



750 9th Street NW
Washington, D.C. 20001-
4524

Kate Harris, Chair
Kevin Beagan, Vice-Chair
NAIC Health Care Affordability and Mitigation (B) Working Group
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650 Washington, DC 20005

Submitted via Email: Joe Touschner (jtouschner@naic.org)

RE: BCBSA Comments on Drafting Group 5: Enhanced Health Care Price Transparency

Dear: Ms. Harris and Mr. Beagan

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide feedback on the Enhanced Health Care Price Transparency Brief developed by the Health Care Affordability and Mitigation (B) Working Group Drafting Group #5.

BCBSA is a national federation of 31 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 95% of hospitals and 91% of doctors across the country and serve individuals covered through Medicare, Medicaid, employer-sponsored coverage, and the individual market.

BCBSA believes that everyone deserves peace of mind when it comes to their health care. As health care costs continue to rise, families, employers, and public programs are facing increasing financial pressure. Consumers are experiencing higher premiums, increased cost sharing, and rising out-of-pocket expenses, underscoring the need for solutions that address the underlying drivers of health care costs. BCBS companies are focused on addressing the root causes of rising costs and advancing a [roadmap](#) that could reduce health care costs by nearly \$1 trillion over 10 years through targeted reforms designed to improve affordability and promote a more sustainable health care system.

Given this commitment to improving health care affordability, BCBSA appreciates the Working Group's efforts to develop issue briefs that serve as educational resources for regulators and policymakers. These

resources provide a valuable overview of policy approaches being considered and implemented across states and can help inform ongoing discussions regarding strategies to improve affordability and access to coverage. BCBSA believes the briefs will be a useful resource for regulators seeking to better understand the range of state policy options, as well as the opportunities and tradeoffs associated with different approaches. BCBSA looks forward to working with the Working Group as it continues its examination of policies that can support affordable, high-quality health coverage and care.

As the Working Group continues to refine these resources, BCBSA encourages the adoption and maintenance of a standardized format across the issue briefs. A consistent structure, including the presentation of state examples, discussion of policy considerations, evaluation of available evidence, and identification of legal, operational, and implementation considerations, would strengthen the briefs and make it easier for regulators and other stakeholders to compare approaches across topics. In addition, BCBSA agrees with recommendations offered by our consumer representative colleagues that each brief clearly articulate the affordability challenge it is intended to address and explain how the featured state approaches are designed to respond to that challenge. Providing this context would enhance the educational value of the briefs and help readers better understand the relationship between specific policy interventions and affordability objectives.

BCBSA also encourages the Working Group to maintain the briefs as neutral educational resources consistent with their stated purpose. The briefs are most effective when they provide an objective assessment of state approaches, including implementation experiences, operational considerations, potential benefits and drawbacks, and any available evidence regarding outcomes. Because states face differing market dynamics, regulatory frameworks, and affordability challenges, the briefs can serve as a particularly valuable resource when they present information in a balanced and non-prescriptive manner, enabling regulators and policymakers to evaluate policy options within the context of their own markets.

Finally, we recommend that the briefs consistently identify when a highlighted policy, law, or regulatory approach is subject to ongoing litigation, legal challenge, enforcement stays, or other significant legal uncertainty. Providing this context is particularly important where legal proceedings may affect implementation, enforceability, or the ultimate viability of a policy approach. Including such information would help ensure regulators receive a complete and balanced understanding of the policy landscape and avoid inadvertently presenting unsettled approaches as established best practices.

In addition to the overarching comments outlined above, BCBSA has provided attached redlines and document-specific comments for the Working Group's consideration. These recommendations are intended to improve consistency across the briefs, enhance contextual information, support the briefs' educational purpose, and ensure that relevant implementation and legal considerations are presented in a balanced manner.

Thank you for the opportunity to provide feedback. We appreciate the Working Group's continued efforts to develop these resources and look forward to continued engagement as the briefs evolve. If you have any questions or would like additional information, please contact Randi Chapman at randi.chapman@bcbsa.com.

Sincerely,

A handwritten signature in dark ink, reading "Clay S. McClure". The signature is written in a cursive, flowing style.

Clay S. McClure, BCBSA
Senior Director, State Affairs

NAIC Health Care Affordability and Mitigation Working Group: Enhanced Health Care Price Transparency

The Health Care Affordability and Mitigation Working Group Briefs are intended to be short, informative briefings for regulators and policymakers on various affordability efforts states have undertaken in recent years to help make health insurance more affordable. They are intended to be high-level and not an exhaustive resource on each issue. They also do not represent policy positions of the NAIC, a given state, author, or workgroup member.

Submission Date

TBD

Contributors

Contributors	Titles of Contributors	States of Contributors
Weston Trexler	Deputy Director	Idaho
Shannon Hohl	Market Oversight Bureau Chief	Idaho
Alex Peck	Chief Deputy Commissioner of Compliance and Actuarial Services	Indiana
Teresa Tetrick	Health Oversight and Compliance	Indiana
Andria Seip	Senior Health Policy Advisor	Iowa
Julie Holmes	Division Director, Rate and Form Compliance	Kansas
Anthony Depner	Research Analyst	Kansas

Contributors	Titles of Contributors	States of Contributors
Chrystal Bartuska	Division Director, Life & Health/Medicare	North Dakota
Carlos Valles	Special Aide	Puerto Rico

Executive Summary

Health care costs represent a major driver of escalating commercial insurance premiums. To combat market inefficiencies, the federal government enacted the Hospital Price Transparency (HPT) Rule (effective 2021) and the Transparency in Coverage (TiC) Rule (effective 2022), mandating public release of gross charges, negotiated in-network rates, and out-of-network historical allowed amounts. In February 2025, a new Executive Order, “Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information,” directed federal agencies to continue the initiative for price transparency. The Centers for Medicare & Medicaid Services (CMS) responded in May 2025 with guidance for new and updated Hospital Price Transparency requirements. [For health plans and issuers, in June 2025 the Departments of Labor, Health and Human Services, and the Treasury issued a Request for Information on implementation of the prescription drug machine-readable file required under the TiC Rule. In December 2025, CMS, the Department of Labor, and the Department of the Treasury jointly proposed a rule \(CMS-9882-P\) to update the TiC requirements.](#)

States are also taking action to improve price transparency in healthcare. Structural barriers have, however, historically limited state-level oversight. As of 2025, 24 states operate All-Payer Claims Databases (APCDs), but states do not have authority to require submission of claims information from employer-sponsored, self-insured plans due to federal ERISA preemption. This preemption creates a significant blind spot in state health care spending data. Early market data also indicates that published pricing information has begun to drive price convergence among providers. [However, this convergence on its own does not produce consumer savings convergence does not by itself lower consumer costs and may push prices upward.](#)

This brief details some of the ways state Departments or Divisions of Insurance (DOIs) have moved beyond passive consumer-facing tools. State insurance regulators and state employee health plans have worked to address cost drivers by integrating standardized TiC data, leveraging APCD data where available, protecting employer access to claims data under the Consolidated Appropriations Act (CAA) of 2021, and supporting structural plan designs, such as reference-based pricing, tiered networks, site-of-care steering, and direct payment rate constraints. Most of the initiatives described below are facilitated by enhanced price transparency.

Commented [A1]: We recommend noting the recent developments for health plans alongside the hospital guidance. Including them gives readers the current state of the federal framework. However, the final rule for CMS-9882-P is currently under review by OMB and may publish prior to the finalization of this brief which would require updating this paragraph.

Commented [A2]: We recommend including additional detail to align with the brief’s body. Page 8 of the brief cautions that convergence toward a market equilibrium does not mean prices are lower for consumers and that the equilibrium point can sit above the prior median for markets that were previously lower cost. The revision reinforces the brief’s central point that transparency on its own does not reduce consumer costs.

Enhanced Health Care Price Transparency

Overview

Health care price transparency rules aim to empower consumers to make informed health care decisions, increase market competition, and ultimately slow the rising costs of medical care and insurance by bringing clarity and standardized access to health care pricing. This brief examines the current state of federal and state healthcare price transparency initiatives, the technical and legal barriers to effective data utilization, and the strategies available to state insurance regulators and institutional purchasers to leverage price transparency data for systemic cost containment and overall improved health care affordability. Federal price transparency mandates enacted between 2019 and 2022, the Hospital Price Transparency (HPT) Rule and the Transparency in Coverage (TiC) Rule, created an unprecedented public record of negotiated health care prices. A February 2025 Executive Order directed federal agencies to require disclosure of actual prices rather than estimates and to strengthen standardization and enforcement. Despite this regulatory progress, persistent structural barriers, some of which this brief discusses, have constrained the practical impact on health care costs. States are responding with an expanding range of strategies, such as hospital price transparency enforcement mechanisms, All-Payer Claims Database (APCD) modernization, and data-driven consumer initiatives.

States with Actions Related to Enhanced Price Transparency

State	Implementation Date	Key Variations/Notes
Arkansas	2023	Imposes state-level financial penalties on hospitals that fail to comply with federal HPT requirements, supplementing federal enforcement.
Arizona	2022	Designated the Department of Health Services as responsible for overseeing hospital compliance with federal HPT rules; requires public posting of noncompliant hospitals.

Commented [A3]: We recommend including in-text citations so that policymakers can easily access the specific state actions to read more.

State	Implementation Date	Key Variations/Notes
California	2017	Passed SB 17, requiring drug manufacturers to report price increases over a specific percentage.
Colorado	2024	Works with third parties to transform complex machine-readable files (MRFs) into an accessible consumer portal. Prohibits hospitals from initiating debt collection against patients for services rendered during any period of HPT noncompliance.
Indiana	2024	Administers an All Payer Claims Database (APCD) housing over 2.3 billion records across 7.7 million unique members. Includes an interactive mapping of procedure cost variations across ZIP codes.
Massachusetts	2025	Uses a centralized data hub to inform tiered provider networks where enrollees pay lower cost-sharing for high-value tiers.
Minnesota	2021	Expanded transparency requirements beyond hospitals to include outpatient surgical centers, large imaging/laboratory providers, and dental service providers.
New Hampshire	2019	Leveraged its APCD to host the "NH Health Cost" tool, which <u>was associated with a decline in imaging prices</u> successfully reduced insurer prices for imaging services and other categories.
Oklahoma	2025	Enacted SB 889 (2025), requiring hospitals to publicly post consumer-friendly, machine-readable price lists for 300 common services, including standard gross charges, payer-specific negotiated rates, and discounted cash prices.
Texas	2019	Passed HB 2536, requiring drug manufacturers to report price increases over a specific percentage. Texas has codified federal HPT rules into state statute with enhanced penalties, extended TiC requirements to short-term limited duration plans, and issued state standardization guidance to improve data usability.
Washington	2025	Passed HB 1382 (2025) to modernize its APCD, removing statutory "proprietary financial information" protections to permit the disclosure of actual contract pricing and payer-negotiated rates.

Commented [A4]: We recommend revising this note to better align the brief's description of the NH Cost Tool on page 8 and avoid asserting an outcome. As written, the row asserts a broader, stronger result than the brief's own body supports. Page 8 notes that roughly 8% of imaging patients used the tool, that it was associated with about a 4% decline in imaging prices over five years, and that the effect did not extend meaningfully to hospital or physician services. Additionally, every other row describes what a state did rather than a result it achieved, so a measured phrasing keeps New Hampshire consistent with the table and with the objectivity the brief maintains elsewhere.

Other Price Transparency Data for Consideration

Key Data Point	Value/Metric	Description
Impacted Population	222,700,000	Number of citizens with private health coverage in 2024. Private health insurance includes employer or union sponsored, coverage purchased directly, or TRICARE.
Commercial Healthcare Spending	~\$1.644 trillion	Direct annual healthcare spending managed by private and public commercial plan purchasers. CMS National Health Expenditure Accounts (2024) report private insurance spending at \$1.644 trillion.
Site-of-Care Cost Difference	1.27 to 13.5 times higher	Increased cost of routine services at a hospital outpatient setting compared to the cost of the same service at an independent physician office.
Hospital Price Transparency (HPT) Compliance Issues	46%	Percent of hospitals that did not comply with the HPT rule.
Consumer Engagement	Less than 10%	Percent of consumers who utilize existing carrier price transparency tools.
Commercial Cash-Price Arbitrage	47%	Percentage of instances where a hospital's self-pay/cash price is lower than the median in-network commercial negotiated rate for the identical shoppable service.
Market Price Convergence	About 80% of markets showed convergence	Percentage of hospital markets (across 10 largest U.S. metros, 37 services) showing inflation-adjusted rate convergence between Dec. 2021 and June 2024. Top-quartile rates fell ~6.3%; bottom-quartile rates rose ~3.4% (annualized). Stronger in outpatient (87.4%) than inpatient (62.5%) settings.

Commented [A5]: We recommend including in-text citations so that policymakers can easily access the source of these data points to understand the context behind the data.

Premium or Other Impacts and Analysis of Price Transparency

Initiative	Metric	Change (%)	Source/Citation
The Drafting Group welcomes sources and input from interested parties on premium impacts of price transparency.			

Key Challenges for Achieving Price Transparency

Data Category	Observation/Finding	Source/Context
Stakeholder Feedback	America's Health Insurance Plans (AHIP) expressed concern about states adding unnecessary burdens on health plans by requiring additional transparency work in addition to the federal requirements.	AHIP (stakeholder comment)
Implementation Challenges	Insurers and Third-Party Administrators (TPAs) frequently assert proprietary intellectual property protections over contracted rate data.	CAA of 2021 (anti-gag and TiC provisions)
	Insurer and hospital TiC files are often extremely large, making them unwieldy to parse, and hospitals have used placeholder values, making the data unreliable.	CMS Price Transparency Fact Sheets (2025-2026)
Legal/Regulatory Issues	Under the Supreme Court's ruling in <i>Gobeille v. Liberty Mutual Insurance Co.</i> (2016), states cannot compel self-insured ERISA plans to report claims data to state APCDs, leaving a blind spot in state healthcare spend tracking.	<i>Gobeille v. Liberty Mutual Ins. Co.</i> , 577 U.S. 312 (2016)

Data Category	Observation/Finding	Source/Context
	State DOIs have direct regulatory authority over risk-bearing insurance carriers but lack direct jurisdiction over health care provider systems and self-funded employer plans.	Maanasa Kona and Nadia Stovicek (Health Affairs Forefront) (2014)
Unexpected Outcomes	A notable market effect of publishing negotiated price data is rate convergence rather than across-the-board cost reduction. See 2024 Turquoise Health analysis of 200+ hospitals across the 10 largest U.S. metro areas.	Forrest Xiao (Turquoise Health) (2024)

Price Transparency Brief

Health care price transparency rules aim to empower consumers to make informed health care decisions, increase market competition, and ultimately slow the rising costs of medical care by bringing clarity and standardized access to health care pricing. Consumers rarely know the price of health care services, resulting in reduced market incentives for providers to compete based on prices. Because the evidence below shows that direct consumer shopping has limited effect on system-wide costs, this brief treats “empowering consumers” and “containing costs” as related but distinct goals, achieved through different mechanisms, with the larger cost effects driven by institutional purchasers.

The Current Healthcare Price Transparency Landscape

Health care pricing in the United States historically operated behind confidential proprietary protection provisions, entirely isolating employers and state regulators from the negotiated contractual prices of covered procedures. The implementation of the federal Hospital Price Transparency (HPT) regulation (2021) under Section 2718(e) of the Public Health Service Act, and the Transparency in Coverage (TiC) rules (2022), sought to dismantle this paradigm by mandating the public disclosure of standard, cash-discounted, and third-party negotiated rates. Despite bipartisan support and federal administrative penalties of up to \$5,500 per day for large non-compliant facilities, the mandated public cost data continues to face significant friction in producing measurable impacts to the costs of health care.

Commented [BCBSA6]: We recommend adding a sentence to the opening that frames consumer empowerment and cost containment as related but distinct goals. The introduction leads entirely on empowering consumers, while the evidence sections attribute the system-wide cost effects to institutional purchasers.

Early empirical data from analysis of published machine-readable file (MRF) data suggests that price transparency is beginning to affect market behavior, though not necessarily by reducing overall costs. A 2024 Turquoise Health analysis examined inflation-adjusted commercially negotiated rates at over 200 hospitals across the 10 largest U.S. metro areas, covering 37 common services from December 2021 to June 2024. The analysis found that 82.8% of markets showed price convergence: rates in the top quartile fell approximately 6.3% (annualized, inflation-adjusted) while rates in the bottom quartile rose approximately 3.4%. Convergence was substantially more pronounced in outpatient services (87.4% of markets) than inpatient services (62.5% of markets). The study's author noted that converging rates are 'an encouraging sign that healthcare markets are responding to price transparency with increased market competition,' while cautioning that convergence toward a market equilibrium does not mean that prices are lower for consumers. The equilibrium point may itself be above the prior median for markets that were previously lower cost. The study does not establish causality between the transparency regulations and the observed convergence, and the authors identify this as an area requiring further research.

Research on consumer engagement with price transparency tools documents consistently low utilization rates. New Hampshire's APCD-based consumer price tool, for example, was used by approximately 8% of patients seeking imaging services and was associated with a 4% decline in imaging prices over five years. These effects, however, do not extend meaningfully to hospital and physician services, where provider switching is substantially less common.

There are several primary reasons why consumer engagement with price transparency tools remains low:

1. **Lack of Financial Incentive for Insured Patients:** Because most patients have health insurance, they are largely insulated from the full cost of their care. Since out-of-pocket costs typically represent only a small fraction of the total negotiated or list price, insured patients often lack a strong financial motivation to price shop. By contrast, self-pay patients (who bear the full out-of-pocket cost) are significantly more likely to use price information and choose lower-priced hospitals for elective procedures. Patients also become much more responsive to price transparency when they face higher cost-sharing or reference-pricing programs (where they must pay the difference if their care exceeds a set benchmark).
2. **Poor Usability and Complexity of Data:** The price data published by hospitals is often inconsistent, difficult to interpret, and fundamentally not consumer-friendly. Consumers struggle to accurately determine what their actual out-of-pocket expenses will be based on the raw data files provided. In one experimental study, only 19% of participants were able to successfully retrieve cost information directly from hospital websites because the task was so complex.

3. **Lack of Awareness:** A major barrier to usage is simply that many patients are unaware that price transparency data or tools even exist. One study found that 64% of participants had never heard of the federal price transparency legislation, despite overwhelmingly agreeing that knowing the cost of a service beforehand is important.
4. **Reliance on Non-Price Factors:** Patients often base their health care decisions on factors entirely unrelated to price. Provider reputation and physician referrals are often more critical to a patient's decision-making than cost, with physicians often referring patients to providers within their own hospital system even when cheaper alternatives exist. Furthermore, when patients do not know what services they need or require emergency care, they do not have the time or ability to price shop.

Deficiencies of Current Machine-Readable File and Transparency in Coverage Data Pipelines

The primary operational barriers to effective price transparency under current federal requirements include the large number of files, the size of data, inconsistent formatting, and variations in file structure. Insurers' and hospitals' machine-readable files are frequently very large and contain substantial superfluous information. Federal requirements mandate monthly updates from commercial insurers regardless of whether underlying rates have changed, generating massive recurring data loads. A proposed rulemaking published at 90 Fed. Reg. 60,432 (December 23, 2025) would move these updates from monthly to quarterly, which CMS has identified as sufficient to capture meaningful rate changes while substantially reducing unnecessary data volume.

A specific and well-documented data quality problem compounds the volume challenge. Hospitals were permitted to enter the numeric placeholder "999999999" for any service lacking sufficient historical claims data; CMS found this practice was used far more broadly than intended, sometimes appearing across many listed services within a single hospital file and rendering those entries non-comparable. May 2025 guidance directed hospitals to discontinue the placeholder and instead report actual dollar amounts drawn from electronic remittance data covering the prior twelve months. TiC files present a [parallel-related issue](#): [because of how plans contract with providers and the current requirement to post rates for all covered items and services, the files they often include negotiated rates for procedures a given provider is unlikely to furnish, because contracts typically cover all of a provider's services and the current regulation requires plans to post all of them. The December 2025 Transparency in Coverage proposed rule cited above would address this by removing in-network rates for these unlikely provider-to-service mappings rates, they frequently include rate configurations for specialized procedures that the reporting provider lacks the clinical capacity to perform, adding further noise to already unwieldy datasets.](#)

Commented [A7]: We recommend reframing the TiC file point to reflect its cause and the pending fix. These entries derive from the structure of the TiC files as currently designed, requiring plans to post rates for all covered items and services per provider.

Compounding this technical challenge are the structural validation issues. Parallel comparison audits evaluating insurer-posted TiC rates against hospital-disclosed lists identify wide, unexplainable discrepancies. Data integrity, inconsistent naming conventions, and limited provider details such as location can also contribute to the deficiencies of MRFs. These underlying inconsistencies [fundamentally devalue/limit](#) the utility of the files, since market analysts cannot rely on their accuracy and utility. Consumers are required to locate and retrieve files from company websites. This is not necessarily an easy task for consumers.

State DOI Strategies: Activating Data for Market Redesign

Historically, direct consumer shopping produces limited and inconsistent impacts on overall health care spending. The most valuable and impactful use of enhanced price transparency strategies lies in its use by institutional purchasers, large employers, state employee health plans, and state regulators rather than individual consumers.

Individual states often lack direct statutory authority to hold health care facilities accountable for pricing practices, however, there are measures that states can take to promote market efficiency:

1. Enforcing TiC and HPT compliance promotes value-based purchasing and competitive pricing. Increasing visibility and enforcement of standards that are already in place allow DOIs an opportunity to make impactful changes without authority. By promoting these data elements, states can empower consumers to make more informed health care decisions.
2. Supporting APCD infrastructure promotes data visibility, enhanced value-based purchasing, policy development, consumer empowerment, and fosters competition and cost control. Enhanced APCD tools, like those used in Indiana, can give consumers the ability to research and utilize real-time pricing data within an APCD database and have more control over their health care.
3. Enforcing employer access to data under the CAA of 2021 promotes trust, data integrity, informed decision making, and greater bargaining power, while also reducing administration costs.

Several states have developed independent enforcement measures that supplement or go beyond federal HPT requirements:

1. Arizona designated its Department of Health Services as responsible for overseeing hospital compliance with federal HPT rules and requires the agency to publicly post information about noncompliant hospitals, creating a public accountability mechanism not present at the federal level.
2. Arkansas imposes state-level financial penalties on hospitals that fail to comply with federal HPT requirements, supplementing federal enforcement resources.

3. Colorado prohibits hospitals from initiating debt collection against patients for services rendered during any period of HPT noncompliance, linking a hospital's billing rights directly to its transparency compliance.
4. Texas has codified the federal HPT rules into state statute with enhanced penalties, extended TiC disclosure requirements to short-term limited duration plans not otherwise covered by federal rules, and issued detailed state standardization guidance designed to improve the usability of disclosed pricing data.

State-level APCD tools provide comprehensive multi-market tracking, but their coverage is substantially constrained by ERISA preemption. As of 2025, 24 states operated APCDs. The Supreme Court's ruling in *Gobeille v. Liberty Mutual Insurance Co.*, 577 U.S. 312 (2016), held that states cannot compel self-insured employer plans, regulated under ERISA, to report data to state APCDs. Because approximately 67% of workers with employer-sponsored insurance (ESI) are enrolled in self-insured plans, this constraint creates a significant reporting gap: in some states, the share of ESI lives reported to the APCD is as low as 25%. States can partially address this gap by offering voluntary participation incentives, such as providing participating employers with access to aggregated benchmark data in return for submission.

These varied state mechanisms demonstrate that DOIs and state health agencies have meaningful tools available to expand the availability of price information. [Because many of these measures build on the federal framework, states add the most value by first enforcing the federal requirements already in place rather than layering on new mandates; where states do adopt additional requirements, aligning them with federal standards and formats, rather than a patchwork of differing or conflicting ones, keeps the underlying data usable across jurisdictions.](#)

Driving Downstream Affordability Structures

While evidence is limited for increased affordability due to price transparency reforms alone, making prices available can support other state affordability efforts. Research supports limiting provider payment rates as one of the most effective strategies for containing costs, and several states have acted in this area.

1. **Oregon** - The State Employee Health Plan capped hospital reimbursements at twice the Medicare rate beginning in 2019. A subsequent peer-reviewed analysis in *Health Affairs* (Murray et al., 2024) found that this policy led to measurable reductions in hospital facility prices paid by the plan. While this approach requires a self-funded purchaser with sufficient market leverage and direct contracting authority, it offers a replicable model for other large public purchasers seeking to contain cost growth without narrowing provider networks.

Commented [A8]: We recommend emphasizing enforcement of existing federal requirements first, and aligning any new state requirements with federal standards and formats. A state-by-state approach using differing forms and rules undercuts can undercut the comparability transparency depends on, limiting the value for patients.

2. **Minnesota** (State Employee Group Insurance Program) and **Massachusetts** (Group Insurance Commission) - State employee health managers in Minnesota (SEGIP) and Massachusetts (GIC) use clinical claims data to tier primary care practices based on total cost of care. Members receive substantially lower out-of-pocket costs when choosing top-tier providers, creating financial incentives for practices to remain cost-competitive to retain patients.
3. **California** (California Public Employees' Retirement System) and Utah (Public Employees' Health Program) - State plans in California (CalPERS) and Utah (PEHP) use benefit tiering to guide patients from higher-cost hospital outpatient departments to lower-cost independent diagnostic facilities for routine services, reducing per-episode spending without limiting clinical access.
4. **Kansas** (State Employee Health Plan) and Utah (PEHP) - Programs in Kansas (SEHP) and Utah (PEHP) use price-transparency data to offer direct cash incentives to members who choose high-value providers, aligning individual cost-sharing decisions with broader plan cost-containment goals.

Approaches for Realizing the Promise of Consumer Price Transparency

Health care price transparency has long been a challenge and has become more prominent in the past five years as insurance premiums continue to rise. There are several ways regulators, insurers, and providers can be more transparent to assist consumers in utilizing appropriate healthcare. Above all, transparency requirements should be calibrated to deliver meaningful benefit to consumers, not simply more data. The value of any requirement depends on whether it actually helps a consumer make a decision, not on the volume or granularity of information data it discloses. Because the evidence shows consumer-facing tools have so far produced modest effects, the recommendations below should be read as necessary but not sufficient - they expand what individual consumers can do, while the larger cost effects documented in this brief come from the institutional purchaser mechanisms described above.

- **Focus on Out-of-Pocket Costs:** Policies and tools should prioritize showing out-of-pocket expenses rather than just hospital list prices or negotiated net prices. Because most patients are insured, out-of-pocket costs are the most relevant factor in their decision-making process.
- **Standardize Data Formats:** Hospitals currently use inconsistent data schemas, making it difficult for developers and machines to process the information. Enforcing a uniform schema with "master field names" across all health systems would significantly improve the ability of third parties to build accurate estimation tools.

Commented [A9]: We recommend anchoring these approaches in meaningful consumer benefit rather than volume of data. Transparency delivers value only when it helps a consumer make a decision, so the guiding test should be usefulness, rather than the amount of information disclosed.

Commented [BCBSA10]: We recommend framing these consumer-facing recommendations as necessary but not sufficient, with the larger cost effects coming from institutional purchasers. This keeps the section aligned with the brief's evidence that institutional purchasers are the main lever on costs, while still supporting the consumer-facing improvements recommended here.

- **Provide Clear Documentation:** Data files should include ~~comprehensive~~ documentation that clearly explains column meanings, how to navigate the data, and applicable terms—coverage limits, and contracting methods (e.g., whether a price is a per-diem cost), so that ~~consumers and developers~~data users can ~~accurately calculate final cost~~easily access the data.
- **Combine Price and Quality Data:** Tools should merge hospital pricing files with quality ratings (such as CMS Hospital Compare) and insurance details, allowing patients to make side-by-side comparisons of both cost and quality simultaneously.
- **Support Workable Implementation of Advanced Explanations of Benefits (AEOBs):** The No Surprises Act requires plans to send enrollees an AEOB, a personalized estimate of what they will owe before scheduled care, but the requirement is not yet in effect and the federal rule remains pending. Because an AEOB is built from the provider's good faith estimate, and the provider holds the billing codes, it is the most reliable route to an accurate consumer price estimate. Realizing that potential depends on the forthcoming rulemaking being workable and states can support that by avoid~~avoiding duplicative or conflicting transparency requirements.~~
- **Implement Reference Pricing:** Research shows that consumers are much more responsive to price transparency when it is combined with stronger financial incentives. Programs like "reference pricing" — where an insurer sets a benchmark price for a procedure, and the patient must pay the difference if they choose a more expensive provider — have been shown to actively encourage price shopping.
- **Increase Public Awareness:** Because most patients do not even know price transparency legislation exists, targeted awareness campaigns are necessary to educate consumers about their right to access cost information before receiving care.

Commented [A11]: We recommend that documentation help users navigate and interpret the existing files while avoiding adding more data to them. The brief notes these files are already large and unwieldy, and consumers rarely retrieve them directly, so documentation adds value by making the data already present easier to use, not by expanding what the files must carry.

Commented [A12]: We recommend highlighting AEOBs as a mechanism well positioned to deliver accurate pre-service estimates. An AEOB is built from the provider's good faith estimate, which makes it the most reliable route to an accurate number.

Commented [A13]: We recommend striking the reference pricing recommendation. Reference pricing is a benefit-design and cost-sharing tool, rather than a price transparency measure, so it sits outside the scope of this list of transparency approaches.

Conclusion

Competition based on price helps to maintain affordability in many sectors, but it has been less effective in containing health care costs because prices are often hidden or unknown to consumers. While factors other than price influence consumers' health care choices, enhanced price transparency could introduce greater efficiency in health care markets and make health insurance more affordable. To date, evidence for this effect is limited, with some experience showing prices may converge rather than lower overall when they are more widely known. Nonetheless, several states have worked to build on federal price transparency requirements and their own all-payer claims databases. States have taken steps to increase compliance with hospital price transparency rules and used their state employee health plans to incentivize the use of higher-value providers. Making provider prices accessible to market participants and regulators can also provide critical support for other health insurance affordability policies, like reference-based pricing, price caps, or oversight of provider integration.

Sources

Brookings Inst: Niam Yaraghi & Xiru Pan, "The hospital price transparency rule is working, but patients still need help using it," Brookings Institute. (Sept. 9, 2025). URL: <https://www.brookings.edu/articles/the-hospital-price-transparency-rule-is-working-but-patients-still-need-help-using-it/>

Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts: 2024 Highlights," (2024). URL: <https://www.cms.gov/files/document/highlights.pdf>

Christopher Whaley, "Health Care Price Transparency: Opportunities for Improving Efficiency and Lowering Costs," Brown University Center for Advancing Health Policy through Research (2025). URL: [https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Briefs/Healthcare%20Price%20Transparency%20Policy%20Brief%20\(1\).pdf](https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Briefs/Healthcare%20Price%20Transparency%20Policy%20Brief%20(1).pdf)

Congressional Research Service "Technical Challenges with Private Health Insurance Price Transparency Data" June 13, 2025. URL: <https://www.congress.gov/crs-product/R48570>

Forrest Xiao, "Examining the Healthcare Market Response to Transparency Regulations," Turquoise Health White Paper (October 2024). URL: <https://turquoise.health/resources/blog/examining-rate-trends-by-annualized-rate-change-over-time>

Jessica Chang and Lindsay Sarfo, "Prices in Hospital Outpatient Departments are Consistently Higher than Physician Offices among Site-Neutral Services," Health Care Cost Institute (August 2025). URL: <https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings>

Jonathan Handsborough, "Indiana All Payer Claims Database: 2025 Annual Report," Indiana Department of Insurance (August 2025). URL: https://iga.in.gov/publications/agency_report/2025-Annual-Report---All-Payer-Claims-Database.pdf

Journal of Medical Internet Research: Negar Maleki, PhD; Balaji Padmanabhan, PhD; and Kaushik Dutta, PhD, "Usability of Health Care Price Transparency Data in the United States: Mixed Methods Study." Journal of Medical Internet Research, Vol. 26 (March 2024). URL: https://pmc.ncbi.nlm.nih.gov/articles/PMC11015359/pdf/jmir_v26i1e50629.pdf

Juan Carvajal, Christopher Ody, and Christopher Whaley, "The Relationship Between Pricing Transparency and Price Competition in the US Health Care Industry." American Bar Association, Antitrust Law Section (Nov. 5, 2024). URL: https://www.analysisgroup.com/globalassets/insights/publishing/2024_aba_article_relationship_between_pricing_transparency.pdf

Kunal N. Patel, Shu-Fang Shih, Chandra Bondugula, et al., "Hospital Compliance with Price Transparency Policy in the U.S.," Journal of Hospital Management and Health Policy (September 2023). URL: <https://jhmp.amegroups.org/article/view/8144/html>

Leelah Klauber, "2025 State Price Transparency Actions," The Source on HealthCare Price and Competition, University of California College of the Law, San Francisco (November 2025). URL: <https://sourceonhealthcare.org/spotlight-on-2025-state-price-transparency-actions/>

Maanasa Kona and Nadia Stovicek, "State Efforts to Improve Price Transparency," Health Affairs Forefront, Georgetown University Center on Health Insurance Reforms (April 2024). URL: <https://www.healthaffairs.org/content/forefront/state-efforts-improve-pricetransparency>

Sonia Ali Malik, "Enhancing Healthcare Cost Transparency: Assessing Implementation Challenges, Criticisms, and Alternative Solutions," Frontiers in Health Services, Vol. 4 (January 2025). URL: <https://www.frontiersin.org/journals/health-services/articles/10.3389/frhs.2024.1379416/full>

Stacey Pogue and Abigail Knapp, "Leveraging Data to Control Costs: How Five State Employee Health Plans Use Claims and Price Transparency Data to Improve Affordability," Center on Health Insurance Reforms (CHIR), Georgetown University McCourt School of Public Policy (April 2026). <https://chir.georgetown.edu/leveraging-data-to-control-health-care-costs/>

U.S. Census Bureau, "Health Insurance Coverage in the United States: 2024," Current Population Reports, P60-288, U.S. Government Publishing Office, Washington, DC (September 2025). URL: <https://www.census.gov/library/publications/2025/demo/p60-288.html>

U.S. Department of Health and Human Services, Office of Inspector General, "Not All Selected Hospitals Complied with the Hospital Price Transparency Rule," (November 2024). URL: <https://oig.hhs.gov/documents/audit/10042/A-07-22-06108.pdf>

Yang Wang, Mark Katz Meiselbach, John S. Cox, Gerard F. Anderson, and Ge Bai, "The Relationships Among Cash Prices, Negotiated Rates, and Chargemaster Prices for Shoppable Hospital Services," Health Affairs (April 2023). URL: <https://pubmed.ncbi.nlm.nih.gov/37011313/>

Further Reading

Centers for Medicare & Medicaid Services (CMS) Technical Guide on Encoding Hospital Price Transparency Machine-Readable Files (2025/2026 updates): <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency>

National Academy for State Health Policy (NASHP) Hospital Cost Tool (HCT 5.0), housing structural cost reports and commercial breakeven calculations across 5,000+ general acute hospitals: <https://tool.nashp.org/>