Weekly Checkup

Improving Price Transparency – Compliance First

MICHAEL BAKER | MARCH 14, 2025

On February 25, 2025, President Trump issued an executive order reaffirming the administration's commitment to improving health care price transparency for patients and consumers. Specifically, the order directs the secretaries of the Treasury, Labor, and Health and Human Services (HHS) to review the status of certain transparency regulations begun by the first Trump Administration – and that if fully complied with could significantly advance health care price transparency. **This piece reviews the key rules at issue and looks at compliance since their implementation. It also underscores the importance of the agencies' strengthening and continuing implementation of current compliance mechanisms before considering whether additional regulations may be needed.**

The issue of increased price transparency has broad bipartisan support. According to a KFF Health Tracking poll from January 2025, 95 percent of people support boosting price transparency rules to ensure health care prices are available to patients, and 61 percent believe it should be a top priority for the government to address. And for good reason: U.S. health care spending reached $4.9 trillion in 2023 – and 57 percent of people say they expect health care to become less affordable.

In fact, three key rules, started under the first Trump Administration, provide the cornerstone of the federal government's transparency work in the commercial market: the Hospital Price Transparency rule, the Transparency in Coverage rule, and the No Surprises Act rules. While each rule covers a slightly different part of the health care system – from hospitals, to insurers, to employers – they were designed to work in concert with one another to provide patients access to the data necessary to make deliberate, economical decisions for their health care. This is important, since some experts estimate that price transparency in health care could save the $1 trillion annually.

The Hospital Price Transparency rule requires hospitals to publish machine-readable files and consumer-friendly price lists for use by patients and payers to analyze shoppable services and find the most cost-effective option for the consumers. Reports indicate there is no uniform measure of compliance with the regulation, with different sources citing 57 percent, 36 percent, and approximately 66 percent compliance. In a separate small survey, the HHS Office of the Inspector General found that 37 hospitals out of 100 were not in compliance with either requirement of the Hospital Price Transparency Rule.

The Transparency in Coverage rule (TiC) required most group health plans and health insurance issuers in the group and individual markets to disclose price and cost-sharing information to participants, beneficiaries, and enrollees. Given that price estimates can vary widely (prices for the same service can differ dramatically within a given metropolitan statistical area), the TiC rule has been a leap forward in advancing the mission of health care transparency. While it is hard to measure exact levels of compliance, there are clear metrics of success.

The No Surprises Act (NSA) protects patients from surprise out-of-network charges, which is one of the most common practices in medicine. While there are some exceptions to plans covered by the law, most Americans seeking care (whether they have insurance or not) are covered by its protections. Some rules governing the NSA have had an uneven rollout due to several lawsuits, but several provisions of the NSA have been successfully utilized by consumers. According to a survey from AHIP, more than 10 million claims were subject to the protections of the federal law.

While compliance continues to be a challenge and limits the applicability of some transparency measures, there are strong real-world examples of transparency working. Employers have leveraged this data to provide better benefits to their employees, and payers – who patients already trust to provide accurate cost information – can better serve those they cover. According to a McKinsey insight, consumers are willing to shop for care at the beginning of a care journey, the most impactful time to make care decisions. An analysis conducted in 2023 found that price transparency in shoppable services may realize anywhere between $17–$81 billion in savings. As an example, a manufacturer in Wisconsin leveraged price transparency to refer an employee to a cheaper, less invasive elbow procedure; instead of $50,000, the procedure cost $16,000.

Though not exhaustive, this evidence points to growing benefits if price transparency in health care continues to improve. The regulations noted above are an important step in achieving this aim, but compliance by key players is often lackluster. **The administration and Congress should remain focused on implementing and strengthening these compliance mechanisms before considering additional laws and regulations that**

may be inefficient or simply duplicative.

CHART REVIEW: MEDICARE PAYMENTS UNDER SCRUTINY

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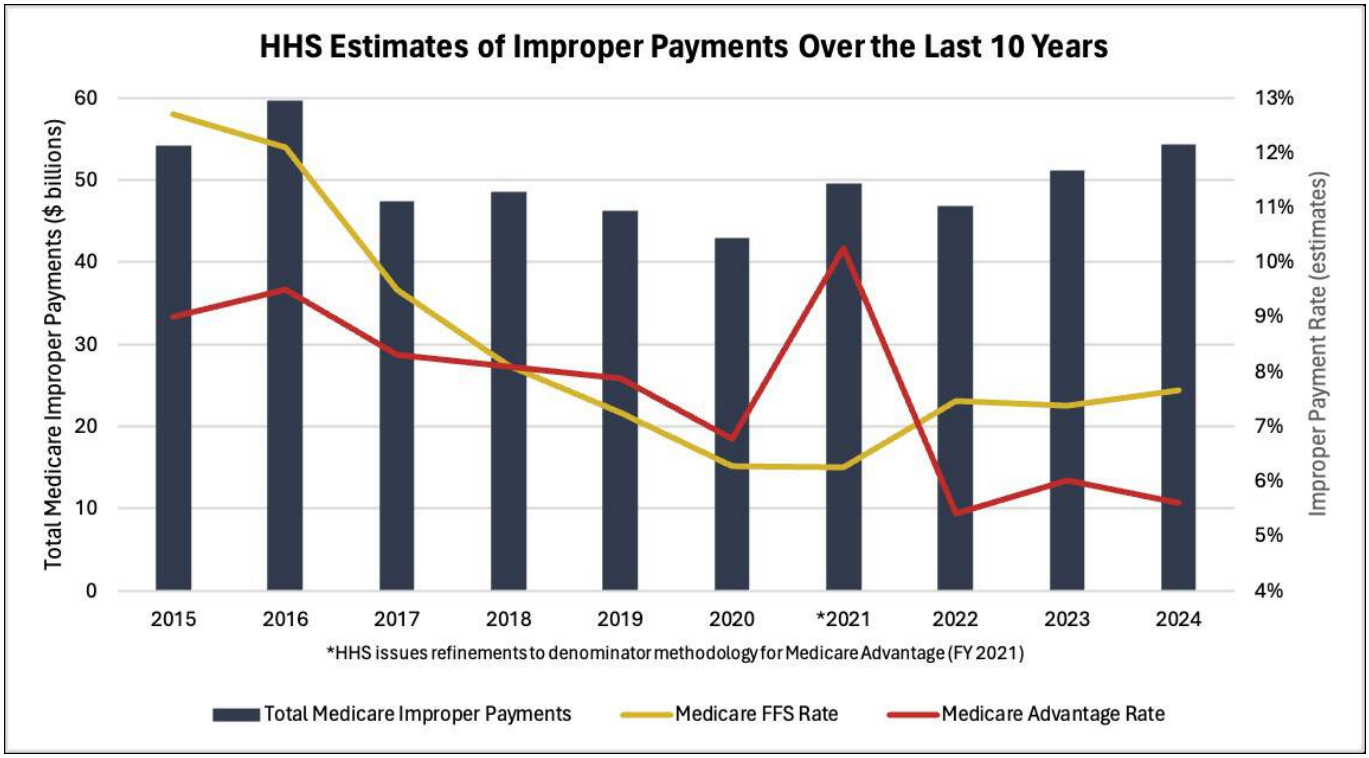
In late February, the House Committee on Oversight and Government Reform held a hearing on the Government Accountability Office's (GAO) updated "High Risk List" to examine which federal programs are most susceptible to waste, fraud, and abuse. Medicare programs – which have retained the "risk-susceptible" designation since 1990 – remain a top concern and are under scrutiny for high rates of improper payments, despite improvements in recent years. In 2024, the Department of Health and Human Services (HHS) estimated that Medicare made $54 billion in improper payments – or approximately 34 percent of all improper payments in the federal government. The GAO has periodically reminded the Centers for Medicare and Medicaid Services (CMS) of its responsibility to combat improper payments.

Each year, HHS issues its Agency Financial Reports, which uses the Payment Error Rate Measurement program to estimate payment integrity for all HHS programs. Over the past 10 years, HHS has estimated increasingly lower improper payments rates for both Medicare fee-for-service (FFS) and Medicare Advantage (MA). After refinements were made to MA improper payment rate calculations in 2021, the MA program has maintained improper payment rates about 2 percent lower than FFS over the past three years. Improper payments in Medicare FFS and MA programs are primarily attributed to "insufficient documentation" and "medical record discrepancies," respectively, which suggests improper payments are linked with regular reporting errors rather than fraud. While efforts to mitigate improper payments – such as the Payment Integrity Information Act of 2019 – have been successful in reducing rates, a gradual increase in total Medicare improper payments since 2022 indicate that HHS and CMS should continue to implement strategies that address potential sources of improper payments.


HHS Estimates of Improper Payments Over the Last 10 Years
Total Medicare Improper Payments ($ billions)
Improper Payment Rate (estimates)
60
50
40
30
20
10
0
13%
12%
11%
10%
9%
8%
7%
6%
5%
4%
2015
2016
2017
2018
2019
2020
*2021
2022
2023
2024
*HHS issues refinements to denominator methodology for Medicare Advantage (FY 2021)
Total Medicare Improper Payments
Medicare FFS Rate
Medicare Advantage Rate