

Submitted by:

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Hearing:

Direct Contracting: A Prescription for Lower Health Care Costs

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Introduction

Chairman Allen, Ranking Member DeSaulnier, and Members of the Subcommittee, thank you for the opportunity to testify today about direct contracting in employer sponsored healthcare.

American employers fund nearly half of all healthcare spending. Many do not set the rate. Many do not control the payment. Many do not see the data. That gap is why healthcare keeps costing more and delivering less. Direct contracting is a proven way to change that.

My name is Mark Newman, and I am the Founder and CEO of Nomi Health, where we serve more than 20 million Americans through their employers. Before Nomi, I founded HireVue, a hiring platform used by tens of millions of job seekers to be seen as more than a resume or a profile. I have spent my career building companies that unlock more opportunity for American workers and the families who depend on them.

Like most Americans, I have my own healthcare story. Mine began after the birth of my son, when I was offered a 30 percent discount if I paid a medical bill directly and immediately, rather than running it through my traditional carrier, which already came with unacceptably high premiums. That moment made the waste between the employer who pays for care and the doctor delivering it impossible to ignore.

That waste shows up as dollars employers cannot track or control. Every healthcare dollar an employer can't account for is a dollar that doesn't become a raise, a benefit, or a job. That disconnect is crippling American workers, and removing it is why I started Nomi Health.

Nomi Health is an employer healthcare operating system built to simplify one of the most broken transactions in America: the one between the employers who buy healthcare and the providers who deliver it. Our platform facilitates direct contracting arrangements that allow self-funded employers to contract directly with physicians, labs, and specialists at a mutually agreed upon rate, pay them near real-time outside the traditional carrier claims process, and see exactly where every healthcare dollar goes via data received on each transaction. Our model serves more than 2,500 self-funded employers, representing 20 million lives and over \$100 billion in healthcare spending.

Today, employers across the country, from Fortune 50 companies to the small businesses that form the backbone of your communities and the American economy, have hit a breaking point.

My testimony today focuses on three areas. First, the current system is failing the three groups it was built to serve - the employers who pay for care, the providers who deliver it, and the patients who depend on it. Second, direct contracting addresses these failures but is not readily available to employers across the country. Third, Congress can help make direct contracting and Centers of Excellence more broadly available by giving employers the protections and resources they need to use those arrangements. Centers of Excellence (CoE) are employer-sponsored plan arrangements that identify and contract with high-performing providers, facilities, or networks for specific services or conditions usually in specific geographic areas. CoEs are typically built to

address costly or complex patient needs and can improve care coordination, lower costs, and help patients get the care they need from the best providers available. Most importantly, Congress must protect these arrangements under the *Employee Retirement Income Security Act of 1974* (ERISA) and guarantee that employers can access and use their own claims data.

The Problem: A System Failing the People It Was Built to Serve

To understand why direct contracting is necessary, consider how the current commercial insurance system actually works. Imagine buying a gallon of milk and being told you will get a bill in 90 days for an unknown amount, while the store waits three months to be paid by an intermediary that takes a cut just for holding the money. We would not tolerate this in any other sector of our economy. Yet, we accept it as the standard for our health care system.

This structural failure inflicts measurable damage to the constituents you represent.

1. The Financial Burden on Workers and Their Families

Every Member on this Committee knows these stories. Every state has them. Nearly everyone has lived one. The parent who pushes back a child's specialist appointment because the deductible has not reset. The worker who receives a bill nine months after surgery and still cannot get a direct answer about what they owe. Behind every statistic in this testimony is a constituent. They are why this hearing matters.

Healthcare is now the number one financial concern for American families, ahead of housing, food, and utilities.¹ 36 percent of Americans report skipping or delaying medical care because of cost.² A study published in the *American Journal of Public Health* found that two-thirds of personal bankruptcy filers cited medical expenses or illness-related income loss as a contributing factor. For the families behind those numbers, this is a household financial crisis that worsens each year.

2. The Financial Burden on Self-Funded Employers

Self-funded employers carry fiduciary responsibility under ERISA for the workers and families on their plans. Yet in practice, many do not negotiate the rates, do not control the payment path,

¹ KFF Health Tracking Poll. *Americans' Challenges with Health Care Costs*. Kaiser Family Foundation, May 2025. Available at: <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>

² KFF Health Tracking Poll. *Americans' Challenges with Health Care Costs*. Kaiser Family Foundation, May 2025. Available at: <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>

and do not receive claims data in a form they can actually use to audit their spending and manage their plan design.

From the largest employers to the small and mid-sized businesses that employ roughly half of America's private workforce, the story is the same: tens of millions of dollars flow into arrangements employers cannot meaningfully see or control, premiums continue to climb year after year, and too often the only available response is to shift more costs onto workers. That means raising deductibles, holding back wages, reducing benefits, or dropping coverage altogether. Every dollar a business overspends on healthcare is a dollar it cannot put toward a raise, a new hire, or new investment.

3. The Operational and Financial Toll on Providers

Legacy insurance networks are breaking the provider ecosystem. Clinicians do not operate in a true free market. They face opaque fee schedules and complex prior authorization hurdles. Crowe Revenue Cycle Analytics found that in the first quarter of 2023, 31 percent of inpatient claims and 32 percent of outpatient claims submitted to commercial payers went unpaid for more than 90 days — more than twice the rate for traditional Medicare. Beyond the delays, Crowe found that approximately eight cents of every dollar billed to commercial payers is either never received or taken back upon receipt, through a combination of bad debt, final denials, and payment takebacks.³ This overhead forces health systems to inflate prices and pushes independent, community-based clinicians into burnout, consolidation, or closure. When a community hospital closes, a cost problem becomes an access problem.

4. The Common Cause

Workers, employers, and providers are not facing three different problems. They are facing three faces of the same one. To understand why, follow the money. For every dollar of care delivered, employers pay \$1.25 to \$1.30 in plan costs. Providers receive \$0.80. The vertically integrated carriers, third-party administrators, and affiliated service providers between these entities keep the difference. Neither the employer paying the bill nor the provider delivering the care can see where it goes. And when employers ask to see, the claims data they need arrives late, incomplete, or restricted.

At Nomi Health, I have seen what direct contracting does. It cuts costs, restores transparency, and pays providers in days instead of months. It removes the middlemen who keep the spread without delivering care. And it lets service providers build benefits around the workers an employer actually covers. Follow the dollar, and workers stop paying the price.

³ Crowe LLP. "Time for a Commercial Break." Crowe Revenue Cycle Analytics, May 2023. Based on data from more than 1,800 hospitals and 200,000 physicians using Crowe Revenue Cycle Analytics software, Q1 2023. Available at: <https://www.crowe.com/news/hospitals-revenues-continue-to-decline-due-to-increasing-delays-and-denials-by-commercial-insurers>

Given this Committee's jurisdiction over ERISA and the 154 million covered lives it governs, you have a unique opportunity to clear the path for direct contracting and improve the lives and health of America's workforce.

The Solution: Direct Contracting at Scale

The conversation around direct contracting has historically centered on narrow models: direct primary care, concierge medicine, cash-pay arrangements. Those models matter, but they operate one patient, one provider, and one transaction at a time.

The real opportunity now lies in **direct contracting at scale**: securing care for an employer's entire workforce across every member, claim, and service. This shifts the paradigm to unlock true affordability.

To make this model work, employers require three fundamental elements:

- **Data:** You cannot contract effectively without knowing exactly what you are buying, what it costs, and where the dollars are going.
- **Control:** If employers are responsible for funding healthcare, they must have the ability to route dollars transparently and accountably to the providers delivering care.
- **Resources:** Employers need access to service providers who can deliver these models, operate in value-based payment models, and provide access to the highest quality providers in a geographic area. To provide access to innovative models there must be competition in the health care market and ERISA preemption protections for service providers who serve self-funded plans.

When employers gain visibility into expenditures, control over payment flows, and the ability to contract at scale, they acquire a powerful mechanism to lower costs and improve care for workers and families.

Transforming the Transaction

Nomi Health has helped cultivate and expand direct contracting as a payment arrangement in which a self-funded employer agrees to a rate or a cost, directly with a provider, pays the provider outside the traditional carrier claims process, and receives full transaction-level data while protecting the privacy of the employees that is in full compliance with federal privacy laws. Direct contracting completely replaces legacy architecture by reconnecting the employer, the provider, and the payment infrastructure. By establishing a system where everyone can finally follow the dollar, the entire transaction changes:

- **The employer** knows exactly what it is buying and what it costs.
- **The provider** knows precisely what it will be paid and when.
- **The worker** knows their exact financial responsibility before receiving care.

Payment moves through a direct, transparent path rather than a legacy claims chain. Employers gain real-time data and instantaneous claims reconciliation. Providers get paid accurately and promptly, allowing them to eliminate administrative markup and pass the structural savings directly back to the plan.

Proof It Works: What Employers See When They Contract Directly

Direct contracting is an active, proven operational strategy. Nomi Health performed an analysis of its enrolled members, which compares beneficiaries enrolled in our facilitated direct contract arrangements versus enrollees in similar geographic areas and comparable risk levels under traditional insurance networks.

The first proof-point is employer cohort performance. We analyzed participating employers and their employees who utilized Nomi Health direct contracts in the state of Michigan against publicly available information. What we found was costs are falling by as much as 29 percent, measured as total medical spend per member per year compared with the statewide commercial benchmark, in a market where that benchmark is rising 10 percent to 15 percent annually. This model isn't just slowing the trend. It's reversing it for employers willing to take control of their health benefit.

The utilization data is just as important. Emergency room visits dropped 16 percent. Urgent care visits decreased 34 percent. Primary care visits climbed 45 percent. That's the pattern employers should want to see: fewer avoidable high-cost visits, more front-door care, and better use of the healthcare system before problems become more expensive.

The second proof point is a risk-adjusted member comparison. We analyzed 7,145 members enrolled in Nomi-facilitated direct contract arrangements against 7,145 members in similar geographic areas and comparable risk levels under traditional insurance.

Risk-Adjusted Member Comparison

Direct Contract Employers vs. Traditional Insurance | CY 2025

Metric	Direct Contract Employers	Employers Under Traditional Insurance	Difference
ENROLLMENT & COST			
Total Enrolled Members	7,145	7,145	—
Medical Claims / 1,000	11,496	19,874	▼ 42%
Medical Paid PMPM	\$316.31	\$531.15	▼ 40%
Medical Paid PMPY	\$3,795.74	\$6,373.79	▼ 40%
Total Medical Paid	\$11,750,021	\$21,340,501	▼ 45%
UTILIZATION (per 1,000 members)			
Avg. Medical Claims / Member	8.16	10.28	▼ 21%
PCP Visits	1,599	753	▲ 112%
ER Visits	100	283	▼ 65%
Inpatient Admissions	35	119	▼ 71%
Outpatient Surgeries	96	162	▼ 41%

Highlighted rows indicate metrics with meaningful cost or utilization differences

Source: Nomi Health | Risk-adjusted, matched cohort | Deidentified CY 2025 | Exhibit 1

The table above tells the story. Direct contracting members cost 40 percent less and used care more appropriately: more primary care, fewer emergency visits, fewer inpatient admissions. These behaviors are bolstered by Nomi Health’s model to eliminate cost-sharing for members where negotiated, which further incentivizes member utilization at provider sites within a direct contract arrangement.

This isn't about paying less for the same broken pattern. It's about changing the shape of care entirely.

The third proof point is operational scale. Nomi processes approximately 42,000 claims per day. 99+ percent of daily payments clear with no delays or complications. In direct contracting arrangements, Tier 1 rates run around 130 percent of Medicare, versus commercial benchmarks of 200 percent to 300 percent of Medicare. Providers can be paid in near real time; rather than waiting weeks under a traditional carrier process.

Direct contracting can't scale on good intentions. It requires infrastructure. Employers need accurate data. Providers need reliable payment. Members need access to affordable and high-quality providers. The model only works if the transaction works.

When payment is faster and cleaner, providers can accept rates that work for employers while improving their own cash flow and reducing administrative burden. That's not a zero-sum outcome. It's a better transaction for everyone in the room that leads to a better patient experience.

Employers don't need to accept healthcare as an uncontrollable expense. When they have the data, contracting freedom, and payment infrastructure to act, they can manage healthcare more responsibly. They can protect workers. They can support providers. They can make the healthcare dollar visible, accountable, and useful again.

The Barriers Holding Direct Contracting from Scaling

Direct contracting works. So why isn't it everywhere?

The barriers aren't clinical. They're legal, informational, contractual, and operational.

Legal uncertainty

There's no clear national framework for direct contracting. Self-funded employers operate under ERISA, but the application of ERISA's preemption protections to direct contracting is widely misunderstood and inconsistently applied. This uncertainty is a real obstacle for employers operating in multiple states.

Employers who want to contract directly with providers, use Centers of Excellence, or create alternative payment arrangements face legitimate questions about how federal and state rules apply. Without clarity, the status quo wins. Large incumbents can absorb complexity. Mid-sized employers can't.

A national framework should give self-funded employers confidence that direct contracting is a lawful, protected, and scalable plan design option while preserving appropriate protections for patients, privacy, provider licensing, and quality.

Data obstruction

Employers are being denied the data they need to manage the plans they fund.

Plan service providers can restrict, delay, or condition access to claims and plan data. Employers receive data too late to act. The data arrives incomplete, aggregated, or restricted in ways that prevent meaningful analysis. In some cases, employers are told they can view information but can't share it with the advisors, auditors, or analytics partners needed to use it.

Congress recognized this problem in Section 201 of the *Consolidated Appropriations Act, 2021*, which prohibits agreements that restrict a group health plan from accessing provider-specific cost or quality information, electronically accessing de-identified claims data, or sharing that information with a business associate. Plans must also attest annually that they aren't subject to prohibited gag clauses.

But the framework is incomplete. Plan sponsors carry the fiduciary duty and the attestation burden, while service providers controlling the underlying data don't always face the same accountability. In some cases, a service provider may even attest on behalf of the employer plan. Employers end up responsible for compliance while remaining dependent on the entities holding the information.

Enforcement has also been too weak. The Departments initially treated the gag-clause prohibition as self-implementing, leaving employers with limited recourse when service providers restricted or delayed access. Without clear standards, meaningful service-provider obligations, and a credible enforcement mechanism like civil monetary penalties, attestation becomes a compliance exercise rather than a real data-access right.

Here's what employers actually need to know: what was billed, what was allowed, what was paid, who was paid, when payment moved, what fees were taken, and how those amounts compare to available alternatives. They also need to use those data with qualified partners who help them evaluate plan performance.

Claims-level data is how employers find the waste. In a deidentified CY 2025 analysis of non-complicated C-sections, we found a median claim cost of \$14,280, a 75th percentile of \$19,394, and a maximum of more than \$337,000 for the same procedure (see Figure 1). Some outliers reflect legitimate clinical, coding, or geographic factors. But employers can't ask the right questions without claims-level data.

We then modeled a conservative savings opportunity: if selected claims between the 50th and 75th percentile were repriced to the median cost for that procedure, the modeled savings for that limited C-section sample exceeded \$1 million.



Figure 1: Deidentified CY 2025 claims-level data showing the full range of values for non-complicated cesarian section (C-section) (DRG 788). Potential cost savings generated of \$1,027,574.

The point isn't C-sections. The point is variation. Claims-level data lets employers see variation that would otherwise stay hidden. It lets them ask better questions about benefit design, provider contracting, site-of-care strategy, and member navigation. This is a fiduciary issue. Group health plan fiduciaries must act prudently, pay only reasonable plan expenses, monitor service providers, and evaluate the fees actually charged. A fiduciary can't meaningfully monitor a third party administrator's (TPA) claims processing or fee arrangements without access to the underlying data. They can't determine whether expenses are reasonable if the vendor controls the claims ledger and the employer sees only high-level summaries.

More reporting isn't the answer if employers can't act on the information. Transparency without usability is compliance theater, not control.

Market interference

Even when employers can identify better options, contract terms can prevent them from acting. Anticompetitive contract language can block employers from steering members to higher-quality, lower-cost providers. It can limit tiering, navigation, direct contracting, and alternative payment arrangements. It protects the intermediary relationship rather than the employer, provider, or worker.

That defeats the purpose of transparency. If an employer can see that one provider delivers better value but can't steer members there, the information has no practical effect. The market can't reward better value if employers are blocked from acting on it.

When employers can't pivot to better care, price transparency becomes information without power.

What Congress Should Do

These recommendations serve one purpose: to give employers the tools required to manage the healthcare dollars they are responsible for funding.

Congress doesn't need to manage healthcare purchasing for employers. Employers can do that. But employers can't act as responsible plan sponsors and fiduciaries if they're denied the data, contracting freedom, payment visibility, and vendor accountability required to manage their plans.

These recommendations aren't a request for a new federal healthcare program. They're a request to make health care cost transparency effective for employers. Each of these recommendations addresses one or more of the barriers employers face today: legal uncertainty, data obstruction, market interference, and operational complexity.

1. Give employers an enforceable right to complete, usable plan data

Self-funded employers should have an enforceable right to the data generated by the plans they fund and administer. Today, that right exists more clearly on paper than in practice.

Congress should require TPAs, carriers, networks, repricers, payment vendors, and other plan service providers to provide self-funded employers and their authorized business associates complete, timely, machine-readable access to plan data. That data includes claims, encounters, eligibility, provider information, pricing, payment, quality, fees, and plan administration records. That access should include the right to use the data with qualified advisors, auditors, analytics partners, direct-contracting partners, and payment vendors, subject to appropriate privacy and security protections. **Nomi Health supports congressional action to ensure the right to these data through Congressman Bob Ounder's (R-MO) *Health Data Access, Transparency, and Affordability (Health DATA) Act of 2026 (H.R. 9228)* and section 7 of the *Patients Deserve Price Tags Act (H.R. 5582/S. 4027)*.**

Congress has already recognized the problem through the gag-clause prohibition. The remaining gap is practical enforcement. Employers shouldn't have a paper right to data while the service providers controlling that data can flout the law by delaying, restricting, conditioning, or formatting access in ways that make it unusable.

A fiduciary duty without usable plan data is an empty obligation.

2. Reaffirm federal safe harbors for self-funded direct contracting

Congress should reaffirm that ERISA preemption safe harbor applies to self-funded ERISA plans and service providers which enter into direct provider contracts, Centers of Excellence arrangements, reference-based payment arrangements, and direct payment arrangements as part of plan design and administration.

Congress should make clear that a self-funded employer and its service providers aren't regulated as an insurance carrier, provider risk-bearing entity, or state-regulated health plan solely because it contracts directly for covered care on behalf of plan participants.

States should retain authority over generally applicable provider licensing, patient safety, privacy, fraud, and consumer protection laws. But state rules shouldn't block or materially impair self-funded ERISA plans from directly purchasing covered benefits for their workers, including arrangements facilitated by third parties such as Nomi Health that help ensure employers realize the best network rates appropriate for their workforce and geographic location.

This gives employers certainty without pretending federal law should erase legitimate state oversight.

3. Ban anticompetitive contract terms that block steering, tiering, direct contracting, or direct payment

Congress should prohibit contract terms that prevent employers, TPAs, networks, or plan service providers from steering members to high-value providers, placing providers in preferred or nonpreferred tiers, contracting directly with willing providers, or paying providers through alternative direct payment arrangements.

This should include anti-steering clauses, anti-tiering clauses, all-or-nothing provisions, most-favored-nation or similar pricing terms that suppress an employer's ability to offer lower-cost alternatives, confidentiality provisions that prevent employers from using cost and quality data, and terms that penalize employers or providers for using direct contracts, Centers of Excellence, or alternative payment vendors. **Nomi Health strongly supports congressional activity to move the *Healthy Competition for Better Care Act* (H.R. 6248/S. 4027) that promotes anti-tiering, anti-steering provisions.**

Transparency only matters if employers can act on it.

4. Direct federal agencies to issue practical implementation guidance for plan fiduciaries

Congress should work with the Department of Labor, in coordination with the Departments of Health and Human Services and Treasury, to develop practical guidance and model resources for HR professionals, plan sponsors, and fiduciaries evaluating direct contracting.

Those resources should include fiduciary checklists, model request for proposal (RFP) questions, model contract provisions, data-access clauses, service-provider compensation questions, quality evaluation criteria, member communication principles, and model payment standards. The guidance should also recognize Centers of Excellence and other direct contracting models as permissible plan design tools, with appropriate quality standards and member protections.

Employers shouldn't need to become healthcare infrastructure companies to buy healthcare responsibly. Guidance should not substitute for enforceable rights, but it can make responsible adoption easier, especially for small and mid-sized employers.

Conclusion: Put the Employer Back in Control of the Healthcare Dollar

The cost of healthcare is the top financial concern in American life, and Members of this Committee have heard it from constituents in every state: the family rationing care against a deductible, the small-business owner choosing between coverage and hiring, the community hospital fighting to keep its doors open. These are not separate problems. They are one problem — a system whose opacity, delay, and misaligned incentives enrich the middle at the expense of everyone on the ends.

Employer-sponsored healthcare is the backbone of coverage for American workers and families. The question is whether the employers funding that system will have the tools to manage it responsibly.

Too many employers today are asked to absorb rising costs without the ability to see the transaction, control the rate, trace the payment, or access the data. That's not a functioning market. It's a system built around business models that benefit when the employer can't follow the dollar.

Direct contracting offers a different path, and it is already working. Employers pay less. Providers are paid more, and faster. Workers get benefits built for their communities, often with little or no cost at the point of care. Nomi Health has facilitated these arrangements across the country and seen the results firsthand. What we need from Congress is the guarantee that employers can see and use their own data to move forward with direct contracting. Federal preemption under ERISA is essential to preserving that path.

I respectfully urge the Committee to support and pass Rep. O'Rourke's the **Health DATA Act (H.R. 9228)** and the **Patients Deserve Price Tags Act (H.R. 5582 / S. 2355)**, which address specifically

the issue of ensuring employers' ability to access their claims data, the ***Healthy Competition for Better Care Act (H.R. 6248/S. 4027)*** that addresses anticompetitive business practices Let employers see it, contract it, and pay it directly.

Thank you for the opportunity to testify. I look forward to your questions.