JOURNAL OF HEALTH CARE FINANCE

Winter 2023

KNOW BEFORE YOU GO: CMS SHOULD USE HOSPITAL PRICE TRANSPARENCY RULE ENFORCEMENT TO ENCOURAGE CONSUMER-DRIVEN HEALTH CARE FOR COST CONTAINMENT

By Rich LeBoutillier

"Nobody's safe. Health insurance? That didn't protect 1 million Americans who were financially ruined by illness or medical bills last year." ~ Elizabeth Warren (Feb. 2005)

INTRODUCTION

The United States (U.S.) has the distinction of being the only developed nation where an accident or injury can easily end in financial jeopardy or ultimately end in bankruptcy.[1] Americans describe the U.S. healthcare system as both expensive and broken,[2] with many healthcare economists believing meaningful cost containment will not occur unless healthcare prices become transparent to consumers.[3] Healthcare prices are transparent when consumers receive cost-of-care information prior to getting services. [4] Price transparency empowers consumers to access the information they need to make informed healthcare choices for non-emergency care.[5] In 2019, the Centers for Medicare and Medicaid Services (CMS) published the first hospital price transparency rule listing hospital requirements, [6] which was followed in 2021 by the second hospital price transparency rule with regulations promulgated to clarify requirements and change penalties.[7] Before the federal price transparency rules, most consumers across the U.S. did not have the means to determine the cost of care or their expected out-of-pocket amounts for shoppable services.[8] A consumer's out-of-pocket amount is what the consumer is expected to pay for their care, and a service that can be scheduled in advance is considered a shoppable service.[9]

The price transparency rules should be enforced, and the rules' requirements expanded to control rising U.S. national health expenditures so that consumers are empowered to shop for high-quality low-cost care because consumer out-of-pocket amounts are forcing individuals to amass medical debt and delay care. Part I of this paper will discuss U.S. healthcare spending, covering the cost of care and medical debt consequences. Part II will explain the federal price transparency regulatory framework together with hospital compliance and CMS enforcement activity. Part III will examine hospital price transparency policy strengths and weaknesses. Lastly, Part IV of this paper will suggest the next steps toward U.S. healthcare cost containment.

---

[1] Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 Wash. U. L. Rev. 127, 130 (2017).
[2] West Health & Gallup, *West Health - Gallup 2021 Healthcare In American Report* (2022), at 2.
[3] Robert Wood Johnson Found., *How Price Transparency Can Control the Cost of Health Care*, Health Pol'y in Brief (Mar. 1, 2016), at 3.
[4] U.S. Gov't Accountability Off., GAO-11-791, Health Care Price Transparency: Meaningful Price Information Is Difficult For Consumers to Obtain Prior to Receiving Care (Sep., 2011), at 2.
[5] Anna F. Borromeo, *A Key to Clarity: How Clearinghouses May Improve Health Care Price Transparency*, 31 Health Matrix 409, 413 (2021).
[6] *Id.*, at 422.
[7] Price Transparency of Hospital Standard Charges, 86 Fed. Reg., 63458, 63941-63942 (Nov. 16, 2021) (to be codified at 45 C.F.R. pt. 180).
[8] George A. Nation, III, *The Valuation of Medical Expense Damages in Tort: Debunking the Myth That Chargemaster-Based "Billed Charges" Are Relevant to Determining the Reasonable Value of Medical Care*, 95 Tul. L. Rev. 937, 945 (April, 2021).
[9] Anna F. Borromeo, *supra* note 5, at 414.

PART I – U.S. HEALTHCARE SPENDING

The U.S. population spends far too much on their healthcare.[10] In fact, in 2020, U.S. healthcare spending totaled $4.1 trillion, of which hospital spending was $1.3 trillion.[11] With healthcare spending now in the trillions of dollars, Americans reported being concerned about paying healthcare bills in 2021, and most Americans expect healthcare costs to rise further in 2022.[12] National health expenditures (NHE) measure the annual amount spent on healthcare in the U.S.[13] Absent effective cost containment, the rise in NHE will endanger individuals' financial stability.[14] For instance, large healthcare expenses may lead to excessive medical debt which, in turn, may lead to individuals sacrificing medical care and forgoing daily necessities.[15] Medical balance billing, the amount a patient or guarantor is billed based on the difference between the healthcare provider's service charge and the insurance carrier's allowed amount for the service, had a significant impact on our nation's health. [16] Due to the cost of care, almost one-third of individuals missed or postponed medical care in the three months prior to taking a 2021 West Health-Gallup survey. [17]

Cost of Care

Case Example

A Colorado case illustrates the worry over exorbitant hospital balance billing and out-of-pocket liability in the absence of price transparency. In 2014, the defendant, French, underwent elective spinal surgery at St. Anthony North Campus ("St. Anthony") in Westminster, Colorado, which is a non-profit organization and part of Centura Health Corp. and Catholic Health Initiatives Colorado.[18] French's spinal surgery cost estimate was $57,601.77 with $1,336.90 due from her after the health insurance payment.[19] French received her healthcare coverage through an employer-self-funded plan.[20] Because her employer's self-funded plan did not have a contract with St. Anthony, French's spinal surgery was considered out-of-network.[21] Prior to surgery, French signed the hospital services agreement (HSA) with St. Anthony and acknowledged responsibility

---

[10] Carl E. Schneider & Mark A. Haw, *The Patient Life: Can Consumers Direct Health Care?*, 35 Am. J.L. and Med. 7, 8 (2009).
[11] Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2020 Highlights* (last modified Dec. 15, 2021), at 1.
[12] West Health & Gallup, *supra* note 2, at 2.
[13] Ctrs. for Medicare & Medicaid Servs., National Health Expenditure Data (last modified Dec. 15, 2021), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical
[14] Susan Adler Channick, *Under the Knife: Health Law, Health Care Reform, and Beyond: Health Care Cost Containment: No Longer an Option But a Mandate*, 13 Nev. L.J. 792, 796 (Spring, 2013).
[15] Adam Crowther, *Out of Control: Patients Are Unwittingly Subjected to Enormous, Unfair, Out-of-Network 'Balance Bills'*, Public Citizen (Apr. 16, 2014), at 4.
[16] Ctrs. for Medicare & Medicaid Servs., Glossary, https://www.healthcare.gov/glossary/balance-billing/
[17] West Health & Gallup, *supra* note 2, at 3.
[18] *Centura Health Corp. v. French*, 490 P.3d 780, 782 (Colo. App. 2020).
[19] *Id.*
[20] *Id.*
[21] *Id.*

for payment of "all charges of the hospital" not paid by her health insurance.[22] The HSA was a patient-hospital contract that assigned financial liability for out-of-network amounts based on St. Anthony's rates.[23] The bill for French's spinal surgery after complications was $303,709.48 of which her health insurance paid $73,597.35 and French paid $1,000.00 making her responsible for $229,112.13.[24] Having already paid $1,000.00, French did not expect a hospital bill, instead, she believed her health insurance would pay.[25] French's $229,112.13 hospital bill was compiled using St. Anthony's hospital rates for each item and service she received.[26] When St. Anthony's collection efforts failed, St. Anthony filed a breach of contract suit against French.[27]

In 2018, the Colorado district trial court found the HSA term "all charges of the hospital" referred to the "reasonable value of the goods and services provided." [28] The trial court jury decided French breached the HSA contract, but French was only liable for $766.74 because the jury also found St. Anthony's hospital rates unreasonable,[29] concluding the meaning of "all charges" was the "reasonable value of the goods and services."[30] The plaintiff, Centura Health Corp., appealed claiming the district court erroneously found that the HSA was "ambiguous," and the district court should not have allowed the jury to determine "the parties' contractual intent." [31] The appeal court ruled in favor of Centura Health Corp. finding the HSA was unambiguous and enforceable because the HSA was supported by St. Anthony's hospital rates.[32] The appeal court reasoned hospitals cannot predict the precise amount a patient will owe.[33] The appeal court found French liable for the $229,112.13 hospital bill holding the HSA requirement to pay "all charges of the hospital" unambiguous because the charges, or prices, were the hospital rates.[34]

On March 8, 2022, the Colorado Supreme Court agreed to hear the case.[35] The Colorado Supreme Court justices appeared skeptical of St. Anthony's charging practices.[36] The Supreme Court of Colorado examined whether St. Anthony's prices were included in the HSA between French and the hospital and whether the HSA term "price" was ambiguous making the HSA unenforceable.[37] The Supreme Court of Colorado ruled in favor of French and reversed the appellate court's

---

[22] *Id.*
[23] Centura Health, *CHADM-001 Hospital Services Agreement* (reviewed Jul., 2017), https://www.centura.org/sites/default/files/inline-files/SAH-Outpatient-Therapy-Patient-Form-Jan-2018.pdf
[24] *Centura Health Corp. v. French*, 490 P.3d 780, 782 (Colo. App. 2020).
[25] *Id.*, at 783.
[26] *Id.*, at 782.
[27] *Id.*
[28] *Centura Health Corp. v. French*, 2018 Colo. Dist. LEXIS 49, 1 (2018).
[29] *Id.*
[30] *Centura Health Corp. v. French*, 490 P.3d 780, 782-783 (Colo. App. 2020).
[31] *Id.*, at 781.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] Marissa Plescia, *5 Medical Bills Making News*, Becker's Revenue Cycle Mgmt. Rep. (Mar. 9, 2022), https://www.beckershospitalreview.com/finance/5-medical-bills-making-news.html?origin=RCME&utm_source=RCME&utm_medium=email&utm_content=newsletter&oly_enc_id=0662I8011134B3U
[36] Michael Karlik, *Justices Critical of Hospital Charging Surgery Patient $229,000 in Medical Bill*, Colorado Politics (Mar. 8, 2022), https://www.coloradopolitics.com/courts/justices-critical-of-hospital-charging-surgery-patient-229-000-in-medical-bill/article_ac22b808-9f1a-11ec-a69c-4fbc01205a72.html
[37] *French v. Centura Health Corp. & Catholic Health Initiatives Corp.*, 509 P.3d 443, 3 (Colo. 2022).

decision, affirming the jury finding that French did not have specific knowledge of St. Anthony's prices and that the prices were not referenced in the HSA.[38] In its analysis, the Supreme Court of Colorado noted that when contracts lack a defined price, a court may determine the reasonable value of the service.[39] No evidence was presented showing French was aware of St. Anthony's prices and that St. Anthony's list of prices was referenced in the HSA between French and St. Anthony. [40] Furthermore, no evidence was presented showing that French agreed to St. Anthony's prices.[41] Because St. Anthony's prices were not transparent to French, the court held the jury was appropriately tasked with setting a reasonable amount for the healthcare services received by French at St. Anthony's.[42] French's medical billing story proves the need for policymakers to prioritize price transparency and balance billing measures protecting individuals from exorbitant unexpected medical costs. [43]

Paying for Care

Obtaining meaningful price and quality information is challenging for consumers.[44] Consumers care about their out-of-pocket amount,[45] yet consumers may be confused when shopping for healthcare services because prices are not easily understood, and accurate out-of-pocket estimates are difficult to obtain.[46]

For insured consumers like French, out-of-pocket amounts depend upon their health insurance plan in-network and out-of-network benefit coverage together with any cost-sharing through the deductible, co-insurance, and copayment amounts.[47] Claims submitted to third-party payers are usually paid at an allowed amount based on rates negotiated by the third-party payer and the provider, with patient out-of-pocket liability determined by the difference between the allowed amount and payer reimbursement plus any cost-sharing amounts.[48] Because out-of-network charges are usually more than in-network charges due to a lack of negotiated rates, consumers are financially responsible for a larger share of the cost of care after receiving services from an out-of-network hospital.[49] Unfortunately, consumers usually discover their out-of-pocket responsibility upon receiving the hospital's bill or their insurance carrier's explanation of benefits – well after services were furnished, as did French. [50]

For uninsured consumers, their out-of-pocket amount may be the hospital's full standard charge amount, or chargemaster rate, for each item and service, less any hospital-offered discounts,

---

[38] *Id.*, at, 3-4.
[39] *Id.*, at 15.
[40] *Id.*, at 19.
[41] *Id.*
[42] *Id.*, at 25.
[43] Ge Bai & Gerald F. Anderson, *US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues*, Health Aff. (Sep., 2016), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0093
[44] Erin C. Fuse Brown, *supra* note 1, at 157.
[45] Am. Hosp. Ass'n, *Administration Finalizes Rule Requiring the Disclosure of Hospital and Health Plan Negotiated Rates*, Regulatory Advisory, 7 (Dec. 4, 2019), at 6.
[46] Erin C. Fuse Brown, *supra* note 1, at 156.
[47] U.S. Gov't Accountability Off., *supra* note 4, at 8.
[48] Leslie Ludtke & Tyler Brannen, *Healthcare Pricing Revealed*, 48 N.H.B.J. 16, 17 (Spring, 2007).
[49] Erin C. Fuse Brown, *supra* note 1, at 138.
[50] U.S. Gov't Accountability Off., *supra* note 4, at 2.

because the uninsured do not receive the benefit of insurance carrier negotiated rates.[51] The chargemaster is a comprehensive list of the hospital's items and services having an established charge.[52] Uninsured consumers should be given the opportunity to shop for lower-cost care through price transparency to avoid price discrimination.[53] Price discrimination occurs when uninsured consumers pay more for their care than what private insurance or Medicare would pay for the same hospital care.[54] The uninsured are particularly vulnerable to high hospital rates and price variation since many hospitals' standard charges are more than what a hospital receives from private insurance or Medicare.[55] Rep. Greenwood (R-Pa.) made it clear that the uninsured are vulnerable to price discrimination when he testified before the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee in 2004 stating that uninsured consumers who can least afford care receive the highest hospitals bills because they are billed standard charges.[56]

High Deductible Health Plans

Deductibles are a major factor contributing to the rise in consumer healthcare costs.[57] The consumer's share of healthcare costs has expanded through increasing deductible amounts and has caused a financial burden on consumers.[58] For those workers eligible for employer-sponsored coverage, a larger number are enrolled in high deductible health plans (HDHPs) than previously.[59] As evidence, the Centers for Disease Control and Prevention (CDC) determined in 2017 that 43% of non-elderly adults had an HDHP, up 14.8% from 2007.[60] Today, 20% of employer-sponsored plans have a $3,000 individual and $5,000 family deductible,[61] and 99% of consumers who obtained coverage through the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010) exchange has an HDHP.[62] HDHPs impact consumer behaviors by deterring treatment[63] and influencing which provider they choose.[64] Furthermore, HDHPs may lead to increased medical debt, with individuals enrolled in an HDHP reporting more difficulty paying medical expenses than non-HDHP enrollees.[65] Cost-shifting through HDHPs disproportionally harms lower-wage consumers who are typically unable to afford their healthcare

[51] U.S. Gov't Accountability Off., *supra* note 4, at 1 and 8.
[52] 45 C.F.R. § 180.20.
[53] Kate Stockwell Farrell et al., *Does Price Transparency Legislation Allow the Uninsured To Shop for Care?* 25 J. Gen. Intern Med. 110, 110 (Feb., 2010).
[54] *Id.*, at 113.
[55] *Id.*, at 110.
[56] Subject: A review of Hospital Billing and Collection Practices Hearing Before the Oversight and Investigations Subcomm. of the House Energy and Com. Comm., 108th Cong. (Jun. 24, 2004).
[57] InstaMed, *Trends in Healthcare Payments: 12th Annual Report* (2021), at 11.
[58] *Id.*
[59] Isaac D. Buck, *When Hospitals Sue Patients*, 73 Hastings, L.J. 191, 204 (Feb., 2022).
[60] *Id.*
[61] *Id.*
[62] Erin C. Fuse Brown, *supra* note 1, at132.
[63] Isaac D. Buck, *supra* note 59, at 204-205.
[64] Ha Tu & Rebecca Gourevitch, *Moving Markets: Lessons from the New Hampshire Price Transparency Experiment*, California HealthCare Found. & Robert Wood Johnson Found. (Apr. 2014), at 5.
[65] Isaac D. Buck, *supra* note 59, at 205.

and become saddled with medical debt.[66] Consequently, CMS acknowledged that HDHP enrollees want more price information to make informed care decisions to avoid medical debt. [67]

Medical Debt Harm

Consumers feel financial stress when they receive medical bills and when they are unable to obtain needed care because of their inability to pay.[68] Unfortunately, health insurance coverage does not protect consumers from financial risk as employer-sponsored plan coverage is eroding and consumer cost-sharing is rising.[69] Making the situation worse, more low-wage workers are now ineligible for employer-sponsored coverage than in the past[70] and the lack of employer-sponsored coverage disproportionately affects racial minorities, making these individuals particularly vulnerable to medical debt.[71] In fact, Black consumers hold 27% of medical debt and are 17% more likely to finance medical debt than other racial groups.[72] As of October 2021, 11% of Americans borrowed to pay medical expenses,[73] with consumers increasingly turning to credit cards as their preferred method of financing medical debt which can subject them to high-interest rates, further plunging these consumers into even more debt.[74] Consumer financial stress is compounded when a hospital refers unpaid medical bills to a debt collector or initiates litigation as experienced by French, and the consumer's credit score is negatively affected which may lead to housing insecurities or other worries about basic needs. [75]

Medical debt is a real concern for older Americans since the Medicare Fee-for-Service (FFS) program does not have an out-of-pocket spending cap.[76] Furthermore, the Medicare FFS program does not cover many services used by older adults, such as long-term care, vision, dental, and hearing.[77] For many older Americans on fixed incomes, out-of-pocket spending is related to overall healthcare affordability with older adults often postponing or avoiding care due to cost.[78]

Because avoiding or postponing essential care is associated with poor health outcomes and higher long-term costs, high out-of-pocket spending has public health policy implications.[79] Ultimately, hospitals damage public health when the cost of care leads to medical debt and care avoidance which adversely affects a patient's social determinants of health through housing loss, change in

---

[66] Erin C. Fuse Brown, *supra* note 1, at 132.
[67] Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524, 65525-65526 (Nov. 27, 2019) (to be codified at 45 C.F.R. pt. 180).
[68] Erin C. Fuse Brown, *supra* note 1, at 130.
[69] *Id.*, at 131.
[70] Isaac D. Buck, *supra* note 59, at 204.
[71] Jennifer A. Brobst, *Open and Unashamed in an Era of Consumer Protection: Unconscionable Hospital Billing Practices and the Chargemaster Racket*, 51 U. Mem. L. Rev. 861, 868 (Summer, 2021).
[72] InstaMed, *supra* note 57, at 12.
[73] West Health & Gallup, *supra* note 2, at 8.
[74] Isaac D. Buck, *supra* note 59, at 212.
[75] Erin C. Fuse Brown, *supra* note 1, at 130.
[76] Gretchen Jacobson et al., *When Costs Are a Barrier to Getting Health Care: Reports from Older Adults in the United States and Other High-Income Countries*, Commonwealth Fund (Oct. 1, 2021), https://www.commonwealthfund.org/publications/surveys/2021/oct/when-costs-are-barrier-getting-health-care-older-adults-survey
[77] *Id.*
[78] *Id.*
[79] *Id.*

personal relationships, or even bankruptcy.[80] The medical debt impact on public health policy manifests as decreased utilization, potential decreased access to care, negative health outcomes, and increased poverty.[81] Price transparency is one piece of a comprehensive strategy to protect consumers against medical debt and adverse public health outcomes by helping consumers understand their hospital bills and shop for services to avoid high-cost care.[82]

PART II – FEDERAL FRAMEWORK

Evolution of Price Transparency

Federal hospital price transparency efforts formally began in 2010 when the ACA created a public charge to control healthcare costs.[83] The ACA requires U.S. hospitals to annually provide a list of standard charges to the public, along with charges by diagnosis-related group (DRG) following Secretary of Health and Human Services (HHS) guidelines.[84] In 2017, President Trump issued Executive Order 13813, stating his administration's commitment to providing Americans with healthcare price data so that consumers could make informed healthcare decisions that included cost information.[85] The Trump Administration claimed that advanced knowledge of hospital prices would insulate consumers from unexpected and excessive bills.[86] When President Trump issued his Executive Order, experts believed shoppable service price transparency would lead consumers to choose lower-cost alternatives resulting in increased market competition and lower prices.[87] In response to Executive Order 13813, CMS issued Price Transparency Requirements for Hospitals to Make Standard Charges Public (the "CY 2020 Rule") which added Title 45 C.F.R. Part 180 to codify hospital price transparency regulations.[88] To assist hospitals with CY 2020 Rule implementation, CMS published Frequently Asked Questions (FAQs) guidance which clarified requirements.[89] Initially, the healthcare industry was against price transparency and the American Hospital Association (AHA) unsuccessfully sued HHS in the District of D.C. Court.[90] The AHA appealed the District of D.C. Court's decision in favor of HHS to the D.C. Circuit Court, arguing that the CY 2020 Rule violated the Administrative Procedure Act, 5 U.S.C.S. § 551, and the First Amendment.[91] In December 2020, the D.C. Circuit Court held that the AHA failed to meet its burden and affirmed the District of D.C. Court's ruling granting summary judgment to the Secretary of HHS.[92] In July 2021, President Biden issued Executive Order 14036 calling on HHS to enforce federal price transparency rules.[93] Under Executive Order 14036, President Biden gave

[80] Isaac D. Buck, *supra* note 59, at 194.
[81] *Id.*, at 217.
[82] Erin C. Fuse Brown, *supra* note 1, at 161.
[83] *AHA v. Azar*, 468 F. Supp. 3d 372, 374-375 (D.D.C. 2020).
[84] 42 U.S.C.S. § 300gg-18(e).
[85] Exec. Order No. 13813, 82 Fed. Reg. 48385, 48385 (Oct. 17, 2017).
[86] Rich Spiker, *Piercing the Healthcare Veil: An Argument for Healthcare Pricing Transparency*, 7 Emory Corp Governance & Accountability Rev 1, 7 (2020).
[87] *Id.*, at 63.
[88] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65524-65525.
[89] *Id.*
[90] Isaac D. Buck, *supra* note 59, at 197.
[91] *AHA v. Azar*, 983 F.3d 528, 2 (D.C. Cir. 2020).
[92] *Id.*, at 32-33.
[93] Exec. Order No. 14036, 86 Fed. Reg. 36987, 36988 (Jul. 14, 2021).

executive support to hospital price transparency efforts stating that Americans' healthcare prices are higher than other countries and that Americans pay far too much for their healthcare.[94]

CY 2020 Rule

Requirements

The CY 2020 Rule implemented the ACA's intent to make each hospital's list of standard charges available to consumers[95] by mandating that hospital charge information be publicly available to consumers through the internet in an electronic format.[96] Federally owned hospitals, including Department of Defense and Department of Veterans Affairs facilities, along with Indian Health Program hospitals, are deemed by CMS to be in compliance with the CY 2020 Rule.[97] From a hospital's website, digitally represented data must be contained in a file format that can be downloaded, or imported, into a computer system for further analysis, hereafter referred to as machine-readable.[98] The CY 2020 Rule provides machine-readable electronic format specifications listing required data elements and descriptions for a hospital's publicly available list of standard charges.[99] For every hospital license, each location with a unique set of standard charges must make publicly available the list of standard charges applicable to that location.[100] The hospital's list of standard charges includes the applicable inpatient and outpatient gross charge, payer-specific negotiated charge with the payer clearly identified, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and discounted cash price.[101] The list of standard charges must include the corresponding Current Procedural Terminology (CPT®) code, Healthcare Common Procedure Coding System (HCPCS) code, DRG, National Drug Code (NDC), or other identifiers for each applicable item or service.[102] A hospital is required to prominently display the location, or link, to the list of standard charges on its website.[103] Consumers must have barrier-free access to a hospital's list of standard charges meaning access is free, does not require a username and password, and does not require a consumer to enter personal information [104] Consumers must be able to locate a hospital's list of standard charges using an automated internet search.[105] A hospital must annually update, or revise, its list of standard charges and identify the date the list was last updated.[106] Separately, a hospital is required to make publicly available their standard charges for a least 300 shoppable services to include as many of the 70 CMS-specified shoppable services as the hospital provides. [107] A hospital must describe each shoppable service in consumer-friendly plain language.[108] Similar to a hospital's list of standard

[94] *Id.*, at 36987, 36988-36997.
[95] 45 C.F.R. § 180.10.
[96] 45 C.F.R. § 180.30(e).
[97] 45 C.F.R. § 180.30(b).
[98] 45 C.F.R. § 180.20.
[99] 45 C.F.R. § 180.50(a)(1).
[100] 45 C.F.R. § 180.50(a)(2).
[101] 45 C.F.R. § 180.50(b)(2).
[102] 45 C.F.R. § 180.50(b)(7).
[103] 45 C.F.R. § 180.50(d)(2).
[104] 45 C.F.R. § 180.50(d)(3).
[105] 45 C.F.R. § 180.50(d)(3)(iv).
[106] 45 C.F.R. § 180.50(e).
[107] 45 C.F.R. § 180.60(a)(1).
[108] 45 C.F.R. § 180.60(b)(1).

charges, shoppable services must be available barrier-free.[109] CMS estimated $11,898.60 as the per hospital CY 2020 Rule requirements implementation cost and CMS estimated $3,610.88 as the per hospital annual requirements maintenance cost. [110]

Enforcement Provisions and Penalties

Under the CY 2020 Rule, CMS will use consumer complaints together with hospital website audits to assess compliance.[111] CMS enforcement actions include (1) issuing a written warning notice describing the violation(s); (2) requesting a corrective action plan (CAP) for any material violation; and (3) imposing a civil monetary penalty (CMP) for failure to submit a CAP that complies with CMS guidelines.[112] CMS may consider failure to make publicly available a list of standard charges and failure to provide a list of standard charges in a machine-readable format as material violations.[113] CMS may impose a $300 per day maximum CMP for violations occurring during calendar year 2021,[114] but a hospital has the right to appeal a CMP through an Administrative Law Judge hearing.[115]

CY 2022 Rule

Requirements

Following the release of the CY 2020 Rule, CMS determined that merely posting hospital standard charges was insufficient to meet the federal government's price transparency goal for consumers.[116] CMS realized that hospitals needed encouragement to reduce barriers and comply with federal price transparency requirements.[117] On November 16, 2021, CMS issued Price Transparency of Hospital Standard Charges (the "CY 2022 Rule") which amended existing price transparency requirements at 45 C.F.R. Part 180 to eliminate remaining hospital price transparency barriers.[118] With the CY 2022 Rule, CMS increased CMPs for non-compliance, deemed state forensic hospitals compliant with 45 C.F.R. Part 180, mandated machine-readable file accessibility, and clarified price estimator tool expectations.[119] The CY 2022 Rule specifies that hospital standard charges must be publicly available without barriers that limit access and requires automated search and direct download capabilities for consumer accessibility.[120] CMS included standard charge accessibility requirements as part of the final rule because the agency found some hospitals did not have downloadable files, required consumers to agree to user terms and conditions, or employed other barriers like registration or passwords.[121] Additionally, the revised requirements specify that hospitals must visually identify the link to the machine-readable file on the hospital's website, so

[109] 45 C.F.R. § 180.60(d)(3).
[110] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 64, at 65525.
[111] 45 C.F.R. § 180.70(a)(2).
[112] 45 C.F.R. § 180.70(b).
[113] 45 C.F.R. § 180.80(a).
[114] 45 C.F.R. § 180.90(c)(2)(i).
[115] 45 C.F.R. § 180.100(a).
[116] Price Transparency of Hospital Standard Charges, *supra* note 7, at 63942.
[117] *Id.*
[118] *Id.*
[119] *Id.*
[120] *Id.*, at 63954.
[121] *Id.*

the link is clear to consumers.[122] The CY 2022 Rule allows hospitals to satisfy the requirement for displaying shoppable services, 45 C.F.R. § 180.60(a)(2)(ii), with a price estimator tool that gives consumers an out-of-pocket estimate amount for any given shoppable service.[123] The price estimator tool must be individualized to each consumer using the consumer's insurance benefits information, if any, along with the hospital's standard charge information to provide a real-time out-of-pocket estimate.[124] The CY 2022 Rule specifies that hospitals are not required to offer a price estimator tool; however, hospitals using a price estimator tool to satisfy the requirement for displaying shoppable services must have a tool that gives consumers an individualized estimate that considers the consumer's specific circumstances and must reflect the out-of-pocket amount expected by the hospital for the shoppable service.[125]

Revised Penalties

CMS noted a high number of non-compliant hospitals during its initial sampling and monitoring[126] and responded by implementing a tiered CMP approach with higher dollar penalties based on hospital bed count.[127] CMS cited four reasons for its decision to implement a tiered CMP approach. First, a tiered approach allows CMS to penalize a non-compliant hospital based on the hospital's bed count.[128] Second, this approach prevents a small hospital with limited financial resources from being penalized the same as a large hospital with more resources.[129] Third, CMS believes the hospital's bed count can be used as an approximation of the number of beneficiaries impacted.[130] Fourth, the Medicare Cost Report can serve as a reliable data source for hospital bed count.[131] The CY 2022 Rule's tiered CMP approach revises 45 C.F.R. § 180.90(c)(2).[132] CMS set the effective date for the tiered CMP approach as January 1, 2022,[133] and CMS will annually adjust the CMP using the Office of Management and Budget (OMB) multiplier for adjusting CMP amounts.[134]

For non-compliant hospitals in CY 2021, the CMP remains at $300 maximum per day as specified at 45 C.F.R. § 180.90(c)(2)(i).[135] For non-compliant hospitals as of January 1, 2022, the CMPs are specified at 45 C.F.R. § 180.90(c)(2)(ii).[136] After January 1, 2022, the maximum CMP for hospitals with 30 or fewer beds is $300 per day regardless of whether the hospital has one or multiple discrete violations.[137] The maximum CMP for hospitals with 31 to 550 beds is $10 multiplied by the hospital's bed count per day regardless of whether the hospital has one or multiple

[122] *Id.*
[123] *Id.*
[124] *Id.*
[125] *Id.*, at 63954-63955.
[126] *Id.*, at 63943.
[127] *Id.*
[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] *Id.*, at 63946.
[133] *Id.*, at 63945.
[134] *Id.*
[135] *Id.*, at 63946-63947.
[136] *Id.*, at 63947.
[137] 45 C.F.R. § 180.90(c)(2)(ii)(A).

discrete violations.[138] The maximum CMP for hospitals with 550 or more beds is $5,500 per day regardless of whether the hospital has one or multiple discrete violations.[139] CMS will determine a hospital's bed count using the most recent Medicare Cost Report.[140] The CY 2022 Rule directs CMS to post any CMP on the CMS website.[141] CMS believes the tiered CMP amounts remain low and that the CMP amounts are consistent with the severity of potential violations, since the violations do not involve patient harm arising from safety or quality concerns.[142]

Hospital Compliance

Originally, CMS claimed the $300 per day CMP maximum was a sufficient deterrent when the agency published the CY 2020 Rule in 2019.[143] However, six months after the rule's January 1, 2020, effective date, many hospitals were non-compliant citing modest penalties as one reason for non-compliance.[144] For some hospitals, the only CY 2020 Rule compliance incentive was avoiding CMPs.[145] One group, Patient Rights Advocate, sampled 500 hospitals between May and July 2021 and found approximately 94% were non-compliant with the CY 2020 Rule, and[146] a study published in JAMA, which surveyed 5,239 hospitals from July to September 2021, also calculated a non-compliance rate of approximately 94% with both the machine-readable, 45 C.F.R. § 180.50 and shoppable service list, 45 C.F.R. § 180.60, requirements.[147] The CY 2020 Rule of $300 per day maximum CMP, together with substantial development costs, were cited by the JAMA researchers as reasons suspected for widespread hospital non-compliance [148] The JAMA researchers recommended that CMS improve hospital CY 2020 Rule compliance through stronger penalties.[149] In a different JAMA article, the authors concluded that non-compliance may continue.[150] Another group, Wakely, analyzed price data from 754 hospitals and found that fewer than 50% posted payer-negotiated rates as of July 2021.[151] A Milliman study, on the other hand, found only 32% of the more than 600 hospitals reviewed were non-compliant between January and March 2021.[152] By the second half of 2021, Patient Rights Advocate sampled 1,000 hospitals and determined 14% were compliant, representing some improvement over the first half of the year.[153] Poor hospital compliance with the CY 2020 Rule led House Committee on Energy and

[138] 45 C.F.R. § 180.90(c)(2)(ii)(B).
[139] 45 C.F.R. § 180.90(c)(2)(ii)(C).
[140] 45 C.F.R. § 180.90(c)(2)(ii)(D)(1).
[141] 45 C.F.R. § 180.90(e)(1).
[142] Price Transparency of Hospital Standard Charges, *supra* note 7, at 63945.
[143] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65596-65597.
[144] JoAnna Younts & Greg Russo, *The Nitty-Gritty of Price Transparency*, 33 Health Lawyer 5, 5 (August, 2021).
[145] Dustin Cragun et al., *Price Transparency: Hospital Perceptions of CMS Regulations*, KLAS Rsch. (Apr. 21, 2022), at 1.
[146] Patient Rights Advocate, *Semi-Annual Hospital Price Transparency Compliance Report* (Jul., 2021), at 1.
[147] Waqas Haque et al., *Adherence to a Federal Price Transparency Rule and Associated Financial Marketplace Factors*, 327 JAMA 2143, 2144 (Jun. 7, 2022).
[148] Suhas Gondi et al., *Early Hospital Compliance with Federal Requirements for Price Transparency*, 181 JAMA Internal Medicine 1396, 1396 (Oct., 2021).
[149] *Id.*, at 1397.
[150] *Id.*
[151]Nick Shaneyfelt et al., *2021 Health Price Transparency: Data Availability and Analysis*, Wakely Brief (Aug., 2021), at 2.
[152] Austin Barrington et al., *Hospital Price Transparency: March 2021 Update*, Milliman Brief (Apr. 5, 2021), at 1.
[153] Patient Rights Advocate, *Semi-Annual Hospital Price Transparency Report* (Feb., 2022), at 1.

Commerce members to express their concern in an April 2021 letter to the Secretary of HHS.[154] The committee members cited a March 16, 2021, Health Affairs article that stated that more than half of the nation's 100 largest hospitals were non-compliant during the first two months of 2021.[155] In some instances, hospitals were non-compliant because they did not include required data elements, such as medical codes, in their file or hospitals did not provide consumers with a searchable file.[156] In particular, committee members were worried that hospitals created access barriers that limited consumers from using a hospital's price information.[157] The committee members referenced a March 22, 2021, Wall Street Journal article where some hospitals were described as blocking their standard charge information from internet search engines, thereby making it difficult for consumers to find hospital price information.[158] Meanwhile, House Committee on Energy and Commerce members also noted other reports which found many hospitals meeting only parts of the rule.[159] The committee members urged the Secretary of HHS to enforce the CY 2020 Rule.[160] Furthermore, the committee members requested that the Secretary of HHS review the agency's enforcement tools and recommended regular audits to determine hospital compliance with the CY 2020 Rule.[161] As of April 2022, CMS issued 345 price transparency warning notices to hospitals and initiated 136 CAPs.[162] In a May 2022 interview with the Healthcare Financial Management Association (HFMA), Jonathan Blum, CMS Principal Deputy Administrator and Chief Operating Officer, explained that hospital compliance is improving and that CMS is promoting senior leadership awareness and accountability of price transparency responsibilities. [163]

On June 7, 2022, CMS took the agency's first enforcement actions after determining Northside Hospital Atlanta,[164] and Northside Hospital Cherokee[165] were non-compliant. Pursuant to 45 C.F.R. § 180, CMS found Northside Hospital Atlanta ("Northside Atlanta") non-compliant with the federal requirement that a hospital's standard charges be made public.[166] According to CMS, Northside Atlanta failed to respond to CMS' April 19, 2021, warning notice and CMS' September

---

[154] Letter from House of Representatives Comm. on Energy and Com. to Xavier Becerra (Sec'y U.S. Dep't of Health and Hum. Serv.) (Apr. 13, 2021), at 1.
[155] *Id.*
[156] *Id.*, at 2.
[157] *Id.*, at 3.
[158] *Id.*, at 9.
[159] *Id.*, at 2.
[160] *Id.*, at 1.
[161] *Id.*, at 3.
[162] Alia Paavola, *The Barriers to Hospital Price Transparency Compliance*, Becker's Hospital CFO Rep. (May 13, 2022), https://www.beckershospitalreview.com/finance/the-barriers-to-price-transparency-compliance.html?origin=CIOE&utm_source=CIOE&utm_medium=email&utm_content=newsletter&oly_enc_id=0662I8011134B3U
[163] Nick Hut, *Price Transparency Update: 6-Figure Fines Have Been Handed Down for Hospital Noncompliance*, HFMA (Jun. 22, 2022), https://www.hfma.org/topics/news/2022/06/price-transparency-update--6-figure-fines-have-been-handed-down-.html?utm_medium=email&utm_source=rasa_io
[164] Letter from John C. Pilotte (Dir. Performance-Based Payment Pol'y Grp., Ctr. for Medicare) to Robert Quattrocchi (President and Chief Exec. Officer, Northside Hospital, Atlanta), RE: Hospital Price Transparency Notice of Imposition of a Civil Monetary Penalty (CMP) (Jun. 7, 2022), at 1.
[165] Letter from John C. Pilotte (Dir. Performance-Based Payment Pol'y Grp., Ctr. for Medicare) to William Hayes (Chief Exec. Officer, Northside Hospital Cherokee), RE: Hospital Price Transparency Notice of Imposition of a Civil Monetary Penalty (CMP) (Jun. 7, 2022), at 1.
[166] Letter from John C. Pilotte, *supra* note 164, at 1.

30, 2021, CAP request.[167] Northside Atlanta was found in violation of the machine-readable file and shoppable services requirements and CMS imposed an $883,180 CMP on Northside Atlanta.[168] The CMP will accrue until CMS determines that Northside Atlanta is fully compliant;[169] however, Northside Atlanta may request an HHS Department of Appeals Board Administrative Law Judge hearing to appeal the CMP, and CMS may impose a CMP for any stated or continuing violation if Northside Atlanta fails to appeal.[170] CMS posted a notice of Northside Atlanta's non-compliance on a CMS website.[171] Similarly, CMS found Northside Hospital Cherokee ("Northside Cherokee") non-compliant with 45 C.F.R. § 180 for hospital price transparency requirements as of April 16, 2021.[172] Northside Cherokee received a CMS warning notice dated May 18, 2021; however, Northside Cherokee did not respond to CMS and on October 27, 2021, Northside Cherokee received a CMS CAP request.[173] The June 7, 2022 CMS letter to Northside Cherokee described violations as failure to make public a list of standard charges (45 C.F.R. § 180.50(a)(2)); failure to make public a list of standard charges in a machine-readable file (45 C.F.R. § 180.40(a)); failure to post information in a single digit machine-readable file (45 C.F.R. §180.50(c)); and failure to follow the CMS naming convention (45 C.F.R. §180.50(d)(5)).[174] The June CMS letter also described violations related to shoppable services as failure to make publicly available a list of standard charges for shoppable services using consumer-friendly descriptions (45 C.F.R. § 180.40(b)).[175] CMS imposed a CMP of $34,200 based on $300 per day for the period September 9, 2021 through December 31, 2021, representing the CY 2021 penalty.[176] Additionally, CMS imposed a CMP of $180,120 based on $10 per day times 114 beds for the period January 1, 2022 through June 7, 2022, representing the CY 2022 penalty. [177]

Next Steps in Price Transparency Legislation

To address perceived price transparency enforcement gaps, two U.S. senators introduced legislation targeting non-compliant hospitals. In March 2022, Sen. Kennedy (R-La.) introduced the Hospital Transparency Compliance Enforcement Act ("Enforcement Act"), S. 3749, which would give hospitals until 100 days after the end of the COVID-19 Public Health Emergency (PHE) to be compliant with price transparency rule requirements.[178] The Enforcement Act would raise CMP thresholds for hospital bed count tiers established under the CY 2022 Rule.[179] If the Enforcement Act is enacted, hospitals with 30 or fewer beds, would face a $600 per day penalty for non-compliance, hospitals with more than 30 but less than 550 beds would face a $20 per bed penalty, and hospitals with more than 550 beds would face an $11,000 per day penalty.[180]

---

[167] *Id.*
[168] *Id.*, at 1-3.
[169] *Id.*, at 3.
[170] *Id.*, at 3, 5.
[171] *Id.*, at 5.
[172] Letter from John C. Pilotte, *supra* note 165, at 1.
[173] *Id.*
[174] *Id.*, at 2.
[175] *Id.*
[176] *Id.*, at 3.
[177] *Id.*
[178] Hospital Transparency Compliance Enforcement Act, S. 3749, 117th Cong. § (2)(A) (2022).
[179] Hospital Transparency Compliance Enforcement Act, S. 3749, 117th Cong. § (2)(A) (2022).
[180] Hospital Transparency Compliance Enforcement Act, S. 3749, 117th Cong. § (4)(A)(i)(ii) (2022).

In June 2022, Sen. Braun (R-Ind.) introduced the Expose Hospitals Violating Price Transparency Act ("Violating Price Transparency Act"), S. 4414, which would compel CMS to publicly post a list of hospitals on the CMS website that received any CMS communications about the hospital's non-compliance.[181] The Violating Price Transparency Act would require the Secretary of HHS to report to Congress information about hospital non-compliance, along with HHS enforcement activities 1 year after enactment and annually thereafter with the report made available to the public.[182] The Violating Price Transparency Act would also require the Government Accountability Office (GAO) to report to Congress about hospital price transparency rule compliance and enforcement with recommendations for improving price transparency, possibly suspending or revoking a hospital's federal tax-exempt status for non-compliance and increasing CMPs. [183]

Regulations Advancing Consumer Protections

In December 2020 Congress passed the No Surprises Act as part of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020) as the second planned phase of federal consumer healthcare protections after hospital price transparency.[184] CMS then engaged in rulemaking to implement the No Surprises Act. The intent of the Requirements Related to Surprise Billing: Part I ("Surprise Billing Rule Part I"), issued by CMS on July 1, 2021, was to safeguard consumers from surprise medical bills generated by out-of-network providers for services furnished at in-network entities, such as hospitals, and to implement a hospital good faith price estimate requirement showing expected consumer out-of-pocket patient financial liability.[185] CMS then issued the Requirements Related to Surprise Billing: Part II ("Surprise Billing Rule Part II") interim final rule to outline the requirements for a federal independent dispute resolution (Federal IDR) process.[186]

The CMS Transparency in Coverage Rule,[187] effective July 1, 2022, is the third planned phase of federal consumer healthcare protections.[188] The purpose of this rule is to assist consumers with additional pricing information before they receive care.[189] Qualified health plans are required to provide individuals, in a timely manner, with their cost-sharing information, such as deductibles, copayments, and coinsurance amounts, for specific items and services upon the individual's request.[190] A cost-sharing estimate must be available to the consumer on a website, or paper form

[181] Expose Hospitals Violating Price Transparency Act, S. 4414, 117th Cong. § (a)(2) (2022).
[182] Expose Hospitals Violating Price Transparency Act, S. 4414, 117th Cong. § (c) (2022).
[183] Expose Hospitals Violating Price Transparency Act, S. 4414, 117th Cong. § (d) (2022).
[184] Requirements Related to Surprise Billing: Part I, 86 Fed. Reg. 36872, 36874 (Jul. 13, 2021) (to be codified at 45 C.F.R. pts. 144, 147, 149 and 156).
[185] *Id.*
[186] Requirements Related to Surprise Billing: Part II 86 Fed. Reg. 55980, 55980 (Oct. 7, 2021) (to be codified at 45 C.F.R. pts. 147 and 149).
[187] JoAnna Younts & Greg Russo, *supra* note 144, at 5.
[188] Ctrs. for Medicare & Medicaid Servs., Transparency in Coverage (last modified Jan. 31, 2022), https://www.cms.gov/healthplan-price-transparency
[189] *Id.*
[190] 42 U.S.C. § 18031(e)(3)(C).

if specifically requested, so that the consumer understands their potential out-of-pocket financial liability and the consumer can shop for items or services among different providers.[191]

PART III – POLICY STRENGTHS AND LIMITATIONS

Healthcare Marketplace

Well before CMS' hospital price transparency requirements, the Federal Trade Commission expressed concern about how healthcare price transparency might allow competitors to see each other's charges and potentially coordinate efforts to keep prices artificially high.[192] Now some experts are concerned that available lower-priced hospitals may raise prices to be consistent with higher-priced hospitals within their market.[193] Even CMS acknowledged that lower-priced hospitals might increase prices after learning what other market hospitals charged and negotiated with payers.[194] On the other hand, some policymakers argue that available hospital prices will enable insurance plans to negotiate lower rates and drive down market prices just as CMS intended.[195] [196]

CMS expects the CY 2020 Rule will reduce the impact of market hospital consolidation.[197] The number of hospital mergers and acquisitions has accelerated leading to market domination and less competition.[198] Hospitals that dominate their market have negotiating strength to obtain higher reimbursement from their payers.[199] In markets with the highest reported hospital consolidation, prices increased between 11% and 54% [200] In small markets, such as New Hampshire, price transparency was not as effective in lowering prices due to limited competition in rural areas and health system dominance in populated areas.[201] Despite small market concerns, policymakers anticipate that available hospital price data will encourage consumer comparative shopping and cost-conscious choices that result in overall lower prices by influencing the healthcare market's supply side.[202]

---

[191] Transparency in Coverage, 85 Fed. Reg. 72158, 72158 (Nov. 12, 2020) (to be codified at 45 C.F.R. pts. 147 and 158).
[192] JoAnna Younts & Greg Russo, *supra* note 144, at 5.
[193] Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Health Care - Challenges and Potential Effects*, 364 New Eng. J. Med. 891, 893 (Mar. 10, 2011).
[194] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65599.
[195] Anna D. Sinaiko & Meredith B. Rosenthal, *supra* note 193, at 893.
[196] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65599.
[197] Isaac D. Buck, *supra* note 59, at 197.
[198] *The Role of Prices in Excess US Health Spending*, Health Aff. Rsch. Brief (Jun. 9, 2022), https://www.healthaffairs.org/do/10.1377/hpb20220506.381195/full/
[199] Isaac D. Buck, *supra* note 59, at 197.
[200] *Id.*, at 196.
[201] Anna D. Sinaiko & Meredith B. Rosenthal, *supra* note 144, at 893.
[202] *Id.*, at 892.

Consumer Challenges

Data Files and Tools

Hospitals worry that patients will not fully comprehend price data.[203] For instance, providing consumers with a hospital chargemaster containing standard charges may not aid transparency efforts,[204] since consumers generally are unable to understand hospital chargemasters whenever these files are made publicly available.[205] Moreover, the court in *AHA v. Azar*, noted that CMS acknowledged posting chargemasters will not help consumers who want to know what they are expected to pay for a hospital stay.[206]

As CMS and hospitals stipulated, simply viewing hospital price data may not provide a clear picture of the true out-of-pocket amount, since the consumer needs to understand what items and services will be included in their encounter.[207] Useful out-of-pocket price information is aggregated at the encounter level, rather than distinct chargemaster line-item charges.[208] If consumers solely rely on a list of chargemaster standard charges without access to episode of care price information, consumers will not be able to accurately predict their out-of-pocket amount.[209] Likewise, standard charge data is not personalized so consumers cannot exclusively use standard charge data to obtain an out-of-pocket cost estimate.[210] A personalized out-of-pocket estimate depends on a consumer's remaining deductible and coinsurance or copayment amounts, as well as their coverage benefits.[211] Thus, a hospital-posted chargemaster list of standard charges may be insufficient to allow consumers to shop for services.[212]

Rather than rely on a difficult-to-interpret list of standard charges, hospitals are increasingly adopting price estimator tools,[213] which enable a consumer to get a personalized shoppable service out-of-pocket estimate.[214] As an incentive for hospitals to provide personalized estimates, CMS deems a hospital as meeting the shoppable services requirement if the hospital has an internet price estimator tool conforming to CMS specifications.[215] Among the CMS specifications, the price estimator tool must have standard charges for a least 300 shoppable services to include as many

---

[203] Nathan Eddy, *Revenue Cycle Leaders Express Concern Over Price Transparency Rule*, Healthcare Fin. (Apr. 27, 2022), https://www.healthcarefinancenews.com/news/revenue-cycle-leaders-express-concern-over-cms-price-transparency-rule
[204] Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 Hastings L.J. 85, 105 (2015-2016).
[205] George A. Nation, III, *Hospital Chargemaster Insanity: Healing the Healers*, 43 Pepp. L. Rev. 745, 777 (2016).
[206] *AHA v. Azar*, 468 F. Supp. 3d 372, 376 (D.D.C. 2020).
[207] Erin C. Fuse Brown, *supra* note 1, at 136.
[208] Ezekiel J. Emanuel & Amaya Diana, *Considering the Future of Price Transparency Initiatives - Information Alone Is Not Sufficient*, JAMA Network Open (Dec. 13, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787076
[209] *Id.*
[210] Anna F. Borromeo, *supra* note 5, at 421.
[211] *Id.*
[212] *Id.*
[213] Ariel Levin, *Hospitals and Health Systems are Working to Implement Price Transparency Policies and Help Patients Understand Costs* (Jun. 16, 2022), https://www.aha.org/news/blog/2022-06-16-hospitals-and-health-systems-are-working-implement-price-transparency-policies
[214] 45 C.F.R. § 180.60(a)(2)(ii).
[215] 45 C.F.R. § 180.60(a)(2).

of the 70 CMS-specified shoppable services as the hospital provides.[216] Price estimator technological advances, along with new vendor products, are making it easier for hospitals to make consumer-tailored out-of-pocket price estimates available for price transparency.[217]

Requiring publicly available hospital price information does not guarantee consumers will use the information.[218] For instance, a study found employees at two companies used their employer's healthcare price tool infrequently and the tool did not produce any measurable savings.[219] Another study looking at consumer use of New Hampshire's online price tool noted that just 1% of the state's residents used the website during its first 3 years.[220]

Quality Information

To supplement price information, consumers need quality information before they can truly make informed decisions about care; however, most public price transparency tools do not correlate price and quality information within one customer-friendly platform.[221] Without balancing quality data, consumers may assume higher priced services equate to higher quality services,[222] and population health suffers when consumers choose inferior care based on lower cost.[223] Price transparency tools may be ineffective when patients choose higher-cost services believing they are choosing higher-quality care, as many Americans equate the higher cost to higher quality.[224] Critics worry that when consumers relate price to quality, price transparency may instead generate higher costs as consumers choose higher-priced hospitals.[225] Without corresponding quality information, price estimator tools do not offer consumers enough information to make value-based care decisions.[226]

Additionally, consumers cannot as easily evaluate clinical quality as they can evaluate the quality of other goods and services.[227] Quality metrics should be required along with price transparency data as part of the same group of files, or internet links, to allow consumers to include both cost and quality for value-based decision-making.[228] When consumers have reliable price and quality information, they are empowered to make informed decisions about healthcare value by choosing high-quality providers who offer the lowest price[229] under a consumer-driven healthcare (CDHC) model [230] To achieve sustainable healthcare cost reduction, price and quality information must be

---

[216] 45 C.F.R. § 180.60(a)(2)(i).
[217] Price Transparency of Hospital Standard Charges, *supra* note 7, at 63955.
[218] Ezekiel J. Emanuel & Amaya Diana, *supra* note 208.
[219] *Id.*
[220] *Id.*
[221] Nat'l Conf. of State Legislatures, *Transparency of Health Costs: State Actions*, https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx
[222] Ha Tu & Rebecca Gourevitch, *supra* note 64, at 10.
[223] Erin C. Fuse Brown, *supra* note 204, at 105.
[224] Anna F. Borromeo, *supra* note 5, at 417.
[225] Julia Hudson, *Have Your Cake and Eat It, Too: How States Could Leverage Data on Quality to Promote Health Care Transparency & Patient Privacy Within Consumer-Driven Health Care Initiatives*, 10 Ind. Health L. Rev. 663, 691 (2013).
[226] Erin C. Fuse Brown, *supra* note 204, at 105.
[227] Anna D. Sinaiko & Meredith B. Rosenthal, *supra* note 193, at 892.
[228] S. Corlette et al., *New Health Care Transparency Requirements: Recommendations for Optimizing Pricing Data to Reduce System Costs*, Georgetown Univ. Health Pol'y Inst. (Sep. 14, 2021), at 10.
[229] U.S. Gov't Accountability Off., *supra* note 4, at 9.
[230] Julia Hudson, *supra* note 225, at 665.

incorporated into the care delivery infrastructure.[231] Price transparency will enable CDHC[232] when hospitals integrate quality information with their prices and provide information on how to use quality metrics and price data so that consumers can make informed choices.[233] [234]

Hospital Challenges

Hospital leaders argued that compliance was a financial burden with no return on investment and many hospitals reported making only a minimal investment to comply.[235] Hospitals cited the need for software investment and outside resources as reasons for price transparency non-compliance.[236] According to the AHA, CMS failed to reflect the actual work effort needed to comply when calculating the agency's implementation cost estimate.[237] Moreover, many proposed rule commentators advanced their opinion that CMS did not consider adequate technical, consultative, and legal hours in the agency's estimated implementation cost, while smaller hospitals and Critical Access Hospitals (CAHs) complained to CMS that the additional costs to comply with the proposed CY 2020 Rule would jeopardize their financial stability.[238] CMS responded to commentators worried about burdensome costs stating that some monetary burden was necessary to achieve the goal of reducing healthcare costs and empowering consumers.[239] CMS also stated that most of the impact would be in the first year during implementation with decreased resources needed in subsequent years.[240]

Hospital leaders were also challenged to understand the resource qualifications and staffing levels needed to achieve and sustain compliance.[241] Many hospitals cannot easily find and retain adequate knowledgeable resources to create, publish, and maintain the required price transparency electronic files with 52% of hospital leaders stating that resource recruitment and retention is a significant issue, leading some hospitals to rely on expensive external information technology vendors and consultants to assist with the design and publishing of required electronic files.[242] Additionally, many proposed CY 2020 Rule commentators expressed the need to hire new staff to implement and maintain the necessary technology, monitoring, and reporting.[243] Furthermore, the AHA wrote that creating tools, such as price estimators, was resource intensive and wasteful during the COVID-19 PHE when financial and staffing resources were badly needed to help patients.[244]

---

[231] Ezekiel J. Emanuel & Amaya Diana, *supra* note 208.
[232] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65526.
[233] Anna D. Sinaiko & Meredith B. Rosenthal, *supra* note 193, at 893.
[234] Caterina DiBiase et al., *Status of Healthcare Price Transparency Across The United States*, Pioneer Inst. (May, 2020), https://pioneerinstitute.org/transparency/national-study-finds-most-states-lack-healthcare-price-transparency-laws/
[235] Dustin Cragun et al., *supra* note 145, at 1-2.
[236] Alia Paavola, *supra* note 162
[237] Am. Hosp. Ass'n, *supra* note 45, at 8.
[238] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65592 and 65599.
[239] *Id*., at 65529.
[240] *Id*.
[241] Dustin Cragun et al., *supra* note 145, at 2.
[242] *Id*., at 1-2.
[243] Price Transparency Requirements for Hospitals to Make Standard Charges Public, *supra* note 67, at 65592.
[244] Am. Hosp. Ass'n, *supra* note 45, at 7.

Hospital leaders pointed to the machine-readable file requirement as problematic.[245] Many hospitals find creating large complex machine-readable files difficult and many hospitals do not see the direct benefit of machine-readable files for patients.[246] During 2021, hospitals prioritized COVID-19 responses over creating machine-readable files which contributed to non-compliance.[247] In response, CMS asserted that the technical burden on hospitals to create machine-readable files should be minimal since most hospitals maintained chargemaster data electronically.[248]

The complex nature of healthcare delivery and reimbursement complicates the process of accurately estimating treatment costs.[249] Hospitals cited complex payment arrangements with multiple insurance carriers as yet another reason for non-compliance.[250] Insurance plan cost-sharing mechanisms, such as deductibles, co-insurance, and copayments, create a challenge for hospitals when trying to estimate a consumer's out-of-pocket amount.[251] Value-based and outcome-dependent reimbursement models further complicate hospital efforts to provide accurate cost estimates and these models reduce the relevancy of posting chargemaster rates.[252]

Hospitals urged CMS to align price transparency and surprise billing implementation efforts.[253] Some hospitals and hospital associations were concerned about consumer confusion over price transparency tools and out-of-pocket disclosures required by the No Surprises Act.[254] To avoid consumer confusion, proposed CY 2020 Rule commentators asked for price transparency enforcement discretion, or delay until surprise billing and healthcare coverage transparency requirements were finalized; however, CMS did not concur with the need for enforcement discretion.[255]

Finally, hospital leaders were concerned that consumers may be confused by different, or conflicting, price transparency information made available by various organizations.[256] According to the AHA, some organizations do not consider CMS guidance when scoring hospital price transparency compliance.[257] For example, a low or non-compliant score may be given when a negotiated rate field is blank even though CMS allows a blank field when the hospital does not have a payer-negotiated rate for the service.[258]

---

[245] Dustin Cragun et al., *supra* note 145, at 1.
[246] Ariel Levin, *supra* note 213.
[247] *Id*.
[248] Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 *supra* note 67, at 65591.
[249] Jennifer A. Brobst, *supra* note 71, at 863.
[250] Eli Kirshbaum, *Monetary Penalties Loom For Texas Hospitals Noncompliant With Price Transparency Rule*, State of Reform (Aug. 11, 2021), https://stateofreform.com/featured/2021/08/monetary-penalties-loom-for-texas-hospitals-noncompliant-with-price-transparency-rule/
[251] Christopher Limbacher, *Healthcare Price Transparency: Reintroducing Competition*, 53 Hous. L. Rev. 939, 948 (Winter, 2016).
[252] Eli Kirshbaum, *supra* note 250.
[253] Price Transparency of Hospital Standard Charges, *supra* note 7, at 63942.
[254] *Id*.
[255] *Id*., at 63947.
[256] Ariel Levin, *supra* note 231.
[257] *Id*.
[258] *Id*.

PART IV – CONCLUSION

Price transparency tools are an important resource enabling consumers to make informed healthcare choices using price as one consideration.[259] Price transparency requirements are expected to have the largest impact on consumers' healthcare cost awareness and the requirements are perceived as supporting health system efficiency through cost reduction.[260] Most individuals agree that a high-performing healthcare system relies on price transparency, and price transparency has bipartisan support since price transparency has the potential to reduce healthcare costs without changing delivery or reimbursement models.[261]

The price transparency rules should be enforced. Until the June 2022 CMS enforcement actions against two Georgia hospitals, many hospitals perceived a lack of urgency from CMS, and unless CMS ramps up enforcement, hospital leaders across the nation may view the penalties assessed against the Georgia hospitals as just one more cost of doing business, especially for large hospital systems and market-dominating hospitals.[262] CY 2020 Rule requirements should be expanded. CMS should expand the required number of shoppable services to give consumers additional price information that reflects encounter-level out-of-pocket estimates,[263] while insurers should increasingly adopt bundled value-based service, or episode of care, reimbursement to facilitate price transparency and lower healthcare costs.[264]

Consumers must be empowered. For society, CDHC outweighs the costs associated with price transparency implementation.[265] Consumers will only be in control of their healthcare costs when they have available healthcare options,[266] and consumers now have more information to make informed care choices as hospital standard charges are made publicly available.[267] Meaningful consumer empowerment must also integrate consumer-friendly price transparency and quality tools together with the consumer's insurance coverage to achieve the goals of cost containment and value.[268] Moreover, many economists and researchers believe that making hospital prices publicly available will stimulate market competition to expand consumer healthcare options.[269] Government can stimulate greater hospital competition by further regulating hospital mergers and acquisitions, promoting new market entrants, and enforcing laws and regulations intended to prevent anti-competitive behaviors.[270]

---

[259] Robert Wood Johnson Found., *supra* note 3, at 2.
[260] *Id*., at 1.
[261] Julia Hudson, *supra* note 225, at 668.
[262] Niall Brennan, *The Fatal Flaw in Hospital Price Transparency Rules*, Medpage Today (Jul. 2, 2022), https://www.medpagetoday.com/opinion/second-opinions/99542
[263] Nick Shaneyfelt et al., *supra* note 151, at 5.
[264] Ezekiel J. Emanuel & Amaya Diana, *supra* note 208.
[265] Rich Spiker, *supra* note 87, at 7.
[266] Jennifer A. Brobst, *supra* note 71, at 883.
[267] *Id*., at 882.
[268] Ezekiel J. Emanuel & Amaya Diana, *supra* note 208.
[269] *The Role of Prices in Excess US Health Spending*, *supra* note 198.
[270] Matthew Fiedler & Christen Linke Young, *Current Debates in Health Care Policy: A Brief Overview*, Pol'y 2020 Brookings (Oct. 15, 2019), https://www.brookings.edu/policy2020/votervital/current-debates-in-health-care-policy-a-brief-overview/

Medical debt and delayed care are consequences of increasing NHEs and are public health concerns. Rising U.S. NHEs contribute to medical debt and medical debt is a socio-economic driver of poor health outcomes.[271] Price transparency helps consumers avoid unexpected hospital bills and medical debt.[272] Consumer medical debt underscores the need for additional government cost-control policies.[273] In response to the societal pressures from medical debt, the Biden Administration announced its intention to address the consumer medical debt burden by curtailing harmful debt collection practices.[274]

Although it is too early for the U.S. to realize the price transparency goals of shoppable care and lower cost, price transparency remains a crucial first step.[275] Price transparency is not a final solution to healthcare cost containment; instead, price transparency should be viewed as the first phase of a cost containment policy.[276] Researchers and policymakers should use hospital price transparency data from machine-readable files and shoppable service lists to better understand healthcare market cost drivers and to craft more effective cost containment strategies.[277] Lastly, the combined results of hospital price transparency and payer price transparency regulations, along with surprise billing regulations are yet to be seen and may bring the U.S. closer to a CDHC model.[278]

[271] Mandy Pellegrin, *How Medical Debt Affects Health*, Sycamore Inst. (May, 2021), at 1.
[272] U.S. Gov't Accountability Off., *supra* note 4, at 2.
[273] Anna F. Borromeo, *supra* note 5, at 413.
[274] Fact Sheet: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection, White House Statements & Releases (Apr. 11, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/11/fact-sheet-the-biden-administration-announces-new-actions-to-lessen-the-burden-of-medical-debt-and-increase-consumer-protection/?mkt_tok=NzEwLVpMTC02NTEAAAGDucbHMMZAEVpqYJw7eYautzpmfu0FopobBQU58TPRk78gCQIpdui8ZdPL3hNeHpKQfsH7EnfwP-e71FNpD7JryEuTpk5tSAOR7aRKMUu6WYNp
[275] Niall Brennan, *supra* note 262.
[276] Sherry Glied, *Price Transparency - Promise and Peril*, JAMA Health Forum (Mar. 4, 2021), at 2.
[277] *Id*.
[278] Isaac D. Buck, *supra* note 56, at 207.