FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs

Every person should have the right to know what a health care procedure costs at different hospitals or health care facilities, whether it is an X-ray, an MRI, or a surgery, yet that is not how it works in the U.S. health care system. Health care is one of the only sectors in the U.S. economy where consumers and purchasers are blinded to the price of a service until after that service has been delivered and they receive a bill.[1] For the two thirds of Americans who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans, and based on which organization has more market power.[2] These health care prices — often referred to as negotiated rates — are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[3] This lack of transparency is alarming, particularly given that high and rising health care prices are the primary driver of our nation's health care affordability crisis.[4]

There is long-standing evidence that the high cost of health care in the United States relative to peer countries is driven by Americans paying much higher prices than people in other countries rather than receiving better health care.[5] These high prices have gotten much worse in recent years because of health care industry consolidation, particularly among hospitals, that has eliminated healthy competition and led to monopolistic pricing, which is most evident in prices paid by private health plans and employers in the commercial market.[6] Importantly, these higher prices not only result in more than $240 billion of waste annually and account for more than one-quarter of the wasteful spending generated in the U.S. health care system each year, but also come directly out of workers' paychecks in the form of annual increases in employer-sponsored health insurance premiums and cost-sharing, and become profits or margins for large health care corporations.[7] With more than 100 million Americans facing medical debt and nearly two-thirds of Americans having to cut spending on food, clothing, and other basic necessities because of the cost of health care, it is clear that our nation faces a health care affordability crisis.[8]

100,000,000+
Americans face medical debt

NEARLY **2/3** of Americans go without basic necessities, such as cutting down on food and clothing.

Fortunately, many policymakers are awakening to the role of abusive health care prices, particularly hospital prices, and are working to implement policy solutions, such as the new federal Hospital Price Transparency rule. This regulation requires hospital to post health care prices — including negotiated rates between hospital corporations and health plans — publicly for the first time. Unveiling health care prices, and specifically negotiated rates, is a key tool to rein in abusive pricing practices and infuse competition back into U.S. health care markets. Unsurprisingly, large hospital corporations have mostly subverted the federal requirements and are actively working to keep their health care prices hidden.[9] Transparency of the price and quality of health

Health care is one of the only sectors in the U.S. economy where consumers and purchasers are blinded to the price of a service until after that service has been delivered and they receive a bill.

care services in the U.S. health care system will help unveil — and uproot — irrational health care prices and low-quality care, and empower consumers, researchers, policymakers, and other purchasers with critical information to rein in prices and improve health care quality for our nation's families. Policymakers must act quickly and decisively to fully achieve the vision behind price and quality transparency in order to increase competition in U.S. health care markets and ultimately drive down health care costs for America's families.

The business of price gouging and keeping prices hidden

Hospitals and health plans negotiate prices for commercially insured patients where the outcomes of those negotiations depend heavily on the competitive market conditions for both parties. Through the consolidation of hospital markets — known as horizontal integration — and the merging of hospitals, physicians, and other health care provider systems — known as vertical integration — hospitals and providers consolidate market power, and thereby increase their leverage in price negotiations with insurers.[10] Unchecked industry consolidation, particularly among large hospital corporations, has led to a growing divide between commercial prices — prices paid by private plans and employers — and Medicare prices.[11] Unlike commercial prices, which are subject to the market power of insurers and providers to negotiate prices, Medicare prices are established administratively and are often considered the benchmark price for health care goods and services across the U.S. health care system.[12] For example, it is well established that commercial prices for hospital inpatient and outpatient care are significantly higher than what Medicare pays for those services.[13] In 2020, commercial prices for inpatient and outpatient hospital services were 224% what Medicare pays for those same services.[14] In some states, commercial health care prices for inpatient and outpatient services are more than 310% of Medicare prices.[15]

Policymakers must act quickly and decisively to fully achieve the vision behind price and quality transparency in order to increase competition in U.S. health care markets and ultimately drive down health care costs for America's families.

Commercial health care prices are not only high but also vary widely across the United States. Two individuals living in

While health plans are directly negotiating prices with hospitals, it is consumers and employers who ultimately pay for health care through insurance premiums, deductibles, and copays.

two different cities, even those in close proximity and with a similar cost of living, can be paying significantly different prices for health care with no connection to input costs or care quality. For example, the average price for a knee replacement for a patient in Tucson, Arizona, is $21,976, while the same procedure costs about $38,000 more in Sacramento, California.[16] Patients in New Mexico pay about 25% above the national average of health care prices, while those in Arizona pay 15% below the national average.[17] Prices also can vary significantly within a U.S. health care market — even within a single hospital system. For example, the price of an MRI at Mass General Hospital in Boston, Massachusetts, ranged from $830 to $4,200, depending on the insurance carrier.[18]

What is particularly concerning about these high and variable health care prices is the lack of transparency in how they are determined. Health plans and hospitals or other health care providers negotiate the price of each health care service and good to establish the negotiated rate. These negotiations occur behind closed doors, and the price – or negotiated rate – that is agreed upon for each health care service is then hidden in contracts between health plans and providers as proprietary information without public insight into or oversight over those health care prices.[19] In other words, big hospital corporations are leveraging the market power they garnered by buying up local doctors to increase prices and then leverage that market power to keep the price of health care services hidden from the public. Importantly, while health plans are directly negotiating prices with hospitals, it is consumers and employers who ultimately pay for health care through insurance premiums, deductibles, and copays.[20] The fact that the actual purchasers of health services are unable to find out how much they will pay until after care is delivered and a bill is received is a prime example of how anticompetitive the U.S. health care system has become.[21]

These large health care corporations have destroyed competition in the health care sector, and hospitals are dramatically increasing their prices year after year without any oversight from policymakers.[22] This practice has become a central strategy in the core business model

Price for a Knee Replacement within the U.S.

$21,976

Patient in Sacramento, California

$60,000

Patient in Tucson, Arizona

The ability of hospitals to increase prices year over year is the direct result of their ability to keep the underlying price of health care service hidden from public oversight and scrutiny.

of health care corporations: generate profit by buying up other hospitals and doctors' offices to become large corporate health care systems that can increase health care prices, and then block policymakers and the public from seeing those prices, while maximizing service volumes of the highest-priced services.[23] The ability of hospitals to increase prices year over year is the direct result of their ability to keep the underlying price of health care service hidden from public oversight and scrutiny. The imperative to price gouge and hide prices is in direct conflict with ensuring that consumers and patients have the the affordable health care they deserve.

Even more alarming is that these high and variable prices have no relationship to the quality of care or health outcomes.[24] Some might think that more expensive services yield higher quality care or better health outcomes, or that lower-priced services would produce lower-quality care or worse health outcomes. But neither is true.[25] The fact that there is no relationship between price and quality is not only a prime example of how broken the U.S. health care markets have become, it also points to the fact that Americans are flying blind when it comes to cost and quality of health care.

The power of price and quality transparency

For too long, health care prices have been hidden from the actual purchasers of health care: consumers and employers. Price transparency holds the promise of unveiling the underlying prices of health care services and goods so that consumers and employers can be better informed and empowered purchasers of health care, and so that researchers and policymakers are able to analyze prices in U.S. health markets to make targeted policy decisions to drive high-value care into the health care system. The most critical pricing information is the negotiated rate, which is widely recognized as the underlying price of health care services and goods.[26] But revealing prices alone is not enough. To truly drive competition and to provide a comprehensive view into U.S. health care markets, price must be paired together with data on quality so that consumers, employers, policymakers, and researchers can assess the actual value of health care services and goods.[27] Unveiling price and quality data would force the health care sector to compete based on rational prices and quality of care rather than buying up doctors' offices to price gouge and generate a high volume of high-priced services that do not improve patient health. Unveiling health care prices and quality data has the power to disrupt the status quo by shifting market dynamics. This shift is an important step to align the business interests of the health care sector with the financial security and

Unveiling price and quality data would force the health care sector to compete based on rational prices and quality of care rather than buying up doctors' offices to price gouge and generate a high volume of high-priced services that do not improve patient health.

health outcomes of our nation's families. Moreover, the American public agrees that this type of transparency is essentia – nearly 90% of voters believe that health care prices should be available to the public.[28]

Making price transparency a reality

Consumer advocates have long sought transparency in health care prices. Following years of consumer advocacy, the Centers for Medicare & Medicaid Services (CMS) finalized the Hospital Price Transparency rule, which requires hospitals to make public their standard charges for the care they provide, specifically negotiated rates by insurer and the particular insurance plan, gross charges, discounted cash prices, and a deidentified maximum and minimum negotiated rate for each service.[29] The rule requires hospitals to publish this information online in a machine-readable format (to allow third parties to easily analyze these data) and to provide a consumer-friendly online tool to allow consumers to compare prices for at least 300 "shoppable" services.[30] Additionally, in 2020, CMS finalized another important price transparency regulation — the Transparency in Coverage rule, which requires health insurers to make similar disclosures and to provide an online tool to allow consumers to estimate out-of-pocket costs.[31]

NEARLY **90%** of voters agree that health care prices should be public.

More than two years after the Hospital Price Transparency rule took effect, far too many hospitals across the country remain out of compliance with the federal

More than two years after the Hospital Price Transparency rule took effect, far too many hospitals across the country remain out of compliance with the federal rule.

rule. Recent estimates suggest as few as one in five hospitals are in full compliance with the rule.[32] Other estimates have found up to 45% of hospitals are not in full compliance with the rule.[33] With so many hospitals still failing to comply with the regulation, more work is needed to achieve meaningful transparency of health care price and quality data.

Hospitals are deploying various tactics to either buck the requirements outright or make the information they disclose very hard to understand.[34] Many hospitals have posted no information on negotiated rates at all.[35] Others hospitals post prices in the form of a percentage of Medicare payment (for example, 120% of Medicare) or as a percentage of gross charges, even though the Hospital Price Transparency rule explicitly requires hospitals to list the standard charges, including negotiated rates, for each individual item or service, rather than listing those prices as a percentage of a second value such as a Medicare payment rate wherever possible.[36] And other hospitals post incomplete required information (that is, using "NA" or blanks).[37]

The following figures display hospital data files from both compliant and non-compliant hospitals in order to contextualize the status of implementation of the Hospital Price Transparency rule, and ways to improve it.

Figure 1 (page 9) displays a compliant hospital data file, which includes all of the data elements required under the Hospital Price Transparency rule. The file clearly lists all the required standard charges (negotiated rates by payer and plan, gross charges, cash prices, and deidentified maximum and minimum negotiated rates) all in dollar amounts, by service description and billing code. This clear and complete disclosure enables the public to easily understand the pricing information, and to make price comparisons across different hospital providers by service. It also allows researchers to easily analyze negotiated rates across services in this hospital system to understand trends around competitive prices. This compliant hospital data file stands in stark contrast to hospital data files shown in Figures 2 and 3 (page 10 and 11, respectively).

Figure 2 shows an example of a hospital data file that discloses prices in multiple different formats in one file, making it nearly impossible to interpret. Specifically, instead of clearly listing the prices for standard charges including the negotiated rates as is required by the Hospital Price Transparency rule, and as demonstrated in Figure 1, the data file in Figure 2 lists some negotiated rates as percentages of gross charges (for example, in this screenshot of the data file, code 193501 for pacemakers). This stands in stark contrast to the Hospital Price Transparency rule's

requirements, which direct hospitals to list standard charges (including negotiated rates) for each individual item or service in dollar amounts whenever possible, rather than listing prices as a percentage of a second value such the hospital's standard gross charges.[38] Importantly, using percentages of gross charges or Medicare rates is not a meaningful piece of pricing information. In fact, it is not a price at all. Posting prices as a percentage of the Medicare rate or gross charges would require individuals to first understand the base Medicare rate or gross charge rate for a given service, and then to make their own mathematical calculation to arrive at an actual price. Simply put, posting prices in this way not only fails to list an actual price but also fails to uphold the intent of the price transparency rule, which is to disclose meaningful pricing information to consumers and other payers to negotiate a better deal and be more informed purchasers of health care.

Figure 3 shows another example of a hospital data file that fails to display the required pricing information in a usable way. This hospital posted prices that do not break down the negotiated rates by payer and plan as is required under the federal rule, but instead offers text descriptions of wide ranges of possible prices paid by payers. Not only is providing pricing information in this way not compliant with the federal rule because it fails to provide negotiated rates by payer and plan, but also it makes the data virtually unusable because it provides ranges of possible prices rather than the actual prices of those health care services.

The examples of hospital data files displayed in Figures 2 and 3 further highlight the ways that hospitals are failing to comply with the Hospital Price Transparency rule and why it is imperative for policymakers to work to strengthen the current rule.

Clear, universal coding information.

Prices broken down by payer AND plan.

Figure 1: Example of a Compliant Hospital

Description	Charge	Medicare CPT®/ HCPCS	De-identified minimum negotiated charge	De-identified maximum negotiated charge	Cash Price/ Self-Pay	Aetna Better Health OhioRISE	Aetna HMO/ POS/ PPO	Aetna Medicare Advantage	Aetna Assure Special Needs Plan
FINE NEEDLE ASPIRATION BIOPSY W/O IMAGE GUIDANCE, EA ADDL LESION	$200.00	10004	$200.00	$200.00	$70.00	$200.00	$200.00	$200.00	$200.00
FINE NEEDLE ASPIRATION BIOPSY W/US GUIDANCE 1ST LESION	$2,543.00	10005	$2,543.00	$2,543.00	$890.05	$2,543.00	$2,543.00	$2,543.00	$2,543.00
FINE NEEDLE ASPIRATION BIOPSY W/US GUIDANCE EA ADDL LESION LESION	$1,481.00	10006	$1,481.00	$1,481.00	$518.35	$1,481.00	$1,481.00	$1,481.00	$1,481.00
FINE NEEDLE ASPIRATION BIOPSY W/CT GUIDANCE 1ST LESION	$2,453.00	10009	$2,453.00	$2,453.00	$858.55	$2,453.00	$2,453.00	$2,453.00	$2,453.00

Dollar amounts for every price.

This image of a compliant data file is a screenshot of a portion of data file listed on a hospital's website that was downloaded by Families USA staff on March 27, 2023 from this website. The image has been designed to avoid identifying the individual hospital and to enable readability by hiding extraneous data in some instances.

Figure 2: Example of a Hospital Data File That Fails to Provide Complete Pricing Data

FacilityCode	PayerName	Term Group Name	Standard Patient Type	Reimbursement Method	Fee Schedule Fields_Code	Fee Schedule Fields_Rate	Fee Schedule Fields_Name	Fee Schedule Fields_Method	Term Criteria (Includes Advanced)	% of Charge Reimbursement
193496	Cigna Commercial	HCH MSH	I	UB92RM	636	0	Pharmacy-Extension of 025X - Drugs Requiring Detailed Coding	Case Rate		
193497	Cigna Commercial	HCH MSH	I	UB92RM	636	0	Pharmacy-Extension of 025X - Drugs Requiring Detailed Coding	Case Rate		
193498	Cigna Commercial	HCH MSH	I	PercentOfChargeRM					[Admission Date] >= '04/01/2019' AND [Payor Plan Code] = 'CIGNA.HMO'	100
193499	Cigna Commercial	HCH MSH	I	PercentOfChargeRM					[Admission Date] >= '04/01/2019' AND [Payor Plan Code] = 'CIGNA.HMO'	100
193500	Cigna Commercial	HCH MSH	Outpatier	UB92RM	274	28.9	Medical/Surgical Supplies and Devices - Prosthetic/Orthotic Devices	Percent of Charges		
193501	Cigna Commercial	HCH MSH	Outpatier	UB92RM	275	28.9	Medical/Surgical Supplies and Devices - Pacemaker	Percent of Charges		
193502	Cigna Commercial	HCH MSH	Outpatier	UB92RM	278	28.9	Medical/Surgical Supplies and Devices - Other Implants	Percent of Charges		
193503	Cigna Commercial	HCH MSH	Outpatier	UB92RM	274	28.9	Medical/Surgical Supplies and Devices - Prosthetic/Orthotic Devices	Percent of Charges		
193504	Cigna Commercial	HCH MSH	Outpatier	UB92RM	275	28.9	Medical/Surgical Supplies and Devices - Pacemaker	Percent of Charges		
193505	Cigna Commercial	HCH MSH	Outpatier	UB92RM	278	28.9	Medical/Surgical Supplies and Devices - Other Implants	Percent of Charges		
193510	Cigna Commercial	HCH MSH	Outpatier	UB92RM	636	40	Pharmacy-Extension of 025X - Drugs Requiring Detailed Coding	Percent of Charges		
193511	Cigna Commercial	HCH MSH	Outpatier	UB92RM	636	40	Pharmacy-Extension of 025X - Drugs Requiring Detailed Coding	Percent of Charges		
193512	Cigna Commercial	HCH MSH	Outpatier	UB92RM	350	658	CT Scan - General	Per Unit Rate		
193513	Cigna Commercial	HCH MSH	Outpatier	UB92RM	351	658	CT Scan - Head	Per Unit Rate		
193514	Cigna Commercial	HCH MSH	Outpatier	UB92RM	352	658	CT Scan - Body	Per Unit Rate		
193515	Cigna Commercial	HCH MSH	Outpatier	UB92RM	359	658	CT Scan - Other	Per Unit Rate		
193516	Cigna Commercial	HCH MSH	Outpatier	UB92RM	610	1113	Magnetic Resonance Technology (MRT) - General	Per Unit Rate		

Instead of listing all prices in dollars, the data file lists most prices as a percent of gross charges and unclearly lists other prices as a "Per Unit Rate."

This image of a data file that fails to provide complete pricing data is a screenshot of a portion of data file listed on a hospital's website that was downloaded by Families USA staff on March 27, 2023 from this website. The image has been designed to avoid identifying the individual hospital and to enable readability by hiding extraneous data.

The data file lists prices for insurers but not by all plans.

Figure 3: Example of a Hospital Data File That Fails to Provide Complete Pricing Data

MS DRG	MS DRG w Description	Gross Charges - 25th %ile	Gross Charges - Average	Gross Charges - 75th %ile	Medicare Adv - Aetna	Medicare Adv - BCBS	Medicare Adv - Humana	Medicare Adv - United	Medicare Adv - Other	Medicaid Mgd Care	Aetna	BCBS	Cigna	Exchange/ Ambetter
1	1 - HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC	656,098.73	1,107,341.71	1,226,629.67	Average payment of 249,497.97, with a minimum and maximum of 45,333.56 and 349,333.66, respectively	Average payment of 315,066.05, with a minimum and maximum of 273,844.86 and 361,618.21, respectively	Average payment of 338,663.71, with a minimum and maximum of 230,863.83 and 817,971.67, respectively	Average payment of 298,990.30, with a minimum and maximum of 43,943.19 and 414,268.86, respectively	Average payment of 45,791.47, with a minimum and maximum of 45,791.47 and 45,791.47, respectively	Average payment of 355,372.05, with a minimum and maximum of 315,050.97 and 653,545.28, respectively	Average payment of 322,686.11, with a minimum and maximum of 0.00 and 606,555.93, respectively	Average payment of 658,319.74, with a minimum and maximum of 0.00 and 2,639,488.73, respectively	Average payment of 404,108.85, with a minimum and maximum of 87,584.48 and 720,633.21, respectively	Average payment of 262,261.23, with a minimum and maximum of 0.00 and 368,629.17, respectively
2	2 - HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC	424,846.34	532,136.92	605,739.10	Payment data is not available for this DRG for this entity for this payer	Payment data is not available for this DRG for this entity for this payer	Average payment of 225,423.50, with a minimum and maximum of 198,843.15 and 252,003.84, respectively	Average payment of 231,175.79, with a minimum and maximum of 192,632.57 and 249,673.81, respectively	Payment data is not available for this DRG for this entity for this payer	Average payment of 215,714.09, with a minimum and maximum of 190,904.34 and 240,523.84, respectively	Payment data is not available for this DRG for this entity for this payer	Average payment of 358,135.60, with a minimum and maximum of 235,372.56 and 598,539.50, respectively	Average payment of 228,808.33, with a minimum and maximum of 227,548.23 and 230,068.43, respectively	Average payment of 317,398.71, with a minimum and maximum of 317,398.71 and 317,398.71, respectively
3	3 - ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT FACE, MOUTH AND NECK WITH MAJOR O.R. PROCEDURES	498,523.15	1,080,309.91	1,216,820.75	Average payment of 593,297.32, with a minimum and maximum of 134,522.19 and 1,286,128.17, respectively	Average payment of 242,709.67, with a minimum and maximum of 159,972.23 and 371,280.07, respectively	Average payment of 202,199.85, with a minimum and maximum of 0.00 and 645,609.45, respectively	Average payment of 280,547.47, with a minimum and maximum of 160,344.46 and 636,340.51, respectively	Average payment of 151,464.77, with a minimum and maximum of 130,801.28 and 163,913.20, respectively	Average payment of 236,354.00, with a minimum and maximum of 202,568.85 and 728,688.61, respectively	Average payment of 407,537.30, with a minimum and maximum of 95,760.81 and 979,563.90, respectively	Average payment of 668,656.87, with a minimum and maximum of 0.00 and 2,537,080.60, respectively	Average payment of 403,374.25, with a minimum and maximum of 230,820.00 and 549,852.16, respectively	Average payment of 311,499.53, with a minimum and maximum of 311,499.53 and 311,499.53, respectively

The data file lists an average payment range instead of a specific price of a service.

This image of a data file that fails to provide complete pricing data is a screenshot of a portion of data file listed on a hospital's website that was downloaded by Families USA staff on March 27, 2023 from this website. The image has been designed to avoid identifying the individual hospital and to enable readability by hiding extraneous data.

This is particularly important given that hospitals have spent years fighting price transparency regulations, including through judicial action,[39] in an effort to avoid regulatory oversight of their anticompetitive health care prices. Given that research suggests hospitals with the highest prices are more likely to avoid disclosing prices, it is critical for policymakers to increase oversight and compliance of price transparency rules to achieve meaningful transparency in the U.S. health care system.[40]

Under the Hospital Price Transparency rule, CMS has the authority to deploy various enforcement tools to increase hospital compliance, including issuing warning notices, utilizing corrective action plans, and ultimately imposing a maximum civil monetary penalty of $2 million annually.[41] CMS reports that it has issued 500 warning notices, over 230 requests for corrective action plans, and two civil monetary penalties resulting in 300 hospitals becoming compliant with the federal rules.[42] With such low compliance, it is clear that the maximum fine of $2 million remains negligible, particularly given that large hospital systems have billions of dollars in cash and investments.[43]

Moreover, the fact that thousands of U.S. hospitals would rather risk paying a $2 million per year fine than comply with federal regulations to disclose prices serves as evidence that hospitals are both making undue profits by keeping health care prices hidden and that they have a powerful financial interest not to disclose how monopolistic prices have become. With so many hospitals failing to comply with the federal regulation, it is clear that more work is needed both to increase compliance with the existing regulation and to make key improvements to the regulation in order to achieve meaningful price transparency.

The fact that thousands of U.S. hospitals would rather risk paying a $2 million per year fine than comply with federal regulations to disclose prices serves as evidence that hospitals are both making undue profits by keeping health care prices hidden and that they have a powerful financial interest not to disclose how monopolistic prices have become.

Recommendations for the Administration

Achieving full transparency of health care price and quality data is a critical step toward driving value into the U.S. health care system and ensuring our nation's families receive the affordable, high-quality health care and improved health they deserve. To that end, CMS should implement the following recommendations in an effort to improve the Hospital Price Transparency rule and increase compliance:

1

Ensure health care price transparency data is useful for consumers

- ***Establish and require a standardized data format.*** To improve the quality of the required data and to reduce hospitals' ability to game the requirements under the Hospital Price Transparency rule, CMS should establish standards for how data should be displayed. Specifically, CMS should require hospitals to use:
  - Actual prices in dollars and cents and explicitly prohibit hospitals from listing prices as a percentages of Medicare payment rates or gross charges,
  - A standard format for machine-readable files that can be analyzed by both machines and people (for example, CSV files, not PDF or JPEG files),
  - A standard code format to report on services (that is, CPT or HCPCS codes, not facility-specific codes), and
  - A standard format for payer information (that is, how to list the name of an insurance company and plan name) to enable comparison between providers.
- ***Establish transparency on a nationally uniform set of services.*** CMS allows hospitals to determine 230 of the 300 "shoppable" services required under the federal rule. To increase transparency across a more nationally uniform set of services, CMS should require hospitals to disclose prices across a set of high-cost, high volume services provided in hospital inpatient and outpatient settings. A reasonable requirement would be the publication of at least 100 total services initially, to include a broadly representative sample of services (i.e. imaging, evaluation and management, core surgical specialties, radiation oncology etc.) including the 50 highest dollar volume (price x volume) inpatient services and the 50 highest dollar volume (price x volume) outpatient services. The number of services should ultimately align across all federal price transparency rules.
- ***Require quality data to be disclosed with pricing data.*** Disclosing quality data alongside existing pricing data is a critical step in providing meaningful transparency in the quality of care and the prices paid for hospital system, and ultimately the health care

system more broadly. It is critical to establish a standard where publicly disclosed price and quality information are paired together in order to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers.

» ***Require price transparency information to be available in languages other than English.*** Currently, CMS encourages but does not require hospitals to make price transparency information available in languages other than English. CMS should require hospitals to post pricing data that is translated into the languages most commonly used by their patient populations and ensure file formats enable digital translation of posted content.

2

Improve enforcement, oversight and compliance

» ***Issue fines for noncompliance.*** CMS should swiftly issue civil monetary penalties to hospitals that fail to comply with the price transparency rule.

» ***Remove the $2 million cap on the civil monetary penalty.*** The $2 million maximum fine remains too small to incentivize compliance, particularly given that large hospital systems possess billions of dollars in cash and investments. We urge CMS to remove the $2 million maximum fine, and to increase the civil monetary penalty for hospitals with 31 beds or more to $300 per bed per day to create a stronger financial incentive for non-compliant hospitals to comply.

» ***Eliminate the price estimator loophole.*** Some hospitals have argued they are complying with the federal rule by hosting a "price estimator tool" on their website. But these tools often fail to list actual negotiated prices or itemized prices that can be easily downloaded by consumers or third parties. The failure to post actual negotiated rates results in a discrepancy between the hospital estimate and the actual price, causing significant confusion for consumers looking for accurate pricing information. CMS should prohibit price "estimates" and specifically require hospitals to list actual itemized prices, and ensure that prices can be easily downloaded by consumers, researchers, and policymakers.

» ***Require hospital executives to attest to compliance with transparency rules.*** CMS should require hospital executives to attest to the completeness and accuracy of disclosed pricing data in compliance with the Hospital Price Transparency rule. This is a similar approach to the attestation requirement for Medicare cost reports.

» ***Report publicly on enforcement activities.*** To keep the public informed on the status of hospital compliance with the Hospital Price Transparency rule, CMS should provide quarterly updates on the CMS website regarding the number of issued warning letters, corrective action plans and civil monetary penalties by specific hospital names.

Recommendations for Congress

In addition to strengthening and improving price transparency through administrative rulemaking, Congress has an important role to play in further strengthening the hospital price transparency rule.

SPECIFICALLY, CONGRESS SHOULD

1. **Conduct hearings and oversight activity** to highlight low hospital compliance and efforts to undermine the federal rules; and
2. **Codify a strengthened Hospital Price Transparency rule into law** based on the recommendations listed above to drive towards meaningful transparency and to prevent efforts to subvert or rollback these rules.

Conclusion

Unveiling health care prices is a critical tool to empower policymakers, researchers, and purchasers, including consumers, to begin driving down America's extreme health care costs. Although important progress has been made by federal policymakers to implement price transparency regulations, more work is needed to achieve full transparency of health care price and quality data and to align the business interests of the health care sector with the financial security and health of our nation's families. Policymakers should work to strengthen the Hospital Price Transparency rule and leverage it as a key tool to unveil abusive health care prices in an effort to drive toward a health care system that promotes transparency and offers meaningful price and quality information to achieve affordable, high-quality health care and improved health for our nation's families.

Endnotes

[1] Danielle Scheurer, "Lack of Transparency Plagues U.S. Health Care System," *The Hospitalist*, May 1, 2013, https://www.the-hospitalist.org/hospitalist/article/125866/health-policy/lack-transparency-plagues-us-health-care-system; Ann Boynton and James C. Robinson, "Appropriate Use of Reference Pricing Can Increase Value," *Health Affairs Forefront*, July 7, 2015, https://www.healthaffairs.org/do/10.1377/forefront.20150707.049155/full/; Sarah Kliff and Josh Katz, "Hospitals and Insurers Didn't Want You to See These Prices. Here's Why," *The New York Times*, August 22, 2021, https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.

[2] Katherine Keisler-Starkey and Lisa N. Bunch, U.S. Census Bureau Current Population Reports, P60-274, *Health Insurance Coverage in the United States*: 2020 (Washington, DC: U.S. Government Publishing Office, September 2021), https://www.census.gov/library/publications/2021/demo/p60-274.html; Kliff and Katz, "Hospitals and Insurers."

[3] "RAND Health Care Price Transparency," Rand Corporation, n.d., https://www.rand.org/health-care/projects/price-transparency.html.

[4] Noam N. Levey, "100 Million People in America Are Saddled with Health Care Debt," Kaiser Health News, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/; Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Mark Smith et al., eds. (Washington, DC: National Academies Press, 2013), https://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning; Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs* 38, no. 1 (January 2019): 87–95, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

[5] Anderson, Hussey, and Petrosyan, "It's Still the Prices."; Matthew McGough et al., "How Does Health Spending in the U.S. Compare to Other Countries?" Peterson-KFF Health System Tracker, February 9, 2023, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/.

[6] Anderson, Hussey, and Petrosyan, "It's Still the Prices"; Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States* (Washington, DC: Urban Institute, January 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_3.pdf.

[7] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA* 322, no. 15 (2019): 1501–1509, https://jamanetwork.com/journals/jama/article-abstract/2752664.

[8] Levey, "100 Million People"; Institute of Medicine, Best Care at Lower Cost; Angela M. Antonelli, "The Aging of America: A Changing Picture of Work and Retirement," Georgetown University Center for Retirement Initiatives, Blog, March 2018, https://cri.georgetown.edu/the-aging-of-america-a-changing-picture-of-work-and-retirement/; Daniel R. Arnold and Christopher M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages* (Santa Monica, CA: Rand Corporation, July 2020), https://www.rand.org/pubs/working_papers/WRA621-2.html.

[9] *The Fourth Semi-Annual Hospital Price Transparency Compliance Report*, PatientsRightsAdvocate.org, February 2023, https://www.patientrightsadvocate.org/february-semi-annual-compliance-report-2023; Justin Lo et al., "Ongoing Challenges with Hospital Price Transparency," Peterson-KFF Health System Tracker, February 10, 2023, https://www.healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/.

[10] Anderson, Hussey, and Petrosyan, "It's Still the Prices."

[11] Berenson et al., *Market Consolidation and High Prices*.

[12] Sabah Bhatnagar, "Medicare Rates as a Benchmark: Too Much, Too Little or Just Right?" Altarum Healthcare Value Hub, February 2020, https://www.healthcarevaluehub.org/application/files/3615/8334/0179/RB_40_-_Medicare_Rates_as_a_Benchmark.pdf.

[13] Christopher M. Whaley et al., *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative* (Santa Monica, CA: Rand Corporation, 2022), https://www.rand.org/pubs/research_reports/RRA1144-1.html.

[14] Whaley et al., *Prices Paid*.

[15] Whaley et al., *Prices Paid*.

[16] Alison Kodjak, "That Surgery Might Cost You a Lot Less in Another Town," *All Things Considered*, National Public Radio, April 27, 2016, https://www.npr.org/sections/health-shots/2016/04/27/475880565/that-surgery-might-cost-you-a-lot-less-in-another-town.

[17] Kodjak, "That Surgery."

[18] Kliff and Katz, "Hospitals and Insurers."

[19] Jaime S. King, "Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers," testimony before the U.S. House Committee on Energy and Commerce and Subcommittee on Oversight and Investigations, July 17, 2018, https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-King-OI-Hrg-on-Examining-State-Efforts-to-Improve-Transparency-of-Health-Care-Cost-2018-07-17.pdf.

[20] David I. Auerbach and Arthur L. Kellerman, "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family," *Health Affairs* 30, no. 9 (September 2011): 1630–1636; Arnold and Whaley, Who Pays for Health Care Costs?

[21] Berenson et al., *Market Consolidation and High Prices*; King, "Examining State Efforts."

[22] Martin Gaynor, *What to Do About Health-Care Markets? Policies to Make Health-Care Markets Work* (Washington, DC: The Hamilton Project, March 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf); Berenson et al., *Market Consolidation and High Prices*.

[23] Sophia Tripoli, Frederick Isasi, and Eliot Fishman, *Bleeding Americans Dry: The Role of Big Hospital Corporations in Driving Our Nation's Health Care Affordability and Quality Crisis* (Washington, DC: Families USA, September 2022), https://familiesusa.org/wp-content/uploads/2022/09/People-First-Care_Role-of-Hospitals.pdf.

[24] Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes" The Commonwealth Fund, January 31, 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

[25] Gunja, Gumas, and Williams, "U.S. Health Care."

[26] King, "Examining State Efforts."

[27] Berenson et al., *Market Consolidation and High Prices*; King, "Examining State Efforts."

[28] John Della Volpe, "Executive Summary of National Healthcare Survey," SocialSphere, February 24, 2022, https://www.patientrightsadvocate.org/feb2022surveyresults.

[29] 84 Fed. Reg. 65,524 (November 19, 2019) (codified at 45 C.F.R. §§ 180.10-.110).

[30] 84 Fed. Reg. 65,524 (November 19, 2019) (codified at 45 C.F.R. §§ 180.10-.110).

[31] 85 Fed. Reg. 72,158 (Nov. 12, 2020) (codified at 26 C.F.R. §§ 54.9815-2715A1 to -2715A3, 29 C.F.R. §§ 2590.715-2715A1 to -2715A3, 45 C.F.R. §§ 147.210-.212)

[32] PatientRightsAdvocate.org, *Price Transparency Report*; Emefah C. Loccoh et al., "Hospital Adherence to the Federal Price Transparency Mandate: Results from a Nationally Representative Sample," Journal of General Internal Medicine (January 2023), https://link.springer.com/article/10.1007/s11606-023-08039-0; Morgan Henderson and Morgane Mouslim, "Assessing Compliance with Hospital Price Transparency over Time," *Journal of General Internal Medicine*

(January 2023), https://link.springer.com/article/10.1007/s11606-022-08020-3.

[33] Turquoise Health, Price Transparency Impact Report: Q3 2022, https://assets.turquoise.health/impact_reports/TQ_Price-Transparency-Impact-Report_2022_Q3.pdf; Meena Seshamani and Douglas Jacobs, "Hospital Price Transparency: Progress and Commitment to Achieve Its Potential," *Health Affairs Forefront*, February 14, 2023, https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential.

[34] PatientRightsAdvocate.org, *Price Transparency Report*; Justin Lo et al., "Ongoing Challenges."

[35] PatientRightsAdvocate.org, *Price Transparency Report*.

[36] 45 C.F.R. Part 180.50(b) – Requirements for making public hospital standard charges for all items and services, Required data elements; U.S. Centers for Medicare and Medicaid Services (CMS), "Hospital Price Transparency Frequently Asked Questions," CMS.gov, last modified November 29, 2022, https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.

[37] PatientRightsAdvocate.org, *Price Transparency Report*.

[38] 45 C.F.R. Part 180.50(b) – Requirements for making public hospital standard charges for all items and services, Required data elements. CMS, "Hospital Price Transparency Frequently Asked Questions."

[39] Morgan Haefner, "Hospitals Lose Appeal in Price Transparency Case," *Becker's Hospital Review*, December 29, 2020, https://www.beckershospitalreview.com/legal-regulatory-issues/hospitals-lose-appeal-in-price-transparency-case.html.

[40] John (Xuefeng) Jiang, Martin A. Makary, and Ge Bai, "Comparison of US Hospital Cash Prices and Commercial Negotiated Prices for 70 Services," *JAMA Network Open* 4, no. 12 (2021): e2140526, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787285?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=122121.

[41] 45 C.F.R. Part 180, Subpart C - Monitoring and Penalties for Noncompliance.

[42] Seshamani and Jacobs, "Hospital Price Transparency: Progress and Commitment to Achieve Its Potential;" U.S. Centers for Medicare & Medicaid Services (CMS), "Enforcement Actions," CMS.gov, last modified June 8, 2022, https://www.cms.gov/hospital-price-transparency/enforcement-actions.

[43] Nancy Kane et al., "Why Policymakers Should Use Audited Financial Statements to Assess Health Systems' Financial Health," *Journal of Health Care Finance* 48, no. 1 (Summer 2021) https://www.healthfinancejournal.com/index.php/johcf/article/view/265.

This publication was written by:
Sophia Tripoli, Director, Center for Affordable Whole-Person Care
Adam Axler, Senior Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):
Sara Brandenburg, Communications Coordinator
Justin Charles, Digital Media Associate
Nichole Edralin, Associate Director, Design and Publications
Jude McCartin, Chief of Staff
Aaron Plotke, Senior Policy Analyst, Families USA

1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org facebook / FamiliesUSA twitter / @FamiliesUSA

VAL2023-19