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THE EMPTY PRICE TAG

Why Hospital Price Transparency Has Fallen Short & How Congress Can Make It Right

> Five years after Congress acted, the information gap persists—and so do the consequences.

TRANSPARENCY EMPOWERS CHOICE

Real prices help patients make informed decisions and employers negotiate better value.

INFORMATION DRIVES COMPETITION

Price visibility exposes inefficiency and rewards high-value providers.

ACCOUNTABILITY BUILDS TRUST

Sunlight deters abuse, strengthens governance, and supports nonprofit missions.

POLICY DESIGN SHAPES OUTCOMES

Better incentives and stronger enforcement turn disclosure into meaningful transparency.

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The Empty Price Tag
Why Hospital Price Transparency Has Fallen Short & How Congress Can Make It Right

For most of the twentieth century, Americans could not compare airline fares before booking a flight. Prices were opaque, competition was muted, and consumers largely accepted whatever the market offered. Airline deregulation changed that. The fares themselves did not suddenly become cheaper because Congress passed a law. They became more competitive because prices became visible. Information transformed the market.

Healthcare remains one of the last major sectors of the American economy where that transformation is incomplete.

Five and a half years after the Hospital Price Transparency Rule took effect, Congress has demonstrated that transparency can be required. What it has not yet demonstrated is how to make transparency routine. Hospitals disclose substantially more pricing information than they did before 2021, yet meaningful transparency remains inconsistent. Independent analyses continue to estimate full compliance at only about one-quarter to one-third of hospitals reviewed, while the Department of Health and Human Services Office of Inspector General has identified widespread deficiencies. CMS has imposed civil monetary penalties against only a small fraction of the nearly 6,000 hospitals subject to the rule. Those numbers matter. But they are symptoms rather than the disease.

The larger issue is whether healthcare should continue operating as the only major sector of the American economy in which purchasers routinely commit to significant expenditures without meaningful access to prices beforehand. In virtually every other market, prices perform an indispensable function. They allow buyers to compare alternatives, reward efficient producers, expose excessive costs, and encourage competition. Healthcare has historically functioned differently. Negotiated reimbursement rates have remained largely invisible to patients, employers, and often even to the purchasers financing coverage for millions of Americans.

Congress attempted to change that dynamic. The Hospital Price Transparency Rule was not designed to regulate what hospitals charge or interfere with negotiations between providers and insurers. It simply recognized that markets cannot function efficiently when one side consistently possesses information the other lacks.

Economist Ronald Coase demonstrated that markets become less efficient when the costs of obtaining information are unnecessarily high. Hidden prices impose exactly those costs. They force buyers to negotiate in the dark, discourage meaningful comparison, and weaken competition before negotiations even begin.

Congress did not create the Securities and Exchange Commission because investors were incapable of buying stocks. It required standardized disclosure because markets work best

when participants share access to essential information. Hospital price transparency rests on the same principle.

Hidden prices increase what economists call transaction costs. They force buyers to negotiate in the dark, discourage meaningful comparison, and weaken competitive pressure. Hospital pricing has long operated under precisely those conditions. Economists have a name for that problem, information asymmetry. Decades of research demonstrate its consequences. Markets become less competitive, consumers make poorer decisions, and prices drift further from the discipline that informed purchasing ordinarily provides. Healthcare has lived with that imbalance for years.

The consequences extend well beyond individual patients trying to estimate the cost of a procedure. Employers purchasing health benefits frequently negotiate contracts without understanding how hospital prices compare across local markets. Researchers studying healthcare spending encounter incomplete or inconsistent pricing information. Antitrust regulators evaluating hospital consolidation often lack the market visibility available in almost every other sector of the economy. Hidden prices do not merely inconvenience consumers; they distort the operation of the marketplace itself.

The persistence of incomplete compliance should therefore concern more than CMS. Hospitals are sophisticated organizations. They negotiate thousands of contracts, process millions of claims, estimate patient responsibility before treatment, and manage extraordinarily complex revenue-cycle systems. The information Congress seeks to make public already exists. The question is not whether hospitals know their negotiated prices. They do. The question is whether current public policy creates sufficient incentive to disclose those prices in a manner that is accurate, comparable, and genuinely useful.

Over the past five years, much of the public discussion has focused on whether hospitals have posted machine-readable files or satisfied reporting requirements. Those questions are important, but they are not the same as asking whether patients can reasonably estimate the cost of care before receiving it or whether employers can compare competing health systems using reliable pricing information. Compliance and transparency are related concepts. They are not identical. The evidence increasingly suggests that many hospitals have learned to satisfy portions of the regulation without fully embracing its purpose.

Equally important, policymakers should resist the temptation to interpret this solely as institutional resistance. Hospitals respond to incentives because every organization responds to incentives. If the financial and competitive advantages of maintaining opaque pricing exceed the expected costs of noncompliance, the resulting behavior should surprise no one. The issue is less about institutional motives than about regulatory design. Fortunately, Congress does not need to begin again.

Several states have already demonstrated that stronger enforcement, greater public accountability, and more carefully aligned incentives can improve transparency without dictating prices or expanding federal control over healthcare. Their experience offers practical lessons for the next phase of national policy.

This report argues that hospital price transparency should be understood as something larger than a compliance initiative. It is an issue of market governance, informed consumer choice, nonprofit accountability, and public confidence. The recommendations that follow build upon lessons already emerging from the states and seek to align regulatory expectations with the economic realities governing hospital behavior. The debate, ultimately, is not about spreadsheets or reporting formats. It is about whether healthcare should continue to operate under rules that would be unacceptable in virtually every other major American market.

This debate is often described as one about transparency. It is not. It is a debate about whether prices should once again perform the economic function they serve everywhere else in the American marketplace: informing decisions before money changes hands rather than explaining them afterward.

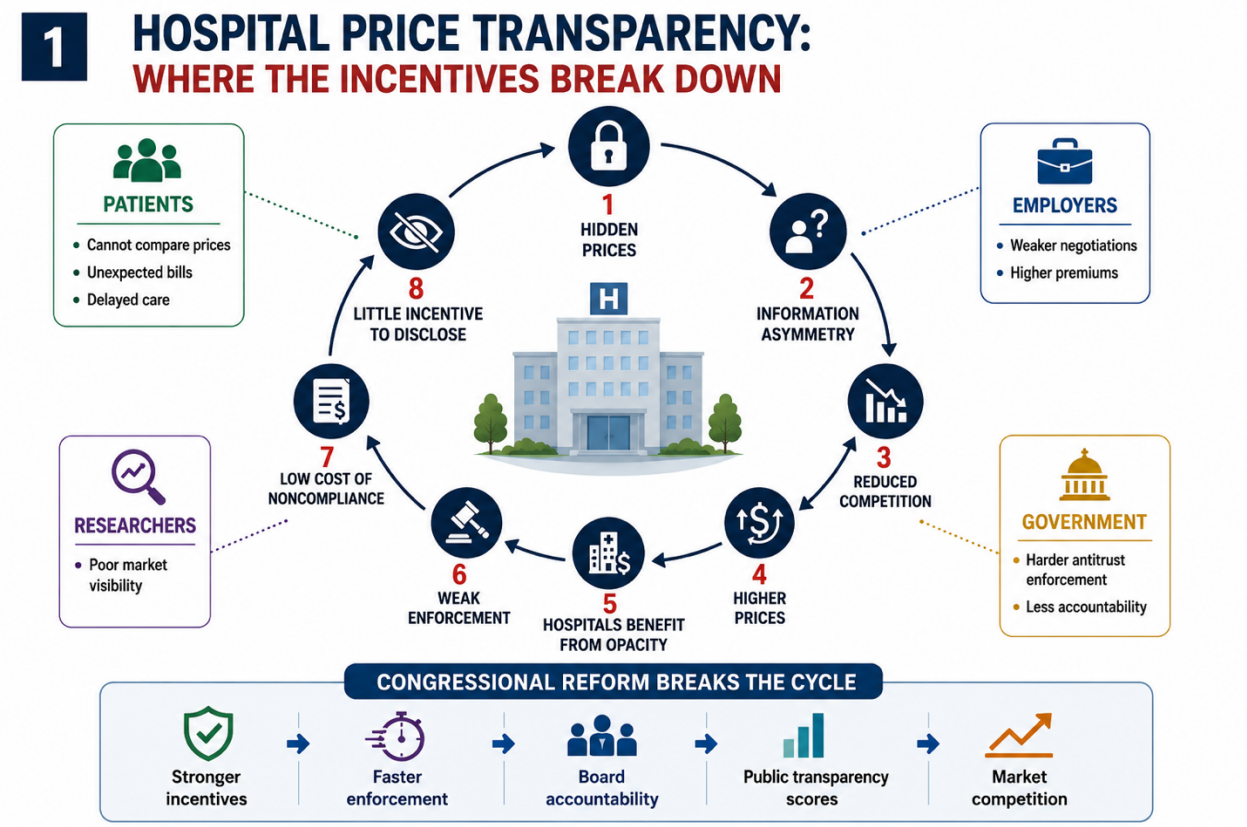

Figure 1. Hospital Price Transparency: Where the Incentives Break Down
The central challenge is not technological capability but economic incentives. Hospitals possess the pricing information Congress seeks to disclose. Until the benefits of opacity no longer exceed the costs of noncompliance, market behavior will remain resistant to change.

1. Why Congress Acted

The Hospital Price Transparency Rule is often described as another federal reporting requirement. That description is accurate, but incomplete. Congress was not simply asking hospitals to post more information online. It was attempting to correct one of the most persistent information failures in the American healthcare system.

For decades, healthcare has operated under a pricing model unlike almost any other major sector of the economy. Consumers purchase homes, automobiles, airline tickets, and financial services with at least some understanding of what they will pay before making a commitment. Prices allow buyers to compare alternatives, reward efficient producers, and encourage competition. Although healthcare presents unique challenges, the underlying economics do not change simply because the product is medical care. Hospital pricing evolved differently.

Negotiated reimbursement rates became confidential commercial information shared between hospitals and insurers but rarely with the employers, patients, or researchers ultimately paying for care. The issue is not that these institutions lack technical expertise. It is that market leaders often possess the greatest ability—and sometimes the greatest incentive—to preserve information advantages that have developed over many years of confidential contracting. Over time, that lack of visibility became accepted as normal. It is anything but normal.

Friedrich Hayek famously described prices as signals that coordinate dispersed knowledge across an economy. When prices are hidden, those signals disappear. Patients cannot compare value, employers cannot negotiate intelligently, researchers cannot observe markets accurately, and policymakers lose one of the clearest indicators of competition.

This is a classic case of information asymmetry, where one side consistently possesses information unavailable to the other. Such markets seldom function efficiently. Prices become less transparent, competition weakens, and consumers lose much of their ability to reward value or avoid unnecessary costs. Congress understood that dynamic when it enacted the transparency provisions now codified in Section 2718(e) of the Public Health Service Act and implemented through 45 C.F.R. Part 180. Effective January 1, 2021, hospitals became responsible for making two distinct categories of pricing information publicly available.

The first requirement serves institutional users. Hospitals must publish a comprehensive machine-readable file identifying their standard charges, including gross charges, discounted cash prices, payer-specific negotiated rates, and de-identified minimum and maximum negotiated prices for every item and service they provide. Researchers, employers, insurers, technology developers, and regulators all rely on these data to analyze pricing patterns and market behavior.

The second requirement recognizes that transparency is meaningful only if ordinary consumers can use it. Hospitals must therefore publish pricing information for at least 300 shoppable services—or provide an internet-based estimator capable of generating individualized cost estimates before care is delivered. The distinction is important. Data that require specialized software or advanced analytical skills may satisfy a reporting obligation without helping the people Congress intended to reach.

CMS has continued refining these requirements. Standardized reporting templates introduced in 2024 were designed to improve consistency across hospitals, while more recent revisions require estimated allowed amounts when negotiated prices are expressed through percentage-based formulas or other contractual methodologies. These changes reflect a reasonable effort to adapt the regulation to increasingly complex reimbursement arrangements. They also expose one of the central tensions running throughout this debate. Disclosure and transparency are not synonymous.

Financial regulators have confronted this distinction for years. Public companies can comply with disclosure requirements while producing filings so complex that few investors fully understand them. Tax law presents similar challenges. Compliance with disclosure rules does not necessarily produce meaningful public understanding. Healthcare now faces much the same question.

Hospitals today publish substantially more pricing information than they did before 2021. That represents genuine progress. Yet the practical value of that information varies enormously. Some institutions have made serious efforts to improve usability, simplify consumer access, and organize pricing information in ways patients can understand. Others have focused primarily on satisfying the technical requirements of the regulation while leaving consumers to navigate extraordinarily complicated datasets. That distinction matters because Congress was pursuing something larger than disclosure for its own sake. The objective was price discovery.

Markets work because buyers and sellers possess enough information to make informed decisions. Without that information, prices cease to perform their most important function. They no longer communicate value, discipline excessive costs, or encourage meaningful competition. Five years after implementation, hospitals have unquestionably become more transparent than they once were. Whether the healthcare marketplace has become substantially more competitive is a more complicated question.

2. Compliance: The Problem Is Not Complexity—It Is Incentives

Five years after implementation, the Hospital Price Transparency Rule has moved beyond its experimental phase. Hospitals have had ample opportunity to understand the regulation, modify internal systems, train staff, and incorporate transparency into routine operations. Whatever implementation challenges existed in early 2021 should, by now, be largely behind them. Yet complete compliance remains elusive.

Independent organizations measure compliance somewhat differently, and their methodologies are not identical. Even so, the broad conclusion has remained remarkably consistent. Whether examining the work of Patient Rights Advocate, the Department of Health and Human Services Office of Inspector General, Turquoise Health, or academic researchers, the picture changes surprisingly little. Full compliance remains the exception rather than the rule, generally ranging from roughly one-quarter to one-third of hospitals evaluated, depending on the methodology employed.

The consistency of those findings deserves more attention than the precise percentages. When organizations using different datasets, different sampling techniques, and different definitions of compliance arrive at essentially the same conclusion, policymakers should resist the temptation to argue over individual numbers. The broader trend is difficult to dismiss.

Hospital executives frequently point to the extraordinary complexity of modern reimbursement systems, and they are not wrong. Commercial contracts differ from one insurer to another. Payment methodologies vary across service lines. Value-based arrangements increasingly replace traditional fee-for-service reimbursement. Prices change as contracts are renegotiated, employers redesign benefits, and insurers introduce new products. Anyone who has spent time around hospital finance departments understands these realities.

The same organizations that describe transparency as technically difficult routinely process millions of claims, reconcile contractual adjustments, estimate patient responsibility before treatment, and calculate insurer payments with remarkable precision. Revenue-cycle management has become one of the most sophisticated administrative functions in modern healthcare. Hospitals know what they are paid. Indeed, they must. Their financial viability depends upon understanding negotiated reimbursement in extraordinary detail. Every contract, every claim, every adjustment, and every appeal require pricing information that is often far more precise than anything contemplated by the transparency rule itself. That is why the compliance debate should no longer focus primarily on capability. It should focus on incentives.

Economists have long recognized that organizations respond to the incentives embedded within regulatory systems. Businesses do not ordinarily ignore legal obligations, but neither do they disregard the economic consequences of compliance. Where legal requirements

align with institutional interests, voluntary compliance tends to follow. Where those interests diverge, regulators should expect slower adoption, greater resistance, and more intensive enforcement. Healthcare is no exception.

Negotiated prices have historically represented valuable commercial information. They influence negotiations with insurers, shape employer purchasing decisions, and affect competitive positioning within regional markets. Information, in other words, has economic value. Making that information public inevitably changes the competitive landscape. Recognizing that reality does not require attributing improper motives to hospitals. Quite the opposite. It requires acknowledging that sophisticated organizations behave much as policymakers should expect them to behave. They evaluate legal obligations alongside operational costs, competitive implications, governance responsibilities, and financial risk. Transparency becomes one factor among many competing priorities.

Some of the nation's largest and best-resourced health systems continue to appear in independent analyses documenting incomplete compliance with federal transparency requirements. Successive reviews have reached similar conclusions regarding several nationally prominent academic medical centers and integrated delivery systems, including major nonprofit hospitals in New York and other highly competitive metropolitan markets.

The significance of those findings is frequently misunderstood. The issue is not that these institutions lack technical expertise. It is that market leaders often possess the greatest ability to preserve information advantages that have developed over many years of confidential contracting.

This is where the work of the Lown Institute adds an important dimension to the discussion. Since the transparency rule first took effect, the Institute has consistently documented patterns of compliance, pricing variation, and nonprofit accountability that extend beyond individual reporting failures. Its research has shown that transparency should not be viewed solely as a consumer convenience. It is closely connected to broader questions of competition, community benefit, and the responsibilities that accompany nonprofit status.

Whether one agrees with every aspect of the Institute's methodology is ultimately less important than the consistency of its observations.

Across multiple reports, Lown has identified recurring relationships between market concentration, pricing practices, and institutional accountability. Those findings complement—not replace—the work of CMS, HHS, Patient Rights Advocate, Turquoise Health, and academic researchers. Taken together, they suggest that incomplete transparency is not an isolated compliance problem but part of a larger pattern affecting the operation of healthcare markets. That conclusion is reinforced by another often-overlooked statistic.

Turquoise Health has reported that most hospitals now publish machine-readable pricing files. At first glance, that appears encouraging. Yet subsequent analyses using those same data found that many hospitals continued to omit required prices for shoppable services or provided information that was incomplete, inconsistent, or difficult to use. Those findings are not contradictory. They simply illustrate the difference between publishing information and creating transparency. Healthcare has encountered similar challenges before.

Electronic health records became nearly universal years ago, yet true interoperability remains an ongoing objective because exchanging information proved far more difficult than digitizing it. Quality reporting programs generated vast quantities of data long before patients found them easy to interpret. Transparency now confronts the same risk. Success cannot be measured solely by the volume of information posted online. It must also be measured by whether that information improves decision-making. That distinction points toward the next question. If hospitals generally possess the necessary pricing information and if compliance challenges are increasingly shaped by institutional incentives rather than technical limitations, then attention naturally turns to the structure of federal enforcement itself. Has the current enforcement framework altered those incentives sufficiently to change behavior? The evidence suggests the answer is, at best, mixed.

3. Enforcement: Good Policy Depends on Credible Incentives

The discussion surrounding hospital price transparency often begins with an assumption: if compliance remains uneven, CMS simply needs to impose larger penalties. That conclusion is understandable, but it oversimplifies the problem.

CMS has accomplished more than it is sometimes given credit for. Since the transparency rule became effective, the agency has created an entirely new enforcement program, developed compliance guidance, revised reporting requirements, responded to complaints, reviewed corrective action plans, and imposed civil monetary penalties where hospitals remained out of compliance. Building a national oversight program affecting thousands of hospitals was never going to be a simple undertaking.

The more important question is whether that enforcement structure has changed institutional behavior. Five years into implementation, the answer appears to be mixed. CMS's enforcement process reflects principles familiar to anyone who has worked with federal regulatory agencies. Hospitals identified as potentially noncompliant generally receive notice of deficiencies, opportunities to respond, time to submit corrective action plans, and additional opportunities to demonstrate compliance before civil monetary penalties become final. That process is consistent with longstanding concepts of administrative fairness. Agencies should encourage correction before punishment whenever possible.

The challenge is that fairness and deterrence are not always the same thing.
One of the more durable findings in regulatory economics is that organizations respond less to the theoretical severity of sanctions than to their expected certainty and timing. A relatively modest penalty imposed consistently and promptly often changes behavior more effectively than a much larger sanction that arrives after lengthy administrative proceedings.

Hospital transparency appears to illustrate that principle. CMS's own procedures frequently require many months before financial penalties become a realistic possibility. During that time hospitals continue operating under largely unchanged economic conditions. Contracts remain in place. Pricing information remains unavailable. Competitive relationships remain essentially the same. Whatever advantage a hospital perceives from delayed disclosure continues throughout much of the enforcement process. Time itself therefore becomes part of the incentive structure.

That observation is important because discussions of enforcement typically focus on the dollar amount of penalties while overlooking the economic value of delay. In competitive markets, preserving an information advantage for another six months may be worth considerably more than the eventual civil monetary penalty. The size of the penalty deserves attention as well.

Maximum annual penalties approaching $2 million appear significant in isolation. They appear less consequential when viewed against the operating revenues of many large integrated delivery systems. For major academic medical centers and multistate hospital organizations, transparency penalties are unlikely to threaten financial stability or materially alter strategic planning. That does not mean penalties should become punitive. It does suggest they should be economically meaningful.

Corporate governance offers a useful comparison. Boards routinely review cybersecurity risks, reimbursement disputes, employment litigation, environmental compliance, and financial controls. Each represents a potential source of legal or financial exposure.

Transparency compliance naturally joins that list. Whether it becomes a priority depends not simply on the existence of penalties, but on the likelihood that noncompliance will affect institutional performance, reputation, or governance.

That brings us to another important aspect of the current rule. Over time, CMS has appropriately recognized that modern reimbursement contracts often rely on methodologies more complicated than fixed negotiated prices. As a result, hospitals may disclose estimated allowed amounts, percentage-based formulas, or algorithmically determined payment methodologies in certain circumstances. The accommodation reflects the realities of increasingly sophisticated payment arrangements. It also creates an unintended consequence.

Information that satisfies a regulatory reporting requirement may still provide limited practical value to patients, employers, or purchasers attempting to understand the likely cost of care. Patient Rights Advocate has argued that many hospitals now rely upon pricing methodologies requiring specialized interpretation, making meaningful comparison difficult despite technical compliance with portions of the rule. Whether one accepts every aspect of that critique, it highlights an important distinction between regulatory disclosure and practical transparency.

Other regulatory systems have encountered similar challenges. Public companies file thousands of pages of disclosures with the Securities and Exchange Commission every year. Investors benefit not because information merely exists, but because reporting standards emphasize comparability, consistency, and materiality. Tax reporting has evolved in similar ways. The objective is not simply disclosure. It is useful disclosure. Healthcare should aspire to the same standard.

The success of the Hospital Price Transparency Rule should ultimately be measured by whether employers negotiate more effectively, patients gain a clearer understanding of healthcare costs before treatment, researchers obtain more reliable market information, and competition becomes more robust. Those outcomes—not the number of machine-readable files uploaded to hospital websites—represent the policy objectives Congress originally sought to achieve.

For that reason, the central question facing policymakers today is not whether CMS should become more aggressive. It is whether the current enforcement framework creates incentives that make transparency the rational business decision. If the answer remains uncertain, Congress should focus less on writing additional regulations and more on strengthening the credibility of the incentives already embedded within the law. That is where the next generation of reform should begin.

4. Transparency, Tax Exemption, and the Public Trust

Hospital price transparency is often presented as a consumer issue. Patients want to know what a procedure will cost before agreeing to treatment, employers want better information when negotiating health benefits, and policymakers hope that greater visibility will strengthen competition. All those objectives are legitimate – and they are also incomplete.

Transparency is equally a question of institutional accountability. Hospitals occupy an unusual position in American society. They compete vigorously for patients, physicians, commercial contracts, philanthropic contributions, and research funding. Many are among the largest employers in their communities and serve as anchor institutions within regional economies. At the same time, a substantial portion of the hospital sector operates as tax-exempt nonprofit organizations that receive significant federal, state, and local tax preferences because they are expected to provide public benefits extending beyond

ordinary commercial activity. That combination of market power and public support creates responsibilities that reach beyond traditional regulatory compliance.

Transparency should be understood as one of those responsibilities. The Hospital Price Transparency Rule was never intended simply to help individual patients compare the cost of imaging studies or elective surgery. Congress recognized that reliable pricing information benefits many participants in the healthcare system simultaneously. Patients make more informed decisions. Employers become better purchasers of healthcare. Researchers gain a clearer understanding of pricing patterns. Regulators obtain better information about competition. Public officials are better positioned to evaluate whether healthcare markets are functioning as intended.

Seen in that light, transparency becomes part of the infrastructure of accountable markets rather than simply another consumer protection initiative.

The Lown Institute has consistently broadened this discussion by examining transparency alongside nonprofit governance, community benefit, and hospital market behavior. Its work has shown that institutions receiving substantial public tax preferences do not always provide community investments commensurate with those benefits, raising important questions about how nonprofit performance should be evaluated. While reasonable observers may disagree about particular methodological choices, the Institute has made a valuable contribution by placing transparency within the larger conversation about institutional accountability rather than treating it as an isolated reporting requirement. That broader perspective becomes particularly important when examining hospitals serving economically disadvantaged communities.

Research published in *JAMA Network Open* found that hospitals caring for larger proportions of disadvantaged patients were significantly less likely to comply fully with federal transparency requirements than hospitals serving more affluent populations. That finding deserves careful consideration, not because it assigns blame, but because it highlights an unintended consequence of weak transparency enforcement. The patients with the greatest financial vulnerability often have the least access to reliable pricing information.

Medical debt continues to affect millions of American families. Even modest differences in hospital pricing can significantly influence whether healthcare expenses remain manageable or become financially destabilizing. Price visibility cannot eliminate those burdens, but it can improve the ability of patients, employers, and referring physicians to make informed choices before care is delivered. Communities with the fewest financial resources should not be the ones receiving the least useful pricing information. The issue also extends well beyond patients.

Employers finance healthcare coverage for well over half of Americans with private insurance. Yet many negotiate contracts without knowing how reimbursement rates

compare across competing hospital systems. Greater pricing visibility improves their ability to evaluate network design, negotiate with insurers, and assess whether increasing healthcare expenditures reflect improved value or simply stronger market leverage. Researchers benefit in similar ways.

Price transparency has already begun generating data that allow economists and health services researchers to examine pricing variation with a level of precision that was largely impossible only a decade ago. Those analyses are improving our understanding of regional market concentration, negotiated reimbursement, and the relationship between competition and healthcare spending.

Antitrust enforcement likewise depends upon reliable market information.
The Federal Trade Commission and Department of Justice increasingly evaluate hospital mergers through the lens of competition and consumer welfare. Negotiated prices provide one of the clearest indicators of market power. When pricing information remains incomplete or inconsistent, regulators lose one of the most informative measures available for evaluating whether consolidation has benefited consumers or simply increased negotiating leverage. Transparency therefore creates value that extends far beyond individual purchasing decisions. It supports competition. It strengthens research. It improves oversight. It helps ensure that institutions benefiting from substantial public support remain accountable not only for the quality of care they deliver but also for the openness with which they conduct their affairs.

That point deserves emphasis because discussions about nonprofit hospitals often become unnecessarily polarized. Most nonprofit hospitals provide extraordinary clinical care, educate future healthcare professionals, conduct important research, and serve communities in ways that cannot be captured by financial metrics alone. Recognizing those contributions, however, should not diminish the expectation that institutions receiving significant public benefits also meet reasonable standards of public accountability. Transparency is one of those standards. Not because disclosure alone solves healthcare's affordability challenges. But because markets -- and public trust -- cannot function well when essential information remains unnecessarily hidden.

5. The Transparency Test: Hundreds of Hospitals Are Still Failing

The preceding discussion explains why hospital price transparency matters—for patients, employers, taxpayers, researchers, and the nonprofit institutions that receive substantial public support. The remaining question is whether these concerns remain largely theoretical or whether they are readily observable in today's healthcare marketplace. Recent federal enforcement actions provide a clear answer.

Five years after implementation of the Hospital Price Transparency Rule, the problem is no longer hidden. It has been publicly documented. The Trump Administration has transformed what was once viewed as an abstract compliance debate into a matter of

public record by publicly identifying approximately **500 hospitals** that federal officials determined were failing to comply with federal hospital price transparency requirements.

The list spans virtually every region of the country and includes hospitals operating under dramatically different political, regulatory, and competitive environments. That matters because it fundamentally changes the nature of the discussion. The debate is no longer about whether hospitals understand what the law requires. They do. Nor is the debate about whether hospitals possess the information Congress asked them to disclose. They do. Hospitals have now had more than five years to implement the rule. Modern revenue-cycle systems calculate negotiated reimbursement with extraordinary precision. Every payer contract, every claim adjustment, every patient estimate, and every reimbursement decision depend upon pricing information hospitals already maintain as part of routine business operations. The question is therefore no longer whether hospitals **can** comply. **The question is why so many continue choosing not to.**

The answer appears to lie less in technology than in economics. Hospitals respond to incentives just as every sophisticated organization does. If maintaining pricing opacity continues to provide competitive advantages while the expected costs of noncompliance remain relatively modest, delayed compliance becomes an understandable—although entirely unacceptable—business decision. The Administration's publication of approximately 500 noncompliant hospitals provides perhaps the clearest evidence to date that the principal obstacle is no longer technical capability. It is institutional behavior.

FIGURE 2

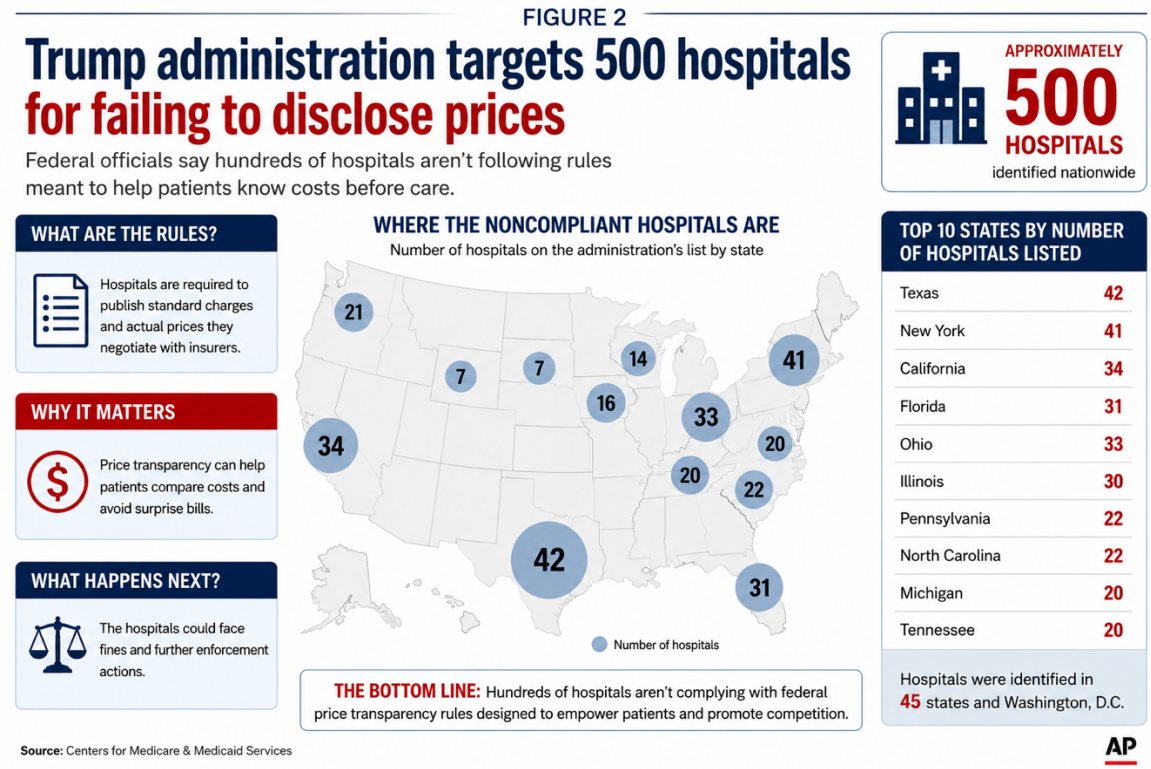

Figure 3. *CMS's public identification of approximately 500 hospitals failing to comply with federal price transparency requirements represents an important evolution in enforcement strategy. Public disclosure increases institutional accountability and reputational pressure while demonstrating that transparency failures persist even in states with stronger hospital accountability laws. The evidence reinforces this report's central conclusion: the remaining barrier is not technological capability but insufficient incentives.*

Texas provides perhaps the most revealing example.

Texas has enacted one of the nation's strongest hospital transparency and accountability statutes, explicitly recognizing that delayed disclosure itself creates economic value. Yet federal enforcement data indicate that approximately **42 Texas hospitals** nevertheless appeared on the Administration's noncompliance list. While the exact number should be confirmed immediately before publication, the policy implication is unmistakable. **Strong legislation alone does not produce transparency. Credible enforcement does.** Texas is hardly unique.

Hospitals in **Tennessee, North Carolina, Maryland, and Kansas**—the very states examined throughout this report because of their emerging approaches to hospital accountability—also appear on the federal list. Their inclusion demonstrates that transparency failures are not confined to one region, one ownership model, one type of hospital, or one political philosophy. They are national.

The significance of Figure 3 extends well beyond simple compliance statistics. These hospitals are not obscure organizations struggling to understand a complicated federal regulation. Many are among the nation's largest and most sophisticated health systems. They employ thousands of people, negotiate billions of dollars in reimbursement agreements, maintain highly advanced financial operations, and routinely calculate patient responsibility to the penny.

When institutions possessing that level of administrative sophistication continue appearing on federal noncompliance lists five years after implementation, policymakers should stop asking whether hospitals can comply and begin asking why many continue concluding that they do not have to.

That question goes directly to the central argument of this report. The principal challenge facing hospital price transparency is no longer technological. It is economic. Organizations respond to incentives. If the financial benefits of maintaining pricing opacity continue to outweigh the practical consequences of noncompliance, policymakers should expect precisely the behavior they are observing today.

The Administration's publication of hundreds of noncompliant hospitals should therefore be viewed as far more than another enforcement action. It represents a turning point in the transparency debate. The question is no longer whether Congress should require

disclosure. Congress already has. The question is whether policymakers are prepared to ensure that continued secrecy becomes more expensive than continued compliance. The encouraging news is that several states have already begun demonstrating how that can be accomplished.

Their experience provides a practical roadmap for Washington.

6. The States Are Showing Washington How to Fix It

Federal healthcare policy often assumes that innovation flows in one direction, from Washington to the states. Hospital price transparency suggests the opposite. Some of the most useful ideas now emerging have been developed not through federal rulemaking, but through state experimentation.

That should not surprise anyone familiar with healthcare regulation. States have long served as laboratories for public policy. Certificate-of-need laws, Medicaid delivery reforms, all-payer claims databases, surprise billing protections, and telehealth initiatives all evolved differently across the country before many of their underlying concepts appeared in federal law. Transparency is following much the same path.

The states have not produced a single model. They have produced something more useful. They have demonstrated that different enforcement strategies can produce the same outcome when they alter institutional incentives.

Texas illustrates the point particularly well. Rather than treating noncompliance as a one-time administrative event, Texas recognized that every additional day of delayed disclosure preserves the very information imbalance the federal law was designed to eliminate. Its penalty structure therefore grows more consequential the longer a hospital remains out of compliance. That reflects an important economic insight. Delay has value. If withholding negotiated prices provides a competitive advantage, even temporarily, then an effective enforcement system must recognize that the benefit of delay increases over time. Static penalties imposed after lengthy proceedings do not fully account for that reality.

Colorado approached the problem differently. Instead of asking how large a civil penalty should be, lawmakers focused on what hospital leadership would notice. Their answer was straightforward: revenue. Colorado's statute limits debt collection activities by hospitals that fail to satisfy transparency requirements and authorizes additional consumer-protection remedies through the Attorney General. Whether every feature of the statute ultimately survives judicial scrutiny is less important than the principle it reflects. Effective regulation changes behavior when it affects decisions made in executive offices and boardrooms, not merely within compliance departments.

Ohio placed greater emphasis on patient protection, linking transparency violations to debt collection practices and statutory remedies available to affected consumers. Other

states, including **Nevada and Oklahoma**, have adopted variations on the same basic idea. The details differ, but the underlying philosophy is remarkably consistent. Transparency should not exist as an isolated reporting obligation disconnected from the day-to-day operation of healthcare markets.

Perhaps the most interesting development has occurred outside the traditional framework of healthcare regulation altogether. Several states have begun treating price transparency not simply as a CMS compliance issue, but as a matter of consumer protection. That shift deserves far more attention than it has received.

State attorneys general possess authorities that differ from those of federal regulators. They investigate deceptive business practices, oversee charitable organizations, evaluate nonprofit governance, review hospital transactions, and respond directly to consumer complaints. They also understand local healthcare markets in ways that national agencies often cannot. They know where consolidation has occurred, where competition has weakened, and where patients repeatedly encounter similar problems.

North Carolina demonstrated how powerful those tools can become. Rather than waiting for new federal initiatives, the Attorney General publicly evaluated hospital compliance, required institutions to explain deficiencies, and released findings that generated substantial public attention. The exercise imposed no extraordinary financial penalties. Its effectiveness came from something less tangible but equally important: reputational accountability. Hospitals pay close attention to reputation.

Healthcare has become increasingly transparent about quality, safety, infection rates, patient satisfaction, and clinical outcomes because those measures influence institutional standing. Transparency itself should eventually occupy the same position. One of the more surprising aspects of the current debate is that hospitals compete vigorously on almost every publicly reported metric except price visibility. CMS publishes quality ratings. Leapfrog assigns safety grades. *U.S. News & World Report* ranks hospitals annually. Accreditation organizations evaluate governance and clinical performance. Yet patients still have remarkably little information about whether an institution consistently provides complete, usable pricing information. That's a missed opportunity.

Transparency should become part of institutional reputation rather than remaining largely invisible outside regulatory circles. Congress has already begun moving in that direction. The Hospital Transparency Compliance Enforcement Act would strengthen enforcement, require greater public disclosure of compliance status, and prohibit practices designed to make pricing information more difficult to locate through internet search engines. Although the legislation has not advanced, it reflects a broader recognition that transparency cannot depend indefinitely upon voluntary compliance supported by relatively modest administrative penalties.

The larger lesson emerging from the states is both simple and encouraging.

Congress does not need to reinvent hospital price transparency. It needs to learn from what is already working. The states have demonstrated that transparency improves when it becomes part of institutional governance, consumer protection, financial accountability, and public reputation—not merely another reporting requirement enforced from Washington. Federal policy should build on those lessons rather than starting over.

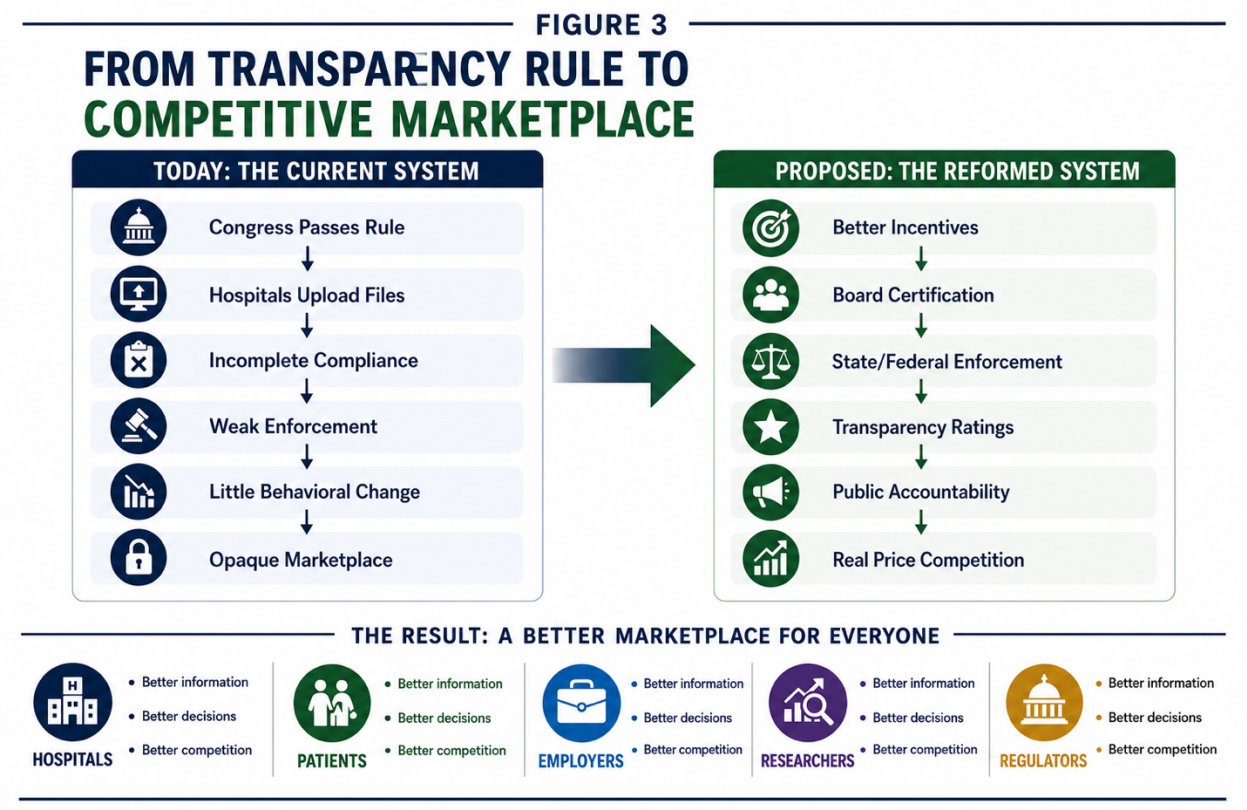

Figure 3. From Transparency Rule to Competitive Marketplace
The next phase of reform should shift the focus from procedural compliance toward stronger incentives, public accountability, and measurable improvements in market competition.

The recommendations that follow correspond directly to the reforms illustrated in Figure 2 and are designed to align institutional incentives with the broader objectives of competition, accountability, and informed consumer choice.

7. A Reform Agenda for Congress

Five years after implementation, the broad outlines of the problem are no longer in dispute. Hospitals understand what the Hospital Price Transparency Rule requires. CMS has demonstrated both the willingness and the authority to enforce it. Independent researchers have identified persistent compliance gaps, and several states have shown

that stronger incentives can improve performance. The challenge facing Congress is therefore different from the one it confronted in 2019.

The question is no longer whether transparency is desirable. It is how to make transparency durable. That distinction matters because healthcare regulation often accumulates new reporting requirements without reconsidering whether existing incentives remain aligned with public policy. Hospital price transparency illustrates that tendency. The federal government has established disclosure obligations. It has created enforcement authority. Yet the practical consequences of noncompliance often remain modest when measured against the economic interests that encourage delayed or incomplete disclosure.

Successful regulation rarely depends on adding more rules. It depends on making compliance the rational business decision. The reforms outlined below are guided by that principle.

Integrate Transparency into Medicare Participation

Price transparency should no longer be treated as a stand-alone administrative requirement. It should become part of the broader framework governing participation in federal healthcare programs.

Hospitals devote substantial attention to Medicare Conditions of Participation because those standards affect core institutional operations. Transparency deserves similar standing. Persistent, willful noncompliance should trigger graduated corrective actions tied to participation requirements rather than relying almost exclusively on civil monetary penalties. The purpose is not to exclude hospitals from Medicare. The purpose is to communicate that price disclosure is a fundamental expectation of institutions participating in publicly financed healthcare.

Move Transparency into the Boardroom

One of the more striking features of the current framework is how often transparency remains confined to compliance offices, information technology departments, or revenue-cycle teams. That is too narrow a view. Hospital boards already oversee financial reporting, cybersecurity, enterprise risk, executive compensation, patient safety, and strategic planning. Public pricing should be discussed with the same seriousness because it affects legal compliance, institutional reputation, and public confidence.

Annual certification by both the chief executive officer and the chair of the governing board would reinforce that responsibility while encouraging transparency to become part of routine governance rather than a periodic compliance exercise. The goal is cultural as much as regulatory. Institutions generally perform best when accountability begins in the boardroom instead of ending in the compliance office.

Connect Tax Benefits to Public Accountability

The debate surrounding nonprofit hospitals often becomes unnecessarily ideological. It need not be. Federal tax exemption reflects a longstanding public judgment that nonprofit hospitals provide benefits extending beyond ordinary commercial activity. That judgment remains appropriate for many institutions. The issue is whether public support should also carry continuing obligations.
Transparency should be one of them.

Hospitals already report extensively on community benefit, executive compensation, governance, and financial performance. Incorporating annual certification of compliance with federal price transparency requirements would require little additional administrative effort while reinforcing an important principle: organizations benefiting from substantial public subsidy should also demonstrate meaningful public accountability. This proposal does not redefine nonprofit status. It simply recognizes that openness is part of the public compact supporting tax exemption.

Measure What Matters

Much of the discussion surrounding hospital transparency has focused on whether institutions have uploaded machine-readable files or satisfied reporting specifications. Those measures have value. The more meaningful question is whether transparency improves the functioning of healthcare markets:

Can employers compare competing hospitals more effectively?
Can patients obtain useful estimates before treatment?
Can researchers better evaluate pricing variation?
Can antitrust authorities assess competition with greater confidence?

Future evaluations should increasingly emphasize these outcomes rather than procedural compliance alone. The objective is not disclosure for its own sake. The objective is better market performance.

Strengthen Federal-State Partnerships

The experience of Texas, Colorado, North Carolina, Ohio, and other states suggests that transparency enforcement works best when federal standards are complemented by local oversight. State attorneys general understand regional healthcare markets in ways that national agencies rarely can. They investigate consumer complaints, oversee nonprofit organizations, review mergers, and enforce state consumer-protection laws. Their responsibilities naturally intersect with many of the issues raised by price transparency. Congress should encourage more systematic cooperation between CMS and state enforcement agencies through information sharing, coordinated investigations, and streamlined referral processes.

Make Transparency Part of Institutional Reputation

One opportunity remains largely unexplored. Hospitals compete intensely on publicly reported measures of quality. CMS publishes Overall Hospital Quality Star Ratings. Leapfrog assigns safety grades. *U.S. News & World Report* rankings influence recruitment, philanthropy, physician referrals, and public perception. Transparency should become similarly visible.

CMS should develop a straightforward public transparency score based on objective compliance criteria and publish those results in a format that patients, employers, researchers, and journalists can easily understand. Reputation changes behavior. Hospitals know that as well as anyone. Transparency deserves the same visibility as other indicators of institutional performance.

Look Beyond Compliance

Perhaps the most important lesson emerging from the first five years of implementation is that transparency should not be viewed as an end in itself. Posting information online is not the policy objective. Improving healthcare markets is. Congress should therefore evaluate future reforms not by the number of files hospitals publish, but by whether purchasers possess better information, competition becomes more robust, and consumers are able to make more informed financial decisions before care is delivered. That is the standard by which the next generation of transparency policy should ultimately be judged.

Conclusion: More Than a Transparency Rule

Five years is enough time to judge whether a major regulatory initiative has accomplished what Congress intended. It is also enough time to distinguish implementation problems from design problems. By either measure, the Hospital Price Transparency Rule has produced an incomplete success.

There is no question that the healthcare marketplace is more transparent today than it was before 2021. Hospitals publish pricing information that previously remained inaccessible. Researchers have gained unprecedented insight into negotiated reimbursement. Employers have begun using publicly available pricing data to evaluate healthcare spending. Patients have access to information that simply did not exist a decade ago. Those developments represent meaningful progress, and they should not be discounted. At the same time, progress should not be mistaken for completion.

The central promise of the legislation was never to populate the internet with machine-readable files or create another federal reporting requirement. Congress sought something considerably more ambitious. It sought to restore one of the essential conditions of a functioning marketplace by ensuring that prices, however imperfect, could begin informing

decisions before care was delivered rather than after the bill arrived. That objective remains unfinished.

The principal challenge is no longer technological. Hospitals possess the necessary information. Revenue-cycle systems process negotiated reimbursement with extraordinary sophistication. The remaining obstacles are institutional and economic. Organizations respond to incentives, and markets respond to information. A transparency policy that ignores either reality should not expect durable success. That conclusion should not be interpreted as criticism of hospitals alone.

Hospitals have adapted to the incentives policymakers established. CMS has implemented the authority Congress provided. States have begun experimenting with innovative approaches that strengthen accountability without abandoning market principles. Each participant has behaved largely as one would expect. The responsibility now rests with policymakers to determine whether the next stage of reform should continue refining the existing framework or more directly address the incentives shaping institutional behavior. The encouraging news is that Congress does not need to start over.

The experience of the past five years has produced an extraordinary amount of practical knowledge. States have demonstrated that transparency becomes more effective when it is connected to governance, consumer protection, and institutional reputation. Independent researchers have identified where compliance continues to fall short. Organizations such as the Lown Institute, Patient Rights Advocate, Turquoise Health, and academic investigators have moved the discussion beyond anecdote by documenting how incomplete pricing information affects patients, employers, nonprofit accountability, and competition. Their work provides policymakers with a far richer evidence base than existed when the rule was first adopted.

Perhaps the most important lesson is also the simplest. Healthcare should not be treated as the lone exception to principles that govern every other major American marketplace. Consumers should not have to commit to significant financial obligations without meaningful access to prices. Employers should not negotiate healthcare benefits while lacking basic information about local market dynamics. Researchers and antitrust authorities should not be asked to evaluate competition without visibility into the prices that competition is supposed to influence.

Price transparency alone will not solve those problems. No serious observer would argue otherwise. Healthcare affordability reflects a complex interaction of demographics, technology, labor costs, consolidation, insurance design, pharmaceutical innovation, and public policy. Transparency is not a cure-all. But it is difficult to imagine a competitive marketplace functioning well when one of its most fundamental sources of information remains hidden. That is ultimately why this debate extends well beyond hospital websites and reporting templates. It concerns the relationship between public trust and public accountability.

Many hospitals receive significant tax preferences because they serve broad public purposes. Medicare and Medicaid purchase care on behalf of millions of Americans. Employers devote an ever-growing share of compensation to health benefits. Patients increasingly shoulder higher deductibles and greater financial responsibility for their care. Every one of those stakeholders has a legitimate interest in understanding how healthcare prices are determined and how they compare across institutions. Transparency is one way of honoring that interest.

Justice Brandeis famously observed that sunlight is often the best disinfectant. The observation has endured because it captures something fundamental about public institutions and competitive markets alike.

Openness, however, does not eliminate every problem. It does, however, create the conditions under which problems become more difficult to ignore and easier to address. Hospital price transparency should be understood in exactly that spirit. Not as an administrative exercise. Not as another compliance obligation.

Markets do not require perfect information. They require enough information for competition to work. Five years after Congress enacted hospital price transparency, that remains the unfinished assignment.

What we need – what we deserve – is a broader effort to ensure that one of the nation's most important sectors increasingly operates according to the same principles of openness, accountability, and informed decision-making that Americans reasonably expect elsewhere in the economy.

That is a goal worth pursuing and it is a goal that remains well within reach.

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Expert Sources, Research Organizations, and Further Reading

The analysis and recommendations presented in this report are informed by a broad range of government publications, peer-reviewed research, independent policy organizations, statutory authorities, investigative journalism, and industry analyses. Readers seeking additional information are encouraged to consult the following resources.

Federal Government Resources

Centers for Medicare & Medicaid Services (CMS)

The principal federal agency responsible for implementing and enforcing the Hospital Price Transparency Rule.

Recommended Resources

- Hospital Price Transparency Program
  https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency
- Hospital Price Transparency Enforcement Activities and Outcomes Database
  https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes
- Hospital Price Transparency Fact Sheets and Guidance
  https://www.cms.gov/newsroom

U.S. Department of Health and Human Services (HHS)
Office of Inspector General

Hospital compliance audits and enforcement evaluations.
https://oig.hhs.gov

Federal Trade Commission (FTC)

Resources concerning healthcare competition, hospital mergers, market concentration, and antitrust enforcement.
https://www.ftc.gov

U.S. Department of Justice
Antitrust Division

Hospital mergers, competition policy, and healthcare market enforcement.
https://www.justice.gov/atr

Independent Research Organizations

Lown Institute
One of the nation's leading organizations examining nonprofit hospital accountability, community benefit, market concentration, and healthcare pricing.

Recommended Resources

- Hospital Fair Share Spending Project
- Hospital Price Transparency Research
- Hospital Price Variation Studies
- Community Benefit Reports
  https://lowninstitute.org

PatientRightsAdvocate.org

Perhaps the nation's leading independent organization monitoring hospital compliance with federal price transparency requirements.

Recommended Resources

- Semiannual Hospital Price Transparency Reports
- National Hospital Compliance Database
- State-by-State Compliance Reviews
- Legislative Updates
  https://www.patientrightsadvocate.org

Turquoise Health

Maintains one of the country's largest hospital pricing databases and produces important research on machine-readable files and transparency trends.
https://turquoise.health

Georgetown University Center on Health Insurance Reforms

Leading academic analysis of federal healthcare policy and transparency implementation.
https://chir.georgetown.edu

Peer-Reviewed Medical and Health Policy Literature

Readers interested in the broader academic literature should consult:
Health Affairs
https://www.healthaffairs.org

Health Affairs Scholar
https://academic.oup.com/healthaffairsscholar
JAMA Network Open
https://jamanetwork.com/journals/jamanetworkopen
The New England Journal of Medicine
https://www.nejm.org
Health Services Research
https://onlinelibrary.wiley.com/journal/14756773
Journal of Health Economics
https://www.sciencedirect.com/journal/journal-of-health-economics
The Milbank Quarterly
https://milbank.org/quarterly

Professional Organizations
Healthcare Financial Management Association (HFMA)

https://www.hfma.org
American Hospital Association (AHA)
https://www.aha.org
Association of American Medical Colleges (AAMC)
https://www.aamc.org
National Academy of Medicine
https://nam.edu
Advisory Board
https://www.advisory.com
Kaufman Hall
https://www.kaufmanhall.com

State Policy Resources

Several states have developed innovative approaches to strengthening hospital price transparency and enforcement. Their legislative and regulatory initiatives provide valuable models for federal policymakers.

Texas
https://capitol.texas.gov
Colorado
https://leg.colorado.gov
Ohio
https://www.legislature.ohio.gov
North Carolina Department of Justice
https://ncdoj.gov
Kansas Legislature
https://www.kslegislature.gov

Nevada Legislature
https://www.leg.state.nv.us
Oklahoma Legislature
https://oksenate.gov

Healthcare Economics and Public Policy

Readers interested in the broader economic and policy issues discussed throughout this report may wish to consult:

Brookings Institution
https://www.brookings.edu
Center for Medicine in the Public Interest
https://www.cmpi.org
American Enterprise Institute (AEI)
https://www.aei.org
RAND Corporation
https://www.rand.org
Urban Institute
https://www.urban.org
National Bureau of Economic Research (NBER)
https://www.nber.org
Congressional Budget Office (CBO)
https://www.cbo.gov

Healthcare News and Industry Publications

Much of the reporting cited throughout this report first appeared in highly respected healthcare news organizations.

Healthcare Dive
https://www.healthcaredive.com
Becker's Hospital Review
https://www.beckershospitalreview.com
Fierce Healthcare
https://www.fiercehealthcare.com
Crain's New York Business
https://www.crainsnewyork.com
NC Health News
https://www.northcarolinahealthnews.org
Kansas Reflector
https://kansasreflector.com
Carolina Public Press
https://carolinapublicpress.org

Primary Legal Authorities

Readers interested in the statutory and regulatory framework should consult:

- Public Health Service Act, Section 2718(e)
  https://www.govinfo.gov
- Code of Federal Regulations, 45 C.F.R. Part 180
  https://www.ecfr.gov
- CMS Hospital Price Transparency Rule
  https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency