Statement before the House Committee on Energy & Commerce Health Subcommittee on “Lowering Health Care Costs for All Americans: Examining Policies to Increase Health Care Transparency.”

Increasing Transparency for Health Care Markets and Policymakers

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Many of the challenges facing health care markets stem, directly or indirectly, from a lack of transparency. Most notably, persistently high health care costs place pressure on federal, state, and household budgets. Yet market actors and policymakers frequently lack the information needed to improve market functioning either through improved competition or policy reforms.

Purchasers frequently make decisions with incomplete information about prices or quality, limiting their ability to signal their preferences and trigger market responses. Similarly, policymakers are responsible for addressing emerging challenges in health care markets but are often hindered by limited access to the information needed to diagnose and design effective policy solutions.

The policies considered in this hearing illustrate the role transparency can play in improving both market functioning and policymaking across several settings. In my testimony, I highlight several promising proposals that would expand the information available to market actors and policymakers, while also identifying opportunities to strengthen other transparency initiatives.

Transparency into plan denial rates and similar information

One of the most important ways that consumers and employers influence health care markets is through their choice of insurance plan. Purchasers must decide how to trade off plan features—like the breadth of networks, cost sharing levels, and other measures of coverage generosity—against premiums. In a well-functioning market, these choices reflect the preferences of individuals (or the employers working on their behalf), helping to shape future insurer offerings and broader market dynamics. If these decisions are made without relevant information, however, there is little reason to think they reflect enrollee preferences or provide accurate signals to insurers about how to best design plans.

The committee is considering a policy that aims to increase transparency into important plan characteristics that may not be salient to consumers when making these choices. Specifically, the proposal would require that private insurers and Medicare Advantage plans provide information on their use of utilization management, their rate of denials, and related information.[1] These are

[1] See "**H.R. ____**, [To amend title XVIII of the Social Security Act and title XXVII of the Public Health Service Act to require the displaying of claim denial rates.]" at https://docs.house.gov/meetings/IF/IF14/20260610/119378/BILLS-119pih-

important features that affect the plan's generosity and are likely central to many enrollees' preferences.[2] When used appropriately, these tools can effectively discourage the overuse of low value care and help target costly care to cases where it is appropriate. Even if employed responsibly, however, greater use of prior authorization and similar tools come with important tradeoffs. Notably, employees may not always be able to access any care at any time (this tradeoff is similar to that of network breadth).

If insurers believe that enrollees have limited advanced knowledge of their denial or utilization management practices, they may be incentivized to use them at a greater rate than enrollees want. Greater use of these tools lowers plan costs, which will be reflected in premiums—the plan feature most salient to purchasers and a primary focus of competition in these markets. In other words, enrollees may be willing to pay more in exchange for lower care management (or sacrifice other plan amenities) but may not have the information necessary to do so.

Importantly, the limited available evidence suggests that the use of these tools varies substantially across insurers. This provides a very strong rationale for greater insight into these plan features. Individuals (or their employers) are likely choosing between plans that have large, unobservable differences in this measure of generosity.

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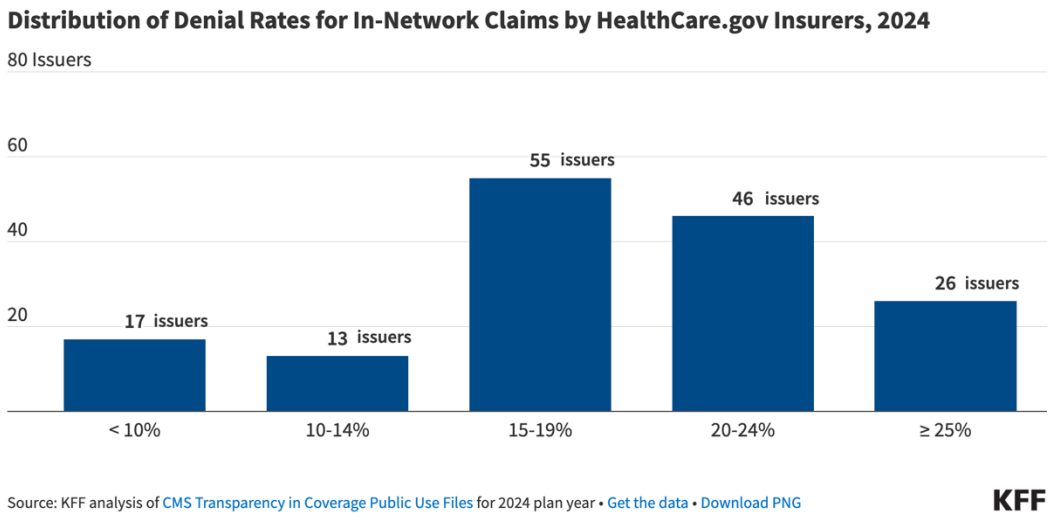
[2] Ashley Kirzinger, Julian Montalvo III, and Liz Hamel, *KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care.* KFF. February 2, 2026.



Note: Figure taken from Michelle Long, Justin Lo, and Kaye Pestaina, *Claims Denials and Appeals in ACA Marketplace Plans in 2024*. KFF. March 24, 2026.

As with all such proposals, policymakers would be well served to keep reporting requirements as simple as possible. Once collected, this information can be presented in a simple format to give enrollees a basic sense for where plans stand relative to their peers and allow them to vote with their feet. For example, one might imagine distinguishing "above average," "about average," or "below average" use of utilization management based on these data.

Transparency into ownership status

Ensuring competitive health care markets represents a persistent challenge to policymakers. This has become more challenging due to recent evolutions in ownership structures and the nature of consolidation. Notably, some health care markets are systematically consolidated through a series of small transactions which need not be reported to regulators. While each individual transaction is unlikely to trigger competitive concerns, the combined effect can significantly increase market concentration.

The committee is considering a proposal that would require several provider types to report information about their ownership status and recent transactions (along with additional information) to the Department of Health and Human Services (HHS).[3] HHS would then be required to make

[3] See "**H.R.** ____, [To amend title XI of the Social Security Act to require mandatory reporting with respect to certain health-related ownership information.]" located at https://docs.house.gov/meetings/IF/IF14/20260610/119378/BILLS-119pih-

these data publicly available. As co-authors and I have written about similar legislative proposals, there are several justifications for such data:[4]

> Data like these would facilitate several types of important analyses. For example, by making available information on each entity's ultimate parent company, it would allow agencies and researchers to more easily and accurately track horizontal consolidation in physician and facility markets and trace its effects. Information on ownership structure would also provide an up-to-date snapshot of emerging trends in different forms of corporate ownership of health care providers, as well as allow for stronger analysis of the effects of private equity, hospital, and payer acquisitions of physician practices.
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> Some similar data are already being reported to the Centers for Medicare and Medicaid Services (CMS), but the bill would greatly improve what is readily available to researchers, especially with respect to physician groups. In particular, there currently is no comprehensive source of data that makes it possible to identify which physician groups share a common owner or determine the ownership structure of the entity with a controlling ownership interest in the group (e.g., private equity, insurer, or hospital).
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> In detail, physician groups are identified in Medicare claims data by their tax identification number (TIN). But in many cases, large parent companies own and operate many TINs. For instance, Envision, owned by private equity firm Kohlberg Kravis Roberts (KKR), operates more than 100 TINs in its emergency medicine staffing business. Moreover, matching TINs to their parent company and the ownership structure of that parent company is often complex and difficult to automate. The best starting point at present is the Medicare Data on Provider Practice and Specialty (MD-PPAS) data extract, which researchers can purchase from CMS. These data include the legal name associated with physician group TINs, from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data, and

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[4] Adler, Fiedler, and Ippolito (2023). "Assessing recent health care proposals from the House Committee on Energy and Commerce." Brookings Institution.

some information on the geographic location where a clinician delivers most of his or her Medicare services.

But that information is often inadequate to identify a practice's parent company. Researchers are therefore forced to identify parent companies by piecing together additional information on ownership from various sources, which make this type of research very resource-intensive and thus limits how much can be done. This manual work also inevitably ends up incomplete, which can result in researchers underestimating the level of market concentration, among other potential problems. Ideally, this proposed legislation would lead to CMS releasing a more robust version of the MD-PPAS data extract that additionally includes the parent company and ownership structure of each physician group TIN (or otherwise link TINs to the relevant parent company and its ownership structure)

Transparency into public programs

Effective oversight of large health programs requires ongoing assessments of their effects on enrollees and health care markets more broadly. However, data on key program features may not always be readily observable, especially when public plans are administered by private entities. One such example is in Medicare Advantage (MA), where pricing or cost sharing information is generally not included in publicly released data. One proposal under consideration would require that pricing and cost sharing information be included in encounter data submitted by MA plans, which are detailed records of health care provided to Medicare Advantage beneficiaries.[5]

This information would assist researchers and policymakers in evaluating the MA program. An updated understanding of how these insurers pay health care providers, for example, is particularly important giving MA's growing enrollment and importance in health markets. In pursuing this, policymakers should make ensure that data are publicly released to allow for policy-relevant analysis. They should also consider adding information on payments made by plans that are not tied to

[5] See "**H.R.** ____, [To amend title XVIII of the Social Security Act to require the inclusion of certain information in Medicare Advantage encounter data.]" located at https://docs.house.gov/meetings/IF/IF14/20260610/119378/BILLS-119pih-HR____ToamendtitleXVIIIoftheSocialSecurityActtorequiretheinclusionofcertaininformationinMedicareAdvantageencounterdata.pdf

specific encounters.[6] Notably, most plans use some form of non-fee-for-service payment (like capitation or a shared savings arrangement). Understanding these additional flows of money are important for assessing overall payments to providers in MA.

Transparency and limitations on broker fees

Finally, the committee is considering an additional proposal aimed at increasing insight into the role of brokers in the MA program and limiting their compensation.[7] Specifically, MA plans would have to report whether individuals were enrolled by brokers and how much they were compensated for doing so. The Secretary of HHS is further directed to establish a maximum compensation amount associated with the enrollment of an individual in MA.

These policies are motivated by the concern that outsized payments may incentivize brokers to push enrollees towards MA plans even when that is likely at odds with enrollee preferences. These concerns are understandable and efforts to increase our insight into this market are reasonable. Directly imposing limitations on broker reimbursement comes with some challenges, however.

First, regulating financial transactions between private entities can be very difficult. This is reflected in the proposed legislative text which attempts to cover a wide array of potential transaction types, including commissions, bonuses, gifts, prizes, and various reimbursements for costs incurred by brokers, along with any additional reimbursements identified by the HHS Secretary. It is possible this encompasses all relevant forms of transactions, but it equally likely that private entities will come up with creative workarounds to maintain higher effective payment rates.

Second, this policy implicitly reflects broader concerns about the MA program that are best confronted directly. Policy experts have long debated the efficiency of spending in the MA program and the extent to which spending translates to enrollee benefits. Some evidence suggests that the last

[6] For a discussion, see Loren Adler and Matthew Fiedler, Response to Request for Information on Medicare Advantage Data. Brookings Institution. May 29, 2024.

[7] See "**H.R. ____**, [To amend title XVIII of the Social Security Act to limit the compensation that may be paid to agents and brokers by Medicare Advantage organizations.]" located at https://d1dth6e84htgma.cloudfront.net/H_R_To_amend_title_XVIII_of_the_Social_Security_Act_to_limit_the_compensation_that_may_be_paid_to_agents_and_brokers_by_Medicare_Advantage_c353940907.pdf

dollar sent to MA plans generates considerably less than a dollar of benefits for enrollees.[8] Other evidence suggests that the aggregate value of enhanced benefits on MA plans account for a large share of rebates to plans. The latter suggests payment reductions may affect benefit offerings relatively quickly, even if not immediately. MA insurers' willingness to offer substantial reimbursement to brokers for additional enrollment is consistent with relatively generous current payment levels. If policymakers view those payments as too high, they should revise them with an understanding of the likely tradeoffs involved. Doing so will naturally reduce the incentive to provide large payments for brokers to enroll beneficiaries.

Third, it also not immediately obvious whether restricting broker reimbursement will achieve policymakers' goals. For example, it's not clear that this provision would lower program spending since plans are likely submitting profit maximizing bids either way. Perhaps more likely, this could decrease MA enrollment by affecting broker behavior but potentially increase profit margins per enrollee if those costs decline.[9]

Conclusion

The policies under consideration help illustrate the broad value of transparency efforts. Those highlighted in my testimony have the potential to improve the functioning of private health insurance markets and deepen our understanding of major federal health programs and market competition. I thank you for the opportunity to testify and look forward to working with you as you pursue these policies further.

[8] E.g., Marika Cabral, Michael Geruso, and Neale Mahoney, "Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage," *American Economic Review* 108, no. 8 (2018): 2048–2087

[9] The effect of this policy would likely further depend on more complex factors, like whether any change in enrollment was systematically correlated with key enrollee characteristics. While important, a full consideration of these kinds of factors is beyond the scope of this testimony.