

Federal Price-Transparency Rules: How Congress Can Make Them More Effective

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KEY TAKEAWAYS

Most Americans have no idea of the actual cost of the most common medical treatments or procedures. Price transparency can help to resolve that problem.

Since the Biden Administration has generally continued the Trump price-transparency initiative, there is potential to build bipartisan support for expanding it.

Congress should act to ensure that these price-transparency initiatives are effective and expand them to enable consumers to benefit from them more fully.

Americans spend more on health care than any other people on the planet. Yet most Americans have no idea of the actual cost of even the most common medical treatments or procedures. The absence of market forces on medical pricing partially explains the excessive health care costs for individuals and families. Price transparency can help to begin to resolve that problem.

America's health care markets are highly concentrated.¹ Big insurance plans dominate state and regional markets and giant hospital corporations are expanding their foothold by buying up independent physician practices. This massive market consolidation contributes to overall spending and higher premiums and deductibles, and results in less competition, fewer choices, worse health outcomes, and misaligned incentives that structurally compromise the delivery of high-quality care.

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Assuming effective implementation and enforcement, price transparency can secure considerable health care savings for individuals, families, and businesses. It cannot come soon enough. Official government studies, as well as press reports, reveal that hospitals, even those in close geographic proximity, often charge wildly different prices for the same medical procedures; and the big price differences even for common “shoppable” medical procedures, such as hip and knee replacements, remain largely unknown to consumers.

By addressing these issues, policymakers can improve the financing and delivery of health care. As the Congressional Budget Office (CBO) reports, “If more consumers started using price information to choose lower priced providers, then, over time, those changes in price sensitivity might pressure providers to accept negotiated prices that were *much lower* than they would be under current law.”² (Emphasis added.)

State policymakers have taken some action on health care pricing, but state authority can only accomplish so much without complementary federal action. That is why the Trump Administration launched an ambitious price-transparency initiative aimed at hospitals and health insurance plans.³ In 2019, the Centers for Medicare and Medicaid Services (CMS) finalized its hospital price-transparency rule requiring hospitals to post the prices of common hospital procedures to provide consumers with easily accessible price information. The CMS followed that action by finalizing an insurer rule in October 2020 requiring health plans to disclose their negotiated prices for medical items and services.

The Biden Administration has continued the Trump Administration’s general approach.⁴ The Biden team retained the Trump Administration’s hospital transparency rules and, after an initial delay, announced the continuation of the health insurance regulation.⁵

Implementation of these rules has been mixed, with enforcement of the hospital rule being especially rocky. Between July and September 2021, for example, fewer than 6 percent of hospitals disclosed their prices as required by the CMS rule.⁶ Compliance has since improved but remains uneven across states and localities. As for the health-insurance-transparency regulation, the original rule was set to take effect on January 1, 2022, but the Biden Administration postponed the effective date to July 1, 2022.⁷ While insurers’ initial compliance appears to be better than that of hospitals, the implementation of the health insurance rule is still ongoing.

To promote price transparency, increase provider competition, and lower costs, Congress should:

- **Codify and improve on the hospital price-transparency rule.** The Trump Administration took administrative actions to initiate its hospital rule. Congress should codify the hospital rule in statute and improve on it by harmonizing reporting requirements to make the information easier for consumers and others to access and use. Congress should also toughen enforcement of the rule to secure stronger hospital compliance and, at the same time, streamline the process to make it easier for hospitals to comply.
- **Closely oversee the implementation of the health insurance price-transparency rule.** As noted, since these insurance regulations are relatively new, Congress should conduct oversight of their implementation and prepare, if necessary, statutory modifications to improve their effectiveness.
- **Allow consumers to share directly in savings.** Congress should expand options for patients to share directly in the financial benefit from these price-transparency initiatives. Congress should create a “shared savings” option, whereby an insurer must pass along savings to an insured person who chooses a less expensive provider based on price transparency and enable people to deposit any such savings into a health savings account (HSA).

Lifting the Veil on America’s Flawed Health Financing and Delivery

Price opacity in health care markets is structural. Major health care decisions about financing and benefits are not made by individuals, but government bodies and large private-sector organizations. American health care financing mostly consists of a series of negotiated agreements between third-party players—a mix of large managed-care corporations, federal agencies, insurers (public and private), employers, and large hospital systems and provider organizations—in state, local, and regional areas around the country. In sharp contrast to almost every other sector of the economy, individuals and families, as health care consumers, exercise very little economic power because they are actively kept in the dark.

As the CBO has observed,

The prices that commercial insurers pay are determined through negotiations with providers. Those negotiations often lead to higher prices because of

providers' market power (the ability to command higher prices than would prevail in a perfectly competitive market) and because of the lack of price sensitivity among insurers, which reflects insensitivity to prices among consumers and employers who select their plans.⁸

Not surprisingly, health insurers and medical professionals and hospitals have routinely tried to keep the substance of these price negotiations confidential.⁹

Insurance markets, despite voluminous state and federal legislation and regulations, are plagued with problems. Given the centralized structure of American health care financing, individuals and families, as a general rule, control neither the health care dollars nor the major health care decisions. Health care decisions are increasingly controlled by government officials through a complex and intrusive array of mandates imposed on both public and private coverage, including employer-based coverage where most Americans get their health care insurance. Consequently, consumer-driven competition for coverage, with some notable exceptions, is severely limited.¹⁰ Since the health sector of the American economy is bound by these government restrictions, responses to consumers' personal preferences and particular needs are compromised.

These heavily regulated, non-competitive markets contribute to higher overall health care spending and higher consumer costs. These broken markets also drive up costs for taxpayers because taxpayers finance huge government subsidies in Medicaid and the Affordable Care Act of 2010 (ACA), while current federal tax policy for employer-based health insurance coverage fuels overspending.¹¹ Moreover, these anti-competitive, heavily regulated, and subsidized markets also distort medical professionals' delivery of care and patients, as consumers of these services, are often bereft of accurate information on the quality of medical outcomes.

Rising Health Costs. Health care is a large and growing sector of the American economy. From 2019 to 2020, for example, national health care expenditures grew by 9.7 percent, reaching a total of \$4.1 trillion (about \$13,000 per person), accounting for 19.7 percent of gross domestic product (GDP).¹² It should be noted, of course, that 2020 was atypical because the sharp spike in health spending was driven by a massive increase in federal (mostly COVID-19-related) spending. In 2021, national health expenditures grew to \$4.3 trillion, or 18.3 percent of GDP.¹³ In any case, health care spending is on an upward trajectory, especially in the giant federal entitlement programs, Medicare and Medicaid.

Of all national health spending measured between 2019 and 2020, hospital spending, which is opaque to most Americans, accounted for the largest share at 31 percent, followed by spending on increasingly concentrated physicians' and clinical services at 20 percent;¹⁴ and much of that spending is also often mysterious or just plain confusing to ordinary Americans.

Heavier health care spending, driven by an aging population and the increasing per capita cost of care, will define Americans' future. According to the CMS, Americans will experience an average annual national health care spending growth rate of 5.4 percent, reaching a total of \$6.2 trillion (about \$19,000 per person) by 2028.¹⁵

Higher Premiums and Fewer Choices. Cost, not coverage, remains America's central health policy problem. In 2022, the Department of Health and Human Services (HHS) reported that America's uninsured fell to a record low of 8 percent.¹⁶ But that low percentage does not tell the entire story. Virtually all citizens and legal residents of the United States have access to some form of health coverage. According to a 2020 CBO report, the large majority (67 percent) of America's uninsured are eligible for subsidized health insurance coverage, either through the ACA health insurance exchanges, Medicaid, or employer-sponsored insurance.¹⁷

The focus on coverage has done little to reduce health care costs for American families. The ACA expanded health coverage, but that growth has been concentrated overwhelmingly in Medicaid—not in either private or employer-sponsored health insurance. In fact, the ACA has crowded out a significant amount of private coverage, reduced personal choice, and dramatically increased premiums in the nation's individual health insurance markets.¹⁸ Health care premiums for working families have more than doubled since the law's implementation in 2014. At the same time, the national health law sharply reduced consumer choice and insurer competition in the nation's individual health insurance markets.

The Quality Factor. Big price variations for identical medical procedures in the same geographical area do not indicate major differences in the quality of health care delivery. Quality in American health care is clearly uneven, and unreasonable prices in any given area are strong evidence of an absence of effective price competition and the opacity of health care pricing.

In 2017, in an effort to improve quality, the CMS introduced the "Meaningful Measures" program, an innovative approach to quality measurement and quality improvement. The program aimed to ensure that factors routinely measured and evaluated align with six overarching quality categories including, for example, a category to "Promote Effective Communication and Coordination of Care." These measures are now

becoming integrated into provider payment models, and, it is hoped, can contribute to improving the evaluation of medical professionals and the quality of medical services.

Nonetheless, Congress needs to do more to encourage effective quality measures. Price transparency is a critical piece to integrate into the overall evaluation of provider performance and thus improve the level and quality of competition in health care delivery.

Advantages of Price Transparency

Price transparency allows real price competition; and real price competition can result in overall health care savings, benefiting employers, consumers, and taxpayers. It can also improve quality of care by contributing to a more accurate measurement of outcomes for the dollars expended and a better evaluation of care and service. Getting better value for America's health care dollars should be a top objective of federal health care policy.

Overall Savings. Preliminary research validates economic theory in that it shows that competitive markets in both insurance and hospital care can indeed lower consumer costs.¹⁹ That much is obvious. The bigger question is how much can be saved in either of these giant health care markets. Though still limited, empirical work on specific price-transparency policies shows a broad range of savings estimates. For example:

- Stephen Parente, a professor of health care finance at the University of Minnesota, finds that federal price-transparency initiatives—for hospitals and for insurers—could result in a wide range of annual savings nationally. Projecting savings for 2025, Parente estimates that employers, consumers, and health insurers could secure at least \$17.6 billion in savings, and they could achieve an “upper bound” savings of \$80.7 billion, if they use a “robust” set of transparency tools.²⁰ Such a national financial achievement would translate into a 6.9 percent reduction in medical spending for all Americans enrolled in private health insurance, including a 7.4 percent reduction in medical expenditures for persons with incomes below 100 percent of the federal poverty line (FPL). Parente observes that “[c]onsumers may have strong incentives to shop with the rise in the use of high deductibles, health plans, and health savings accounts.”²¹ Furthermore, as others have noted, price-transparency initiatives could, in turn, help to drive greater transparency of quality in care delivery as well.²²

- Rand Corporation analysts conducted a narrower study focused exclusively on hospital-price transparency. Specifically, the researchers found that hospital-price transparency could reduce annual hospital spending between \$8.7 billion and \$26.6 billion. The analysts also emphasized, however, that these estimates were also highly uncertain and would differ depending upon whether employers or consumers would drive the purchasing decisions.²³ Because employers are the main purchasers of health insurance in the United States, their access to data on the comparative price and the quality performance of hospitals and medical professionals could enable them to steer employees to more cost-efficient medical providers, and thus secure major savings (up to \$26.6 billion) for both the companies and their employees. As the Rand researchers note, the analytical basis for quantifying a patient-driven response to price transparency is limited, and their estimate for aggregate savings under that scenario is modest: between \$8.7 billion to \$11.1 billion.²⁴ The individual market, where patients exercise limited choice over benefits and coverage, is only a fraction of the total health insurance market.
- The CBO posted more modest estimates. It reports that price transparency would reduce health care prices by up to 1 percent. The CBO emphasizes that its conclusions are highly uncertain and dependent on the details of implementation.²⁵ The CBO examined two other policy options to lower insurance payment for medical services including federal caps (price controls) on the growth of payments to hospitals and medical professionals as well as other various pro-competition policies in health care markets. All these measures would also reduce health care prices, in some cases dramatically, but consequences for consumers and medical professionals would be very different and may entail undesirable trade-offs such as rationing.²⁶

Other Benefits. Even with limited empirical data, one can expect certain positive results based on well-understood theoretical research. Unquestionably, price transparency can improve health market efficiency. According to a study from the American Academy of Actuaries,

Removing the secrecy of price negotiations might equalize prices across payers. It may bring down the prices of some “outlier” services and on the other hand, it may provoke increases in unit costs for providers who have previously

been lower cost. It may provide more information for patients shopping for care. When coupled with quality data, it may establish the baseline for efficiency comparisons.²⁷

As noted, sound information on medical costs would be especially valuable for employers. Employers often do not have useful information on prices for medical treatments and procedures and cannot easily navigate the byzantine systems of health care financing. Writing in *Heath Affairs Forefront*, Maanasa Kona and Sabrina Corlette, policy analysts at Georgetown University, observe,

Large employers in particular have a lot to gain. These employers usually contract with insurers to administer health benefits for their employees while bearing financial risk themselves. Third party administrators have little incentive to procure the best deals for employers when negotiating with providers. Large employers have sometimes struggled to get access to their own claims data from third-party administrators, hindering them from being actively involved in developing cost-containment strategies. Access to negotiated prices may give employers the tools they need to exert downward pressure on provider prices.²⁸

One of the most important benefits of price transparency in health care would be the positive impact on individuals and families. Regarding price transparency, as the CBO has noted, health care prices could be much lower than they are today. This would especially be true for consumers who enroll in high deductible health insurance plans. As the American Academy of Actuaries point out, “Consumers with high deductible health plans (HDHPs), which have a significant up-front deductible that applies to almost all services, are very price-sensitive and may be avid users of new transparency tools.”²⁹

A robust price-transparency policy—combined with new direct savings incentives (such as “shared savings” and expanded health savings accounts)—would enable individuals, families, and insurers to secure significant personal savings while intensifying competition among medical professionals participating in the nation’s individual markets.

State Price-Transparency Initiatives

Several states have tried to make health pricing more transparent and empower patients with crucial information on quality.

Colorado, Maryland, and Massachusetts were pioneers in price transparency. In 2012, Massachusetts took steps to empower patients with accurate price and quality information with the passage of An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. This act requires all third-party administrators and health plans to provide access to health care price estimates via phone number or website and requires providers to disclose expected charges for a given admission, service, or procedure within two working days of a request.³⁰ In 2017, Colorado enacted Transparency in Direct Pay Health Care Prices, a law requiring health professionals to disclose charges that must be paid directly by a patient beforehand and not through a third-party payment.³¹ In that same year, the Maryland Health Care Commission launched the “Wear the Cost” website, a state website that allows patients to compare the costs of common, “shoppable” hospital procedures.³² Since then, Maryland has expanded the number of price transparent procedures, and Colorado and Massachusetts have also taken additional steps to enhance their initial efforts.³³

More recently, several other states have undertaken transparency initiatives. For example, Alaska, Minnesota, and Tennessee require health insurers to provide price estimates for benefits and services. Florida hospitals must provide price estimates for hospital services within seven days of a person’s request, and California and Rhode Island impose a provider price disclosure requirement for persons without health insurance coverage.³⁴

Federal Price-Transparency Rules

The 2019 Trump Administration price-transparency initiative was a historic step in federal health policy, and a major departure from previous federal regulatory initiatives. It has laid the foundation for a potentially powerful resurgence of real-market-price competition.

Interestingly, the foundations of President Donald Trump’s new market rules were laid with enactment of the ACA. The ACA authorized the Secretary of HHS to issue regulations requiring hospitals to post their prices; and, indeed, in 2015, the HHS issued an initial rule to accomplish that objective. James Capretta, who holds the Milton Friedman Chair at the American Enterprise Institute, observes, however, that “[c]ompliance was uneven...as many hospitals posted enormously complex data files that were not easily read or understood by anyone, including experts. Even so, what emerged was a picture of irrational and arbitrary pricing differences that cause real harm to consumers.”³⁵

Recognizing the poor state of the health markets, in 2019 and 2020, the Trump Administration took major steps to rectify these competition deficiencies by developing new rules that would provide much greater transparency in hospital and insurance plan pricing.

The Hospital Rule. In November 2019, after President Trump’s executive order on the topic, the CMS finalized its major rule that would require hospitals to provide transparent prices for the most common shoppable hospital procedures, services, or goods.³⁶

1. Under the rule, effective January 1, 2021, hospitals were required to post five sets of prices for medical treatments or procedures:³⁷
2. The list price (the “gross” price before any discounts);
3. The discounted price (the price paid by people who get a discount for cash payment);
4. The negotiated price (the “network” price paid by insurers under contract with the hospital);
5. The minimum negotiated price (the lowest network price paid by an (unidentified) insurer); and
6. The maximum negotiated price (the highest network price paid by an (unidentified) insurer).

The rule called for posting prices for 300 such shoppable items. The requirements were straight-forward: Hospitals are to provide “clear, accessible pricing information online.” They were to present this information in two formats: (a) “as a comprehensive machine-readable file with all items and services”; and (b) “[i]n a display of shoppable services in a consumer-friendly format.”³⁸

Hospitals must comply with the price-transparency requirements or face a fine. The fines for non-compliant hospitals range from \$300 per day for small hospitals with thirty or fewer beds to \$5,550 per day for large hospitals with more than 550 beds.

The hospital rule survived legal challenges from major hospital organizations. Nonetheless, despite federal court victories, CMS implementation has been plagued by a lack of compliance. In 2021, researchers writing for JAMA Internal Medicine estimated that more than four of five hospitals did

not comply with the CMS rule.³⁹ In response, the CMS issued more than 300 warnings in 2021,⁴⁰ and the first fines, totaling over \$1.1 million, were imposed on just two hospitals in 2022.⁴¹

Even though the CMS increased the financial penalties for larger hospitals,⁴² securing compliance remained a struggle. The Foundation for Government Availability (FGA) reported that in 2022 nearly two-thirds of hospitals, including many large hospitals and hospital systems, remained non-compliant.⁴³ For example, 37 percent of Massachusetts hospitals did not post the discounted cash price of services.⁴⁴

While the compliance problem remains, more recent data show progress. According to Turquoise Health, a private consulting firm, the number of hospitals that posted “machine-readable” files increased from 3,292 in the fourth quarter of 2021 to 5,163 in the fourth quarter of 2022.⁴⁵

The Health Insurance Rule. In October 2020, the Trump Administration finalized its original health insurance rule. The Biden Administration, however, initially delayed the effective date of the rule, which finally took effect in July 2022. Under the rule, all health insurers, including insurance offered by self-insured employers, must disclose their in-network prices, charges allowed for out-of-network medical services, and the negotiated drug prices, and provide estimates, via computer platform, for estimated out-of-pocket costs. With requirements phased-in over the next two years, insurers and their plans must provide:⁴⁶

- Machine-readable files containing in-network rate files for all covered items and services between the plan or issuer and in-network providers, as well as allowed amounts for, and billed charges from, out-of-network providers.
- An Internet-based price comparison tool (also available by phone, or in paper form, upon request) allowing an individual to receive an estimate of his cost-sharing responsibility for a specific item or service from a specific provider or providers. As of January 1, 2023, the requirements applied to 500 items and services.
- An Internet-based price comparison tool (or disclosure on paper, upon request) allowing an individual to receive an estimate of his cost-sharing responsibility for a specific item or service from a specific provider or providers. Beginning on January 1, 2024, the requirements will apply to all items and services.

Under the latest version of the federal rule, failure to comply with the requirements would result in a fine of \$100 per day, per enrolled person affected.

Thus far, most insurers are complying with the letter of the health insurance rule; and in response to the requirements, they are providing a mass of complex insurance data. However, the result is far from consumer friendly. As Kona and Corlette observe, these data, as currently provided, are “largely inaccessible and indecipherable to anyone without access to a supercomputer.”⁴⁷ To address this gap, private-sector firms and app developers have begun to transform these data into more broadly accessible consumer information on customized digital platforms.

Improving Price Transparency: A Congressional Agenda

Despite state and private-sector activities in this area, there remains a great need for Congress to complement, not supplant, these efforts. Congress should:

1. Secure and Improve upon the Hospital-Transparency Rule. The Trump Administration used administrative actions to launch important transparency rules. Congress should codify these hospital rules in statute and improve them. First, Congress should make hospital prices clear on a comparative basis. As the CBO observes, “Because the Hospital Price Transparency rule does not require a standard format, hospitals currently post files in a variety of formats. That variety makes combining the data and comparing prices among hospitals time-consuming for third parties, such as benefits consultants that help employers choose which health plans to offer and companies that help consumers shop for health care.”⁴⁸ This standardization should also apply to the definition of medical services or service packages, as the CBO suggests, and should include a listing of individual services to facilitate consumer cost comparisons.⁴⁹

Second, Congress should tighten enforcement of hospital price-transparency requirements. For example, Senator John Kennedy (R-LA) is sponsoring the Hospital Transparency Compliance Enforcement Act (S. 468), a bill that would codify the federal regulatory requirement to list hospital charges in a consumer-friendly fashion and double the regulatory fines.⁵⁰ In the House of Representatives, Cathy McMorris Rodgers (R-WA) and Frank Pallone (D-NJ) are sponsoring The Patient Act of 2023 (H.R. 3561), a bill that would also provide the public with the prices of hospitals and insurers. The House Energy and Commerce Committee recently reported out the bill by a bipartisan vote of 49 to 0.⁵¹

Beyond codifying the federal rule and making enforcement adjustments, Congress should also inquire about the best methods to streamline the process to make compliance easier. This can best be accomplished through public hearings with testimony from hospital industry officials.

2. Oversee and Monitor Implementation of Insurance Rule. As noted, since these regulations are relatively new, Congress should monitor their implementation and, if necessary, adopt improvements. For example, Senators Mike Braun (R-IN) and Maggie Hassan (D-NH) have recently asked CMS Administrator Chiquita Brooks-LaSure, to update the health insurance rule. Noting that some insurance companies are “relying on gaps” in rule implementation to evade responsibility, the Senators urge Brooks-LaSure to improve data accessibility and usability: “Experts have highlighted potential solutions, urging CMS to limit file sizes, create a standardized reporting template, reduce frequency of reporting, and require clear organizational system and standardized labeling. These changes would allow the public to use the data more effectively, while simplifying the reporting process for plans.”⁵² Congress should conduct oversight on implementation of this rule to ensure efficient and effective enforcement.

3. Allow Consumers to Share Directly in Savings. If an insured consumer chooses a more cost-effective treatment or provider option, he should be able to share in those savings with the insurer. Congress should create a “shared savings” option, where the consumer could then either pocket a portion of the savings or, if available, deposit those savings into his HSA.

Creating such an option would entail ancillary statutory changes. For example, Congress should address the ACA’s medical loss ratio (MLR) requirement for health insurers. The law specifies that insurers must allocate 80 percent of their premium revenues to medical benefits, services, and quality improvement, reserving no more than 20 percent for administrative costs (such as marketing costs) and profits. For large group insurers, including participants in Medicare Advantage, the ratio is 85 to 15.

In enacting a “shared savings” option, Congress should amend the ACA’s MLR provisions to clarify that any shared savings payments by insurers to enrollees are “benefit” payments and are not to be classified or counted as an insurer’s “administrative” costs. These changes would jointly harness the incentives of insurers and consumers to choose cost-effective care and encourage patients to use the growing amount of transparent price information to optimize their “shopping” of hospital services and procedures.

4. Expand HSAs to Enable Consumers to Benefit from Savings.

Congress should allow savings secured by shopping for medical goods and services to be deposited in HSAs, even if the newly deposited amount exceeds the annual limit on pre-tax contributions to the account. Similarly, Congress should allow Americans aged 65 and older who are enrolled in a Medicare Advantage Medical Savings Account (MA-MSA) plan to deposit shared savings into such accounts and clarify that Medicare beneficiaries can use the funds in either a pre-retirement HSA or a MA-MSA plan to pay for direct primary care. Congress should also index the limits on tax-free contributions to HSAs to the annual catastrophic limits set for the plans in the health insurance exchange markets under the ACA.⁵³ In 2023, for example, the ACA's catastrophic limits are \$9,100 for individual coverage and \$18,200 for family coverage.⁵⁴

Conclusion

Price transparency is enormously popular. Over 90 percent of Americans say that they are in favor of health care price transparency.⁵⁵ Rarely is something so universally desired and accepted in health policy.

Because the Biden Administration has generally continued the Trump price-transparency initiative, there is a potential of maintaining and building bipartisan support for expanding price-transparency measures. Ensuring patient access to accurate price and quality information has the potential to drive competition and to empower patients to make more rational decisions about their choice of medical professionals and shoppable hospital services.⁵⁶ If effectively implemented, the normal economic benefits of competition in free and open markets—lower costs and higher quality—will flourish.

Nonetheless, there is much more to be done. Congress should codify and improve upon existing hospital price-transparency regulations to ensure that consumers have access to accurate prices of common health care services and goods in an easily accessible and consumer-friendly format. Congress should carefully follow and oversee the implementation of recent insurance regulations to ensure insurers provide information that is useful to consumers and employers in the health insurance markets. Finally, Congress should give patients the ability to benefit from making smart choices by expanding options for sharing directly in any savings they achieve from price shopping.

Given the complexity of American health care financing and delivery, there is no “magic bullet” solution to rising health care costs or suboptimal quality of care. However, price transparency is an indispensable part of the

solution that can address health care cost, access, and quality concerns by empowering individuals, driving competition, stimulating innovation, and improving medical outcomes.

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Endnotes

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