistent cost increases with attenuating quality – especially in recent years – that reliance and trust looks increasingly misplaced. It is only because health care markets so clearly do not function that we are here today and that PBGH and our purchaser members are managing health care costs ourselves.

American businesses should not be tasked with fixing the U.S. health care system. American companies have core businesses that should be prioritized, whether it is building cars or computers or selling groceries. They should be able to rely on vendors like health plans and consultants to effectively work on their behalf. And they should be able to expect responsible leadership from a more than $5 trillion industry that they pay for on behalf of their workforce. Unfortunately, that is not the case. What is increasingly clear is that no actor in the system has been willing to prioritize health care affordability over their own revenue.

It is also clear that health care executives and Boards of Directors have not prioritized affordability despite concerns from their customers. In fact – as is evident from positions taken today – the industry opposes efforts to contain costs. A recent example that exemplifies this position is the California Hospital Association's decision to sue the Office of Health Care Affordability for limiting cost growth to approximately 3% annually, a target that was set with median household income growth in mind. Even though that limit would permit more than 15% cost growth over 5 years (far from seeking to *lower* costs), the hospital association sued over the existence of any limits whatsoever. In their press coverage, a hospital CEO said that these limits will prevent them from demanding double digit cost increases. That is precisely the point. Unfortunately, the leaders of the industry have not assumed a leadership role in addressing the affordability crisis, leaving it to policymakers and purchasers.

Conclusion

Thank you for your leadership in driving improved affordability and competition in U.S. health care through transparency and accountability for stakeholders across the health care system. We believe that policy intervention is necessary to create the conditions for a competitive market. Employers that purchase health care on behalf of over 180 million Americans can leverage those changes to achieve better care at lower costs. Employers want to partner with high-quality providers and invest in care that improves health – specifically primary and maternity care.[85] We need to redirect funds away from administrative waste and unjustified profit margins into care that keeps people healthy and out of the hospital in the first place.

We also appreciate that hospitals serve essential care roles in their communities. We want and need all areas of the country to have access to high-quality hospital care and want to ensure payment models (and amounts) enable that goal. Rural and safety net hospitals need support, and all hospitals need adequate funding. But fair hospital prices do not include paying for multi-billion-dollar investment funds,[86] excessive ad campaigns,[87] or other non-clinical activities – especially when hospital bills are bankrupting everyday Americans.

New hospital price transparency confirms that pricing currently has no correlation to quality, and we know that lower cost hospitals can and do provide excellent care. Rational pricing for all U.S. hospitals, enabled through competition and useable quality data will translate into affordable care for all Americans.

We look forward to working with you to make the improvements we need and that American businesses and patients deserve.

Endnotes

[1] Keisler-Starkey and Bunch (Sep. 2024) "Health Insurance Coverage in the United States: 2023" *U.S. Census Bureau* [Link]

[2] Robinson (1995) "Health Care Purchasing and Market Changes in CA" *Health Affairs,* Vol. 14, No. 4 [Link]

[3] PBGH (Dec. 2020) "Lessons in Scaling Transformation: Impact of California Quality Collaborative's Practice Transformation Initiative" *CQC* [Link] at **p. 11** and **p. 22**

[4] See, Woods et al. (Mar. 23, 2019) "How Employers are Fixing Health Care" *Harvard Business Review* [Link] and Slotkin et al. (Jun. 8, 2017) "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees" *Harvard Business Review* [Link]

[5] PBGH (Oct. 16, 2025) "PBGH Unveils Breakthrough Data Demonstration Project" *Announcements* [Link]

[6] Auerbach and Kellermann (Sep. 2011) "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family" *Health Affairs,* Vol. 30, No. 9 [Link]

[7] PBGH and KFF (Apr. 2021) "How Corporate Executives View Rising Health Care Costs and the Role of Government" *Executive Survey* [Link]

[8] Bell et al. (May 27, 2025) "2025 Milliman Medical Index" *Annual Analysis* [Link]

[9] PBGH (May 13, 2025) "PBGH Announces Jumbo Employers' Top 5 Health Care Priorities" [Link]

[10] HCCI (Apr. 2024) "2022 Health Care Cost and Utilization Report." Health Care Cost Institute [Link] *(According to the Health Care Cost Institute, overall health care prices grew 14% from 2018 – 2022 while utilization grew only 4%)*

[11] Richman (May 17, 2023) "Written Testimony Before the House Ways and Means Committee" [Link] at **p. 2**

[12] Brot et al. (Dec. 2024) "Is There Too Little Antitrust Enforcement in the U.S. Hospital Sector" *American Economic Review,* Vol. 6, No. 4 [Link]

[13] Richman (May 17, 2023) "Written Testimony Before the House Ways and Means Committee" [Link] *("When nearby hospitals merge, prices go up; cities with fewer competing hospitals exhibit higher prices; and even hospitals acquired by distant health systems increase prices more than unacquired, stand-alone hospitals. In fact, most of America's unsustainable health care costs are driven by hospital care, and most of that price inflation over the past decades has been due to hospital mergers.")*

[14] Wofford (Feb. 12, 2025) "How Hospitals are Raising Drug Prices" *Third Way* [Link]; Fronstin and Roebuck (Aug. 19, 2021) "Location, Location, Location: Spending Differences for Physician-Administered Outpatient Medications by Site of Treatment" *EBRI* [Link]; and Fronstin and Roebuck (Jun. 29, 2023) "Location, Location, Location: Spending Differences for Biologic and Biosimilar Medications by Site of Treatment" *EBRI* [Link]

[15] See, e.g., Bao and Bardhan (Mar. 2024) "Measuring Value in Health Care: Lessons from Accountable Care Organizations" *Health Affairs Scholar,* Vol. 2, No. 3 [Link]; Smith (Jan. 13, 2021) "CMS Innovation Center at 10 Years — Progress and Lessons Learned" *New England Journal of Medicine,* Vol. 384, No. 8 [Link]; and

O'Malley et al. (Jul. 17, 2024) "Why Primary Care Practitioners Aren't Joining Value-Based Payment Models: Reasons and Potential Solutions" *The Commonwealth Fund* [Link]

[16] Eisenberg et al. (Jul. 2021) "Large Self-Insured Employers Lack Power to Effectively Negotiate Hospital Prices" *The American Journal of Managed Care*, Vol. 27, No. 7 [Link]

[17] An analysis by KFF published in 2024 found 82% of metropolitan areas in the United States have one or two health systems that exert control over 75% of the market. Regarding inpatient hospital care, 97% of metropolitan areas are highly concentrated according to the FTC and DOJ's definition of "highly concentrated" (HHI indicator > 1,800). This level of consolidation across the country is the result of over two decades of virtually unscrutinized mergers and acquisitions. As illustration, a December 2024 paper by Brot et al. documented that of 1,164 mergers between acute-care hospitals that occurred between 2000 and 2020, a mere 13 were challenged by the FTC.

[18] Beerman (Jul. 2023) "The Exec: Elizabeth Mitchell Has a Message from U.S. Employers" *HealthLeaders* [Link] *(Mergers and acquisitions are playing into [a growing access crisis, particularly for primary and maternity care" . . . "[a]ll the evidence shows that M&A has had no positive impact on quality but a clear impact on prices." However, payers and providers "are [not] responsive to jumbo employers . . . Employers are clear about what [health care] they would like to buy, and the suppliers just don't care.")* and Mitchell (Jun. 2019) "Lowering Health Care Costs: Creating Functional Markets and Purchasing Value for Patients" *Senate HELP Committee Testimony* [Link] *("Although [PBGH and its members] prefer market solutions to the problem of high [health care] costs, many parts of the health care market are fundamentally broken.")*

[19] Eisenberg et al. (Jul. 2021) "Large Self-Insured Employers Lack Power to Effectively Negotiate Hospital Prices" *The American Journal of Managed Care*, Vol. 27, No. 7 [Link]

[20] For prime examples of hospitals resisting public efforts to put downward pressure on prices and costs, one needs only look at the fierce resistance (and widespread noncompliance to this day) of price transparency, generally. Specifically, hospitals – through the California Hospital Association – has sued California's Office of Health Care Affordability over its cost growth targets, which were set based on California citizen's average income growth year-to-year and with the primary goal of requiring hospitals to operate more efficiently.

[21] Bannow (Mar. 3, 2025) "Sutter Health Settles Sweeping Antitrust Case, Narrowly Avoiding Trial" *Stat+* [Link]

[22] House Energy & Commerce Committee (Jan. 22, 2026) "Health Subcommittee: Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability" *Hearing* [Link]

[23] Center for Health and Democracy (*N.D.*) "Sunshine Report on UnitedHealth Group" *Report* [Link]

[24] Fiore (Nov. 30, 2023) "Insurer Now Has Ties to 10% of Doctors" *Medpage Today* [Link]

[25] Insurance is fundamentally a margin business. When health care costs increase, health insurers' margin opportunity also increases – and they are able to increase profits in absolute terms. A growing body of empirical work (**Ex:** Link / Link / Link) shows that health insurers often lack a true incentive to reduce health care costs in the fully insured market. This is also true in the self-insured market, where it is employers – not insurers – who bear the financial risk, and third-party administrators typically derive revenue, in part, on a percentage of claims costs.

[26] 26 USC § 4975(e)(3) at [Link]

[27] For detailed descriptions of fiduciary duty in various contexts, including ERISA, see: Laby (Oct. 1, 2012) "Selling Advice and Creating Expectations: Why Brokers Should be Fiduciaries" *Washington Law Review*, Vol. 87, No. 3 [Link] *("The fiduciary standard is the highest standard under the law" **p. 744**)*; Frankel (May 1983) "Fiduciary Law" *California Law Review*, Vol. 71 [Link] *("Courts regulate fiduciar[ies] by imposing a high standard of morality upon them" . . . "the highest moral value" **p. 14** and **15**)* and Rhoades (Sep. 23, 2015) " " *("The fiduciary standard is referred to as 'the highest standard under the law.'" – especially the "sole interests" standard under the ERISA statute, **p. 7**)*

[28] DOL (Sep. 2019) "Understanding Your Fiduciary Responsibilities Under a Group Health Plan" [Link] at **p. 2**

[29] Employers' fiduciary responsibility also requires them to consider the quality of health care services when making purchasing decisions. See Binder at al. (Jul. 19, 2023) "The CAA and Health Care Quality" *The Leapfrog Group* [Link] and, more specifically from ERISA's regulator: DOL (Feb. 19, 1998) "Information Letter to SEIU, AFL-CIO, CLC" *Employee Benefits Security Administration* [Link]

[30] Simon (Nov. 2022) "Standards of Care and Supplemental Fiduciary Duties Governing the Conduct of Trustees Investing and Managing Assets of Public Employee Retirement Systems in the 50 States and the District of Columbia" SSRN [Link] *(Documenting that "ERISA's [fiduciary] standard of care has been adopted in whole by 27 states and the District of Columbia" and that fiduciary standards have been adopted based on the framework of the Third Restatement of Trusts, upon which ERISA's protections are built.)*

[31] See, e.g., O'Malley et al. (Jan. 2019) "New Approaches to Measuring the Comprehensiveness of Primary Care Physicians" *Health Service Research*, Vol. 54, No. 2 [Link]; Rose et al. (Oct. 2018) "Primary Care Visit Regularity and Patient Outcomes: An Observational Study" *Journal of General Internal Medicine*, Vol. 34, No. 1 [Link]; Kronman et al. (2008) "Can Primary Care Visits Reduce Hospital Utilization Among Medicare Beneficiaries at the End Of Life?" *Journal of General Internal Medicine*, Vol. 23, No. 9 [Link]; Macinko et al. (2007) "Quantifying the Health Benefits of Primary Care Physician Supply in the United States" *International Journal of Health Services*, Vol. 37, No. 1 [Link]; and Parchman and Culler (Aug 1994) "Primary Care Physicians and Avoidable Hospitalizations" *Journal of Family Practice*, Vol. 39, No. 2 [Link]

[32] See, e.g., PBGH (Sep. 9, 2024) "PBGH Comments on CY 2025 MPFS Proposed Rule" *Comment Letter* [Link]; PBGH (Sep. 12, 2025) "PBGH Comments on CY 2026 MPFS Proposed Rule" *Comment Letter* [Link]; and, most recently, PBGH (Mar. 6, 2026) "PBGH Comments on Notice 2026-05, Treasury / IRS Guidance on Direct Primary Care" *Comment Letter* [Link]

[33] PBGH (Dec. 2023) "End-of-Year Report: California Advanced Primary Care Initiative" *CQC* [Link]

[34] Basu et al. (Apr. 30, 2020) "Utilization and Cost of an Employer-Sponsored Comprehensive Primary Care Delivery Model" *JAMA Network Open*, Vol. 3, No. 4 [Link] *(Finding that those employees that received routine primary care had total PMPM spending of $204.5 vs. $538)*

[35] See PBGH's attributes of Advanced Primary Care, which includes integrated behavioral health care.

[36] See **Table 1** in Milstein and Kothari (Oct. 20, 2009) "Are Higher-Value Care Models Replicable?" *Health Affairs Forefront* [Link]

[37] PBGH (Dec. 2020) "Lessons in Scaling Transformation: Impact of California Quality Collaborative's Practice Transformation Initiative" *CQC* [Link] at **p. 11** and **p. 22**

[38] PBGH (Oct. 2021) "Employer Health Plan Common Purchasing Agreement for Advanced Primary Care" [Link]

[39] CQC (Nov. 2022) "Advanced Primary Care: Measurement Pilot" [Link]

[40] The six health plans were (1) Aetna, (2) Anthem, (3) Blue Shield of California, (4) Health Net, (5) Oscar, and (6) United Healthcare.

[41] PBGH (Nov. 2023) "Advanced Primary Care Measure Set" *CQC* [Link]

[42] PBGH and IHA (Dec. 2023) "Measuring Advanced Primary Care in California" *CQC* [Link]

[43] PBGH (N.D.) "PBGH Care Excellence Program" *Initiative* [Link] and PBGH (N.D.) "Advanced Primary Care Solution" *One-Pager* [Link]

[44] PBGH (Apr. 28, 2025) "PBGH Announces Five Bay Area Clinics in Altais Medical Group Have Achieved the PBGH Care Excellence Silver Award" *Announcements* [Link]

[45] See, e.g., PBGH (Sep. 9, 2024) "PBGH Comments on CY 2025 MPFS Proposed Rule" *Comment Letter* [Link]; PBGH (Sep. 12, 2025) "PBGH Comments on CY 2026 MPFS Proposed Rule" *Comment Letter* [Link]; and, most recently, PBGH (Mar. 6, 2026) "PBGH Comments on Notice 2026-05, Treasury / IRS Guidance on Direct Primary Care" *Comment Letter* [Link]

[46] PBGH (Jul. 7, 2025) "PBGH Provisions for Purchasers Included in One Big Beautiful Bill Act" *Announcements* [Link]

[47] Slotkin et al. (Jun. 8, 2017) "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees", *Harvard Business Review* [Link]

[48] Shockey (Mar. 6, 2026) "Boeing Comment Letter Re: Notice 2026-05" [Link] at **pgs. 2** and **3**.

[49] Osborn (Dec. 16, 2025) "32BJ Health Fund and Northwell Direct Announce Largest Direct Health Care Contract of its Kind in the Country, Delivering Major Savings and Expanding Access to Care" *Northwell Direct Newsroom* [Link]

[50] Mount Sinai (Mar. 6, 2026) "Mount Sinai Health System and 32BJ Health Fund Partner to Deliver In-Network Access to High-Quality Health Care" *Press Release* [Link]

[51] Herrera and DeAngelis (Mar. 5, 2025) "Thousands of N.Y. Patients Lose In-Network Care Due to Mount Sinai, Anthem Contract Disputes" *CBS News* [Link]

[52] Kaiser Family Foundation analysis puts the figure at between 55 – 60% of total spending. The Health Care Cost Institute's data shows total spending is 45.1%. Milliman's 2025 Medical Index places the figure at 48.5%. EBRI estimates the total spending to be higher, at 69%, but its analysis includes hospital-employed physician professional fees.

[53] Bell et al. (May 27 2025) "2025 Milliman Medical Index" *Annual Analysis* [Link] *("Healthcare costs for the average person increased 6.7%, from $7,378 in 2024 to $7,871 in 2025. Outpatient facility care and pharmacy are the primary drivers of this increase, with pharmacy costs rising 9.7% and outpatient facility care costs rising 8.5%. Together, these service categories contributed to 69% of the year-over-year cost increase.")*

See, also, Opsahl (Feb. 11, 2025) "Testimony of Cora Opsahl, Director, 32BJ Health Fund at New York State Joint legislative Budget Hearing on Health" *Written Testimony* [Link] *("In recent years, spending increases are being driven by the hospital outpatient sector. In 2019, [32BJ Health Fund] spent roughly equivalent amounts on*

hospital inpatient and outpatient services. But from 2019-2023, our hospital inpatient spending decreased by 6% while hospital outpatient spending increased by 25%.")

[54] Richards et al. (Jul. 6, 2020) "Treatment Consolidation After Vertical Integration" *RAND Corporation* [Link] *(Finding that formerly independent physicians "shift nearly 10% of their Medicare and commercially insured [patients] away from ambulatory surgical centers (ASCs) to hospital outpatient departments and are up to 18% less likely to use an ASC at all" post-hospital acquisition.)*

[55] Eisenberg (Jun. 4, 2021) "32BJ Severs Ties with NewYork-Presbyterian Amid Broader Fight for Pricing Transparency" *POLITICO* [Link]

[56] Perry (2025) "Mark Perry's Chart of the Century (Using BLS Data)" *AEI* [Link] *(Showing hospital prices have risen 256% between January 2000 and December 2024, with overall inflation only having increased 87.3% over the same time period. The next highest factor of the economy is College Tuition and Fees (187.9%), and Medical Care Services have 'only' increased 138.6%.)*

[57] See, e.g., Chernew (Jul. 30, 2025) "Fee-For-Service, Accountable Care Organizations, And Medicare Advantage: Why?" *Health Affairs*, Vol. 44, No. 8 [Link] and GAO (Jun. 2025) "Highlights of a Forum: Reducing Spending and Enhancing Value in the U.S. Health Care System" *GAO-25-107465* [Link]

[58] Mulkey at al. (Mar. 2024) "Capitated Payment for Primary Care in Self-Funded Health Insurance Arrangements in California: An Exploration" *PBGH California Quality Collaborative and the Integrated Healthcare Association* [Link]

[59] See the section on the results of PBGH's Purchaser-Driven Contracting RFI in PBGH (Jan. 22, 2026) "PBGH Statement for the Record in House Energy and Commerce Committee Hearing Examining Health Insurance Affordability" *Statement* [Link] *("Independent TPAs were more likely to affirm purchasers' rights to their data . . . This initiative demonstrates a clear divide between traditional insurers/TPAs and new TPA market entrants willing to be transparency and flexible to support purchasers' affordability goals.")*

[60] See PBGH (Jan. 29, 2025) "PBGH Launches Groundbreaking Health Care Data Project, Tackling Data Transparency Challenges and Strengthening Employer Fiduciary Compliance" *Announcements* [Link] and, more generally, Miller (Dec. 2012) "Ten Barriers to Healthcare Payment Reform and How to Overcome Them" *Center for Healthcare Quality & Payment Reform* [Link]

[61] PBGH "Are We There Yet? Making Transparency Work for Purchasers and Patients" *Webinar* [Link]

[62] PBGH (Oct. 6, 2025) "Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers" *Whitepaper* [Link]

[63] The case was *UFCW & Employers Benefit Trust et al. v. Sutter Health*. For more details on the role PBGH played, see PBGH (Jun. 5, 2024) "PBGH Response to RFI on Consolidation in Health Care Markets" [Link]

[64] See PBGH "Sutter Health" [Link] and Covered California (May 17, 2018) "Reports and Research for May 2018 Board Meeting" [Link] at **p. 40** and **Table 11** on **p. 41**.

[65] Gudiksen et al. (Sep. 2020) "Preventing Anticompetitive Contracting Practices in Healthcare Markets" *The Source on Healthcare Price and Competition* [Link]

[66] See PBGH (Oct. 31, 2023) "PBGH Letter to Tri-Agencies on CAA 201 Gag Clause Prohibition Compliance Attestation and Purchaser Data Access Challenges" *Letter* [Link] and PBGH (Mar. 15, 2024) "PBGH Response to ERISA RFI" *Comment Letter* [Link] at **pgs. 13 and 14**.

[67] See e.g., Gaynor (2018) "Examining the Impact of Health Care Consolidation" *House Energy and Commerce Committee Testimony* [Link] *("Extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians,* ***without offsetting gains in improved quality or enhanced efficiency****")*; and Goldsmith et al. (Feb. 2015) "Integrated Delivery Networks: In Search of Benefits and Market Effects" *National Academy of Social Insurance* [Link] *(Finding that there is "****no difference in clinical quality or safety scores****" between Integrated Delivery Networks and their in-market competitors)*

[68] "Health Competition for Better Care" Act, 119th Congress (H.R. 3120 / S. XXXX)

[69] PBGH (Nov. 5, 2024) "PBGH Supports Site Neutral Legislative Framework Issued by Senators Cassidy and Hassan to Improve Competition and Reduce Health Care Costs" *Announcement* [Link]

[70] For evidence that site neutral payment reforms would reduce consolidation, see: Whaley et al. (*N.D.*) "Addressing Site-of-Care Payment Differentials in the U.S. Health Care System" *Center for Advancing Health Policy Through Research* [Link]

For evidence that private sector payment policy is influenced by Medicare's payment policies, see: Clemens and Gottlieb (Feb. 2017) "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments" *Journal of Political Economy*, Vol. 125, No. 1 [Link]

For quantification of the impacts of the commercial market adopting site neutral payment reforms as a result of the federal government's actions, see: Parente (Aug. 27, 2024) "Impact of Site-Neutral Payments for Commercial and Employer-Sponsored Plans" *Inquiry*, Vol. 61 [Link] *(Finding "the potential cost savings of applying site-neutral payment policy to the commercial insurance market to be $58 billion for year 2022" and the "10-year total employer market premium reduction" ranging from 5 – 5.35%, resulting in an "employer-sponsored insurance (ESI) tax subsidy savings of $140 billion to the federal government" over 10 years.)*

[71] Clemens and Gottlieb (Feb. 2017) "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments" *Journal of Political Economy*, Vol. 125, No. 1 [Link]

[72] Whaley et al. (Dec. 2024) "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative" *RAND* [Link]

[73] MedPAC has noted that hospitals have acquired more physician practices in recent years partly in response to the current payment incentives, and hospital employment of physicians has increased – lessening market competition and increasing costs with no corresponding increase in quality of care. *("We have found that Medicare payment policy encourages vertical integration, and vertical integration in turn increases Medicare program costs,"* ***p. 295****)*

[74] See a summary of high-profile research in support of these statements in PBGH's March 2025 policy issue brief, especially on **pgs. 3** and **4** (and corresponding **Footnotes 5 - 25**).

[75] See PBGH (Sep. 15, 2025) "PBGH Comments on CY 2026 OPPS Proposed Rule" *Comment Letter* [Link] and, upon CMS finalizes its site neutral payment reforms: PBGH (Nov. 21, 2025) "PBGH Celebrates Wins on Transparency and Affordability in CMS's 2026 OPPS Final Rule" *Announcements* [Link]

[76] CBO originally projected the No Surprises Act would decrease commercial insurance premiums by 0.5 – 1 percent "in most years" post-NSA enactment.

[77] Hoadley and Watts (Aug. 25, 2025) "The Substantial Costs of the No Surprises Act Arbitration Process" *Health Affairs Forefront* [Link]

[78] *Ibid*, at **Exhibit 4**.

[79] See, e.g., *Ibid*, at **Exhibit 3** and Duffy et al. (Oct. 17, 2024) "No Surprises Act Independent Dispute Resolution Outcomes for Emergency Services" *Health Affairs Scholar*, Vol. 2, No. 11 [Link]

[80] Fiedler and Adler (Mar. 27, 2024) "A First Look at Outcomes Under the No Surprise Act Arbitration Process" *Brookings* [Link] *("It is notable that large investor-backed provider groups have accounted for a large and disproportionate share of IDR cases; practices affiliated with just four such companies – TeamHealth, SCP Health, Envision, and Radiology Partners – generated 74% of line items in our sample.")* and Hoadley and Lucia (Mar. 1, 2024) "Report Shows Dispute Resolution Process in No Surprises Act Favors Providers" *The Commonwealth Fund* [Link]

[81] See, e.g., 32BJ Health Fund's approach in Clason (Nov. 24, 2025) "Employers Urge More Transparency in Surprise Billing Disputes" *Bloomberg Law* [Link]

[82] Wennberg (Mar. 2026) "Rising Coding Intensity and its Impact on Health Care Affordability" *BlueCross BlueShield Association* [Link]

[83] Crespin et al. (Dec. 2024) "Upcoding Linked To Up To Two-Thirds Of Growth In Highest-Intensity Hospital Discharges In 5 States, 2011–19" *Health Affairs*, Vol. 43, No. 12 [Link]

[84] Patton et al. (May 14, 2025) "Changes in Coding Intensity Suggest How Upcoding Is Happening Across Outpatient Settings" *Trilliant Health* [Link]

[85] For many PBGH members, maternity care is a high priority. See, especially, PBGH (May 2024) "Comprehensive Maternity Care (CMC) Common Purchasing Agreement" [Link]

[86] See Diaz (Aug. 26, 2022) "23 Health Systems with Investment Arms" *Becker's Health IT* [Link] and Allen (Dec. 3, 2024) "Financialization in Health Care: History, Current Trends, and Impacts on Patients" *Healthcare Value Hub* [Link]

[87] Goldman (Feb. 11, 2025) "Nonprofit Hospital Draws Backlash for Super Bowl Ad" *Axios* [Link]