

From Captive Bargaining to Outside Options: Re-Anchoring Price Formation in US Hospitals

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ABSTRACT

Prices in competitive markets are disciplined by a buyer's outside option: the credible ability to purchase elsewhere. In the US commercial hospital market, this condition fails. Local consolidation leaves many purchasers without a viable alternative, while anti-steering, anti-tiering, and all-or-nothing contract clauses strip buyers of the freedom to direct patients even where alternatives exist. Consequently, negotiated prices are not formed at arm's length.

Federal policy has mistakenly treated this structural crisis as an information problem. Five years of mandated price disclosure have produced price convergence rather than cost reduction. Transparency cannot discipline a market whose buyers have nowhere to go. Moreover, existing benchmarks—such as Medicare multiples, the qualifying payment amount (QPA), and aggregates of disclosed rates and cash prices—cannot detect this systemic failure because they are all derived from the same insular transactions. Each metric merely locates a provider relative to other domestic providers, failing to establish whether the baseline level is reasonable. Compounding this, Medicare's own payment rates are annually recalibrated from hospital-submitted cost reports—costs that the Medicare Payment Advisory Commission (MedPAC) has shown rise alongside commercial revenue.

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To restore discipline, we propose a two-part intervention: an accessible outside price composed of procedure-level reference prices authored independently and published by a multi-stakeholder institution, paired with a prospective prohibition on restrictive contracting clauses. Neither mechanism can succeed alone. Finally, we outline the specific conditions under which this proposal should be judged to have failed.

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1. Introduction

Our goal is to outline a path toward substantially more affordable employer-sponsored health insurance (ESI/ERISA) by establishing a functioning hospital market for approximately 154 million plan participants under 65 with employer coverage (KFF, 2025).

The primary driver of healthcare unaffordability is price: commercial hospital rates average 254% of Medicare, with extreme geographic variation. For example, the median facility rate for a cesarean delivery can range from \$11,547 in one market to \$27,199 in another.

Hospital consolidation has enabled health systems to operate as price-setters rather than market participants, forcing ERISA plans to act as passive price-takers. An entity whose prices are being regulated cannot simultaneously control the price-setting mechanism. INET's response to the RFI submitted in early August reached this exact conclusion ([Alvelda & Ferguson, 2026](#)). The missing provider-side price discipline is the RFI's most glaring omission.

Because healthcare constitutes the greatest percent of non-interest federal government spending (U.S. Department of the Treasury, 2025) and because healthcare, with national spending of ~\$5.3 trillion in 2024 according to the Centers for Medicare & Medicaid Services (CMS, 2025c), is arguably the largest industry in the world's largest economy, creating a legitimately functioning commercial healthcare market should remain Congress's greatest priority.

We therefore recommend that Congress create an independent authority or utility tasked with publishing hospital procedure reference prices determined entirely outside provider control. A price the hospital did not author. The reference price functions solely as a commercial insurance buyer's baseline figure during negotiation, imposing no binding obligation and establishing no legal price cap. It is deliberately plain: a procedure, a price, a date, and a scope that price covers. A provider that agrees on the price with a plan accepts it as payment in full; a provider that declines remains free to negotiate as it does today.

Our proposal would essentially establish a transparent, functioning market that allows commercial health plans to shop legitimately for hospital services, i.e., on a competitive basis.

This approach has a clear precedent. When Oregon capped its state employee health plan payments relative to Medicare, it saved \$107.5 million in just 27 months while keeping every targeted hospital in-network (Murray, Brown, et al., 2024). Unlike our proposal, however, Oregon's cap is mandatory, and a hospital paid under it must accept the capped amount as payment in full (OR Rev. Stat. § 442.394). We cite Oregon to illustrate the mechanism, not to estimate what a voluntary benchmark would save.

Prices written outside a negotiation already move the prices agreed within it. When Medicare changed its physician fees, each \$1 change moved private insurers' prices by \$1.16, although Medicare binds none of those contracts (Clemens & Gottlieb, 2017).

The federal government saw the same pattern in a small sample of its own defense purchases. When negotiators benchmarked prices using only a seller's own catalog or past rates, they achieved discounts in 9% of cases. But when they brought further price analysis, such as commercial sales or cost information to the table, that success rate jumped to 41% (GAO, 1999). The difference was not the diligence of the negotiators it was the source of the standard.

Most of the necessary infrastructure is already in place. Private vendors routinely supply reference-price benchmarks and contracting tools, though none comes from an entity that publishes its methods and is insulated from the parties being priced. Past health reforms failed to contain costs because they targeted health system behavior rather than the prices themselves, allowing suppliers to adapt and restore their margins. The ultimate barrier is not a lack of tools, it's regulatory permission for buyers to use them.

Two specific policy interventions resolve this challenge:

1. **Ban Anti-Competitive Contracting:** Congress should immediately prohibit hospital anti-steering and all-or-nothing clauses. This step requires no price controls, creates no bureaucracy, reduces federal deficits (by about \$4.9 billion over ten years in the Congressional Budget Office's score of the same-titled bill in the last Congress; CBO, 2024), and enjoys existing bipartisan support.
2. **Establish Independent Benchmarking:** The reference pricing benchmark must be housed in an independent entity entirely free from the influence of the hospital systems it evaluates.

While banning anti-competitive clauses is a quick win, establishing an independent pricing authority provides long-term cost containment. Both measures fall directly under this Committee's jurisdiction: lowering commercial healthcare spending reduces tax-exempt employer health plan costs that directly frees up added income for workers as taxable wages.

As a provider of procedure-level hospital price benchmarks for self-funded employers, Third-party administrators (TPAs), and commercial insurers, Sylk Health has a financial interest in expanding benchmarked pricing. To address this transparently, Section 11 outlines a clear, time-bound framework to evaluate our methodology independently. While we strongly support the RFI's goals - expanding Medicaid and Marketplace coverage, creating public options, and enforcing administrator accountability - these initiatives cannot succeed without a crucial structural requirement: reference prices set independently and accepted as payment in full.

2. Why an inside-market benchmark price fails (cross-cutting)

The US does not have a functioning hospital market. As of 2016, 90% of hospital markets were highly concentrated (Fulton, 2017), and in 47% of metropolitan areas, one or two health systems controlled all inpatient care in 2024 (Godwin et al., 2026). Commercial rates averaged roughly 254% of Medicare in 2022 (Whaley et al., 2024).

This excess spending is driven by unit price, not service volume, a conclusion established over two decades ago by Gerard Anderson and colleagues. Comparing 30 industrialized nations in 2003, and the median wealthy country in 2019, Anderson and his colleagues (2003, 2019) demonstrated that the US has fewer hospital beds, physicians, and nurses per capita than median peer countries. Americans do not consume more care; they are charged higher prices for it.

The fundamental flaw in healthcare pricing is that no entity can simultaneously act as both the party being priced and the party setting the price. Financial markets learned this during the LIBOR manipulation scandal: because LIBOR relied on what banks claimed they would pay rather than audited transactions, banks moved the numbers in their favor. The United Kingdom's Financial Services Authority found that Barclays, one of the submitting banks, took requests from its derivatives traders into account when it made its submissions (Financial Services Authority, 2012). Global securities regulators responded by requiring benchmarks to be anchored, where possible, in observable, arm's length transactions, and their administrators to manage conflicts of interest and publish their methods (IOSCO, 2013).

Drug pricing supplies an example. Payers long set drug payments by reference to the average wholesale price (AWP) that First DataBank, a commercial publisher, usually derived by applying a markup to the manufacturer's wholesale acquisition cost (National Association of Chain Drug Stores v. New England Carpenters Health Benefits Fund, 2009). Health benefit funds later alleged that First DataBank and the wholesaler McKesson had agreed to raise that markup from 20% to 25% on more than 400 brand drugs. The defendants disputed the allegations, McKesson settled for \$350 million, and First DataBank stopped publishing AWP in 2011 (New England Carpenters Health Benefits Fund v. First DataBank, Inc., 2009a, 2009b; U.S. Department of Health and Human Services, Office of Inspector General, 2011). A benchmark that buyers pay against becomes a target for those who are paid, so its author must be independent of them.

While negotiated commercial hospital rates reflect observable transactions, they fail the arm's length test. A transaction reveals true value only if the buyer can refuse it. Anti-steering, anti-tiering, and all-or-nothing contracting terms exist explicitly to deprive commercial buyers of the ability to walk away, meaning negotiated rates reflect monopoly leverage, not market value.

Why do existing Benchmarks Fail?

- **Commercial Medians Create Price Floors:** Standard domestic benchmarks invite low-cost providers to demand higher rates, turning price caps into floors. For example, under the No Surprises Act, median Independent Dispute Resolution (IDR) arbitration awards surged to 459% of the Qualifying Payment Amount by Q4 2024 (Georgetown CHIR, 2025).
- **High Medicare Multiples Ratify Inflation:** While Medicare multiples are structurally superior because Medicare sets rates independently, setting the baseline too high ratifies inflated pricing. Indiana's 2023 benchmark of 285% of Medicare is a prime example: because the state's five largest non-profit health systems already averaged ~252% (Indiana Department of Insurance, 2025), the benchmark imposed zero financial discipline.

Independent benchmarks change negotiation outcomes. A classic General Accounting Office (GAO, 1999) study analyzed federal purchasing behavior. When government buyers negotiated sole-source contracts using only the vendor's catalog or past prices, they secured lower prices in 9% of cases (3 of 33). When buyers added further price analysis, such as commercial sales or cost information, they negotiated lower prices in 41% of cases (13 of 32).

Stronger evidence comes from Medicare's published prices. When Medicare changed its physician fees, a \$1 change moved private insurers' prices by \$1.16 (Clemens & Gottlieb, 2017). For hospitals, a 10% cut in Medicare inpatient rates led to an estimated cut in private rates of 3% or 8% depending on the model (White, 2013). Medicare binds none of those private contracts. Neither study tests a published price without a large payer behind it; this is why Section 11 proposes an independent test.

Federal procurement law already treats a seller's own price as insufficient evidence of a fair price. Since 1962, a contractor negotiating a large federal contract without competition has generally had to certify its cost or pricing data (Truth in Negotiations Act, 1962; 10 U.S.C. § 3702). Where certified data are not required, contracting officers must rely "first on data available within the Government; second, on data obtained from sources other than the offeror; and, if necessary, on data obtained from the offeror" (48 C.F.R. § 15.402(a)(2)). Commercial plans have no comparable outside check on a hospital's price.

Consumer price-shopping yields only a one-time cost reduction; steering patients within a concentrated health system generates non-recurring savings rather than bending the long-term cost curve. Bending the curve requires empowering institutional buyers. Under our model, no provider is forced to accept the published benchmark price, however, those who do must accept it as payment in full.

This approach directly addresses the central finding of Alvelda and Ferguson's (2026) INET analysis of the RFI. Evaluating 71 proposals on how much of each premium dollar reaches care, on usable access and on how easily each can be gamed, they identify the lack of a provider-side pricing mechanism as the RFI's single largest omission that leaves an estimated \$306 billion a year in hospital pricing unaddressed.

Alvelda and Ferguson reject codifying the industry's voluntary prior-authorization pledge because metrics chosen and reported by regulated entities amount to self-measurement. A published reference price resolves this structural flaw: while provider adoption remains voluntary, the benchmark's authorship is entirely external and independent. Their analysis establishes the gap; our proposal provides the mechanism to close it.

3. What a price covers (cross-cutting)

A price is meaningless until its underlying unit is clearly defined. Any benchmark that cannot explicitly define what it prices will fail during hospital contract negotiations. To preserve objectivity, neither private data suppliers nor Congress should independently define clinical episodes. A supplier that decides what enters a price becomes an interested party to the comparison it sells.

The workable solution is a universal, externally set service scope established by regulation or an independent utility. Because this scope is defined externally:

- Individual sellers cannot unbundle care into narrow, separate billable components.
- Providers must quote a single flat price against the standardized bundle, absorbing routine clinical variations.
- Buyers can compare two published prices directly without complex actuarial modeling.
- Risk-selection games (cherry-picking low-risk patients) are prevented by requiring every posted rate to state explicit clinical eligibility criteria.

A standardized scope complements federal payment models rather than competing with them. For instance, Medicare's mandatory bundled payment program covers a 30-day post-discharge window, whereas its voluntary program spanned 90 days until it ended in December 2025 (CMS, n.d., 2026a). A provider's reference price covers the specific clinical window under its direct control that serves as a clear subset of the broader federal episode. This rate prices core clinical care upfront while leaving longer-term post-acute "tail" risk with the purchaser who can readily track those downstream costs via existing claims data.

Drawing price boundaries strictly at hospital discharge ignores where spending variance is highest: post-acute care. Because skilled nursing facilities cost significantly more than home health, flat inpatient rates incentivize hospitals to discharge patients prematurely and shift costs downstream. While CMS manages this by comparing 30-day episode spending with a risk-

adjusted target price, an independent reference price prevents cost-shifting through two distinct mechanisms:

1. Readmission Penalties: Incorporating a defined readmission window that penalizes premature discharges.
2. Mandated Care Setting Transparency: Requiring providers to state their assumed post-acute care setting explicitly, ensuring a price quoted for home health care cannot be swapped for high-cost institutional care.

A pre-established scope remains fixed during negotiations. While commercial contracts are re-cut continuously and vary wildly by payer for identical care, a standardized scope bound to a multi-year reference rate provides both parties an unyielding baseline. Just as Medicare participation legally bars providers from billing beneficiaries beyond statutory cost-sharing, a provider-accepted reference price secures that same protection by contract.

Establishing a standardized scope isolates pricing subjectivity, removing it from the definition of the billing unit and confining it strictly to individual patient complexity. The reality that hospital prices bear no relationship to underlying costs is not a counterargument to this model. It is its core justification. If commercial hospital rates reflected actual costs, external benchmarks would be unnecessary. An independent benchmark is required precisely because commercial prices reflect monopoly leverage: a distortion that any internal commercial market benchmark will inevitably perpetuate.

4. An independent benchmark utility (Section 1, Part I, p. 21)

Comparable rich countries anchor hospital prices to schedules set outside any single bilateral negotiation. Germany's diagnosis-group schedule, England's National Health Service payment scheme and Japan's uniform fee schedule are each set collectively and published in advance (InEK GmbH, 2025; NHS England, 2026; Matsuda, 2019). No individual hospital authors the price it's paid. Germany revises its catalogue each year and Japan every two years: both protect patient access as they do so.

England is the instructive case here because its published scheme still requires a provider and a commissioner to agree to certain elements locally (NHS England, 2026). A national schedule and local negotiation are not alternatives. The published figure is negotiated: precisely what we propose. The US can charter an authority or utility by statute, funded by reporting fees and insulated from hospitals. An official charter also establishes a clear regulatory home for this function that would fill the oversight vacuum created when the Department of Justice and Federal Trade Commission withdrew their antitrust safety zones for price-information exchanges in 2023 (Mekki, 2023; Federal Trade Commission, 2023).

The authority or utility should draw on all-payer claims, remittance data, Medicare multiples and international comparators, and refreshed annually. It should provide a carve-out for rural, critical-access and teaching hospitals. Quality measures belong beside every price and should come from outside the market. The International Consortium for Health Outcomes Measurement (ICHOM) publishes condition-specific standard sets, developed globally and available at no cost (ICHOM, n.d.). In sum, a purchaser can read outcomes beside a price without either number being authored by the seller.

The supply-side infrastructure for this proposal already exists - and market participants are demanding the exact same framework. Turquoise Health currently ingests up to 300 terabytes of monthly machine-readable data produced by federal transparency rules, publishing over 400 standardized service packages under an open license. In June, the firm urged Congress to mandate open-license bundle standards free of royalty or licensing restrictions, ensuring price comparisons rest on uniform rather than proprietary definitions (Skenes, 2026). This is precisely the published service scope described in Section 3: requested by an industry actor, not merely proposed by us. Similarly, the National Academy for State Health Policy (NASHP) applies the same standardizing principle to hospitals' own Medicare cost reports, so that costs and margins can be compared across facilities (NASHP, 2023, 2026). By acting now, Congress would be completing work the market has already begun, rather than commissioning a new system from scratch.

What the market's own data cannot supply, however, is a price whose author publishes its methods, answers for them in public and is independent of sellers. This is not a failure of any individual firm, and the case for a utility rests on that governance, not on any claim that no one else could produce an outside price. Machine-readable files merely record existing negotiated or administered rates; hospital cost tools rely on self-reported facility data. Medicare sits outside the bilateral negotiation, but not wholly outside the market. Congress sets the overall level of Medicare's hospital payments, while hospitals' own cost reports help set the relative payment for each type of stay and the weights in the index that updates those payments each year (CMS, 2025b). Since at least 2005, the Medicare Payment Advisory Commission (MedPAC) has reported that hospitals under less financial pressure, in particular those with high margins on non-Medicare patients, have faster cost growth, a pattern it reports most clearly for nonprofit hospitals. In 2020 it warned that "an increasing differential between Medicare and commercial prices may create pressure to increase Medicare prices as well" (MedPAC, 2005, 2020). Medicare multiples should therefore be one input to the benchmark rather than the benchmark itself. The missing ingredient is independent provenance or an input that must necessarily originate from an external authority.

Benchmarking against a price schedule not written by the seller is a well-established concept in US health policy, as seen in federal drug purchasing (38 U.S.C. § 8126). In December 2025,

CMS advanced this principle by proposing the Global Benchmark for Efficient Drug Pricing (GLOBE) model, finalized in September 2026, which calculates manufacturers' inflation rebates for selected Part B drugs against prices paid in 19 comparable nations selected via published economic criteria rather than manufacturer negotiation. Although a previous international benchmarking effort was vacated on procedural grounds (*California Life Sciences Association v. Centers for Medicare and Medicaid Services*, 2020), we cite it to highlight its underlying logic, not as settled law (CMS, 2026b). Foreign prices would inform rather than dictate such a benchmark, requiring adjustments for bundle comparability, quality and exchange rates. We are not asking Congress to impose foreign rates on domestic providers.

The unexamined question is what occurs when a reference price is authored outside the market it seeks to discipline and providers accept it as payment in full. Christopher Whaley's June 2026 testimony surveyed state-level initiatives in California (CalPERS), Oregon, Montana, Washington, Indiana and Vermont, but every benchmark he analyzed was derived from domestic prices, either multiples of Medicare or domestic commercial data (Whaley, 2026). We ask Congress to direct ASPE, CBO and/or the GAO to model the alternative: a reference price established outside internal market leverage.

5. Employer plans and fiduciary duty (Section 1, Part III, p. 27; Section 2, Part III, p. 63)

A plan fiduciary required to prove a hospital rate is "reasonable" currently lacks an independent benchmark against which to prove it. Commercial negotiated rates are endogenous to the hospital market concentration documented herein, compounded by third-party administrators who routinely block access to underlying claims data (Handorf et al., 2025a; Whaley, 2026). An externally authored reference price, accepted by participating providers as payment in full, provides fiduciaries with precisely what ERISA burden demands: a baseline established outside the commercial negotiation being tested.

Today, approximately 154 million non-elderly Americans hold employer-sponsored coverage, primarily through self-funded plans whose sponsors are fiduciaries under ERISA (KFF, 2025). Section 404 requires a prudent process for spending plan assets. Section 406 strictly prohibits transactions with parties in interest - making "reasonableness" an affirmative defense that fiduciaries must prove under Section 408(b)(2). This statutory architecture was central to *Cunningham v. Cornell University* (2025), where a unanimous Supreme Court held that Section 408 exemptions are affirmative defenses that fiduciaries bear the burden of pleading and proving. With private litigation trackers recording 155 ERISA fiduciary class actions in 2025 - including 39 against health plans (Encore Fiduciary, 2026) - fiduciary duty has likely become the fastest-growing source of legal pressure on plan sponsors.

A plan operationalizes an external benchmark by contracting directly with a hospital or physician group for a bundled rate. Because the provider agrees to accept this rate as payment in full,

members are shielded from balance billing without needing to pay cash out-of-pocket, fund health savings accounts, or make individual financial arrangements. The plan pays the agreed rate and member cost-sharing is computed directly from it - protecting lower-wage workers who are least able to absorb unexpected costs. In exchange, providers gain prompt payment, simplified single-billing, and multi-year revenue stability. For example, in December 2025, the 32BJ Health Fund (a Taft-Hartley plan covering 170,000 SEIU participants) negotiated terms with Northwell Direct averaging 184% of Medicare with annual increases capped at 5%, projecting \$46 million in first-year savings alongside reduced member cost-sharing (32BJ Health Fund & Northwell Direct, 2025). While this direct-purchaser agreement illustrates what a provider-agreed rate looks like in practice, we cite it to demonstrate the contracting model rather than to rest our core argument on it.

California's public employee system (CalPERS) demonstrates both the power of reference pricing and its essential conditions. When CalPERS introduced reference pricing for joint replacements, high-priced hospitals reduced their rates by roughly a third to preserve volume (Robinson & Brown, 2013). However, two conditions dictate whether such arrangements succeed. First, as seen in CalPERS's early model, when patients rather than providers absorb the difference between the reference price and the hospital's charge, average out-of-pocket spending rose by \$1,991 (Brodke et al., 2019) - a gap that a provider-agreed rate eliminates. Second, plans must align their stop-loss coverage. Standard stop-loss policies reimburse based on the carrier's internal "reasonable and customary" charges rather than the plan's contracted rate, often omitting bundled or case-rate structures entirely (Hub International, 2018; National Association of Insurance Commissioners, n.d.). Because stop-loss policies are medically underwritten and repriced annually, a sponsor that adopts a provider-agreed rate without aligning its stop-loss carrier risks buying savings that stop-loss coverage refuses to recognize.

Congress should direct the Labor Department's Employee Benefits Security Administration (EBSA) to confirm that a documented review of independently sourced reference prices satisfies Section 404 prudence requirements. This guidance should outline benchmark selection, quality metrics, plan document amendments, stop-loss coordination, and enforcement mechanisms pairing benchmarks with provider-accepted rates. While EBSA can establish administrative guidance, only Congress can enact a formal statutory safe harbor. Furthermore, ERISA protections should serve as a regulatory floor, allowing states targeted authority to exceed federal standards on transparency and balance billing. When providers refuse to accept reference rates, plans should rely on narrow network design and hold-harmless provisions rather than unilaterally repricing claims after care is delivered.

Finally, while employers with complete claims data are 29 percentage points more likely to contract directly with providers (National Alliance, 2025b), smaller self-funded plans require the shared infrastructure proposed here to achieve equal leverage.

6. Anti-steering, anti-tiering and all-or-nothing contracts (Section 3, Part II, p. 75)

The RFI asks how to prevent vertically integrated insurers from steering patients to their own subsidiaries at inflated transfer prices. While we support those restrictions, we urge the Committee to apply the exact same principle to the provider side of the market. Dominant hospital systems routinely deploy anti-steering and anti-tiering contract clauses that prohibit health plans from routing patients to lower-cost providers or placing them in preferred benefit tiers - alongside all-or-nothing terms that force insurers to include every facility in a system. These restrictive terms actively undermine buyer leverage; a reference price becomes a credible cost-control tool only if a plan is legally permitted to steer patients toward providers that agree to accept it as payment in full.

Federal enforcement and courts have already established this boundary. The \$575 million Sutter Health settlement (approved in 2021) prohibited all three clause types and barred Sutter from interfering with insurers' narrow, tiered networks that steer patients to non-Sutter facilities (California Office of the Attorney General, 2021). Similarly, the 2018 Atrium Health consent decree voided and prospectively banned anti-steering provisions (U.S. Department of Justice, 2018). The Department of Justice filed complaints on identical theories against OhioHealth and New York-Presbyterian in 2026, securing a proposed consent judgment in the OhioHealth matter within four months (U.S. Department of Justice, 2026a, 2026b). Statutory vehicles like the *Healthy Competition for Better Care Act* (H.R. 6248) would allow Congress to codify these limits nationwide - reaching every health system rather than just those subjected to litigation - without setting prices directly (U.S. Congress, House, 2025). The Council of Economic Advisers projects that a nationwide ban would reduce hospital prices in directly affected markets by 18% (with a plausible range of 11% to 26%), lower employer premiums in those markets by 6.5% and yield roughly \$45 billion in annual national savings across the roughly one-quarter of commercially insured individuals currently bound by these terms - though these represent economic projections rather than formal CBO scoring (Council of Economic Advisers, 2026).

These anti-competitive terms are foundational to how the modern hospital market formed. Health systems have systematically avoided competition not only through contracting clauses, but also through non-merger affiliations that crowd out rivals while evading antitrust agency review (Montague et al., 2021; NASHP, 2021). Traditional antitrust litigation has failed to interrupt this pattern: five major cases against five systems over more than a decade (Council of Economic Advisers, 2026) barely touch a landscape where nine out of ten hospital markets are already highly concentrated. A clear, prospective statutory rule banning this conduct is the only practical remedy. Congress does not need to litigate antitrust violations to outlaw specific contract terms.

The real-world impact of exercising buyer leverage was demonstrated when the 32BJ SEIU Health Fund removed a high-cost health system from its network after negotiations stalled (Whaley, 2026). Combining rigorous claims analysis, strategic network exclusions, and direct provider contracting, the fund saved approximately \$100 million annually - funding a \$3,000 member bonus and the largest wage increase in the union's history (Patient Rights Advocate, n.d.). Prior to these interventions, escalating health costs were consuming 40 cents of every wage dollar negotiated at the bargaining table. This single Taft-Hartley fund provides a concrete, empirical example of the health-benefit-to-wage trade-off modeled by the Congressional Budget Office (CBO, 2022a).

7. Third-party administrators and re-pricers (Section 2, Part III, p. 66; Section 3, Part III, p. 76)

Third-party administrators (TPAs) face a structural, systemic conflict of interest driven by rent-seeking incentives. An intermediary compensated as a percentage of processed spending has no financial reason to drive spending down. Economists refer to this dynamic as dual agency: the administrator purports to act for the plan sponsor while simultaneously serving and profiting from the providers the plan pays. Because administrators often measure "savings" against artificially inflated billed charges, three structural reforms follow none of which require another passive disclosure rule.

1. Spread-pricing re-pricers earn a percentage of the difference between a hospital's billed charge and the negotiated out-of-network payment, with fees reaching up to 50% of that spread (Handorf et al., 2025b). As a result, the administrator's revenue increases alongside the very charges it is supposedly disciplining. Similarly, vertically integrated administrators - owned by corporate parents that also own physician groups - sit on both sides of the transaction. When a self-funded plan pays above-market rates to those clinical practices, it directly enriches its own administrator's parent company.
2. Plan sponsors cannot police costs they cannot inspect. Despite the 2021 statutory ban on gag clauses, employers still face significant barriers to accessing their own claims data. Although the January 2025 federal guidance (FAQs Part 69) clarified that downstream terms restricting data scope are illegal (U.S. Department of Labor et al., 2025), robust enforcement remains absent, forcing some employers to litigate simply to view their own records (Whaley, 2026). Enacting the "Patients Deserve Price Tags Act" - that caps claims-data response times at 15 days and prohibits administrative restrictions (U.S. Congress, Senate, 2026c) - is an essential prerequisite. However, transparency alone does not lower costs (Whaley, 2026); disclosure merely tells a sponsor what it paid, not what it should have paid.
3. Addressing care delays and improper denials requires administrative accountability. Denial, appeal, and overturn data must be reported at the administrator level and expanded to self-funded plans - where documentation is thinnest. A sponsor

cannot audit a pattern of improper denials without data access - and the precise claims files needed to expose billing distortions are those needed to uncover denial patterns.

While we agree with the diagnosis put forward by Georgetown's Center on Health Insurance Reforms (CHIR) in its "Fair Pay, Fair Play TPA" proposal, we question its remedy on two counts. Its fee schedule, informed by Medicare and tied to Medicare participation (Monahan et al., 2026), relies on a domestic administered rate rather than an external baseline insulated from internal market leverage - inheriting rather than resolving the question of rate derivation. Furthermore, creating a new public entity to process claims is a far heavier legislative lift than publishing an independent benchmark. Ultimately, these two approaches are complementary: Georgetown's proposal secures employer data access while ours supplies the external price signal.

A structural conflict of this magnitude cannot be cured by a disclosure form. Congress established the proper statutory precedent in the Consolidated Appropriations Act, 2026, by treating pharmacy benefit managers (PBMs) as covered service providers under ERISA and making 100% rebate pass-through a condition of reasonable compensation (Consolidated Appropriations Act, 2026, § 6702). The same logic applies to health plan administration: Congress should prohibit TPA and re-pricer compensation calculated as a percentage of billed charges, allowed amounts or savings relative to chargemaster rates. Administration should be compensated strictly via flat, fully disclosed per-member-per-month (PMPM) fees with all repricing savings passed through to the plan bearing the risk. Administrators remain essential infrastructure; the goal is to eliminate the conflict, not the administrator.

8. Related-party payments and medical loss ratio (Section 3, Part III, p. 79)

Of the concepts presented by the Committee, we can speak directly to two: disallowing internal price markups within Medical Loss Ratio (MLR) calculations and benchmarking related-party transactions against prices paid to unaffiliated entities. We strongly support both provisions, with one critical qualification regarding the benchmark.

Comparing affiliated to unaffiliated rates carries a structural blind spot: the unaffiliated rate is still a price negotiated by that same insurer. A dominant insurer that owns provider practices can inflate affiliated and unaffiliated rates in tandem. As a result, a simple comparative test will detect crude, isolated markups but it will entirely miss uniform price inflation across an insurer's portfolio.

Furthermore, the MLR framework creates a perverse incentive that is easily overlooked. Under current regulations, a payment to an affiliated provider is classified as medical spending rather than administrative overhead. This allows the insurer to satisfy its MLR minimum-spend threshold while keeping revenue within its corporate family. Because the MLR allowance for

administration and profit is a percentage of premium, higher medical spending raises premiums and, with them, the dollars an insurer may keep (45 C.F.R. § 158.210) - reflecting the exact same structural flaw found in percentage-based intermediary compensation. This is why the Committee's first concept, a fee-based metric tied to a growth rate, is so vital to pair with affiliate rate caps.

Independent analyses consistently converge on this issue. The Committee's inquiry asks how pricing benchmarks can eliminate excess profits generated through affiliated entities, while INET's Alvelda and Ferguson rank affiliate benchmarking as the single most effective, evasion-resistant tool available (Alvelda & Ferguson, 2026). Yet both perspectives encounter the same limitation: an enforcement test built solely on domestic, unaffiliated commercial rates relies on prices generated by an already distorted market.

To close this loop, related-party transactions should be benchmarked against the lower of the insurer's local unaffiliated rate or an independently sourced external reference price. The test does not cap what an insurer pays its affiliate; it only stops the excess from counting as medical spending. It is the only place where we propose that the reference price apply to a private party by rule rather than through a voluntary contract.

9. All-payer claims databases and transparency (Section 3, Part III, p. 85)

A price benchmark is only as good as the data feeding it. We strongly support expanding All-Payer Claims Databases (APCDs), establishing federal standardization for claims formats, centralizing the submission of machine-readable price files from hospitals and health plans and creating the national provider-ownership database referenced in the RFI (Whaley, 2026). However, a critical legal precedent dictates whether this framework can succeed: in *Gobeille v. Liberty Mutual Insurance Co.* (2016), the Supreme Court ruled that ERISA preempts state reporting mandates for self-funded health plans - the very sector covering most insured workers (KFF, 2025). While states may compel data from fully insured plans, they cannot mandate reporting from self-funded plans. Consequently, any comprehensive claims-reporting requirement must be enacted at the federal level: meaning the Committee's data goals depend entirely on statutory authority that only Congress possesses.

Governance for this database should default to de-identified claims data subject to rigorous privacy and security oversight. Data publication design also requires careful calibration: because releasing a simple market median can inadvertently create a pricing floor or target for providers. Public disclosures should be structured to support institutional benchmarking rather than merely broadcasting local market midpoints.

10. Public-option benchmarks, federal rate review and cost-sharing (Section 1, Parts I to III, pp. 21 to 39)

Oregon's cap on hospital payments for state employees, set at 200% of Medicare for in-network care and 185% out-of-network, achieved significant savings, driving outpatient prices down by 25% with no evidence that hospitals shifted costs by raising prices on other commercial payers (Murray, Brown, et al., 2024). However, the evaluation highlights a trade-off that advocates must acknowledge: enrollee utilization increased, costing roughly \$10.3 million of the state's savings (Murray, Norton, et al., 2024). It also offers a cautionary lesson: initially low-priced hospitals steadily raised their rates toward the cap until the state adopted a "lesser-of" provision (OR Admin. R. 101-080-0010). Colorado experienced a similar upward drift when its rate-setting process prohibited setting any rate below 80% of the prior year's level. To prevent price floor migration, any contract that adopts the reference price should pay the lower of the negotiated rate or the reference price with participating providers accepting that amount as payment in full.

Hospitals frequently argue that lower public payment rates force them to cost-shift by charging commercial plans more. While a degree of cross-subsidization exists, cost-shifting cannot explain the current pricing gap. According to the American Hospital Association's own data, Medicare reimburses roughly 83 cents on every dollar of hospital costs (American Hospital Association, 2025). Using the same association's data, CBO found that private payers paid about 145% of hospital costs in 2018 (CBO, 2022b). A disparity of this scale reflects market leverage, not cost recovery. Moreover, this defense ignores that hospital operating costs inflate alongside available commercial revenue. MedPAC analysis shows that hospitals with the least commercial cushion maintain lower operating costs reporting Medicare margins of negative 6.6% in fiscal year 2024, compared to negative 13.9% at high-margin institutions (MedPAC, 2026). An operating cost base that inflates to absorb excess commercial revenue cannot simultaneously serve as the justification for higher commercial prices, a conclusion shared by CBO, MedPAC, and Blavin, et al. (CBO, 2022b; MedPAC, 2026; Blavin et al., 2023).

A federal public option represents one of the most powerful policy levers before the Committee; the central question is how to optimize its design. The Committee makes specific inquiry regarding the ACA Section 36B "firewall" that denies premium tax credits to employees offered coverage deemed affordable under statutory definitions, locking workers into employer plans regardless of what those plans negotiate. Repealing the firewall would transition an estimated 1.8 million people out of employer plans and reduce the uninsured population by 1.4 million: the 1.8 million representing roughly 1.2% of employer-sponsored enrollment (Commonwealth Fund, 2024). Because the firewall was designed to prevent employer coverage reductions, its repeal should be paired with the fiduciary standard outlined above. State-level Section 1332 innovation waivers offer the ideal testing ground to prove a reference price model before Congress establishes a national framework.

The Committee must also determine provider payment rates for a federal option; a question current legislative proposals handle in contrasting ways. Medicare-X sets payments directly to Medicare rates (U.S. Congress, Senate, 2025b), granting administrative discretion to add up to 50% in rural areas. The Affordable CHOICE Act directs the HHS Secretary to negotiate rates, using Medicare as a default fallback (U.S. Congress, Senate, 2026a). The Choose Medicare Act establishes a floor and a ceiling: payments cannot fall below Medicare rates in the aggregate nor exceed the average rates paid by Exchange insurers (U.S. Congress, Senate, 2025a). However, capping payments at the commercial average relies on the very market dynamics driving inflation today. While the Secretary would be the nation's largest healthcare buyer, bargaining leverage alone does not alter underlying market power. Drafters relied on commercial averages because an independent benchmark was unavailable; supplying that benchmark is what makes a public option viable.

Finally, the Committee asks whether federal regulators should have the authority to reject unjustified premium increases. Any rejection authority requires an objective baseline against which to evaluate rates and that baseline cannot be generated by the very industry being regulated. Because premium increases are primarily driven by hospital prices, regulatory review must evaluate rate filings against an external, independent reference price. Applying this logic to cost-sharing is equally vital: because patient deductibles and coinsurance are calculated from negotiated prices, establishing a reference price that participating providers accept as payment in full directly lowers out-of-pocket costs while eliminating balance billing.

11. Recommendations

Eighty-six pages distill into three core reforms and three enabling measures. Each proposal specifies the executive actor, statutory authority, implementation timeline and jurisdictional committee or either Finance or Health, Education, Labor and Pensions (HELP). None of this constitutes fully drafted statutory text.

Three Core Reforms

1. Establish an Independent Benchmark Authority or Utility: Charter an independent entity to publish hospital reference prices that participating providers accept as payment in full. Governance must include purchasers, providers, patients, actuaries, and academics, with no single interest holding a majority. The entity must be insulated from affected providers and vendor commercial interests. It must publish its methodology, data sources, and assumptions for every price; adjust for geography, case mix, and facility type; and exempt critical access, sole community, rural, and safety-net teaching hospitals. Adoption remains voluntary for all payers and providers. Congress would enact this via a new part of the Public Health Service Act (PHSA), hosting the entity within HHS, or under the Social Security Act on the model of the Patient-Centered

Outcomes Research Institute. Board appointments could occur within 12 months of enactment, with initial prices published within 24 months and in all markets within 60 months (Section 1, Part I; HELP under the PHSA route, Finance under the Social Security Act route).

2. Prohibit Restrictive Hospital Contracting Clauses: Bar anti-steering, anti-tiering, and all-or-nothing clauses in contracts between hospitals and group health plans or issuers prospectively, leaving existing contracts intact until renewal. For plans and issuers, Congress would amend the PHSA, ERISA and the Internal Revenue Code, as the pending Healthy Competition for Better Care Act would (U.S. Congress, House, 2025; U.S. Congress, Senate, 2026b); for hospitals, it could add a Medicare condition through the provider agreement under 42 U.S.C. § 1395cc - reaching every health system without requiring case-by-case litigation - effective for contracts entered into, amended or renewed from 12 months post-enactment (Section 3, Part II; Finance for the Medicare condition, HELP for the plan-side ban).
3. Clarify ERISA Fiduciary Standards: Direct EBSA to confirm that a documented review of independently sourced reference prices, paired with provider-agreed rates accepted as payment in full, constitutes a prudent fiduciary process. Reviews must cover benchmark selection, quality metrics, plan-document amendments, stop-loss coordination, ongoing monitoring, and balance-billing protections. This measure operates under existing law: Congress would direct the Employee Benefits Security Administration (EBSA) under ERISA §§ 404(a)(1)(B) and 408(b)(2), issuing guidance within 12 *months* (Section 2, Part III; HELP).

Three Enabling Measures

1. Standardize Price Definitions: Require published prices to explicitly state component coverage against a standardized minimum baseline including facility, professional, and anesthesia fees, implants, imaging, readmission windows, and assumed discharge disposition enabling true apples-to-apples price comparisons. The Secretary would act via rule under existing hospital price transparency authority (PHSA Section 2718(e)) for calendar years beginning in 2028 (Section 3, Part III; HELP, with Finance for a Medicare route).
2. Eliminate Percentage-Based Intermediary Fees: Prohibit third-party administrator (TPA) and re-pricer compensation calculated as a percentage of billed charges, allowed amounts or savings measured against a provider's own chargemaster. Administrative services must be billed as a fully disclosed fee per member per month (PMPM), with all repricing savings passed directly to the plan bearing the claim. Congress would act under ERISA § 408(b)(2) - mirroring statutory requirements established for pharmacy benefit managers (PBMs) - effective for plan years beginning 24 months post-enactment (Section 2, Part III; HELP).

3. Close the Related-Party MLR Loophole: Test affiliate and intercompany payments against the lower of the local unaffiliated commercial rate or an independently sourced external benchmark. The Secretary would act via rulemaking under the Medical Loss Ratio (MLR) provisions of PHSa Section 2718, with a parallel standard for Medicare Advantage and Part D under the Social Security Act, effective for the first reporting year following final rule publication (Section 3, Part III; HELP for commercial coverage, Finance for Medicare Advantage and Part D).

Deliberate Omissions

1. No Statutory Safe Harbor: We do not request that adopting a published reference price carry a statutory presumption of prudence, as safe harbors represent a policy decision reserved exclusively for Congress.
2. No Mandatory Rate Ceiling: Reference prices do not function as a statutory cap or maximum payable amount; rather, they serve as an objective baseline brought into private negotiations. Providers who agree accept the rate as payment in full; those who decline retain full discretion to do so. The related-party test in Section 8 is the one place where the reference price applies to a private party by rule.

Separately, we urge the Committee to direct ASPE, CBO and/or GAO to model the macro-level impact of an independent, external reference price accepted as payment in full. No commercial vendor should serve as the official data source of record for this modeling.

Criteria for Empirical Evaluation: The validity of this framework should be judged against clear empirical benchmarks. Because adoption is voluntary, comparing plans that adopt the benchmark with plans that do not would largely measure who chose to adopt it. The evaluation should instead measure the effect of publication itself. The authority should not evaluate its own work. GAO, or an independent evaluator it selects, should publish the evaluation plan before the first prices appear, including the minimum fall in rates that will count as success. The authority should publish benchmarks in successive groups of markets, with the order drawn by lot among similar markets, as CMS did in randomly selecting the areas covered by the Global Benchmark for Efficient Drug Pricing model (CMS, 2026b). The main test compares the first group with a final group held back for 36 months. The outcome is contracted rates across all commercial payers in a market, reported as a full distribution and separately for the most concentrated markets so that a fall in high prices offset by a rise in low ones counts as failure. Congress should tie the authority's continued funding to the result.

The 36-month evaluation window reflects empirical evidence from Oregon's state employee payment cap: outpatient price reductions took the full study period to fully manifest; inpatient prices did not shift significantly until the second year and low-cost hospitals initially raised rates toward the cap until a "lesser-of" rule corrected the incentive (Murray, Brown, et al., 2024). A

voluntary price, which reaches a contract only when that contract is renegotiated, should take longer still. First-year readings often mask underlying structural adjustment while the mechanism takes hold; evaluation must occur at the three-year mark.

12. Conclusion

Neither of the two core recommendations functions independently. Without prohibiting anti-steering and anti-tiering clauses, buyers cannot leverage an independent reference price. Conversely, without a reference price benchmark, buyers freed from restrictive contracting terms quickly exhaust local alternative options. If the Committee seeks an immediate, actionable step this legislative session, banning restrictive contracting clauses represents the essential down payment: it sets no government rates, creates no new administrative agency and incurs no federal fiscal cost (CBO, 2024). Bipartisan legislation is already pending in both chambers and enforcement can be achieved simply by conditioning Medicare hospital participation agreements on the exclusion of these terms. The independent benchmark utility then renders this down payment durable, supplying the objective pricing standard that a consolidated industry cannot generate on its own. Together, these two interventions represent the minimal regulatory threshold required to achieve maximum impact, i.e., create a functioning commercial healthcare market.

The benefits extend far beyond formal budget scoring. Workers regain the wage growth that healthcare cost inflation has historically absorbed, echoing the experience of union trust funds that translated plan savings into record pay increases. Plan sponsors gain a legally defensible framework to satisfy their existing ERISA fiduciary duties. Providers who agree to published reference prices benefit from prompt claims processing, single-component billing and predictable financial terms.

The cost of inaction compounds rapidly. Restrictive contracting clauses impose an estimated annual cost of \$45 billion (Council of Economic Advisers, 2026) with every year of delay further denying buyers the ability to act on transparent pricing data.

The core legislative bargain rests on three pillars: a credible pricing benchmark established outside provider influence; provider acceptance of that benchmark as payment in full; and, the legal freedom for plan sponsors to direct care accordingly.

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