AMERICAN EXPERIMENT

GUIDANCE TO CONGRESS ON HEALTH CARE PRICE TRANSPARENCY LEGISLATION

Steps Congress should take to extend and strengthen the current rules

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Executive Summary

A package of bipartisan health policies is currently moving through the U.S. House of Representatives to strengthen federal price transparency requirements on providers and health plans. The House proposals would largely put two Trump-era rules in federal statute: the hospital price transparency rule and the health plan price transparency rule known as Transparency in Coverage. As Congress continues to work on price transparency, the preamble discussions from these two rules offer the first and best place to look for guidance. These principles and objectives are outlined in this report. Using this as a guide, the report recommends steps Congress should take to extend and strengthen the current rules.

The main goal of the price transparency rules is to deliver more affordable health care. While the main goal may be simply and strongly stated, the federal rules were also guided by a more detailed set of principles and objectives aimed more pointedly at ensuring patients and those who support patients can ultimately access the pricing information they need when they need it.

Key principles and objectives

- Prices should be disclosed to give consumers the information they need to hold health plans and providers accountable and push them to innovate better ways to deliver coverage and care.
- Prices should be disclosed *publicly* to strengthen the ability of other entities to develop tools and resources to support health care consumers.
- *All* hospitals should be required to report pricing information.
- *All* health plans should be required to report pricing information.
- Patients should have access to pricing information for *all* health care items and services.
- Patients should have access to all the information they need when they sit down with their provider to make the best health care decisions. This objective was further supported by the following more specific objectives.
    - Patients should have access to real-time pricing and cost-sharing information.
    - Pricing and cost-sharing information should reflect the explanation of benefits a patient will receive from their health plan.
    - Pricing information should be provided in dollar amounts, not percentages or formulas.
    - Health plans should provide patients with their most accurate estimate for out-of-network costs.
    - Patients should be able to access all the rate information necessary to estimate their cost sharing for in-network care.
- Price transparency information should be easily accessible to researchers, software developers and other health innovators that are positioned to use the information to help consumers.
- Consumers should not need to depend on third parties.
- Price transparency should not require hospitals or health plans to change how they do business.

Recommendations

- Use the federal rules as the foundation for legislation to build up a more robust set of price transparency policies.
- Expand the hospital price transparency requirements to more care settings and to care provided in hospitals by providers who are not employed by the hospital.

- Require hospitals to disclose information through the data files in a standardized format.
- Move closer to real-time disclosure of pricing and cost-sharing information.
- Make pricing and cost sharing information easily accessible to a patient's authorized representative.
- Provide the authority to extend key interoperability policies that CMS implemented through rulemaking in recent years to all health plans subject to Affordable Care Act (ACA) individual and group market reforms.
- Align price transparency requirements with the requirements of the No Surprises Act. ■

Introduction

A package of bipartisan health policies is currently moving through the U.S. House of Representatives to strengthen federal price transparency requirements on providers and health plans. Yes, bipartisanship can and does happen in Congress. In fact, this price transparency package reflects policies that originated in federal rules implemented under the Trump administration which were then endorsed by an executive order issued by President Biden within six months of his taking office. If enacted, this legislative package would cement a set of policies in federal law to guarantee that patients can know the price of health care upfront before they receive care.

The House proposals would largely put two Trump-era rules in federal statute: the hospital price transparency rule and the health plan price transparency rule known as Transparency in Coverage. I had the privilege of participating in the development and finalization of these price transparency rules in the Trump administration. My work focused on the health plan rule. This rule is the product of over two years of thoughtful deliberation across three federal agencies. Our decisions focused on what's best for the patient. While we certainly listened to input from stakeholders in the health sector, this input was always evaluated on whether it would improve the patient experience. This deliberation becomes evident as you review the health plan rule and read the explanations for all the changes we made and did not make from the proposed to the final. I witnessed a similarly thorough and thoughtful process from my colleagues at the Centers for Medicare & Medicaid Services (CMS) who finalized the hospital rule.

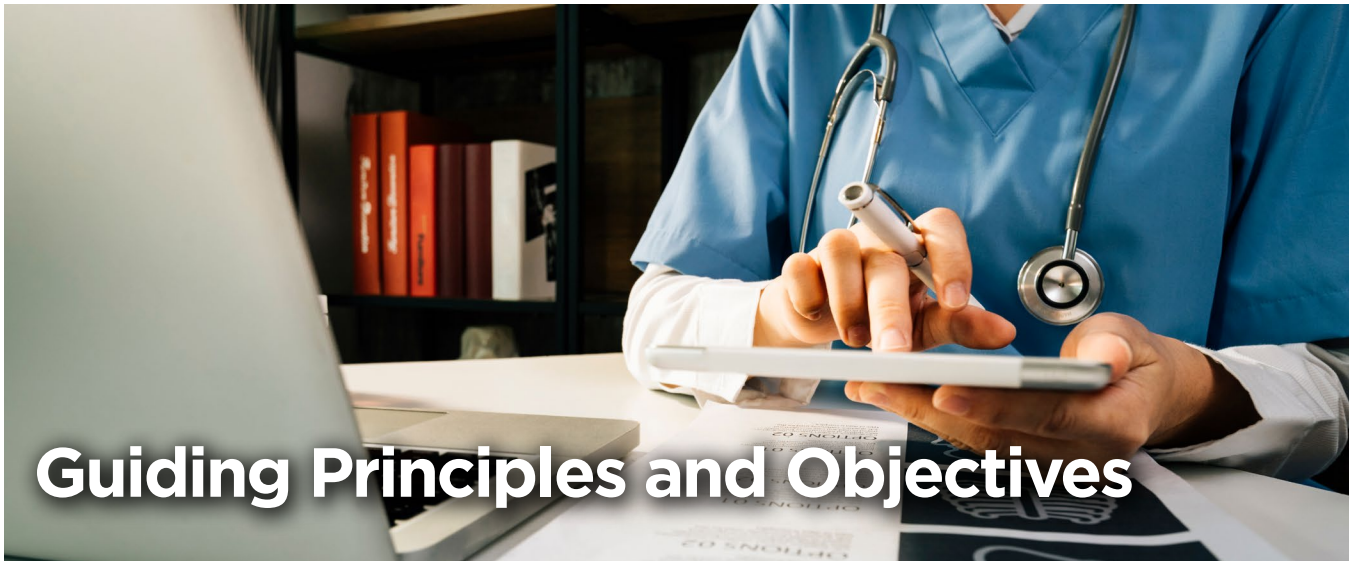
As Congress now engages in its own deliberations, the preamble discussions from these two rules published to justify and explain the new regulations offer the first and best place to look for guidance. After all, Congress is using these rules as the starting point for legislation. But these rules should just be the starting point. The rules themselves were constrained by what the statute authorized, and Congress is not bound by such constraints. When considering improvements, however, Congress should still pay close attention to the price transparency principles and objectives that guided the rules. These principles and objectives are outlined here and followed by recommendations on steps Congress should take to extend and strengthen the current rules. ■

Summary of the Current Rules

If the hospital and health plan rules are the starting point for Congress's work, then a brief summary of these rules is the obvious place to start this discussion. CMS finalized the hospital rule on November 15, 2019. This rule requires all hospitals to 1) display online pricing for 300 shoppable services in a consumer-friendly format and 2) post a comprehensive machine-readable file with pricing for all items and services. For both requirements, the prices hospitals must post include their negotiated rates with all third-party payers. This includes private plans, Medicare Advantage, and Medicaid managed care health plans. These requirements took effect on January 1, 2021.

Considering the thought and effort that went into finalizing these rules, a better understanding of what shaped them offers an important guide to Congress as it considers how to codify and improve upon what is now in place.

The health plan rule follows a similar price reporting framework which requires health plans to provide an online self-service shopping tool and post machine readable files that include negotiated rates. The self-service tool is private-facing and must provide real-time pricing and cost-sharing information tailored to the individual consumer. Instead of just one machine readable file with negotiated rates, health plans must post three files: an in-network file, a prescription drug file, and an out-of-network file. While these files generally require health plans to post their negotiated rates, they must also include additional pricing information that patients need to estimate their own cost sharing as applicable. The machine-readable files requirement took effect on July 1, 2022 with the exception of the prescription drug file, which the Biden administration has delayed until further guidance and rulemaking can be provided. The self-service tool began to take effect on January 1, 2023 for 500 shoppable items and services, and takes full effect on January 1, 2024 for all items and services. ■



Guiding Principles and Objectives

The main goal of the price transparency rules is to deliver more affordable health care. The hospital rule unequivocally states, "there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs."[1] Likewise, the health plan rule expresses a clear "view that price transparency efforts are crucial to providing consumers (individual and institutional) with meaningful and actionable pricing information in an effort to contain the growth of health care costs."[2]

While the main goal may be simply and strongly stated, the rules were also guided by a more detailed set of principles and objectives aimed more pointedly at ensuring patients and those who support patients can ultimately access the pricing information they need when they need it. Some of these principles and objectives are clearly stated in the rules while some are more subtly revealed in patterns that flow through the decisions made. Considering the thought and effort that went into finalizing these rules, a better understanding of what shaped them offers an important guide to Congress as it considers how to codify and improve upon what is now in place. The following discussion identifies key principles and objectives that guided the finalization of each rule.

Prices should be disclosed to give consumers the information they need to hold health plans and providers accountable and push them to innovate better ways to deliver coverage and care. American innovators lead the world in developing new life-saving and life-enhancing medical treatments and cures.[3] However, few people would call America's health care system efficient or consumer friendly. When it comes to the delivery of health care, innovation in the health care sector fails to keep pace with nearly every other comparable sector of the economy. Why? As the health plan rule explains: "Without transparency in pricing, market forces cannot drive competition."[4] Without strong competition, the incentives to innovate and improve are far weaker in the health care sector versus other industries. Price transparency unleashes key information consumers need to pressure health plans and providers to innovate better, more efficient ways to deliver coverage and care.

Importantly, the consumers discussed here and in the rules are not just individual health plan shoppers and patients, but also employers and the taxpayers who fund public health programs. As the health plan rule explains in its justification of the rule, there are "substantial governmental interests in … assisting other consumers of health care, such as employers and government health benefits programs, in

evaluating and negotiating coverage options and obtaining the most value for health care dollars."[5] Employers, in fact, are the largest consumer of health plans. The health plans they choose for their employees cover 54 percent of the population.[6] Moreover, using pricing data, employers can help steer employees to higher value providers.

Prices should be disclosed publicly to strengthen the ability of other entities to develop tools and resources to support health care consumers. The self-service tool provides personalized pricing and cost-sharing information that some may argue is all a consumer needs. However, the health plan rule recognized five specific reasons why public disclosure through the data files is both appropriate and necessary. Public disclosure would 1) inform uninsured consumers; 2) allow individuals to evaluate health plans; 3) allow employers to evaluate health plans; 4) enable consumers to better understand their pricing information with the support of new software tools; and 5) assist regulators and researchers in oversight, program design, and policy analysis.[7]

Each of the five use cases clearly focuses on serving the consumer as the "ultimate beneficiary."[8] Among the entities supporting consumers, software developers offer the most promise and were top of mind in drafting the rules. With this data public, the health plan rule explains how "industry actors will likely be incentivized to design innovations to deliver the help and information consumers need to make informed health care decisions based, at least in part, on the important factor of price."[9] The rule references "IT developers who could be incentivized to design and make available internet-based tools and mobile applications" as "main avenues" for this innovation.[10] Since the rules have been finalized, IT developers have already invested millions in creating new consumer tools even as the data remains difficult to process.

All hospitals should be required to report pricing information. For price transparency to work best, all health care entities within the system should be subject to similar requirements. This is especially true when entities directly compete. Otherwise, there will be incentives to inefficiently shift resources and activities to and from areas based on whether prices can still be hidden from patients. Therefore, the hospital rule opted for an expansive definition of hospital based on state and local hospital licensure as "the best way to ensure that [the statute] applies to each hospital operating within the United States" [11] and rejected recommendations to narrow it.[12]

All health plans should be required to report pricing information. Like the hospital rule, the health plan rule applies as expansively as the statute currently allows. Specifically, the rule covers all group health plans and individual health insurance market coverage that are subject to the ACA's individual and group market reforms. These health plans are often referred to as ACA-compliant plans. Importantly, group health plans that are self-insured (the company pays for care directly) are treated the same as fully-insured plans (the company pays an insurance premium for care), which helps ensure the rule does not steer employers to prefer one approach over the other.

Since the rules have been finalized, IT developers have already invested millions in creating new consumer tools even as the data remains difficult to process.

The proposed rule sought comment on whether some types of plans should be exempt from some or all aspects of the rule based on their reimbursement or payment models. Ultimately, the regulations did not include any exemptions.[13] This decision was rooted in the "view that, for transparency in coverage to be truly effective, consumers should have access to all pricing information related to their care so they can make meaningful decisions about their health care spending."[14]

While the rule did not include exemptions,

the statutory requirements do not apply to (and, therefore, exempt) Medicare Advantage, Medicaid managed care, and other private plans that are not subject to the ACA's market reforms. Because these plans generally don't compete with plans subject to the ACA's market reforms, these exemptions don't present the same issue as imposing transparency on hospitals and exempting non-hospital providers that compete with hospitals like ambulatory surgical centers (ASCs). That said, consumers with these exempted plans would similarly benefit from transparency and, maybe more important, transparency would help taxpayers assess the effectiveness of government-funded health plans. Fortunately, the hospital rule does require hospitals to report negotiated rates for these plans because its requirements apply to all third-party payers. Therefore, the hospital rule fills a gaping transparency hole that the health plan rule did not have the statutory authority to fill.

Patients should have access to pricing information for all health care items and services. Just as patients should have the opportunity to know prices in advance from *all* health care providers, they deserve to know the price in advance for *all* items and services offered by the provider. This is important for the patient's own use, but also to avoid introducing opportunities and incentives to steer care to items and services with less transparent pricing. Nonetheless, many commenters on the health plan rule suggested that disclosures through both the self-service tool and the data files should be limited to only shoppable services.

The health plan rule rejected imposing any limits. While pricing for shoppable services may be used more often, the rule noted "that what is considered useful and meaningful pricing information is likely to be unique to an individual's circumstances."[15] More pointedly, the rule explained "that release of this information for *all* items and services, as proposed, is crucial for advancing the key objectives of the final rules to spur innovation, increase competition, and empower consumer activities in the health insurance markets."[16]

The hospital rule likewise did not impose any limits on what items and services must be disclosed. However, this is largely because the statute provided less discretion to impose any limits. The main issue with the hospital rule focused on whether, in addition to disclosing prices for individual items and services, hospitals should be required to disclose pricing for service packages, such as diagnostic related groups (DRGs) or Ambulatory Payment Classifications (APCs). Many commenters urged CMS to not include service packages in the definition of "items and services," claiming it would not be feasible in part because service packages are often unique to the payer. The rule rejected these comments, but acknowledged hospitals may provide different outpatient service packages and therefore declined to define outpatient service packages as being too prescriptive.[17]

The hospital rule, however, did run into one major obstacle to requiring the disclosure of all items and services a patient receives in the hospital. CMS concluded that the statute did not give them authority to require hospitals to disclose pricing for items and services provided in the hospital by physicians and non-physician practitioners who are not employed by the hospitals, such as anesthesiologists.[18] The statute requires disclosure "of the hospital's standard charges for items and services *provided by the hospital.*" Because physicians and non-physician practitioners who are not employed by the hospital practice independently and establish their own charges from the hospital, items and services they provide cannot be considered "provided by the hospital."

Note that the disclosure of all items and services through the health plan data file has resulted in some unforeseen difficulties. Initial efforts to work with the data file have found the files are much larger and harder to work with than they need to be. This is because insurers are reporting rates for all items and services for a provider even when they don't provide the item or service. For instance, pricing data for a psychiatrist would include a data field for a pacemaker which a psychiatrist would never provide. As a result, the files are filled with what researchers have called "zombie rates" that have no practical use. According to

recommendations from a group of researchers, this issue can likely be addressed through administrative action.[19]

Patients should have access to all the information they need when they sit down with their provider to make the best health care decisions. During my time at CMS, "empowering patients and doctors" was a core goal that guided our work.[20] To support this goal, we advanced the following vision: "Patients should be empowered to make informed decisions, without administrative red tape getting in their way or their clinician's way. To truly empower patients, CMS must unleash information so that – patients have access to quality, cost, and personal data."[21] The price transparency rules were a key part of our strategy to implement that vision.

To empower patients, we were particularly focused on ensuring they had the information they needed to make the best health care decisions when they met with their provider. Getting an appointment with a provider can be difficult and it's imperative that the patient and the provider are prepared to make the best use of that time. Pricing information for care options and referrals should be an important part of that conversation, especially for patients in plans with higher cost-sharing requirements. Therefore, the price transparency rules established policies to meet the following objectives.

- **Patients should have access to real-time pricing and cost-sharing information.** Health care pricing is subject to change, and a consumer's cost-sharing status can change any time a new claim for an item or service is processed. Knowing the price and the cost-sharing responsibility in real-time instills greater confidence in the decision and protects patients against surprises from changed circumstances. The health plan rule supports this objective by requiring health plans to provide a self-service tool that provides information on pricing and cost-sharing "in plain language through real-time responses"[22] that "is accurate at the time the request is made."[23] While this might not account for claims made which have not been fully processed, it provides the best estimate at the time of request.

  The data files also support the goal of real-time pricing by requiring health plans to update these files monthly. Monthly updates are far from real-time, and the proposed rule therefore sought comment on whether plans should update the file more frequently or within 10 days after any new rates are effective. Many commenters complained about the burden of monthly updates. Because the process of updating the files is automated, the rule did not find these comments persuasive. The rule kept the monthly cadence "to balance the need to ensure the data is current and accurate for consumers with minimizing burdens on plans and issuers."[24]

  Both rules also considered whether to require hospitals and health plans to make the information required under the rule available through a standards-based application programming interface (API) instead of the self-service tool and the data files. An API is a data interface that would allow someone to ping the health plan or hospital for pricing data in real-time. Using an API would ensure access to the most up-to-date information. Importantly, this would allow third-party developers to create enhanced tools that could potentially combine more information to better support a patient's decisions with their provider. As discussed in more detail later, the rules did not adopt the API approach, but they both agreed an API approach would be a logical next step.

- **Pricing and cost-sharing information should reflect the explanation of benefits a patient will receive from their health plan.** Patients should know how their claim will be processed and paid for by their health plan when they are considering their health care options. Historically, patients have had to wait until *after* they received a health care item or service to know the price the plan would pay and how much cost-sharing they would be required to pay. Health plans provide this information in an explanation of benefits

(EOB) that can be delivered weeks or months after the care is provided to the patient. The rules are structured to provide the information a patient needs to construct an EOB in advance of receiving care. The hospital rule requires disclosure of both gross charges and payer-specific negotiated charges because they are "necessary starting points" for a patient to understand their cost-sharing obligations and, when combined with information about the plan's benefit design, could "provide the information necessary to create what could be considered an EOB in advance of a service."[25] Likewise, the content elements that the health plan rule requires a plan to disclose through the self-service tool "generally reflect the same information that is included in an EOB after health care services are provided."[26]

Importantly, this would allow third-party developers to create enhanced tools that could potentially combine more information to better support a patient's decision with their provider.

The content elements of the health plan data files are similarly focused on allowing a patient to create an EOB.[27] While it may be difficult for a patient to construct an EOB in advance on their own, the public disclosure of pricing information, as discussed in more detail later, allows third parties to develop apps and software to help patients understand their cost-sharing obligations.

After the finalization of the hospital and health plan rules, Congress enacted the No Suprises Act as a part of the Consolidated Appropriations Act of 2021 which adopts new requirements on providers and health plans to provide patients with an Advanced EOB (AEOB). Under this new framework, providers must provide health plans with a good faith estimate (GFE) of the expected charges for items and services after they are scheduled.[28] Upon receiving the GFE, the health plan must provide the patient with an AEOB.[29] While these requirements overlap with the price transparency rules, the pricing data required by the rules continues to provide important information to allow patients to construct an EOB to plan for future services before they schedule the services.

- **Pricing information should be provided in dollar amounts, not percentages or formulas.** Health plans use various payment models to reimburse providers for both in-network and out-of-network care. Some of these models establish a clear dollar amount that the health plan contracts to pay in-network providers while others, such as value-based payment arrangements, base payments on a contracted formula or algorithm. Both the hospital rule and the health plan rule conclude that alternative payment models should still provide pricing information in dollar amounts. As the health plan rule explains, "disclosure of formulas is not likely to be helpful or understandable."[30] Therefore, the rules require hospitals and plans to report base rates in dollar amounts before adjustments from any formula. In addition, when using a standardized formula, such as a percent of Medicare rates, the health plan rule clearly requires plans to disclose the rates "that result from using such a formula, as a dollar amount."[31] CMS guidance applies the same standard to hospitals.[32]

  This does not mean the rules expect hospitals and plans to always report dollar amounts. The rules acknowledge that there may be payment models where a dollar amount is not set or cannot be calculated. For instance, the health plan rule acknowledges that some capitated plans that do not process claims individually may not have set a price and, therefore, would not need to report a price.[33] Also, some payment models set prices as a percent of billed charges for both in-network and out-of-network providers.

Because plans may not have the necessary information from an out-of-network provider to calculate a dollar amount for the percent of billed charges, health plans may report the percentage instead of a dollar amount.[34]

While the rules acknowledge there may be rare cases where dollar amounts cannot reasonably be calculated, they set forth a clear expectation that hospitals and health plans must make a good faith effort to disclose pricing in dollar amounts. After the rules were finalized, federal guidance provided more clarity and some additional flexibility on when a hospital and health plan must report dollar amounts.[35] Unfortunately, most hospitals continue to avoid full compliance and may be taking advantage of certain flexibilities to avoid disclosing pricing when they should be reporting dollar amounts.[36]

- **Health plans should provide patients with their most accurate estimate for out-of-network costs.** While health plans should be able to achieve accurate real-time pricing and self-service information for in-network items and services, accurate estimates for out-of-network care is far more challenging. The proposed health plan rule would have required health plans to just disclose the "maximum allowed amount" they would pay to out-of-network providers through the self-service tool.[37] However, after further consideration of the comments and closer analysis of the market, the rule rejected this in favor of giving health plans more flexibility to provide a more accurate estimate. Though the final rule continued to define the out-of-network allowed amount as the "maximum amount" the health plan would pay, it changed the disclosure requirement to allow health plans to report "any other rate that provides a more accurate estimate."[38] This recognizes that some plans don't use a predetermined amount and might use usual, customary, and reasonable (UCR) amounts as the allowed amount or some other reference or may adjust payments higher in certain circumstances which can make it hard to report a maximum. The rule also added a requirement to report a percentage of bill charges if that is how the plan pays out-of-network providers. So, percent of billed charges is an "either/or" situation under the rule, not an "and." The rule took this approach after finding some plans used this method. In this case, a percentage is just as meaningful to enrollees. In both circumstances enrollees will need to ascertain what the provider will bill them and then calculate how much they may need to pay out of pocket with the allowed dollar amount or percentage.

- **Patients should be able to access all the rate information necessary to estimate their cost-sharing for in-network care.** As previously discussed, the requirement to publicly disclose pricing data through the data files serves several purposes. This includes enabling consumers to use and understand price transparency data beyond what their health plan might provide through the self-service tool. The Departments understood that a raw data file would be hard for most consumers to navigate. But, as the rule explains, the "requirement to make pricing information publicly available could allow health care software application developers and other innovators to compile, consolidate, and present this information to consumers in a manner that allows consumers to consider price as a factor when making meaningful comparisons between different coverage options and providers."[39] The idea is to give developers the data they need to make a better self-service tool for consumers. This requires providing access to all the pricing information that goes into a cost-sharing estimate.

  The proposed rule would have required plans to post a "negotiated rate file." This was modified in the final rule to require plans to post an "in-network rate file" which must include "*all applicable rates*," including negotiated rates, underlying fee schedule rates or derived amounts, as applicable. This was intended to clarify how plans with alternative reimbursement arrange-

ments were to disclose rates and to ensure public disclosure of all rates used to determine cost sharing. If health plans do not provide all applicable rates, then developers would struggle to develop software that can provide reasonable cost-sharing estimates.

Price transparency information should be easily accessible to researchers, software developers and other health innovators that are positioned to use the information to help consumers. The data files were never intended to be consumer friendly, but they were always viewed as possibly the most important requirement to ultimately help the consumer make better health care decisions. In any complex market like health care, consumers need help to navigate their options. While financial institutions figured out how to allow customers to aggregate sensitive financial information into one online app over a decade ago, health care information largely remains trapped with the health plan and the health provider where the patient received treatment. With this information trapped—and trapped even though the patient owns the information—there's been little opportunity for innovators to develop tools to help people use their information to better navigate the health care system.

Considering health plans and hospitals have worked hard to hide pricing information, consumers can't depend on them to navigate the information.

As the health plan rule explains, price transparency unlocks key information for "innovators to compile, consolidate, and present…to consumers in a manner that allows consumers to consider price as a factor when making meaningful comparisons between different coverage options and providers."[40] Though the rules require hospitals to report pricing for shoppable services and require health plans to offer a self-service tool for consumers to estimate their cost sharing, the data files open the opportunity for other innovators to develop even more sophisticated tools to better help consumers navigate the health system. Considering health plans and hospitals have worked hard to hide pricing information, consumers can't depend on them to navigate the information. The apps and decision tools third-party developers create combined with new health system research assessing price and outcomes will become an indispensable resource to help consumers get the most value from their health plan and their provider.

To ensure the data files were accessible to developers and researchers, the hospital and health plan rules set forth standardized data elements that must be publicly reported. The health plan rule took this standardization a step further and requires a standardized format for posting the data as well. The lack of standardized formatting in the hospital data files has made the data difficult for developers and researchers to capture and organize. While the hospital rule declined to require standardized formatting, it recognized the value and expressed a willingness to revisit the decision in the future. CMS is now revisiting the decision in a proposed rule to require a standardized format.[41]

Consumers should not need to depend on third parties. While innovators may ultimately develop more sophisticated and helpful consumer tools, that does not diminish the importance of the tools that hospitals and health plans must provide. The health plan self-service tool and hospital posting of shoppable services are critical tools to ensure that consumers can gain quick access to actionable pricing information directly from providers and plans without needing to depend on anyone else.

Price transparency should not require hospitals or health plans to change how they do business. The goal of the rules is to force hospitals and health plans to disclose their current prices and payment arrangements, not force any change in how they do business. The rules carefully work to accommodate the wide variety of payment models between plans

and providers without forcing a hospital or plan to change their payment methods or add new business processes. As noted previously, both rules acknowledge there may be payment models that can't calculate a dollar amount and do not force these plans to change their processes. For instance, the health plan rule clearly states that capitated plans do not have to provide a derived amount if the amount is not calculated in the "normal course of business."[42] More broadly, the health plan rule touches on how the rule can accommodate several different payment approaches, such as value-based contracting,[43] reference pricing plans,[44] level-funded plans,[45] direct primary care,[46] payments based on usual, customary, and reasonable (UCR) amounts,[47] payments based on percent of billed charges,[48] and different approaches to third-party funding of cost sharing.[49] Likewise, the hospital rule declined to define how hospitals should report service packages to give "hospitals flexibility to display their standard charges for service packages that are unique to each of their payer-specific contracts."[50] ■

Recommendations

Using the preceding principles and objectives from the federal price transparency rules as a guide, Congress should consider several opportunities to strengthen and improve the rules. As noted previously, the price transparency rules only had the statutory authority to go so far. Both rules identify specific policies that could improve price transparency, but where the statute did not authorize regulatory action. There are also areas where the rules stopped short and appropriately took a more cautious approach which Congress can now revisit. It's also worth noting that five years have passed since these rules were originally conceived and there are likely new opportunities to advance price transparency for Congress to consider today. With that in mind, Congress should consider the following recommendations to expand price transparency across America's health care system.

Use the federal rules as the foundation for legislation to build up a stronger set of price transparency policies. The major elements of the hospital and the health plan price transparency rules are already in force and the procedures for disclosing pricing information are in place.[51] Even without congressional action, these requirements and processes will deliver a high level of price transparency by the time hospitals and health plans come into full compliance. With nearly everything in place, now is not the time to reverse course and start something different. That will only stall the introduction of price transparency and the consumer benefits that will follow. Therefore, Congress should keep all the major elements of each price transparency rule in place, including the prescription drug data file required under the health plan rule that is not currently being enforced. As the health plan rule explains, the two rules are complementary and, "[a]s a result of these rules, regardless of where a consumer seeks information, be it their plan or issuer, or their hospital, they will have guaranteed access to up to date and accurate pricing information."[52]

Expand the hospital price transparency requirements to more care settings and to care provided in hospitals by providers who are not employed by the hospital. Currently, the statute only requires hospitals to report their standard charges which means prices remain hidden or more difficult to uncover at every other care setting. This is particularly problematic in the case of care settings that directly compete with hospitals. As explained previously, if

different price transparency rules apply to health care entities that directly compete, there will be incentives to inefficiently shift resources and activities to and from areas based on whether prices can still be hidden from patients.

In response to comments suggesting the hospital rule should apply to other providers, the rule noted the statute did not provide the "authority to apply the price transparency requirements to non-hospital sites of care."[53] This includes ambulatory surgical centers (ASCs) that compete directly with hospitals. To fill this gap in the federal law, Minnesota recently expanded the hospital price transparency requirements to include facilities that provide radiology services, laboratory testing, orthopedic surgical procedures, ophthalmologic surgical procedures, anesthesia services, oncology services, and dental services.[54] All states should consider doing the same under current law, but Congress can obviate the need for this type of state action by carefully expanding the hospital price transparency requirements to non-hospital care settings.

As noted previously, CMS also concluded that the statute does not provide the authority to require hospitals to disclose prices for items and services provided in the hospital by physicians and non-physician practitioners who are not employed by the hospital. Congress should expand price transparency to all practitioners who provide care in a hospital. While a physician and non-physician practitioner not employed by the hospital may bill independently, the hospital should still have a duty to know and report the prices for all care administered within its facility.

Require hospitals and other care settings to disclose information through the data files in a standardized format and to post the files to a prominent place on their website. The early experience with the hospital data files clearly shows that CMS should have required a standardized format from the start. Hospitals are making the data files available in widely varying formats to make it more difficult to aggregate the data and provide price comparisons across hospitals. States like Texas and Minnesota have already enacted laws to force hospitals to standardize this data set. This will help, but the standardized format should ideally come from the federal government to ensure that prices can easily be compared across states. While CMS has already proposed rules to fix this problem, Congress should still step in to ensure price transparency data is reported in a standard format that can easily be accessed and aggregated by entities working to help consumers. Currently, this information can be difficult to find on a hospital's website and so, to improve access, Congress should also require providers to post the data files in a prominent place on their websites.

Move closer to real-time disclosure of pricing and cost-sharing information. Both the hospital and health plan rules considered alternatives that would require real-time disclosure of pricing information. The proposed hospital rule sought comment on requiring hospitals to disclose standard charges through a standards-based API and the burden an API approach would add. The final hospital rule opted to require disclosure through the data files but described this approach as "a good initial step."[55] The rule goes on to note how CMS continues to advance the use of APIs in other contexts in cooperation with the Office of the National Coordinator (ONC) and, as disclosure of standard charges matures, the use of APIs or other technology may be revisited. This largely mirrors the health plan rule which noted that a "standards-based API would be a natural next technological step."[56]

Ensuring patients have all the information they need when they sit down with their provider to make the best health care decision depends on the patient having a fully informed provider in the room with them.

Since the price transparency rules were finalized, CMS and ONC have accumulated substantially more experience in implementing a standards-based API

approach in other contexts. In March 2020, CMS finalized the Interoperability and Patient Access rule which requires certain health plans to implement and maintain a standards-based "Patient Access API" that allows patients to access their claims and encounter data, including data on costs, through a third-party application. The rule also required certain plans to maintain a "Provider Directory API" to make provider directory information publicly available. CMS began enforcing these rules July 1, 2021 and, after six months, a review of compliance by Defacto Health found a majority of payers (67 percent) were already in compliance with publishing the Provider Directory API and the remaining payers were "making efforts to launch their APIs."[57] Last December, CMS proposed rules to add new disclosures through the Patient Access API and implement a Provider Access API that gives providers access to the same patient claims and encounter data that is available through the Patient Access API.[58] This expanded use of the Patient Access API just 17 months after plans began publishing it suggests CMS has a substantial level of comfort with implementing these API requirements.

Based on this growing use of APIs to provide immediate access to patient data, CMS now appears to have gained the experience necessary to require health plans to implement and maintain a Price Transparency API. As this was always viewed as the natural next step, Congress should direct the federal government to officially move in this direction. Because the data files are already available, CMS should be given the time and flexibility they need to implement a Price Transparency API without compromising other priorities. Taking this approach does not mean Congress should stop enforcing the data files. An API should be seen as a complement to the data files. Health plans should not be allowed to stop publishing the data files until a successor technology has clearly demonstrated it can provide at least the same level of functionality to consumers.

Make pricing and cost-sharing information easily accessible to a patient's authorized representative. Ensuring patients have all the information they need when they sit down with their provider to make the best health care decision depends on the patient having a fully informed provider in the room with them. The hospital rule recognized: "As consumers' healthcare costs continue to rise, clinicians are in a unique position to discuss the financial impacts of healthcare decisions with their patients."[59] To put clinicians and others in an even better position to discuss financial impacts, "many commenters" to the health plan rule recommended "to also require that plans and issuers make cost-sharing information easily accessible to authorized representatives—which may include health care providers—so that they can better respond to patient inquiries."[60] While the rule recognized the "value in provider access," it did not require provider access because that would have gone beyond the "statutory obligation for plans to make this information available to participants, beneficiaries, and enrollees."[61]

Congress should now step in and provide the authority to require health plans to make the self-service tool available to providers and other authorized representatives. Patients will not always have the means to access the self-service tool when they discuss options with their provider. Moreover, it will always be easier for a provider to have direct access to a tool they are familiar with versus relying on a patient to share the information. This is particularly true in a telehealth appointment. Giving providers and other authorized representatives access should not be particularly burdensome on health plans because, at a minimum, the plan would just need to create a separate access point to the same self-service tool for the authorized representative.

Requiring provider access to the self-service tool would align with the previously discussed Provider Access API which CMS recently proposed in rulemaking. Again, if finalized, this would require certain health plans to give providers access to a patient's claims and encounter data. To justify the Provider Access API requirement, the proposed rule concluded: "Research shows that patients achieve better outcomes when their record is more complete and there are more data available to the healthcare provider at the point of care."[62] The proposed rule also noted how "[e]nsuring that providers have access to

relevant patient data at the point of care could also reduce the burden on patients to recall and relay information during an appointment."[63] The same holds true for patient cost-sharing information.

Provide the authority to extend the Provider Directory API, Patient Access API, and the proposed Provider Access API to all health plans subject to the ACA's individual and group market reforms. Federal statutes currently limit the reach of key interoperability policies that CMS implemented through rulemaking in recent years. These rules are aimed at giving patients ownership and control over their health care data, but the statute limits their application to Medicare Advantage, Medicaid managed care plans, CHIP managed care entities, and qualified health plan (QHP) issuers on the federally-facilitated exchanges (FFEs). Ideally, patients and their providers could access all relevant health care data—including pricing, claims, and encounter data—together in one place. To make this happen, Congress should provide the authority to align the price transparency requirements with interoperability requirements. Right now, there is currently just a narrow slice of health plans—QHP issuers on the FFEs—that must meet both price transparency and interoperability requirements. Extending that regulatory framework to all health plans would substantially increase the incentives for third-party developers to create the consumer tools necessary to pull patient data into one place in a useful way for patients and their providers.

Align price transparency requirements with the requirements of the No Surprises Act. As noted previously, the requirements to provide an AEOB under the No Surprises Act overlaps with the price transparency rules. Both aim to help the patient understand how much they will ultimately need to pay for an item or service. The price transparency rules work to help patients construct an EOB earlier in the shopping and decision-making process. This helps patients compare cost estimates for different treatments and across multiple providers. The AEOB provides the patient with cost-sharing information further into the process once they have made their decision and are ready to schedule a service with a specific provider. This helps ensure they won't be surprised after they get a bill after completing a scheduled service. While the price transparency requirements and AEOB serve separate roles in the decision-making process, they are complementary and there are likely ways to align them to better serve the patient and reduce the burden on providers and health plans.

The No Surprises Act also requires health plans to maintain a price comparison tool. CMS has determined this tool is "largely duplicative of the internet-based self-service tool" and intends to issue proposed rulemaking on whether compliance with the self-service tool meets compliance with the No Surprises Act.[64] Considering the overlap and duplication between the AEOB and price comparison tool requirements of the No Surprises Act with the price transparency requirements, Congress should consider ways to better align the policies to improve the information patients can access and reduce any duplicative burdens on health plans and providers. ■

Conclusion

Transparency was always an essential part of the Affordable Care Act's comprehensive approach to regulating private health coverage. Congress embedded both the hospital and health plan transparency requirements upfront in Title I, Part A of the Affordable Care Act with all the other major reforms to individual and group health coverage that the law prioritized to take effect shortly after passage. As the health plan rule explains: "By including transparency in coverage in this set of requirements that apply to most private coverage, Congress established transparency as a key component to PPACA's comprehensive framework for regulating private health coverage."[65] The health plan rule goes on to describe how Congress rejected an amendment to the Affordable Care Act which would have adopted a more prescriptive and narrow approach to transparency. Instead, Congress added transparency in coverage provisions through the manager's amendment which enacted "a far more comprehensive and expansive approach toward providing transparency."[66]

Though it took more than ten years to fully implement a comprehensive set of price transparency regulations under the framework established by the Affordable Care Act, the finished product has garnered strong bipartisan support. There appears to be wide recognition that the Affordable Care Act's framework and probably any framework that continues to depend on private health care options needs price transparency to work. The package of bipartisan bills moving through the U.S. House of Representatives reflects this consensus. The current approach to price transparency in this package appropriately builds from the price transparency regulations now in place. As this work progresses, Congress should consider the opportunities to further expand price transparency recommended in this report. Consistent with the approach taken in the Affordable Care Act, Congress should also take care to enact an appropriate balance of prescriptiveness with discretion to ensure the law can accommodate future technologies and evolutions in health care markets. ■

Endnotes

1 84 FR 65524, 65526.

2 85 FR 72158, 72160.

3 Foundation for Research on Equal Opportunity, World Index of Health Innovation at https://freopp.org/wihi/home (finding the United States ranks first in the number of new drugs and medical devices gaining regulatory approval).

4 Id. at 72161.

5 85 FR 72158, 72170

6 U.S. Census Bureau, Health Insurance Coverage in the United States: 2021 (September 2022), available at https://www.census.gov/library/publications/2022/demo/p60-278.html.

7 Id. at 72209-12.

8 Id. at 72212.

9 Id. at 77214.

10 Id. at 77214-15.

11 84 FR 65524, 65530.

12 Id. at 65532-33.

13 85 FR 72158, 72226.

14 Id. at 72195.

15 Id. at 72181.

16 Id. at 72217 (emphasis added).

17 84 FR 65524, 65534-35.

18 Id. at 65534.

19 Georgetown University Center for Children and Families, "Transparency in Coverage: Recommendations* for Improving Access to and Usability of Health Plan Price Data," available at https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.

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21 Id.

22 85 FR 72158, 72275.

23 Id. at 72179.

24 Id. at 72244.

25 84 FR 65524, 65540.

26 85 FR 72158, 72179.

27 Id. at 72231.

28 Consolidated Appropriations Act of 2021, Division BB, Section 112 (adding section 2799B-6 to the PHS Act).

29 Consolidated Appropriations Act of 2021, Division BB, Section 111 (adding section 9816(f) to the IRC, section 716(f) to ERISA, and section 2799A-1(f) to the PHS Act).

30 85 FR 72158, 72195.

31 Id.

32 CMS, "Hospital Price Transparency Frequently Asked Questions (FAQs)," June 27, 2023, available at https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.

33 85 FR 72158, 72227.

34 Id. at 72199.

35 *See* CMS, "Hospital Price Transparency Frequently Asked Questions (FAQs)," June 27, 2023, available at https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf (allowing hospitals to indicate a standardized algorithm in the data files when a standardized dollar amount cannot be displayed) ; CMS, "FAQS About Affordable Care Act Implementation Part 53," April 19, 2022, available at https://www.cms.gov/files/document/faqs-part-53.pdf (allowing disclosure of a percentage when a health plan contracts to pay an in-network provider a percentage of billed charges); and CMS, "FAQS About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49," August 20, 2021, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf (deferring enforcement of the requirement to publish data files related to prescription drug pricing pending further rulemaking).

36 *See* Patient Rights Advocate, *Fifth Semi-Annual Hospital Price Transparency Compliance Report* (July 2023), available at https://www.patientrightsadvocate.org/july-semi-annual-compliance-report-2023 (finding only 36 percent of 2,000 hospitals reviewed were fully compliant with the hospital rule and that 507 of 1,228 hospitals which post negotiated rates still failed compliance because their data was missing or substantially incomplete). *See also* Zeynep G. Gul, Danielle R. Sharbaugh, and Cailey J. Guercio, et al., "Large Variations in the Prices of Urologic Procedures at Academic Medical Centers 1 Year After Implementation of the Price Transparency Final Rule," *JAMA Network Open*, January 5, 2023, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800083 (finding compliance among 153 academic hospitals in reporting commercial rates for five common urologic procedures ranged from 29 percent to 56 percent).

37 85 FR 72158, 72198.

38 Id. at 72198-200.

39 Id. at 72210.

40 Id.

41 88 FR 49552.

42 85 FR 72158, 72227.

43 Id. at 72228.

44 Id. at 72191.

45 Id. at 72208.

46 Id. at 72192.

47 Id. at 72199.

48 Id. at 72199-200.

49 Id. at 72178.

50 84 FR 65524, 65535.

51 By January 1, 2024, health plans will need to expand the self-service tool from 500 items and services to all items and services. This will complete the implementation of the rules with the exception of the prescription drug data file, which has been delayed indefinitely.

52 85 FR 72158, 72166.

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57 Ron Urwongse, "Payer Compliance: Provider Directory APIs in the first six months since CMS Final Rule enforcement," Defacto Health, January 18, 2022, at https://defacto.health/2022/01/18/payer-compliance-provider-directory-apis-in-the-first-six-months-since-cms-final-rule-enforcement/.

58 CMS, "Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P: Fact Sheet," December 6, 2022, available at https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact.

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60 85 FR 72158, 72180.

61 Id.

62 85 FR 72158, 76255.

63 Id.

64 CMS, "FAQS About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49," August 20, 2021, available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.

65 85 FR 72158, 72159.

66 Id. at 72169.

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