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History of Price Transparency in U.S. Healthcare

How Healthcare Became a Market Without Visible Prices

Foreword from the CEO, Simple Healthcare

For decades, healthcare leaders have been forced to make financial, strategic, and operational decisions with limited visibility into one of the most fundamental components of any market: price. Unlike other major sectors of the economy, U.S. healthcare evolved into a system where pricing information became fragmented, contractual, and largely inaccessible to the organizations responsible for managing cost, value, and access.

Recent federal price transparency rules represent a structural shift. Prices are no longer entirely hidden. But disclosure alone does not create accountability, competition, or better purchasing decisions. In practice, the published files are often difficult to interpret, inconsistent across sources, and unreliable without validation.

The next phase of price transparency will be defined by whether leaders can convert disclosure into decision-ready intelligence. That requires more than collecting files. It requires cleaning, normalizing, contextualizing, benchmarking, and interpreting pricing data so it can be used with confidence in negotiations, planning, and policy analysis.

This paper explains how the United States arrived at its current pricing environment, why earlier transparency efforts struggled to create impact, and what must change for price transparency to become economically meaningful. Our intent is to offer healthcare leaders a clear framework for understanding both the promise and the limitations of today's price transparency era, and the practical requirements for turning it into a sustainable cost control tool.

— David Muhlestein, CEO, Simple Healthcare

Executive Abstract

The U.S. healthcare system operates at a scale unmatched globally yet remains one of the only major industries in which prices have historically been invisible at the point of decision.

This paper traces how healthcare evolved from a direct-pay service economy into a multi-layered financing system where prices became embedded in private contracts, administrative schedules, and institutional reimbursement frameworks. It examines why early transparency efforts failed to create usable markets, how recent federal mandates have fundamentally altered the data landscape, and why disclosure alone has not produced meaningful economic change.

While millions of negotiated rates are now technically public, inconsistent formatting, data quality gaps, and limited usability continue to prevent pricing data from supporting real decisions.

The paper concludes that healthcare has crossed a one-way threshold: prices are no longer hidden. The strategic question now is whether the industry can convert disclosure into operational intelligence that enables informed purchasing, effective negotiation, accountable reimbursement, and ultimately, sustainable cost control.

1. Introduction and Significance

For decades, the United States has operated a healthcare system that would be considered structurally unsound in almost any other sector of the economy. Buyers routinely commit to complex, high-value transactions without knowing the price in advance. Providers deliver services without quoting rates. Payers negotiate contracts that few outside closed institutions ever see. Employers, who finance much of the system, purchase healthcare with limited visibility into what they are actually buying.

U.S. healthcare spending reached approximately **$4.5 trillion** in 2022, accounting for 17.3 percent of gross domestic product[1]. At the same time, **medical debt is widespread**, and personal bankruptcies tied to medical bills remain a recurring feature of the U.S. system for more than 23 million people[2].

Despite the large-scale financial impact of healthcare, transaction-level prices have historically been difficult to see and harder to understand, leaving patients and purchasers without the information required to make fully informed choices (Bernstein & Crowe, 2024; Pollack, 2022).

Modern price transparency policy is aimed at changing this reality. In 2021, CMS implemented the Hospital Price Transparency Rule, requiring hospitals to publish standard charges online, including payer-specific negotiated rates (CMS, 2021). Beginning in 2022, CMS implemented major components of the Transparency in Coverage (TiC) rule, requiring most health plans and issuers offering individual or group coverage to disclose negotiated prices and consumer cost-sharing information (CMS, 2020b; CMS, 2020c).

1. CMS, 2023a; Gunja et al., 2023
2. Himmelstein et al., 2019; Palosky, 2022

The goal of these initiatives is to empower patients to compare costs of services ahead of time, as well as spur competition in a market that has long been plagued by opacity (CMS, 2020b, 2021). In 2025, the White House reiterated the federal focus on "clear, accurate, and actionable" pricing information as an ongoing policy priority through an updated executive order (House, 2025).

Yet disclosure alone does not create usable price intelligence. The published files are often massive, inconsistently structured, and difficult to validate. As a result, prices are now technically visible, but rarely interpretable. The central challenge has therefore shifted. It is no longer whether prices can be disclosed. It is whether fragmented, inconsistent, and often unreliable disclosures can be transformed into structured, trustworthy information capable of supporting negotiation, planning, regulation, and purchasing behavior (Justin Lo et al., 2023; GAO, 2024).

To understand why this is difficult, it is first necessary to understand how healthcare payment models evolved. The same forces that expanded insurance coverage, developed networks, and introduced prospective and value-based payment also separated the delivery of care from the visibility of price. The sections that follow explain that evolution, then trace the modern history of transparency efforts and the constraints that continue to limit their value.

2. Historical Payment Models: Background

2.1 Pre-Insurance Era (Pre-1900s)

In the nineteenth century and early twentieth century, there was essentially no health insurance in the United States. Healthcare was delivered primarily by private physicians, often in patients' homes, and households paid fees out-of-pocket for each visit. Hospitals were relatively few and rudimentary, so most treatments occurred outside institutional settings (Moseley, 2008). Because medical technology was limited and illness often meant lost wages, households frequently worried more about income loss than medical bills.

To address income disruption, industrial sickness funds emerged as voluntary, worker-financed programs managed by fraternal organizations, unions, and some employers (Murray, 2008). In short, health care was largely unregulated, and individuals bore nearly all the cost themselves (Pollack, 2022).

2.2 Early Insurance (1920s-1940s)

The first durable forms of health insurance emerged during the Depression era. In 1929, a group of Dallas school teachers arranged a prepaid plan with Baylor University Hospital. For a fixed monthly fee, the plan covered up to 21 days of inpatient care (Thomasson, 2019). Similar nonprofit hospital prepayment plans spread during the 1930s, and by 1937, 26 plans with 600,000 members had formed. These plans were consolidated by the American Hospital Association under the Blue Cross model (Gorman, 2006). Physicians, fearing loss of income control, then formed Blue Shield plans in the mid-1930s to cover physician fees (Gorman, 2006; Lichtenstein, 2024). These early "Blues" models operated as community-rated nonprofits and proved that group coverage could work but also introduced an institutional layer between patients and prices (Gorman, 2006; Lichtenstein, 2024).

2.3 Employer-Sponsored Insurance (1940s to 1960s)

Employer-based insurance expanded rapidly during World War II. Wage and price controls limited employers' ability to raise cash compensation but allowed firms to compete for workers by offering fringe benefits such as health insurance (Pollack, 2022). The IRS ruled in 1943 that employer-paid health insurance premiums were tax-deductible for employers and excluded from employees' taxable income (Polzer, 1998). As a result, enrollment surged, reaching roughly 75 million people by 1950, or 49 percent of the U.S. population (Fronstin, 1998). Employer-sponsored insurance remains a dominant coverage source today (Bureau, 2021).

2.4 Networks and Prospective Payment (1970s to 1990s)

By the 1970s, healthcare spending growth accelerated, prompting both private and public payers to introduce mechanisms to manage utilization and control costs. Managed care expanded through HMOs and PPOs, which negotiated defined fee schedules and directed care within contracted networks. Specifically, health maintenance organizations focus on preventive care, and have their own network of providers where members get healthcare services based on a fixed prepaid fee. The HMO Act of 1973 accelerated this growth by funding and deregulating HMOs and requiring large employers to offer HMO options alongside traditional fee-for-service plans (Scofea, 1994; Fox & Kongstvedt, 2012). HMO enrollment grew from roughly 3 million in 1970 to approximately 35 million by 1991 (Billas, 2012).

Another major shift was the move to prospective payment. In 1983, Medicare switched from reimbursing hospitals per diem to a fixed bundled payment per patient episode, based on Diagnosis-Related Groups (DRGs). Under DRGs, hospitals received a set payment for treating a patient's diagnosis, regardless of their actual costs (Brady & Robinson, 2001). In 1992, Medicare implemented the Resource-Based Relative Value Scale to standardize physician payments nationally – based on the resource cost of services (Levy & Borowitz, 1992). These reforms marked a gradual transformation from traditional fee for service models (where physician payments were tied to the services/procedures they performed) towards value-based models, hence rewarding quality instead of quantity.

2.5 Value-Based Models vs. Fee-for-Service (2000s to Present)

In the 2000s and 2010s, attention shifted toward value-based care. Although fee-for-service remains dominant across much of U.S. healthcare (Filbin, 2022), policy initiatives have increasingly pushed providers towards "value". In 2010, the Affordable Care Act introduced Accountable Care Organizations (ACOs), which refer to groups of providers that share savings if they meet quality targets while reducing costs. In April 2012 CMS announced the first 27 Medicare ACOs under the Shared Savings Program (CMS, 2012).

Several years later in 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which in turn created the Quality Payment Program, offering clinicians either the Merit-based Incentive Payment System (MIPS) that adjusts FFS payments based on quality metrics, or bonuses for participating in Advanced Alternative Payment Models (APMs) that take on more risk (CMS, 2015).

Despite these reforms, reimbursement is still largely FFS, although value-based contracts are becoming increasingly common. At the same time, consumer cost-sharing increased through high-deductible plans and related designs, creating pressure for patients to act as purchasers without consistent price visibility. This tension helped elevate price transparency as a policy response.

3. The Modern Transparency Problem: Why Prices Were Not Visible

Confidential contracting became the norm as insurer-provider negotiations expanded. Hospitals and physician organizations treated contract rates as business-critical information, while insurers argued negotiated prices were proprietary assets. Legal and commercial arguments frequently framed pricing data as protected trade secrets (Pragid & Cameron, 2021). For employers and patients, this meant the most relevant prices were embedded in contracts and not available at the time decisions were made.

> Transparency advocates argued that price information could support competition, consumer empowerment, and more rational purchasing.

However, evidence also suggested that not all patients want to make complex medical decisions based on pricing information alone, and often value physician advice (Levinson et al., 2005). The implication for leaders is that transparency must be designed to support decisions, not merely disclosure. To understand how price transparency efforts can be improved, it is important to first understand why and how price transparency emerged as a policy solution.

4. Price Transparency Efforts Before Federal Mandates (Pre-2010)

Before the Affordable Care Act, transparency initiatives were largely state-driven and fragmented. Some states experimented with hospital rate-setting or mandatory reporting, including Maryland's all-payer approach and New Jersey's reporting requirements (Murray & Gudiksen, 2025). These programs were designed primarily for oversight and cost containment, not consumer shopping.

Federal mandates like the Balanced Budget Act of 1997 also focused on quality reporting, not costs that consumers faced. Throughout this period, hospitals and payers generally resisted disclosing negotiated prices, arguing that rates are proprietary "trade secrets" (Pragid & Cameron, 2021). Without standardized definitions or formats, and the lack of a single authority requiring price disclosures, most patients remained unaware of their potential costs.

4.1 Crowdsourcing, Nonprofits, and Market Awareness

Beginning in the early 2000s, nonprofit and journalistic projects attempted to fill information gaps by publishing price data from non-government sources. RAND's employer-sponsored Hospital Price Transparency Study involved a multi-state analysis of commercial hospital prices, and results were made public(RAND Health, 2015). The Health Care Cost Institute also assembled a large claims database for research and launched consumer-facing tools intended to improve access to price information (Kaiser Health News, 2015).

Media organizations also used crowdsourcing. In 2014, KQED and NPR launched PriceCheck, inviting patients to submit what they paid for procedures (Aliferis, 2014). Other consumer-facing efforts, such as Castlight Health, Healthcare Bluebook, and ClearHealthCosts, aggregated insurer and consumer price data, increasing awareness but remaining constrained by incomplete and inconsistent underlying data.

5. Federal Data Releases and the Precursor to Negotiated Rate Disclosure (2010s)

Federal data releases in the early 2010s represented an important shift toward broader disclosure. A long-standing restriction on the release of physician-level Medicare payment data originated from litigation including Florida Medical Association v. HEW (1979) (JUSTIA, 1979). In 2013, the restriction was lifted, and in 2014, CMS released Medicare Part B physician payment data covering claims for more than 880,000 physicians (Crane et al., 2014).

In 2013, CMS also published inpatient charge data for the 100 most common DRGs across approximately 3,400 hospitals, revealing substantial variation in listed charges even within local markets (CMS, 2013). These releases improved visibility into Medicare billing patterns and hospital list prices, but they did not expose commercial negotiated rates, which govern most transactions in the employer-sponsored market.

The chargemaster became a focal point for public attention in this period. Chargemasters list thousands of items and services with associated charges, but historically these figures were not designed to represent what payers actually pay. As a result, the public availability of charges increased awareness of price variation, while reinforcing the limitation that charges are not decision-grade prices for negotiation or purchasing (Bernstein & Crowe, 2024; Pollack, 2022).

6. Federal Action: Mandated Negotiated-Rate Disclosure (2019 to 2025)

6.1 Executive Order and Regulatory Foundation

In October 2019, Executive Order 13877 directed federal agencies to expand price and quality transparency and to promote standardization and comparability of published information (The American Presidency Project, 2019). CMS followed with two major rules: the Hospital Price Transparency Rule and the Transparency in Coverage rule (CMS, 2021; CMS, 2020b; CMS, 2020c).

6.2 Hospital Price Transparency Rule (Effective 2021)

The Hospital Price Transparency Rule requires hospitals to publish (1) a comprehensive machine-readable file listing standard charges for all items and services, including gross charges, payer-specific negotiated rates, discounted cash prices, and minimum and maximum negotiated rates, and (2) consumer-friendly pricing information for at least 300 shoppable services (CMS, 2021). CMS is authorized to audit hospitals and impose civil monetary penalties for noncompliance (CMS, 2021).

Compliance improved over time but remained inconsistent. Industry reporting cited CMS estimates suggesting improved compliance by 2023 (AHA, 2023) CMS has since issued guidance and technical "templates" to standardize file formats, and finalized a rule requiring hospitals to place a link to their MRF, as well as an attestation of accuracy, on their homepage (CMS, 2023b).Despite progress, independent analyses continue to identify challenges that limit usability, including inconsistent data formats and categorization structures (Justin Lo et al., 2023).

6.3 Transparency in Coverage Rule (Effective 2022 and Beyond)

The Transparency in Coverage rule, effective beginning in 2022, applies to most employer-sponsored and ACA marketplace plans. It requires plans to publish three machine-readable files monthly: in-network negotiated rates, out-of-network allowed amounts and billed charges, and prescription drug pricing information (CMS, 2020c). It also requires consumer cost-sharing estimation tools, beginning with 500 shoppable services and expanding over time (CMS, 2020c).

The scale of disclosure has been substantial, with major insurers posting files containing millions of negotiated rates. Yet usability challenges persist due to file complexity, inconsistent reporting conventions, and limited validation mechanisms. These constraints reinforce the emerging conclusion that transparency's limiting factor is no longer access, but transformation into reliable, comparable, decision-ready information.

7. Current Status: Uses, Limitations, and the Shift to Pricing Intelligence

Where pricing data has been systematically structured and contextualized, it is beginning to support benchmarking, negotiation analysis, and market evaluation. Employers and consultants use pricing intelligence to compare contracted rates against market ranges, identify outliers, and focus negotiation attention on high-impact services. Health systems and insurers can evaluate competitive positioning across service lines and geographies. Researchers and policymakers can study consolidation, market power, and site-of-care dynamics.

However, these use cases remain limited to organizations capable of overcoming the technical barriers embedded in raw disclosures. Government audits and independent analyses document widespread challenges, including inconsistent service definitions, missing contractual context, inaccurate rate expressions, and extreme file complexity (OIG, 2024; Justin Lo et al., 2023; GAO, 2024).

> In practice, the published files are repositories rather than decision-grade datasets. They require cleaning, normalization logic, and continuous validation before they can support comparison or inference

As a result, the constraint on price transparency is no longer solely regulatory. It is analytical. The organizations able to convert fragmented disclosures into coherent, trusted pricing intelligence will determine whether transparency reshapes healthcare economics or remains confined to compliance.

Executive Timeline: The Evolution of Healthcare Pricing and Transparency

Pre-1900s – Direct Pay Medicine

Care delivered primarily in homes and small practices. Patients paid physicians directly. Prices were visible, negotiable, and localized. Financial risk was driven more by lost wages than by medical bills.

1920s–1930s – Prepayment and Early Insurance

Hospital prepayment plans (Baylor, Blue Cross) and physician service plans (Blue Shield) introduced pooled risk and institutional financing. Healthcare began shifting from purchase to coverage.

1940s–1960s – Employer-Sponsored Insurance

Federal wage controls and tax policy embedded health insurance into employment. Employers became the dominant purchasers. Insurers became the primary negotiators of healthcare prices.

1970s–1990s – Networks and Prospective Payment

HMOs and PPOs expanded. Medicare adopted DRGs and later standardized physician payment. Pricing became an administrative and contractual function rather than a patient-facing one.

2000s–2010s – Value-Based Reform without Price Visibility

ACOs, quality-linked payment programs, and MACRA reshaped incentives. Cost-sharing increased, but transaction-level prices remained largely inaccessible.

Executive Timeline: The Evolution of Healthcare Pricing and Transparency Cont.

Early 2000s–2010s – Early Transparency Efforts

State reporting, nonprofit databases, and crowdsourced projects revealed price variation but lacked negotiated-rate visibility and standardization.

2013–2015 – Federal Data Releases

CMS released physician Medicare payment data and hospital charge data. Public attention focused on variation, but disclosures centered on charges rather than commercial negotiated prices.

2019–2020 – Regulatory Foundation

Executive Order 13877 directed agencies to require disclosure of actual prices and improve standardization.

2021 – Hospital Price Transparency Rule

Hospitals required to publish negotiated rates and shoppable service prices. First large-scale negotiated-rate disclosure mandate.

2022–2024 – Transparency in Coverage Rule

Insurers required to publish in-network and out-of-network negotiated rates and provide cost estimation tools. Millions of contract prices entered the public domain.

2024–Present – The Intelligence Phase

Attention shifts from access to usability. The strategic challenge becomes transforming fragmented disclosures into reliable pricing intelligence.

8. Looking Forward: From Disclosure to Decision Infrastructure

8.1 Legislative and Policy Momentum

Price transparency policy continues to evolve. Bipartisan proposals have sought to strengthen and expand disclosure requirements, increase penalties for noncompliance, and promote standardization. The Lower Costs, More Transparency Act passed the U.S. House in December 2023 and included extended requirements for pharmacy benefit managers and ambulatory surgical centers to disclose cost information (Opong-Wadee, 2023). Other proposals such as the Health Care PRICE Transparency Act 2.0 would expand disclosure expectations and promote clearer presentation of negotiated rates and cash prices (Faculty, 2024). Academic commentary emphasizes that transparency can also promote provider competition and patient choice when implemented with usable tools (Miller et al., 2020).

8.2 Data Quality, Standardization, and Validation

As transparency data volumes grow, usability depends on quality and standardization. Stakeholders have highlighted the need for consistent service descriptors, billing codes, units of measure, site-of-care indicators, bundling logic, and automated error detection. GAO has emphasized that CMS needs more information on completeness and accuracy of hospital pricing data (GAO, 2024), and independent analyses continue to document challenges that limit comparability (Justin Lo et al., 2023).

8.3 Future Uses and Practical Requirements

If transparency data becomes reliable and decision-ready, it can support several high-value use cases. First, it can strengthen purchasing and negotiation by enabling benchmarks and market comparisons. Second, it can support consumer empowerment when paired with clinical guidance and quality signals, enabling more informed choices without substituting price for medical judgment (Levinson et al., 2005). Third, it can inform policy interventions where pricing patterns suggest limited competition or where disclosure highlights inconsistent or extreme pricing.

These benefits depend on an intelligence layer: pricing data must be integrated with utilization, provider attributes, quality metrics, and benchmarks that reflect real-world payment dynamics. Transparency becomes economically meaningful when prices can be compared accurately and acted upon with confidence.

9. Conclusion

The United States now possesses unprecedented volumes of healthcare pricing disclosures through hospital and insurer transparency mandates. Healthcare has crossed a one-way threshold: prices are no longer entirely hidden. However, transparency in the economic sense remains limited by inconsistent reporting, incomplete context, inaccessible data formats, and variable data quality.

The future of transparency will not be determined by additional file postings alone. It will be determined by whether healthcare can build the standards, validation mechanisms, and analytical infrastructure required to transform disclosure into operational intelligence. If that transformation occurs, pricing data can begin to function as an economic signal that improves negotiation, purchasing discipline, and accountability. If it does not, transparency risks becoming another compliance exercise that changes what is published without changing how healthcare is purchased.

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