REDUCING FRAGMENTATION: A TRANSPARENT AND EFFICIENT APPROACH TO THE AMERICAN HEALTH CARE SYSTEM

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I. INTRODUCTION

In July 2020, Caroline Eichelberger rushed to find medical assistance for her son, Nathan, after a stray dog attacked him at a Utah campsite.[1] Nathan needed to receive a rabies shot that only hospital emergency rooms administered.[2] Ms. Eichelberger's health insurance plan included a high deductible of $3,500, so she called local hospitals and her insurer to inquire about the price of the services needed for her son.[3] Ms. Eichelberger received little information from the hospitals and from her insurer.[4] Layton Hospital in Layton, Utah, informed Ms. Eichelberger that the charge for the inquired services would be $787 if she paid in cash and noted that the price with her insurance would not be available for another week,[5] which would be a week too late for her son to receive the necessary treatment. To her surprise, the hospital billed her an additional $2,260 after she elected to pay in cash and informed her that the hospital employee neglected to inform her of the cost of additional treatment related to her son's care.[6]

Ms. Eichelberger could have looked up this information if this scenario occurred today after the passage of the Hospital Price

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[1] *See* Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why*, N.Y. TIMES (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *See id.*

[6] *See id.*

Transparency Rule. This rule requires hospitals to make their standard charges for services public.[7] If this information was available upon her original request, Ms. Eichelberger would have learned that her insurance pays $4,198 for the services that her son needed; the regional insurer owned by the health system that Layton Hospital is a part of pays $1,284 for those services; other insurers like Regence BlueCross BlueShield pay $3,457 for those services; and uninsured patients pay $3,704.[8] Most consumers judge insurance plans based on their preferred doctors and hospitals; however, because "[m]ore Americans than ever are enrolled in high-deductible plans" that require the payment of thousands of dollars before coverage kicks in,[9] the out-of-pocket cost of services is increasingly important as well. Patients struggle to afford these bills; accordingly, sixteen percent of insured families have a median of $2,000 in medical debt.[10]

The fragmentation of the U.S. health care system is what makes information availability—such as price transparency—so important. Our health care system needs price transparency information along with health care efficiency data because of its divided design between the federal and state governments. The health care systems of other countries like the United Kingdom are better equipped to provide price transparency information and health care efficiency data because countries like the United Kingdom do not have to navigate a fragmented health care system similar to the current one within the United States.

In terms of ensuring health care efficiency within the United Kingdom, under the NHS, the Secretary of State, Public Health England, NHS England, and Clinical Commissioning Groups (CCGs) reduce health disparities.[11] These entities take measures such as ensuring that local CCGs receive enough resources to handle inequalities and "financially incentivizing reductions in inequalities in

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[7] *See* 45 C.F.R. § 180 (2022).

[8] Kliff & Katz, *supra* note 1.

[9] *See id.*

[10] *Id.*

[11] *See* Ruby Thorlby, *The English Health Care System*, *in* INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS 59, 66 (Rosa Tikkanen, Commonwealth Fund & Elias Mossialos et al., London Sch. Econ. & Pol. Sci. eds., 2020) https://www.commonwealthfund.org/international-health-policy-center/countries/england#cost-containment. Public Health England is an agency of the Department of Health in England and CCGs are groups of local general practitioners who commission and pay for the community care and hospital services in their areas. *Id.* at 59, 60.

certain areas," like early cancer diagnosis.[12] The NHS is able to accomplish health care price transparency and efficiency in part because Parliament, the Secretary of State for Health, and the Department of Health are responsible for health legislation and policy in England.[13] NHS England, the government-funded body, oversees the day-to-day workings of the NHS.[14] Additionally, the government owns the hospitals commissioned under the CCGs and the general practitioners contracted under the NHS.[15]

Unlike the fragmented U.S. health care system, systems like the NHS leave room for price transparency and are centralized enough to implement measures to see where care is needed, where disparities in health care quality lie, and where health care waste can be reduced. Since these services are government-owned and the service providers are government employees, the government works to ensure that "doctors and hospitals provide quality care at a reasonable cost" by collecting and analyzing data and using their purchasing power to influence providers.[16] If Ms. Eichelberger acquired the rabies shot for her son at a hospital under the NHS, instead of worrying about her high deductible and calling around to local hospitals to find the cheapest option, Ms. Eichelberger would know that England is a single-payer system with universal coverage,[17] so coverage at her local hospital would be free.[18] In other words, the costs of services under the NHS are more transparent than in the United States.

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[12] *Id.* at 66.

[13] *Id.* at 59.

[14] *Id.*

[15] *See id.*

[16] Kimberly Amadeo, *What Is Universal Health Care?*, BALANCE (Mar. 15, 2022), https://www.thebalance.com/universal-health-care-4156211.

[17] Adam Briggs et al., *What Can the U.S. and England Learn from Each Other's Health Care Reforms?*, COMMONWEALTH FUND (Mar. 30, 2018), https://www.commonwealthfund.org/blog/2018/what-can-us-and-england-learn-each-others-health-care-reforms.

[18] *See About NHS Hospital Services*, NHS (Apr. 11, 2019), https://www.nhs.uk/nhs-services/hospitals/about-nhs-hospital-services ("Hospital treatment is free if [one] ordinarily resides in the [United Kingdom]"); *see also* Thorlby, *supra* note 11 (explaining that in the United Kingdom, the NHS provides free public health care to all English residents, including hospital care). The NHS website lists emergency department or casualty services that deal with genuine life-threatening emergencies as free, except for emergency treatment once you have been admitted to the hospital. *When to Go to A&E*, NHS (Nov. 19, 2021), https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-go-to-ae.

Ms. Eichelberger did not struggle to find hospital systems close to her family home that provided the necessary service for her son during his medical crisis.[19] If the hospital systems around her home did not offer the necessary service, however, Ms. Eichelberger would be stuck traveling out of state. In England, an absence or deficiency of certain health care services is fixed through the NHS because this centralized system has access to data from different geographical locations throughout the region and can therefore investigate the absence or shortage of services in specific areas.[20] The U.S. government does not have a similar centralized system to provide this necessary information and instead relies on the states to handle health care deficiencies.

Since a centralized data system does not currently exist within the fragmented U.S. health care system, information is not available to allow consumers to understand what they are buying. Additionally, information is not available to state policymakers to understand the cost and quality of health care services to inform efficient policy decisions. Today, more Americans than ever before are stuck with high-deductible plans.[21] In the United States, wealthier Americans can afford first dollar coverage, an insurance policy that does not require an insured to pay a deductible for the insurance company to start paying for health care services.[22] On the other end of the scale, low-income Americans and Americans with disabilities rely on Medicaid, a health care program jointly funded by the states and federal government with nominal or minimal deductibles based on what a state pays for a necessary service.[23] Located in the middle of the scale are Americans with high-deductible health care plans, plans that require the insured to pay more health care costs before the insurance

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[19] *See* Kliff & Katz, *supra* note 1.

[20] *See* Thorlby, *supra* note 11, at 59, 66.

[21] *See* ROBIN A. COHEN & EMILY P. ZAMMITTI, HIGH-DEDUCTIBLE HEALTH PLAN ENROLLMENT AMONG ADULTS AGED 18–64 WITH EMPLOYMENT-BASED INSURANCE COVERAGE 1, 2, 5 (2018); *see also* Kliff & Katz, *supra* note 1.

[22] *What Is First Dollar Coverage?*, HUB, https://www.hubinternational.com/insurance-glossary/f/first-dollar-coverage/#:~:text=First%20Dollar%20Coverage%20is%20an,pressure%20placed%20on%20the%20insured (last visited Feb. 17, 2022).

[23] *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited Feb. 17, 2022); *see also Cost Sharing Out of Pocket Costs*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/cost-sharing/cost-sharing-out-pocket-costs/index.html (last visited Feb. 17, 2022).

company payment for services kicks in.[24] High-deductible health plans require individuals and families to pay more money out of pocket until they meet their deductibles and also require the payment of lower monthly insurance premiums.[25]

In 2022, the IRS defined a high-deductible health plan as a plan with a deductible of at least $2,800 for a family and $1,400 for an individual.[26] About 60 percent of adults aged eighteen to sixty-four years old have employment-based health insurance coverage.[27] From 2007 to 2017, the number of Americans with employment-based health insurance coverage enrolled in high-deductible plans with a health savings account increased from 4.2 percent to 18.9 percent, and Americans with employment-based health insurance coverage enrolled in high-deductible plans without a health savings account increased from 10.6 percent to 24.5 percent.[28] Additionally, during this period, enrollment in traditional plans—private health insurance plans with yearly deductibles less than the yearly IRS definition for a high-deductible health plan—decreased.[29]

The increase in high-deductible plans means that less Americans are using health care services or seeking services when care is needed.[30] For instance, between 2004 and 2013, copayments and deductibles rose for many Americans and predominately affected Americans with lower-incomes; between 2004 and 2012, expenditures (i.e., spending funds on medical expenses) fell $19.27 annually for the poorest quintile of the American population.[31] The increase in high-deductible plans also means that more Americans could face medical debt, and thus more Americans like Ms. Eichelberger will inquire

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[24] *High Deductible Health Plan (HDHP)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/high-deductible-health-plan/#:~:text=For%202021%2C%20the%20IRS%20defines,or%20%2414%2C000%20for%20a%20family (last visited Feb. 17, 2022).

[25] COHEN & ZAMMITTI, *supra* note 21, at 1.

[26] *High Deductible Health Plan (HDHP)*, *supra* note 24.

[27] COHEN & ZAMMITTI, *supra* note 21, at 1.

[28] *Id.*

[29] *Id.* at 1–6.

[30] *See* Dan Mangan, *Wealthy Spending More on Health Care than Poor and Middle Class, Reversing Trend*, CNBC (July 6, 2016, 5:35 PM), https://www.cnbc.com/2016/07/06/wealthy-spending-more-on-health-care-than-poor-and-middle-class-reversing-trend.html.

[31] *See id.*; *see also* Samuel L. Dickman et al., *Health Spending for Low-, Middle-, and High-Income Americans, 1963–2012*, 35 HEALTH AFFS. 1189, 1189–91 (2016).

about the costs of health care services.[32] This increasing reality that more Americans than ever before are using high-deductible plans highlights the importance of the out-of-pocket cost of services and the need for health care price transparency information. Due to the fragmentation between the federal government and state governments, Americans cannot readily access price transparency information to understand what they are buying, and state policymakers cannot comprehend the trends in health care costs and health care quality. In recent years, in the United States, the federal and state governments have taken measures to improve the lack of information concerning health care price transparency and efficiency through legislation; and yet, there are still barriers in place that prevent both goals from advancing.

To improve price transparency and overall efficiency within the United States, the federal government must bolster regulations such as the Hospitals Price Transparency Rule and the Insurance Price Transparency Rule. Furthermore, the federal government and state governments must work together to enact legislation to ensure the success of All-Payer Claims Databases (APCDs). In Part II, this Comment will discuss the history of the Hospital Price Transparency Rule and the Insurance Price Transparency Rule and their relation to the Healthcare PRICE Transparency Act. In Part III, this Comment will examine the APCDs and the litigation challenging them. Part IV will explain the measures our federal and state governments need to take to make health care price transparency and efficiency information available to reduce fragmentation for the portion of the American population with high-deductible insurance plans.

II. THE HISTORY OF HEALTH CARE PRICE TRANSPARENCY

This Part will focus on two price transparency rules that the federal government adopted—the Hospital Price Transparency Rule and the Insurance Price Transparency Rule. Since no centralized system exists within the United States for consumers with high-deductible plans to estimate the costs of their health care services, price transparency is necessary to reduce health care fragmentation. Centers for Medicare & Medicaid Services (CMS) proposed and adopted these transparency rules following an executive order from former President Trump. Around the same time, the Healthcare PRICE Transparency Act was introduced into the House of

[32] *See* Kliff & Katz, *supra* note 1.

Representatives but has yet to be passed by both houses of Congress. Today, the Hospital Price Transparency Rule and the Insurance Price Transparency Rule are adopted, but the enforcement of the Insurance Price Transparency Rule only recently began under the Administration of President Biden.

A. *The Development of the Hospital Price Transparency Rule*

Transparency in health care not only would provide consumers with high-deductible plans like Ms. Eichelberger with the information they need to make informed decisions, but it would also increase competition and drive down health care costs for these consumers.[33] The debate surrounding health care price transparency goes back to the passage of the Affordable Care Act (ACA) when Congress enacted Section 2718(e) of the Public Health Service Act.[34] This Section required hospitals to make public a list of their standard charges for the items and services they provide and to update their lists annually.[35] Previously, hospitals satisfied this requirement of the Public Health Service Act by publishing their chargemaster—the list that hospitals provide detailing the rate charged for services.[36] CMS, however, recognized that chargemasters "are 'usually highly inflated' and 'bear little relationship to market rates'" because they provide fee-for-service, nondiscounted prices.[37] As a result, CMS proposed a rule in August 2019 to expand the amount of information that hospitals are required to report to the public under section 2718(e).[38] In November 2019, CMS promulgated its final rule, the "Price Transparency Requirements for Hospitals to Make Standard Charges Public" ("the Hospital Price Transparency Rule").[39]

The Hospital Price Transparency Rule requires hospitals to make the following types of charges available to the public: "[g]ross charges:

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[33] Chris Wheeler & Russ Taylor, *New Year, New CMS Price Transparency Rule for Hospitals*, HEALTH AFFS. (Jan. 19, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210112.545531/full/?utm_medium=email&utm_source=sharpspring&sslid=MzcxMrUwsDQwsTQzAgA&sseid=MzK0NDG1NLUwMQIA&jobid=6faa1fbd-6166-4e41-af9e-a69fb0dd2d2.

[34] *Id.*

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] 45 C.F.R. § 180 (2022); *see also* Wheeler & Taylor, *supra* note 33. This final rule is codified at 45 C.F.R. § 180 (2022).

the non-discounted rate, as reflected in a hospital's chargemaster; [d]iscounted cash prices: the rate the hospital would charge individuals who pay cash . . . ; [and] [p]ayer-specific negotiated charges: the rate that a hospital has negotiated with a third-party payer (for example, an insurer) . . . ."[40] Under this rule, hospitals are also required to report the "[d]e-identified minimum negotiated rates: the lowest rates that a hospital has negotiated with all third-party payers, without identifying the payer; and [d]e-identified maximum negotiated rates: the highest rates that a hospital has negotiated with all third-party payers, without identifying the payer."[41] Along with the mandatory reporting requirements, the Hospital Price Transparency Rule requires hospitals to provide a machine-readable file that contains the above-noted charges for all items and services that the hospitals provide, if the hospitals established a regular rate for a service or item.[42] Hospitals are also required to provide consumers with a "consumer-friendly" list of the above-mentioned charges for 300 of the hospitals' "most 'shoppable services,'" which are services a health care consumer can schedule in advance.[43] CMS already noted 70 shoppable services that hospitals are required to provide to consumers and left the remaining 230 shoppable services for the hospitals to choose.[44]

The Hospital Price Transparency Rule became effective on January 1, 2021, and each hospital within the United States is now required to provide these charges online in a comprehensive and shoppable display.[45] CMS provides guidance and examples on what this setup should look like.[46] For example, an "INSERT BLADDER

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[40] 45 C.F.R. § 180(b) (2022).

[41] *Id.*

[42] Wheeler & Taylor, *supra* note 33.

[43] *Id.*

[44] *Id.*

[45] *Hospital Price Transparency*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 6, 2022, 2:34 PM), https://www.cms.gov/hospital-price-transparency.

[46] *See* Terri L. Postma, *Compliance with Hospital Price Transparency Final Rule: 8 Steps to a Machine-Readable File*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 2021), https://www.cms.gov/files/document/august-11-2021-hospital-price-transparency-odf-slide-presentation.pdf. CMS encourages hospitals to comply with the comprehensive and shoppable display requirement in an excel based format and guides the hospital to list the item/service under a tab labeled description and then across from the description, a hospital should plug in the billing code, the gross charge, the discounted cash price, the charge that the hospital negotiated with a third party such as an insurance company for the service or item, the minimum negotiated charge, and the maximum negotiated charge. *Id.*

CATH, SIMPLE" would be listed under the description for a service or item; 51702 could signify the billing code; $1,543 could signify the gross charge; $771.50 could signify the discounted cash price; the negotiated plan price could end up at $912; another negotiated plan price could end up at $550; the minimum negotiated price would then amount to $550; and the maximum negotiated price would then amount to $912.[47] The goal of this final rule is to make it easier for consumers with high deductibles to compare prices between hospitals, estimate the cost of the services that a hospital provides before they seek treatment, and essentially allows consumers to "shop" for the hospitals that work best for their situations.[48] In order to enforce compliance with this final rule, noncomplying hospitals will face civil monetary penalties for their refusal to adhere to the rule's requirements.[49] Noncomplying hospitals can face a penalty of up to $300 per day or $10 per bed per day, a penalty that advocates believe does not have enough strength to force hospitals to comply,[50] especially since the hospital industry spent years fighting congressional efforts to enact price transparency.[51]

The nonprofit organization Patient Rights Advocate surveyed one thousand hospital websites of the six thousand hospitals required to follow this final rule, and found that only 14.3 percent of hospitals fully complied with the Hospital Price Transparency Rule and 85 percent of hospitals did not meet at least one or more of the Hospital Price Transparency Rule requirements.[52] In another study, Morgan Henderson and Morgane Mouslim from the journal, *Health Affairs*, collected price transparency files from the one hundred largest hospitals in the United States based on bed count.[53] In order to ensure compliance with the Hospital Price Transparency Rule, this study sought to confirm that the hospitals' files were machine-readable and

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[47] *Id.*

[48] *Hospital Price Transparency*, *supra* note 45.

[49] *Id.*

[50] *See* PATIENT RTS. ADVOCATE, SEMI-ANNUAL HOSPITAL PRICE TRANSPARENT COMPLIANCE REPORT 3, 4 (2022), https://www.patientrightsadvocate.org/semi-annual-compliance-report-2022.

[51] Dan Diamond, *Nearly All Hospitals Flout Federal Requirement to Post Prices, Report Finds*, WASH. POST (July 16, 2021, 2:42 PM), https://www.washingtonpost.com/health/2021/07/16/hospital-cost-transparency.

[52] PATIENT RTS. ADVOCATE, *supra* note 50, at 1–2.

[53] Morgan A. Henderson & Morgane C. Mouslim, *Low Compliance from Big Hospitals on CMS's Hospital Price Transparency Rule*, HEALTH AFFS. (Mar. 16, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210311.899634/full.

contained the following: "the gross charge, [the] discount cash price, [the] payer-specific negotiated charges, [the] deidentified minimum and maximum charges, and description[s] of, and codes for, the items and services provided by the hospitals."[54] Additionally, in order to ensure compliance with the Hospital Price Transparency Rule, this study checked to verify that the hospitals listed the name of the plan and the payer for the payer-specific negotiated charges.[55] This study found that sixty-five of the one hundred hospitals studied were noncompliant, and of the sixty-five noncompliant hospitals, fifty-three did not list the payer-specific negotiated charges with the name of the plan and the payer.[56] Moreover, twelve of the sixty-five noncompliant hospitals did not provide price transparency files or only provided links to searchable databases for third-parties to look up price transparency information, but these databases could not be downloaded.[57]

Currently, CMS issues warning letters to noncompliant hospitals requesting that those facilities initiate a corrective action plan, and then CMS imposes civil monetary penalties on the hospitals that still do not comply.[58] To further deter noncompliant facilities, CMS threatens to publicly identify those hospitals by posting their names on a CMS website.[59] The potential price penalty from the government cannot exceed $2,007,500 a year, per hospital,[60] a penalty that advocates believe should be higher to ensure compliance from hospital systems that generate billions of dollars in revenue (i.e., in 2019, N.Y.U. Langone, a hospital system that includes five inpatient hospitals, received $5 billion in revenue).[61] In June 2022, CMS issued the first civil monetary penalties to two Georgia Hospitals, together totaling about $2 million.[62] Seeing how the current proposed penalties under this final rule may have no effect on big hospital systems and only two

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[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] *Hospitals*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021, 8:00 PM), https://www.cms.gov/hospital-price-transparency/hospitals#key-provisions.

[59] *Id.*

[60] Press Release, Ctrs. for Medicare & Medicaid Servs., CMS OPPS/ASC Final Rule Increases Price Transparency, Patient Safety and Access to Quality Care (Nov. 2, 2021), https://www.cms.gov/newsroom/press-releases/cms-oppsasc-final-rule-increases-price-transparency-patient-safety-and-access-quality-care.

[61] Kliff & Katz, *supra* note 1; *see* Diamond, *supra* note 51.

[62] *See Enforcement Actions*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 8, 2022, 2:18 PM), https://www.cms.gov/hospital-price-transparency/enforcement-actions.

civil monetary penalties have been imposed almost two years after this final rule became effective, advocates like Patient Rights Advocate are hopeful that the Biden Administration will employ stricter and more meaningful penalties to hold hospitals accountable.[63]

The enforcement of penalties could be necessary to enforce this final rule, as evidenced by the failure of most hospitals to comply and CMS's issuance of only two civil monetary penalties and only 170 warning letters as of July 2021.[64] The United States has made strides in health care transparency since the initial reporting of the highly inflated chargemaster rates that bore little relationship to market rates under the Public Health Service Act. For instance, in 2013, Bayonne Hospital Center in Bayonne, New Jersey, listed the charge for congestive heart failure as $121,080.[65] This charge was grossly inflated and not reflective of what insurers and Medicare paid at the time.[66] Today, under the Hospital Price Transparency Rule, hospitals are required to report much more than a highly inflated chargemaster. Without the enforcement of penalties, however, price transparency may not be achieved under this final rule.

B. *Criticisms of the Hospital Price Transparency Rule*

The Hospital Price Transparency Rule is not perfect, and there are valid arguments against its enforcement; however, it is needed to prevent circumstances such as the one that Ms. Eichelberger and her family experienced. But critics argue that this final rule is unhelpful because the price information that hospitals are required to disclose does not include medical care expenses not covered by insurance, such as copayments; yet CMS notes that the negotiated prices between insurers and hospitals drive these out-of-pocket costs paid by patients, even though patients may have to pay a fraction of these negotiated prices.[67] Additionally, CMS notes that this final rule aims to provide patients with "real-time, personalized, access to cost-sharing information, including an estimate of their cost-sharing liability, through an internet-based self-service tool," and CMS believes that adherence to the requirement of a machine-readable format for price

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[63] *See* Diamond, *supra* note 51.

[64] *See* Kliff & Katz, *supra* note 1; *see also Enforcement Actions*, *supra* note 62.

[65] Sarah Kliff, *Here's Why Hospitals Set High Prices*, WASH. POST (May 19, 2013, 11:39 AM), https://www.washingtonpost.com/news/wonk/wp/2013/05/19/heres-why-hospitals-set-high-prices.

[66] *See id.*

[67] Wheeler & Taylor, *supra* note 33.

disclosure will encourage third-parties to create tools to breakdown the price data from hospitals.[68] Next, critics in the industry argue that compliance with the final rule is impossible because many prices for hospital services are the result of complex algorithms and cannot be calculated in advance.[69] But in accordance with this final rule, CMS observed that if hospitals run into this issue, they can state that the information requested is not available.[70]

A common argument against the final rule is that increased price transparency will raise health care prices.[71] Yet CMS studies contradict this view.[72] For instance, one study found that in thirty states with regulations that required public access to hospital prices, the regulations "lowered the price of shoppable procedures . . . by approximately 5 percent overall compare[d] to prices for non-shoppable procedures."[73] Another study that evaluated the impact of price transparency tools found on the web observed that "one user of those tools was able to reduce its costs by 10 percent to 17 percent."[74] Lastly, a major criticism of the final rule is that the potential cost of compliance is out of proportion to the rule's benefits.[75] For example, CMS estimates an average hospital will spend about $11,898.60 in its first year of compliance to the Hospital Price Transparency Rule.[76] CMS also estimates that the cost of compliance per hospital will decrease to $3,610.88 in the following years.[77] Yet hospitals argue that the cost of compliance will exceed the expectations of CMS and cost "hundreds of thousands of dollars."[78]

CommonSpirit, a hospital system with more than 140 hospitals, holds more than three thousand agreements with payers, and each agreement possesses ten to fifteen unique benefit plans.[79] CommonSpirit is larger than the average hospital system, possesses more agreements with payers than the average hospital system, and will

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[68] *Id.*

[69] *Id.*

[70] *Id.*

[71] *See id.*

[72] *Id.*

[73] Wheeler & Taylor, *supra* note 33.

[74] *Id.*

[75] *See id.*

[76] *Id.*

[77] *Id.*

[78] *Id.*

[79] Wheeler & Taylor, *supra* note 33.

end up spending more than the estimated $11,898.60 during its first year of compliance. For instance, if CommonSpirit paid CMS's estimated compliance cost per hospital, it would end up spending more than one million dollars during its first year of compliance. Compliance costs are expected to decline when the health care industry's practices surrounding compliance become standard and third-party price aggregators create tools to digest price data, eventually taking the upfront costs of compliance away from the hospitals.[80]

C. *The Arguments Surrounding the Hospital Price Transparency Rule Turned into a Lawsuit: The AHA Lawsuit*

The arguments against the Hospital Price Transparency Rule culminated in a 2019 lawsuit against this final rule. The American Hospital Association (AHA) commenced a lawsuit in the U.S. District Court for the District of Columbia on December 4, 2019, arguing that the Hospital Price Transparency Rule "exceeded CMS's statutory authority under the ACA, violated the First Amendment, and is arbitrary and capricious under the Administrative Procedures Act."[81] On appeal, the D.C. Circuit Court affirmed the lower court's rejection of the arbitrary and capricious argument against the final rule under the Administrative Procedure Act (APA), finding that the information published under the final rule would not confuse patients because the published information is equivalent to out-of-pocket costs for uninsured patients and patients paying cost sharing, such as deductibles and copayments.[82] The D.C. Circuit Court did not touch the issue of whether CMS's interpretation of "standard chargers" included negotiated rates with third-party payers, but if the D.C. Circuit Court supported the government's interpretation of "standard charges," the agency's interpretation could have been appealed and even overturned at the Supreme Court level, therefore resulting in the Supreme Court overruling the reporting requirement of negotiated rates with third-party payers.[83]

The D.C. Circuit Court also supported the final rule's reliance on third-party services to develop tools to analyze and breakdown the published price data and commented that "anticipating that third-party price aggregators and researchers will bring more efficiency to

[80] *See id.*

[81] *Id.*

[82] *Id.*

[83] *Id.*

an industry as large and important as health care hardly str[uck] [them] as irrational . . . [as] such services are ubiquitous in other industries where prices are publicly available, such as travel booking websites."[84] By doing so, the D.C. Circuit Court allowed for the emergence of third-party platforms to help synthesize health care costs for consumers, especially consumers with high-deductible plans. If price aggregators can collect and breakdown the information published by compliant hospitals into platforms as easily accessible as travel booking websites, health care consumers with high deductibles will be able to shop for the best prices offered for their necessary health care services. This publicly available price data comparison tool could pressure hospitals negotiating above average price plans with payors to lower their negotiated prices, and therefore drive down the costs of necessary services.

Lastly, the D.C. Circuit Court affirmed the lower court's holding on the First Amendment challenge against the appellant's argument that the final rule is not reasonably related to CMS's interests because the required information does not include out-of-pocket costs for patients paying cost sharing.[85] The court found that it is better to have at least some accurate information over none at all, and even though compliance has the potential to be burdensome, it is not the type of burden that concerns the First Amendment.[86] Despite the win for the Hospital Price Transparency Rule and the fact that the time for an appeal has run on the *AHA v. Azar* lawsuit, the potential for the continuation of lawsuits against price transparency is not impossible as other price transparency rules are only beginning to be enforced through the federal government.[87]

D. *The Improving Price and Quality Transparency in American Healthcare Executive Order, the Insurance Price Transparency Rule, and the Healthcare PRICE Transparency Act*

President Trump issued the Improving Price and Quality Transparency in American Healthcare to Put Patients First Executive Order on June 24, 2019.[88] Previously, this Part focused on the Hospital

[84] AHA v. Azar, 983 F.3d 528, 539 (D.C. Cir. 2020).

[85] *See id.* at 542.

[86] Wheeler & Taylor, *supra* note 33.

[87] *See* Katie Keith, *Two New Lawsuits Challenge Insurer Transparency Rule*, HEALTH AFFS. (Aug. 16, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210816.547849/full.

[88] *See* Exec. Order No. 13877, 84 Fed. Reg. 30,849 (June 27, 2019).

Price Transparency Rule and its effect on hospitals within the United States. The Hospital Price Transparency Rule was one of two rules CMS was required to enact under the former President's Executive Order, and as seen, this rule requires price transparency through the U.S. hospital system. For instance, the Executive Order from the Trump Administration required the Secretary of Health and Human Services to propose a rule requiring hospitals to publicly post standard charge information including "charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision making and allow patients to compare prices across hospitals."[89]

In addition to the Hospital Price Transparency Rule, this Executive Order also required the Secretary of Health and Human Services to propose a rule requiring "healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care."[90] In November 2020, CMS promulgated this final rule, known as "Transparency in Coverage" ("the Insurance Price Transparency Rule").[91] This final rule imposes price transparency requirements on health insurers in group and individual markets and price transparency requirements on group plans.[92]

Under the Insurance Price Transparency Rule, group health plans and health insurers in individual and group markets are required to "provide cost-sharing information to enrolled individuals on request through an online tool on their website and in paper form"[93] and to "disclose negotiated rates for in-network providers and historical out-of-network allowed amounts in two machine-readable files posted on

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[89] *Id.*; *see also* Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Completes Historic Price Transparency Initiative (Oct. 29, 2020), https://www.cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative.

[90] Exec. Order No. 13877, 84 Fed. Reg. 30,849, 30,850 (June 27, 2019); *see also* CMS Completes Historic Price Transparency Initiative, *supra* note 89.

[91] Transparency in Coverage, 85 Fed. Reg. 72,158, 72,158 (Nov. 12, 2020).

[92] Katie Keith, *Trump Administration Proposes Transparency Rule for Health Insurers*, HEALTH AFFS. (Nov. 17, 2019), https://www.healthaffairs.org/do/10.1377/hblog20191117.364191/full.

[93] *Id.*; *see also Transparency in Coverage Final Rule Fact Sheet,* CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 29, 2020), https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f.

their website."[94] In other words, the Insurance Price Transparency Rule requires health insurers in group and individual markets and group health plans to provide (1) their in-network provided rates for covered services and items on public websites; (2) their out-of-network billed charges and allowed amounts for covered services and items; (3) and their negotiated historical net prices and negotiated rates for covered prescription drugs in a machine-readable format.[95] CMS believes that this new rule will decrease medical costs for insurers and consumers, estimating a savings of about $128 million per year and achieving one of the main goals of price transparency.[96] Yet other costs in some markets are expected to increase, with the bulk of costs falling on third-party administrators and insurers.[97] For instance, CMS notes that these rules would result in higher premium tax credits, estimating an increase of around $12 million per year to cover premium increases of 0.03 percent from market insurers.[98]

Additionally, CMS estimates the increase of compliance costs for insurers, estimating costs of around "$433 million to develop a self-service tool" to aid in the dissemination of cost sharing data, $211.4 million to develop "negotiated rate file[s]," and $230.7 million to develop "allowed amount files[s]."[99] Moreover, CMS estimates yearly maintenance costs of about $25.7 million for the self-service tool, $70.6 million for the negotiated rate file, and $28.8 million for the allowed amount file.[100] In practice, the Insurance Price Transparency Rule aims to set up a self-service tool to allow consumers to shop for services through their insurance company, and this final rule should allow consumers to see the prices for prescriptions before they are responsible for any cost-sharing payments.[101] Although a major goal of price transparency is decreasing costs for consumers, insurers under the Insurance Price Transparency Rule—like the hospitals under the Hospital Price Transparency Rule—brought up the potential for this new rule to raise costs for insurers, which—in the case of insurers—

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[94] Keith, *supra* note 92.

[95] DEP'TS OF LABOR, HEALTH & HUMAN SERVS., & TREASURY, FAQS ABOUT AFFORDABLE CARE ACT AND CONSOL. APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 49 (2021) [hereinafter FAQS ABOUT AFFORDABLE CARE ACT].

[96] Keith, *supra* note 92.

[97] *Id.*

[98] *Id.*

[99] *Id.*

[100] *Id.*

[101] *See id.*

CMS is not denying.[102] Instead, CMS presumes that these costs are reasonable because they allow for an "increase in reference pricing and the use of network data to aid the review and approval of health insurance rates."[103] Despite CMS's justification, the threat of lawsuits against the Insurance Price Transparency Rule arose, just as it did after the promulgation of the Hospital Price Transparency Rule.[104]

Although CMS adopted the Hospital Price Transparency Rule and the Insurance Price Transparency Rule after the issuance of an executive order, a similar bill—the Healthcare PRICE Transparency Act—was introduced into the House of Representatives in May of 2021.[105] Currently, this bill is referred to the House Committee on Energy and Commerce's Subcommittee on Health.[106] Similar to the regulation on price transparency, this bill aims to provide statutory authority for price transparency at the federal level.[107] Like the Hospital Price Transparency Rule, the Healthcare PRICE Transparency Act seeks to require hospitals to publish their standard charges for services, negotiated rates with insurers, discounted cash payments for uninsured patients and patients with high deductibles, and billing codes.[108] Additionally, similar to the Insurance Price Transparency Rule, the Healthcare PRICE Transparency Act aims to require insurers to publish their in-network and out-of-network charges for services and items and their negotiated prices for prescription drugs; additionally, this Act seeks to require insurance plans to create a self-service tool to enable consumers to shop for price information.[109] Although introduced after the adoption of CMS's final rules, the Healthcare PRICE Transparency Act aims to bolster the dissemination of health care price information at the federal level.

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[102] Keith, *supra* note 92.

[103] Keith, *supra* note 87.

[104] *See* Keith, *supra* note 92.

[105] *Health Care PRICE Transparency Act: Summary*, CONGRESS.GOV, https://www.congress.gov/bill/117th-congress/house-bill/3029 (last visited Feb. 17, 2022).

[106] *Id.*

[107] *See* Health Care PRICE Transparency Act, H.R. 3029, 117th Cong. (2021).

[108] *Id.*

[109] *Id.*

E. *After the D.C. Circuit Court Upheld the Hospital Price Transparency Rule, New Lawsuits Challenging Price Transparency Arose*

CMS only recently began enforcing the Insurance Price Transparency Rule of the Trump Executive Order, and two lawsuits are already challenging its constitutionality. The U.S. Chamber of Commerce—joined by a local Texas chamber of commerce—and the Pharmaceutical Care Management Association (PCMA) filed two separate lawsuits challenging the Insurance Price Transparency Rule under the APA, focusing only on the requirements related to the disclosure of pricing information.[110] The lawsuits maintain that Sections 1311(e)(3)(A) and 1311(e)(3)(B) of the ACA "do not authorize the disclosure of information in 'machine-readable files' because these files are inconsistent with the 'plain language' requirement."[111] Under Section 1311(e)(3)(A), plain language is defined as "'language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.'"[112] Plaintiffs argue that a person does not read machine-readable files because these files include complicated data that the average person cannot understand.[113] Plaintiffs also argue that even if this information is translated in a consumer-friendly way by third parties, it will still not fall under "plain language" as defined by the ACA.[114]

The Chamber of Commerce and the PCMA believe that federal officials "cannot require the disclosure of 'historical net price' information" under the APA for four main reasons.[115] First, the Chamber of Commerce and the PCMA assert that requiring the historical net price information to be reported under the Insurance Price Transparency Rule exceeds the authority of the U.S. Department of Health and Human Services (HHS), the Department of the

110 Keith, *supra* note 87.

111 *Id.*

112 *Id.*

113 *Id.*

114 *Id.*

115 *Id.*

Treasury, and the Department of Labor (DOL).[116] This is because the ACA requires health plans seeking to be certified as qualified health plans under the ACA to disclose certain information under Section 1311(e)(3)(A)(i)–(viii)—such as enrollment data—to the appropriate Health Insurance Marketplace, the Secretary of HHS, and the state insurance commissioner.[117] This Section has a "catch-all" phrase allowing the disclosure of "[o]ther information as deemed appropriate by the Secretary" of HHS.[118] The Chamber of Commerce and the PCMA state that the reporting of historical net price information should not be included under the catch-all phrase because it is dissimilar to the disclosure requirements of Section (e)(3)(A)(i)–(viii).[119] Specifically, they believe that the information required to be reported under Section 1311(e)(3)(A) (i.e., data enrollment) is simple, coverage-related information that is already available to patients.[120] The Chamber of Commerce and the PCMA maintain that the historical net price of prescription drugs is confidential, complex information not readily available to patients and that if Congress wanted to grant HHS the authority to require the publication of trade secrets, Congress would have included this requirement in the ACA.[121]

Next, the Chamber of Commerce and the PCMA argue that allowing disclosure of historical net prices under the catch-all phrase of section 1311(e)(3)(A)(ix) of the ACA implicates constitutional questions.[122] For instance, the Chamber of Commerce and the PCMA believe that the disclosure of historical net prices under the catch-all phrase violates the Takings Clause of the Fifth Amendment because the mandatory reporting of this information will deprive insurers of the competitive advantage that comes with possessing trade secrets.[123] Additionally, the Chamber of Commerce and the PCMA accuse HHS of taking the regulation of private health insurance away from the states.[124] Next, the Chamber of Commerce and the PCMA assert that the Insurance Price Transparency Rule violates the APA because the requirement for disclosure of historical net prices was not included in

[116] Keith, *supra* note 87.

[117] *Id.*; *see also* 42 U.S.C. § 18031(e)(3)(A).

[118] § 18031(e)(3)(A)(ix).

[119] Keith, *supra* note 87.

[120] *Id.*

[121] *Id.*

[122] *Id.*

[123] *Id.*

[124] *Id.*

the proposed rule; and therefore, HHS, the Department of the Treasury, and the DOL were not given the opportunity to comment and respond to this requirement.[125] Lastly, the Chamber of Commerce and the PCMA claim that the historical net price requirement for prescription drugs is arbitrary and capricious and will not lower the out-of-pocket costs for patients paying cost-sharing fees, such as copayments.[126]

Although *AHA v. Azar* upheld the Hospital Price Transparency Rule that derived from the same Executive Order as the Insurance Price Transparency Rule, the prior ruling in *AHA v. Azar* did not stop the filing of similar lawsuits concerning indistinguishable arguments against the Insurance Price Transparency Rule. Yet both lawsuits have already been withdrawn.[127] For instance, the U.S. Chamber of Commerce and the Texas affiliate withdrew their suit against the Insurance Price Transparency Rule after President Biden and his Administration delayed the challenged provisions from taking effect.[128] Previously, CMS released a document delaying some enforcement provisions of the Insurance Price Transparency Rule from January 1, 2022 to July 1, 2022, so the entities withdrew their suits since the postponement would give them more time to comply with the rules or figure out their next steps.[129]

The document released by CMS notes that the DOL and HHS recognized the number of provisions insurers were required to implement by the original January deadline and the considerable amount of time and effort needed to acquire machine-readable files available in the form required by the Insurance Price Transparency Rule.[130] Therefore, "the Departments will defer enforcement of the requirement to make public the machine-readable files for in-network rates and out-of-network allowed amounts and billed charges, until July

[125] Keith, *supra* note 87.

[126] *Id.*

[127] *See* Anna Wilde Mathews, *Business Groups Withdraw Suit Challenging Health-Price Transparency Rule*, WALL ST. J. (Aug. 26, 2021, 1:29 PM), https://www.wsj.com/articles/business-groups-withdraw-suit-challenging-health-price-transparency-rule-11629998986; *see also* Robert King, *PCMA Pulls Lawsuit Over Rebate Disclosure After Reaching Deal with Biden Admin*, FIERCE HEALTHCARE (Dec. 2, 2021, 4:50 PM), https://www.fiercehealthcare.com/payer/pcma-pulls-lawsuit-over-rebate-disclosure-rule-after-reaching-deal-biden-admin.

[128] Mathews, s*upra* note 127.

[129] *See id.*

[130] FAQS ABOUT AFFORDABLE CARE ACT, *supra* note 95.

1, 2022."[131] Moreover, enforcement of a provision of the Insurance Price Transparency Rule requiring the disclosure of drug prices "was delayed indefinitely pending new rule making."[132] Daryl Joseffer, the Senior Vice President of the U.S. Chamber Litigation Center, noted that a new suit brought by the Chamber of Commerce is not out of the question.[133] Joseffer characterized the Biden Administration's response as a positive one but recognized the possibility of a future suit given continuing issues with the developing rule.[134] Enforcement measures for insurers that do not comply with machine-readable file requirements are looming on the horizon, with the potential imposition of civil monetary penalties of up to $100 a day, per violation, and for every person affected by such violation.[135]

The lawsuits against the Hospital Price Transparency Rule and the Insurance Price Transparency Rule arose from the arguments and debates surrounding price transparency noted above. Potential challenges to price transparency and the findings of *AHA v. Azar* will continue to appear unless the federal government takes additional measures to enforce these rules. If the government does not, families like the Eichelbergers could face increasing medical debt.

III. ALL-PAYER CLAIMS DATABASES

Part II of this Comment laid out the price transparency rules enacted by the federal government—which require hospitals and health insurers in group and individual markets and group health plans to make certain standard charges public—and the debates surrounding the implementation of these rules. As mentioned, health care price transparency is important to reduce health care fragmentation within the United States because there is no centralized system for consumers with high deductible plans to estimate the costs of their health care services. Part III will discuss another tool necessary to reduce fragmentation within the United States health care system—All-Payer Claims Databases (APCDs). On the state level, these databases are necessary for state policymakers to understand the costs and quality of health care and to inform efficient policy decisions, so consumers can have access to needed care.

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[131] *Id.*

[132] Mathews, *supra* note 127.

[133] *Id.*

[134] *Id.*

[135] *Plans and Issuers*, CTRS. FOR MEDICARE & MEDICAID SERVS. (May 17, 2022, 12:43 PM), https://www.cms.gov/healthplan-price-transparency/plans-and-issuers.

A. *What are All-Payer Claims Databases and What are They Used for?*

APCDs are databases through which states gather health care claims data from Medicaid, Medicare, state-regulated private insurers, and state employee health plans.[136] Before 2016, "public, private, state and federal, medical, dental and pharmacy plans" were required to submit claims data in states with legislatively enacted APCDs.[137] The collection of individual claims data allows policymakers to analyze health care utilization and spending within each state.[138] Through the mandatory collection of aggregate claims data, APCDs identify "variable pricing and usage patterns across providers and variable spending patterns across multiple payers."[139] APCDs can identify "health system waste and corresponding opportunities for cost containment by revealing excessive or outlier claims by service; provider and/or payer."[140] APCDs can also analyze trends and outliers in health care cost and utilization within each state's health care system.[141] Additionally, APCDs can identify providers by price through analyzing the variations in reimbursements across health care payers for specific procedures and treatments.[142] Policymakers can use claims data "to make informed health policy decisions by identifying extreme price variation, analyzing health care market trends and spending, and quantifying wasteful and low-value spending."[143] Today, eight states have passed legislation to install APCD systems, and eighteen states have existing APCDs, including the home state of the Eichelberger family.[144]

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[136] *Transparency and Disclosure of Health Care Prices*, NCSL (Sept. 7, 2021), https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.

[137] MAGDA SCHALER-HAYNES, ALL PAYER CLAIMS DATABASES: ISSUES AND OPPORTUNITIES FOR HEALTH CARE COST TRANSPARENCY IN NEW JERSEY ii (2013).

[138] *Id.*

[139] *Id.* at 1.

[140] *Id.* at 3.

[141] *Id.*

[142] *Id.*

[143] *Transparency and Disclosure of Health Care Prices*, *supra* note 136.

[144] *See Interactive State Report Map*, APCD COUNCIL, https://www.apcdcouncil.org/state/map (last visited Nov. 25, 2022).

B. *How Does Claims Data Information Help Policy Makers Improve Health Care Efficiency?*

The American health care system lacks an effective method at the federal level to measure efficiency throughout the states, thus leaving it up to the states to track the output and quality of health care. If each state enacts its own APCD and publishes the collected information, states will be able to rely on the published data to improve health care efficiency within each state. For instance, APCDs can "serve as the basis on which cost containment and payment reform initiatives are designed."[145] "New Hampshire used APCD data to compare rates of coronary artery disease between Medicaid and commercial plan[s]" and to allocate scarce resources based on population need and to make benefit design changes.[146] Kansas used the data collected from its state APCD to create cost containment strategies for its state employee health plan and Medicaid.[147] "APCDs can also identify disparities in care and spending by region or community and establish a basis on which to reward provider efficiency."[148] For example, the New Hampshire Insurance Department used commercial claims for ground ambulance services to examine unknown utilization rates and charged amounts for emergency/non-emergency ambulance transport by carrier and county.[149] This claims data revealed that the top ten ambulance companies providing services to New Hampshire residents only represented 40 percent of the transports and billed charges to New Hampshire residents, which the study attributed to the "high number of ambulance companies providing services" to New Hampshire residents.[150] This data also revealed that the basic life support non-emergency average charge by county ranged from about $350 to over $600.[151]

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145 SCHALER-HAYNES, *supra* note 137, at 12.

146 *Id.*; *see also* Denise Love et al., *All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency*, 99 COMMONWEALTH FUND 1, 5 (2010).

147 SCHALER-HAYNES, *supra* note 137, at 12.

148 *Id.*

149 N.H. INS. DEP'T, A STUDY OF GROUND AMBULANCE TRANSPORT COMMERCIAL CLAIMS DATA 2 (2011), https://www.nh.gov/insurance/reports/documents/nhid_amb_trans_study022411.pdf; *see also* SCHALER-HAYNES, *supra* note 137, at 12.

150 N.H. INS. DEP'T, *supra* note 149, at 14.

151 *Id.* at 12.

APCDs track health care spending and trends.[152] For instance, Massachusetts compiles data by category, service, and geographical area to create an annual report on health care spending trends.[153] Moreover, Rhode Island's APCD data revealed the top fifteen clinical complaints and costs of emergency room visits.[154] Additionally, Minnesota utilized its APCD data to analyze the cost and usage of services considered low-value.[155] This Minnesota study revealed that in 2014, of the 175,306 encounters for low-value services, 69,008 encounters were for MRIS, X-Rays, or select CT scans.[156] APCDs can also inform state policy for market regulation.[157] For example, Massachusetts discovered that increases in health care costs threatened the long-term success of the state's insurance expansions; so in 2012, state legislators made it a priority to keep the increase of health care costs below the gross state product's rate of growth.[158] Massachusetts used its APCD data to prevent increased spending by insurers and providers, which led to the 2015 state court decision to prevent Partners HealthCare from purchasing South Shore Hospital.[159]

APCDs help assess geographical variations in utilization.[160] For instance, "[t]he Oregon Health Authority publishes quarterly reports that compare per-member per-month costs and utilization, by service category, for commercially insured, public employees, and public payers."[161] A study on primary care spending in Oregon showed the "percentage of total medical spending allocated to primary care" and the per-member per-month primary care spending.[162] This study revealed that in 2015, Care Coordination Organizations (CCOs) allocated 12.5 percent of total medical spending to primary care.[163] That same year, per-member per-month, primary-care spending for

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[152] APCD COUNCIL, INFORMING HEALTH SYSTEM CHANGE – USE OF ALL-PAYER CLAIMS DATABASES 1–2 (2018).

[153] *Id.* at 2.

[154] *Id.*

[155] *Id.*

[156] *Id.*

[157] John D. Freedman et al., *All-Payer Claims Databases – Uses and Expanded Prospects After* Gobeille, 375 NEW ENG. J. MED. 2215, 2216 (2016).

[158] *Id.*

[159] *Id.*

[160] APCD COUNCIL, *supra* note 152, at 2.

[161] *Id.*

[162] *Id.*

[163] *Id.*

CCOs was about $41 while per-member per-month, non-primary care spending for CCOs was around $285.[164] The year before, per-member per-month, primary-care spending for CCOs was about $38 while per-member per-month, non-primary care spending for CCOs was around $255, and CCOs allocated 13.1 percent of total medical spending to primary care.[165] Therefore, in 2015, the percentage of allocated CCO spending to primary care service decreased, although the amount of money per-member per-month increased.[166]

The collection of health care claims data through state APCDs allows for the evaluation of health care practices that do not have enough patients from a single insurer and patients enrolled in smaller health plans.[167] APCDs allow policymakers to monitor the "incidence and prevalence of acute and chronic diseases," study practice-pattern variations and disparities, provide opportunities for researchers to better understand the United States health care system, and give these researchers opportunities to test ways to improve care.[168] Additionally, APCDs can identify the extent to which state residents leave the state for health care services and, conversely, come into the state for health care services.[169] Thus, APCDs show where services are either abundant or lacking, and they hint at the quality of services within the state.[170] For example, New Hampshire used its aggregated claims data to identify the population leaving New Hampshire for health care services.[171] This study noted that New Hampshire would be able to measure the population coming into the state for care when its neighboring states adopt APCDs as well.[172] If the Eichelberger family could not find the emergency service that they needed in Utah, they would have been forced to travel to a neighboring state. The implementation of APCDs can correct this issue by noting the services each state lacks.

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[164] *Id.*

[165] *Id.*

[166] *See* APCD COUNCIL, *supra* note 152, at 2.

[167] *See* Freedman, *supra* note 157.

[168] *Id.*

[169] *See* Love, *supra* note 146, at 5.

[170] *See id.*

[171] *Id.*

[172] *Id.* At the time of the release of this study, all of New Hampshire's neighboring states adopted APCDs. *Id.*

C. *Voluntary Issues Pre-Gobeille and the Gobeille Lawsuit*

Without mandatory enactments of APCDs, states will have to rely on voluntary submissions; states with voluntary initiatives, however, have struggled to collect health care data. States with voluntary initiatives cannot enforce reporting compliance like the states that grant the legislative authority to collect data.[173] States without legislative authority to collect data can establish a private APCD and collect data from participating carriers who voluntarily offer claims data.[174] States like Wisconsin and Washington utilize voluntary and private claims data aggregation efforts.[175] Although these voluntary initiatives aggregate some data claims, legislative mandate is the only way to ensure near-universal APCD participation.[176] Moreover, there are three reasons why voluntary reporting challenges the public release of comparative reports between states: (1) voluntary initiates cannot obtain health care data submissions from all payers in a state, so the data provided is most likely incomplete; (2) the use of the aggregated data can be restricted if any of the data contributors oppose a public release; and (3) privacy laws can prevent private entities from releasing aggregate patient data if they do not have the legal authority to do so.[177] For example, the Maryland Health Services Cost Review Commission "linked data reporting to . . . [health care] reform and used its legal authority to expand required reporting beyond facilities to include carriers, pharmacy benefit managers, and third-party administrators."[178]

The problems inherent in voluntary reporting were brought to light when the Supreme Court limited the ability of states to adopt mandatory APCD programs. In a 2016 case, *Gobeille v. Liberty Mutual Insurance Co.*, the Supreme Court held "the federal Employee Retirement Income Security Act (ERISA) preempts state laws requiring self-insured employer-sponsored health plans to submit claims data to APCDs."[179] This case involved a Vermont law that required entities, including health insurers, to report health care

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[173] *Id.* at 7.

[174] *Id.* at 8.

[175] *See* SCHALER-HAYNES, *supra* note 137, at 2.

[176] *Id.*

[177] Love, *supra* note 146, at 8.

[178] *Id.* at 9–10.

[179] Jack Pitsor, *Bringing Health Care Prices to Light*, 28 NCSL: LEGISBRIEF, no. 4, Feb. 2021, at 1, 2, https://www.ncsl.org/Portals/1/Documents/Health/1-Health-Care-Prices_04.pdf.

claims-related payments to a state agency for compilation in a health care database, an APCD.[180] Vermont's law required governmental agencies, health insurers, and health care facilities "to report any information relating to health care costs, prices, quality, utilization, or resources" to the state agency (APCD).[181] The respondent in this case, Liberty Mutual Insurance Company, maintained a health plan that qualified as an "employee welfare benefit plan" under ERISA.[182] Through its plan, Liberty Mutual used Blue Cross Blue Shield of Massachusetts as a third-party administrator.[183] Although the plan was a voluntary reporter under Vermont regulation because it covered less than the two-hundred-person cutoff for mandatory reporting, Blue Cross serves thousands of Vermonters and is a mandated reporter.[184]

The issue in *Gobeille* was whether ERISA preempted the Vermont state law.[185] The Court noted that welfare benefit plans governed by ERISA must file an annual report to the Secretary of Labor, including a financial statement listing assets and liabilities and receipts and disbursements of funds.[186] Further, when welfare benefit plans report data on disbursements, this reporting includes paid claims.[187] The Court found that Vermont's state law and regulation governed "plan reporting, disclosure, and . . . recordkeeping . . . [which were] fundamental components of ERISA's regulation of plan administration."[188] Therefore, the Court found that ERISA preemption bars states' mandatory APCDs because they interfere with the "single uniform national scheme for the administration of ERISA plans."[189] For APCDs, the Court's holding meant that ERISA preempts any state law requiring the disclosure of payments relating to health care claims in plans under ERISA.[190] "With more than 60% of the U.S. workforce covered by ERISA plans, this has resulted in APCDs missing claims data for a significant segment of the [U.S. health care]

[180] 577 U.S. 312, 315–16 (2016).

[181] *Id.*

[182] *Id.* at 317.

[183] *Id.*

[184] *Id.*

[185] *Id.* at 319.

[186] *Gobeille*, 577 U.S. at 321.

[187] *Id.*

[188] *Id.* at 323.

[189] *Id.* at 326–27.

[190] *See* Pistor, *supra* note 179.

market."[191] Consequently, states, such as New Hampshire and Virginia, created voluntary submission processes, which allow employers to choose whether or not they want to opt in to their state's APCD to submit their self-insured health claims data.[192] Despite the efforts from these various states to continue reporting health care claims data to APCDs, as mentioned above, legislative mandate is the only way to ensure near-universal APCD participation to attempt to improve statewide health care efficiency.

IV. REDUCING FRAGMENTATION

In the U.S. health care system, both consumers and state policymakers lack access to price transparency information and data on the costs, trends, and quality of health care necessary for informed and efficient decision-making. To reduce fragmentation for the portion of the American population with high-deductible insurance plans and to help address some of the faults of our fragmented system, there are two objectives that our state and federal legislatures must meet. These objectives will help spread price transparency information at the federal level and information regarding health care efficiency at the state level. First, following *Gobeille*, our legislatures must ensure the success of APCDs. Second, our federal legislatures must uphold the integrity and authority of the regulations promulgated under the Hospital Price Transparency Rule and the Insurance Price Transparency Rule against challenges in the courts.

A. *Ensuring the Success of All-Payer Claims Databases Post-ERISA*

Is all hope lost after the ERISA ruling? The Court's majority suggested that the states should require the collection of self-insured plan data through the DOL and, potentially, HHS.[193] In July of 2016, the DOL proposed expanding plan reporting and requiring submission of data, which could include the health care claims data that would otherwise be lost due to *Gobeille*.[194] This solution is harder than it sounds because no federal agency, including the DOL and

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[191] *Id.*

[192] *Id.*

[193] The DOL has regulatory authority over self-insured plans and could mandate that the health care claims data be shared with APCDs. Freedman, *supra* note 157, at 2216–17; *see also* Erin C. Fuse Brown & Jaime S. King, *The Consequences of* Gobeille v. Liberty Mutual *for Health Care Cost Control*, HEALTH AFFS. (Mar. 10, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160310.053837/full.

[194] Freedman, *supra* note 157, at 2217.

HHS, collects claim-level price and quality data similar to the types that APCDs used to require.[195] For instance, statistical and summary data would not be helpful in analyzing "whether the prices charged by a large health system jumped when they acquired a physician group."[196]

Congress should revise or repeal ERISA since the scope of ERISA preemption has gone beyond the statute's original intent and prevents the execution of original state functions to assure uniformity in employee benefit requirements.[197] Congress should therefore revise ERISA to allow state legislatures to enact legislation requiring self-insured, employer-sponsored health plans to submit claims data to APCDs. This seems unlikely considering Congress's continued failure to act. Therefore, our federal or state governments should enforce a provision and/or provisions whereby the missing claims data, which the ERISA suit preempts, is required to be reported by health care providers to APCDs.[198] Legislatures crafting such requirements should consider the analysis in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* This case involved a New York state law that required hospitals to set surcharges against patients with insurance plans administered by a commercial insurer or by health-maintenance organizations, but not against patients with Blue Cross Blue Shield plans.[199] In response to this scheme, commercial insurers who administered plans governed under ERISA filed suit.[200] The Supreme Court determined that state laws creating an indirect economic effect on covered employee benefit plans may not be preempted under ERISA, such as the case here.[201]

Following the effect of *Travelers*, hospitals—intermediaries between states and ERISA covered plans—could avoid ERISA preemption when handling ERISA covered plans. *Travelers* seems to suggest that ERISA preemption does not reach intermediaries like hospitals.[202] Therefore, hospitals and doctors should be able to provide aggregate information to state APCDs without fear of ERISA

[195] Brown & King, *supra* note 193.

[196] *Id.*

[197] *Id.*

[198] *See id.*; *see also* Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 82 (2016).

[199] N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 645 (1995).

[200] *Id.*

[201] *See id.* at 647.

[202] *See id.*

preemption because they are intermediaries between state laws affecting ERISA covered plans and employee benefits plans covered by ERISA. This reporting could be challenged, however, and could result in the influx of additional lawsuits considering how reluctant hospitals were under *AHA v. Azar* to provide claims data information regarding pricing information. But it could also be necessary if Congress refuses to amend ERISA to allow state laws requiring self-insured employer-sponsored health plans to submit claims data to APCDs.

B. *Upholding the Integrity and Authority of the Hospital Price Transparency Rule and the Insurance Price Transparency Rule Against Challenges in Courts*

Congress should enforce the holding of the D.C. Circuit in *AHA v. Azar*, especially considering the potential for additional lawsuits against the Insurance Price Transparency Rule. For instance, Congress could enact legislation supporting the holding of *AHA v. Azar* or pass the Healthcare PRICE Transparency Act to bolster support for price transparency on the federal level, or at the very least offer legislation or guidance underscoring that the language used in the Hospital Price Transparency Rule is not arbitrary and capricious to deter similar suits against CMS's final rules. Lastly, CMS should enforce penalties for hospitals that do not comply with the Hospital Price Transparency Rule and insurers that are not in compliance with the reporting requirements concerning machine-readable files under the Insurance Price Transparency Rule. Current penalties are potentially too low to affect multi-million-dollar systems, and merely posting non-compliant facilities on a website is not a sufficient deterrent. Additionally, with only two civil monetary penalties imposed and no known enforcement measures concerning the Insurance Price Transparency Rule, additional enforcement measures are needed on the part of CMS to ensure compliance with these rules.

V. CONCLUSION

The American health care system lacks the centralized means necessary to acquire price transparency and overall efficiency. To reduce these issues, legislatures must bolster regulations such as the Hospital Price Transparency Rule and the Insurance Price Transparency Rule against legal challenges and enforce penalties against multi-million-dollar systems. Although APCDs are also used for price transparency, they are key for overall health care quality and efficiency since these systems could—if implemented across all fifty states—collect health claims data and analyze where services are

needed, which areas services are wasted in, and what the disparities are across the states. Federal and state legislatures must come together to enact legislation to ensure the success of APCDs post *Gobeille*. Together, these two goals could help ensure that consumers and policymakers are better equipped with the information they need to make health care-related decisions. Addressing the lack of transparency and efficiency in the American health care system will help consumers and patients with high deductibles like Ms. Eichelberger and her son, ensuring not only that they receive requested information but that their communities possess necessary and quality health care services.

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