

Using Existing Base Rate Systems as Pathways to Simpler and Improved Healthcare Price Transparency: Where Are We Now and Where Do We Need to Go?

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Uwe Reinhardt, health economist and professor at Princeton University, shared his viewpoint that “buying healthcare in America is like shopping blindfolded in Macy’s and getting the bill months after you leave the store”. This was from a 2014 interview, and even after a decade, the sentiment still holds. America’s private, employer-sponsored insurance landscape is one of the few markets where an identical service can be sold at wildly different prices to each buyer.

Currently, base rate payment systems exist for inpatient, outpatient/ambulatory, and physician services. Private insurers spend roughly 60% of their total healthcare spending using existing base rate payment systems (inpatient hospital costs, outpatient hospital costs, ER costs, doctor visits, and ambulatory/outpatient care)¹.

This paper will review the current state of health care price transparency given the laws and processes now in place, and how the real buyer of nongovernment private healthcare insurance coverage, the employer-employee dyad, might leverage existing base rate payment systems to provide a truly new level of price transparency. In addition, it will suggest changes to the current system to improve transparency even further.

Health insurers (e.g., Blue Cross, Aetna, Cigna, etc.), on behalf of their employer clients, negotiate prices with physicians and healthcare systems, often keeping the employer-employee dyad who is purchasing the plan blind to these agreements. When you enter a department store,

you expect to know how much you will spend before purchasing the goods. Should buying some healthcare services be any different? You also expect Walmart to provide lower pricing than Neiman Marcus. That said, two different zones of healthcare purchasing often confuse the discussion of price transparency:

- i. Zone One: An episode of care where the patient wants to know what their personal dollar exposure will be in deductibles, co-pays, etc., for a diagnostic or treatment event (e.g., knee replacement, MRI scan, or normal delivery) during the plan year. Pricing in this zone is driven by the benefit design within that patient's specific health plan.
- ii. Zone Two: The annual configuration and premium pricing of employer-sponsored health plans. Here, the employer, usually with inadequate price information, often selects among the insurer's networks of hospitals and doctors to be included in their employer-sponsored plan (hopefully a network attractive to employees). For example, this can include high-priced hospitals and physicians that may cause the monthly premium contribution paid by the employer and employee (through payroll deductions) to be correspondingly higher. Large employers may have multiple plan offerings available to employees, but their self-insured plan is normally the dominant offering to their employees.

To illustrate the two zones, consider a family of four. The parents work for an airline company that pays a percentage of the family's health insurance cost. If their child goes to the pediatrician's office for an annual well-child visit, the family will likely be charged a pre-determined co-pay of, say, \$30 at the beginning of the appointment. This value is often posted on the insurance card for that employer-sponsored plan. This example event transaction is referred to as "Zone One".

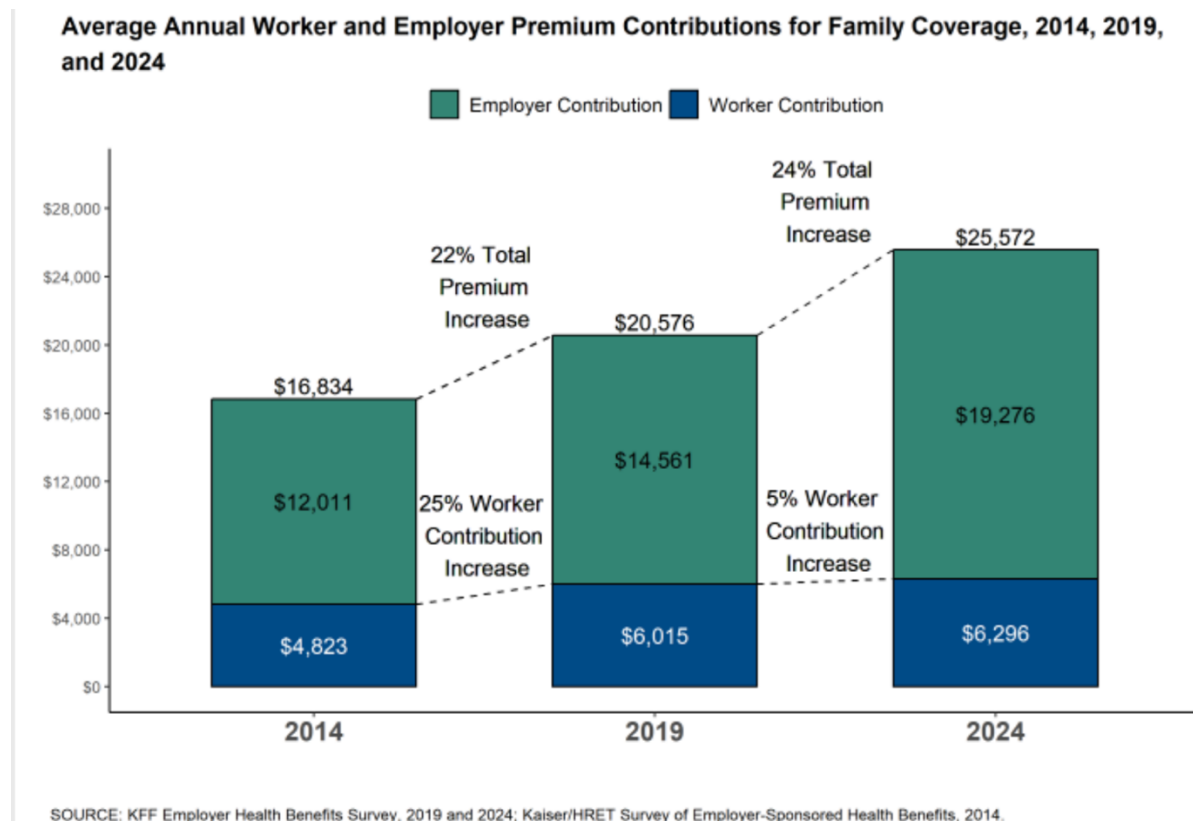
Despite recent regulations to improve physician and hospital price transparency, most consumers do not compare prices before receiving a Zone One episode medical care. It is estimated that roughly 60% of people do not actively shop around for healthcare services². A few studies have speculated why this number persists. One factor could be narrowed down to preserving existing relationships with a patient's current providers. Across the United States, over 80% of patient survey respondents reported an excellent or good relationship with their clinician³. In Zone One transactions, employees are also only exposed to their plan's deductible and co-pay design for that episode of care.

Another critical factor highlights the difficulty of simply finding the necessary information to truly compare episode prices between providers in Zone One. To calculate the total cost of an episode of care, a consumer would have to understand all the inputs of the equations, some of which are not easily accessible. A study conducted among New Hampshire residents suggested that only 1% of residents engaged with sites to shop around for their episode of care⁴. This study highlighted that the most frequently searched services were emergency room visits, imaging, and

outpatient visits. Even when prospective patients are prompted with an episode-specific price transparency tool, user engagement is still low^{5,6}.

Putting any claims volume differences aside, the biggest driver of costs for the employee-employer dyad buyer is the Zone Two annual configuration of the health plan network. Zone Two costs, and the monthly premium contributions needed to fund the plan for a particular year, can vary greatly depending on whether the plan includes high-priced versus low-priced providers. The same family of four who receive employer-sponsored insurance pays part of the plan’s total cost through payroll deductions. The employer-employee dyad, which funds a company’s private insurance plan, pays different proportions of the annual premium amount per enrollee. For example, a family plan may require a monthly total premium of \$2,600, which is often split around 80/20 between the employer and employee. Figure A shows the breakdown between how much an employee pays versus how much the employer generally pays for the health insurance premium over the years 2014, 2019, and 2024⁷. The share paid by covered employees varies between individual and family plans, 16% vs 25%, respectively. For this discussion, we will take an average of this and estimate that employers pay 80% of their plan’s premium cost and employees cover 20%. They are handcuffed together as the buyer who fronts 100% of the company’s self-insured plan annual cost.

Figure A



If high-priced providers are replaced in the plan's network with more price-efficient ones, the monthly cost may drop by X amount, which could result in significant savings. The main point here is that both the employer and employees need to be able to see these provider price differences to be prudent buyers. It also enables the employer to more clearly discuss with their employees the cost/benefits of hospital A versus hospital B being included or excluded from their plan. Again, approximately 60% of people with employer-sponsored health insurance are in self-insured plans where the employer (and indirectly the employee) bears all the cost risk. In these types of plans, the large insurers (e.g., Blue Cross, Aetna, United, etc.) normally provide administrative services only (ASO). The full cost of the actual medical claims is paid by the monthly contributions of the employer-employee dyad.

Another issue is that there are political and economic incentives to preserve the “confidentiality” of Zone Two prices between the insurer and the providers. For the hospital, if smaller insurance companies know how much larger insurance companies are paying, they may gain additional negotiating power for lower hospital rates. Medicaid and Medicare already pay much lower prices to hospitals and physicians; private insurers, and the employer-employee dyad that funds them, pay much more. In a RAND report of 2022 data, it found that employer plans and private insurers pay 254% of what Medicare pays hospitals for inpatient and outpatient services⁸. On the side of the providers, if patients can more easily find out that they can receive the same service(s) for less with a competitor, they may switch providers. This can become complicated very quickly, but for providers with high prices, providing clear price transparency has business risks.

Recent Healthcare Price Transparency Legislation Has Been Confusing and Not Effective

In recent years, Congress has passed numerous federal transparency laws in an attempt to promote readily available price shopping. In 2021, the “Hospital Price Transparency Rule” mandated that all hospital systems must publish “payer-specific negotiated rates, gross charges, discounted cash prices, and minimum and maximum negotiated rates” in a readable format⁹. In 2022, the “Transparency for Coverage” rule demanded that health plans and group insurers provide electronic and paper copies of expected out-of-pocket costs, a requirement for both in-network and out-of-network providers¹⁰. The same year, the “No Surprises Act” covered individual and group enrollees who received non-emergency or emergency services from out-of-network providers at an in-network facilities¹¹. There was also the creation of an independent dispute resolution process between providers and health plans through the implementation of this act.

In early January 2023, the House of Representatives introduced the “Health Care PRICE Transparency Act” to the 118th Congress¹². Similar to the 2021 “Hospital Price Transparency Rule”, this bill sought to launch a more standardized process of data reporting that required hospital and health plan organizations to directly post prices on their websites. As of early

January 2025, this bill had not been signed into law; therefore, a future bill must be introduced as this legislation was not passed.

Past administrations have received criticism for a lack of completeness in enforcing the accuracy and accessibility of pricing by hospitals and health plans¹³. However, the past may not be an indication of the future. Improved physician and hospital price transparency in healthcare holds bipartisan support, despite the failure to pass the PRICE Act this past congressional session¹⁴. The Kaiser Family Foundation reported that 95% of Americans believe that it is important for Congress to pass a law that improves patients' access to hospital pricing. Of these voters, 60% believed it should be a top concern for Congress as of December 2022¹⁴.

Under the current administration, President Trump signed an executive order to allow consumers to more easily compare prices for treatments and prescription drugs¹⁵. The "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" executive order is targeted at the Treasury, Labor, and Health and Human Services departments within the Executive branch. In his first term, the administration signed an Executive Order on Improving Price and Quality Transparency in American Healthcare to push for the publication of hospital prices. However, only 14% of hospitals complied with publicly posting their prices. With his threat of imposing higher fines for non-compliance in this term, time will tell how hospitals respond. Revenue cycle analysts predict that this executive order will be harder for smaller rural, community hospitals to comply with as they lack the infrastructure that larger hospital systems possess. This could lead to an inequitable burden of fines on smaller hospitals that cannot afford to pay for their non-compliance.

How Does Much of Healthcare Pricing Currently Work?

In 1982, Medicare changed the way it reimbursed hospitals for inpatient services by implementing a new system known as the Prospective Payment System, which then included about 383 Diagnosis-Related Groups (DRGs)¹⁶. This change was the result of Congress passing the Tax Equity and Fiscal Responsibility Act in 1983. Before implementing the DRG system, Medicare simply paid hospitals based on their historical costs attributable to Medicare patients. In contrast, the DRG system determines all reimbursements prospectively, regardless of actual costs incurred for providing services, which meant that hospitals needed to learn to manage their costs more effectively.

Essentially all hospital systems today use the DRG diagnosis assignment system for most of their inpatient prices, but they might be paid by some insurers in different ways, like per diem and case management in certain circumstances. Again, today, the overwhelming majority of hospital inpatient revenue and health plans' inpatient claims cost is determined by the DRG base rate system. In the DRG system today, all hospital inpatient admissions are assigned to one of over 740 clinical DRGs, and each DRG has a specific numeric weight. In the DRG payment calculation, the total cost of care for services is the product of the DRG weight multiplied by the

negotiated **base rate**. Table 1 shows the calculations used to determine how much the hospital will be paid for the sample services described. For essentially all employer-sponsored health insurance, the base rates vary and are privately negotiated between insurance companies and healthcare systems. So, if all insurers use the same DRG weighting system, and most do, then the only difference in inpatient pricing between Hospital A and Hospital B in each market is their negotiated base DRG rate or payment amount. Since the base rates differ dramatically between hospitals, an illustrative example is shown below in Table 1. The key point here is that what normally differs from hospital to hospital is the negotiated base rate.

Table 1: Illustrative Example of DRG Prospective Total Payment

DRG Code	Procedure Description	DRG Weight (1)	Base Rate (2)	Actual Payment
399	APPENDIX REMOVAL WITHOUT CC	1.11	\$6,498	\$7,213
7	LUNG TRANSPLANT	12.3	\$6,498	\$79,925
509	JOINT ARTHROSCOPY	1.33	\$6,498	\$8,642

1. FY 2024 IPPS Final Rule Home Page | CMS. (n.d.). Retrieved January 29, 2025, from <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipp-final-rule-home-page#Tables>

2. Wisness, K. (2023, November 13). The FY 2024 IPPS Final Rule: What You Need to Know. *BESLER*. <https://www.besler.com/insights/fy-2024-ipp-final-rule-what-you-need-to-know/>

For physician payments, a similar weighting system with a dollar base rate is also used. Physicians use Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) codes to bill for the overwhelming majority of physician services. The total cost of care determined for physician services is slightly more complex to calculate. Table 2 shows an illustrative example of the calculation used to determine the total cost of physician services (RVU= Relative Value Unit). The RVU weight is multiplied by the negotiated base rate conversion factor. The base rate for a given metro area typically includes the following: GPCI= Geography Practice Cost Index based on geographic location; PE = Practice Expense; MP = Malpractice Insurance. The key point here is that the RVU weight multiplied by the base rate conversion factor equals the payment to the physician.

Table 2: Illustrative Examples of CPT/HCPCS Payment Total

HCPCS	Procedure Description	Work RVU Weight (1)	Work GPCI (2)	PE RVU Weight	PE GPCI	MP RVU Weight	MP GPCI	Base Rate Conversion Factor	Actual Payment
44950	APPECTOMY	10.6	1	6.11	0.997	2.61	1.128	\$32.74	\$643
32851	LUNG TRANSPLANT	59.64	1	22.12	0.997	14.64	1.128	\$32.74	\$3,216
29886	KNEE ARTHROSCOPY	8.49	1	9.17	0.997	1.74	1.128	\$32.74	\$642

1. RVU25A | CMS. (n.d.). Retrieved January 29, 2025, from <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu25a>

2. 2025 Geographic Practice Cost Indices (GPCI). (n.d.). Retrieved January 29, 2025, from https://www.cgm.com/usa_en/articles/articles/gpci-geographic-practice-cost-indices.html

While the government’s Medicare DRG weights and RVU rates are publicized, the base rate DRG and RVU dollar values negotiated between employer-sponsored health plans and providers are usually not transparent. Again, private insurance payments are often much higher than the

rates paid by Medicare and Medicaid programs. Over 75% of the nation's inpatient hospitals use the DRG prospective payment schedule outlined by CMS¹⁷. As previously mentioned, these private negotiations contribute to the 254% greater payments made by private insurance companies compared to CMS payments for Medicare and Medicaid¹⁸.

Alternatively, in the Medicare Hospital Outpatient Prospective Payment System (HOPPS) procedures are grouped in Ambulatory Payment Classifications (APCs). According to a subject matter expert consulted on this topic, the use of APCs by private insurers is more variable than their use of the DRG and CPT systems. Commercial plans often customize their reimbursement structures based on various factors, such as geographic location, employee population size, and the risk profile of the covered individuals. However, it is still a core base rate system (like the DRG system) that has the opportunity to be standardized. It can still be recommended that a national APC system, using common weights, be implemented for all plans to allow for expanded pricing transparency.

As the weights in these base rate systems are already substantially standardized across the country, formalizing that standardization and making negotiated base rates transparent would enable real comparative price information to be available to all buyers at a new level.

The Benefits of Improved Healthcare Pricing Transparency for All Buyers is Significant

The United States spends a larger percentage of its national Gross Domestic Product (GDP) on healthcare compared to any other developed country. In 2023, this percentage grew to 17.6%, reaching \$4.9 trillion, equaling over \$14,500 per person¹⁹. The cost aberration of our system is in part, buried in our opaque pricing systems.

Enabling true health care pricing transparency to allow patients and their employers to be more prudent buyers has external societal benefits. Transparency can help to improve social welfare and health equity. By allowing the employee and employer to price shop in a meaningful way, it provides them the opportunity to select lower-cost providers. Additionally, by engaging in open price shopping, there is potential for a more price-competitive market for high-cost procedures. A more competitive healthcare services market would help to drive down unit costs so that all similar services are comparably priced²⁰.

The American Hospital Association (AHA) is the national industry association that represents hospitals and certain other healthcare providers. The organization released a statement in July of 2024 supporting Congress's attempts to promote healthcare price transparency. However, one has to wonder if their hospital members who have prices that are "above the average" would want those prices to be publicly visible with base rate transparency? Regardless, AHA voiced its concern regarding Congressional removal of the price estimator tool, which would hinder price transparency for Zone Two consumers. AHA also expressed hesitancy over the feasibility of updating estimated prices and stated that there would need to be a hospital official who would

verify the legitimacy of the published procedure estimates and compliance with statutory regulations.

The American Health Insurance Plans (AHIP) is an association of health insurance providers, including Medicare Advantage, Medicaid managed plans, employer-sponsored plans, and the individual market. Their stated goal is to provide affordable health insurance to all Americans²¹. AHIP put out a statement in support of healthcare price transparency, commenting:

“Better health outcomes and more affordable health care are goals we can all get behind, and increased price transparency is a step in the right direction. Health insurance providers will continue to roll out cost comparison tools and features, making improvements so that people can get the information they need to make important decisions about their health and care”²².

Limitations of Price Transparency

Price transparency is not a solution to fix all of America’s healthcare issues and does have limitations that must be addressed. For example, price transparency does not address the unequal distribution of and access to medical services between higher and lower socioeconomic groups. Increasing transparency does not change inequitable allocations of resources between affluent patients and low-income patients. In some cases, patients with the highest medical needs may not benefit the most from pricing transparency.

When considering the payment set-up for a Zone Two transaction today, a healthcare system’s negotiation with payors is a primarily confidential process, often invisible to the dyad buyer. This process can also allow healthcare systems with monopoly-like pricing power in their markets to protect the high prices they get from commercial plans. Uninsured patients usually pay little to nothing in claims. As already noted, Medicare and Medicaid pay less than the cost of their beneficiaries' care due to their government-mandated “take it or leave it” prices. If Zone Two pricing becomes truly transparent, smaller insurance companies/employers will press for the likely lower rates afforded to much larger insurers. Health systems that hold near monopoly positions in their markets with significant pricing advantages as it currently stands are not motivated to have other lower market share health systems see their higher prices.

While it is important to acknowledge that some privacy may be needed in contracts between insurers and hospitals, it is equally important to recognize the public obligation most hospitals have to their community. Further, essentially all hospitals participate as Medicare providers, and requiring price transparency as another one of the conditions of Medicare participation could help ensure universal transparency compliance. Releasing the negotiated base rate prices may be opposed by some hospitals and healthcare systems, but isn’t it also a moral obligation to the patients and communities those hospital systems serve?

What could an expanded, transparent base rate national system that offers real price comparisons in healthcare look like?

Fully leveraging the current base rate systems would require the following changes:

- i. Require all insurers and providers to use a single national set of weights, with possibly some adjustments for geographic cost differences, for their base rate payment models, like the published weights provided by Medicare today. Patients and employers could calculate the cost of care beforehand using the simple equation: $\text{Payment} = \text{Base Rate} \times \text{DRG Weight}$. The price paid by the employer-employee dyad can be easily compared using DRG and CPT base rates.
- ii. Require providers to publish their negotiated base rates with all their payers so the buyers, particularly employers and their employees, can compare the prices when they are selecting healthcare networks to use for their plan. Again, for all inpatient costs, simply comparing DRG base rates pretty much tells the whole story.

Hospitals and physicians with monopoly-like pricing leverage in their markets will likely face deserved public accountability and scrutiny. Tax-exempt not-for-profit hospitals account for over 85% of the US hospital dollar market share^{23,24}, and therefore, they are ultimately accountable to the communities they serve. Why not be price transparent with their communities?

Prescriptive Steps to Achieve Simpler Healthcare Pricing Transparency

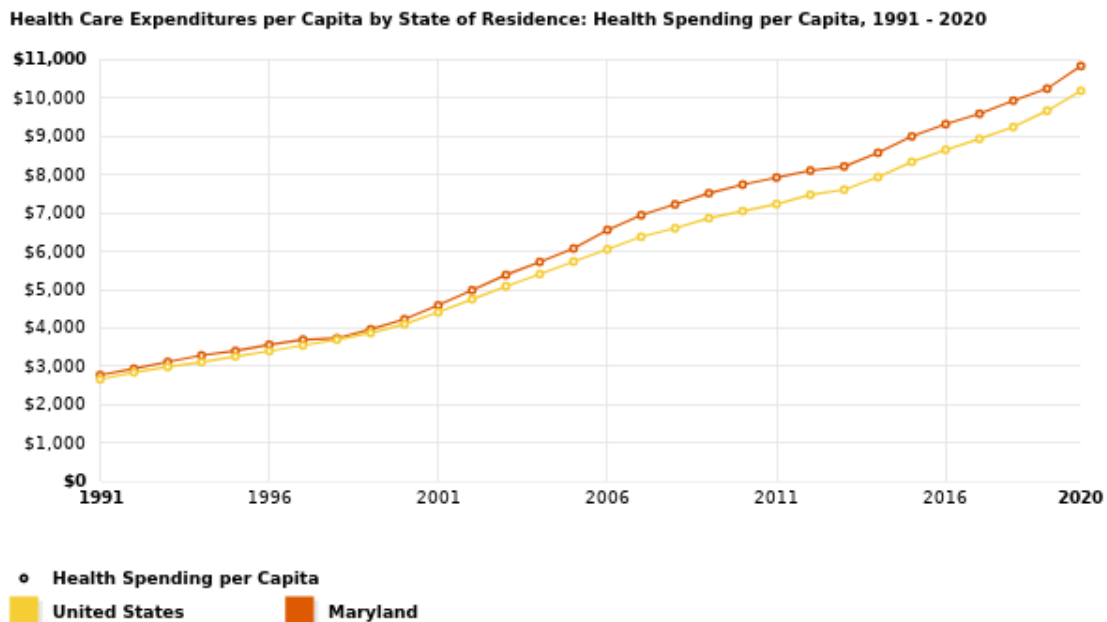
Implementing the following steps will allow our healthcare system to move toward achieving price transparency:

1. Require all health systems to operate using a standard national DRG base rate system for inpatient payment, and a similar structure for CPT codes used to determine physician fees. We are close to single-weight base rate systems today.
2. Publicize inpatient DRG, physician CPT, and outpatient PPS (OPPS) base rates for each hospital on their websites.
3. Use national weighting systems for hospital DRG inpatient and APC outpatient prices, and the same for physician fees using CPT RVU weights.

As previously stated, these base rate systems are used to price most healthcare services today. Improving transparency and mandating the publication of these base rates will allow buyers to compare future healthcare costs and plan configurations. Enabling price transparency will allow consumers to be prudent buyers in the market. This is a small step that may afford us the ability to take off our blindfolds that Uwe Reinhardt spoke about in 2014.

Appendix - One State Exception: Maryland's Health Services Cost Review Commission (HSCRC)

Dating back to 1970, Maryland set prices for all payers for healthcare services. They obtained a waiver from the Centers for Medicare and Medicaid Services (CMS). This waiver exempted Maryland from the national Medicare DRG system. However, despite Maryland’s cost regulation initiative, prices continued to rise. Consequently, Maryland was one of the top 20 state spenders in healthcare for many years, signaling a need to create a way to reduce avoidable utilization²⁵.



SOURCE: KFF's State Health Facts.

In early January 2014, Maryland began implementing its new All-Payer Model under the state’s Section 1115A Medicare waiver²⁶. The state turned away from the traditional inpatient admission payment model under CMS to an innovative model that focused on improving care, health outcomes, and reducing costs. The program has three focus areas, including, 1) experimenting with payment models, 2) performance measurement, and 3) total cost of episodic care. The state was given five years and several program markers to achieve. If they failed to meet the standards, they would transition back to the traditional national CMS payment model. These markers included:

- lower hospital readmissions
- lower hospital-acquired infections
- savings to the Medicare program
- Improved population health metrics

This program was overseen by the HSCRC, which is a state agency that regulates healthcare costs and services in Maryland, created in 1971.

By the end of December 2018, the program ultimately produced \$975 million in savings, largely attributed to the decrease in outpatient and emergency department visits²⁷. Research did not suggest an improvement in population health, but there were modest improvements in quality metrics. For example, avoidable hospital admissions dropped by 6%²⁸. Evaluation at the end of the five years highlighted a need for comprehensive coordination throughout the entire healthcare system²⁹.

After 2018, the state transitioned to a Total Cost of Care (TCOC) model, so that services would be coordinated across specialties³⁰. The model invested in primary care improvements, gave providers with better outcomes higher compensation, and crafted unique goals based on the unique needs of Marylanders.

During the first four years of the program, the TCOC reduced Medicare spending by 2.1% and hospital admissions by 16.2%. In addition, it reduced disparities in outcomes between black and white beneficiaries and between those living in areas with different Social Vulnerability Index (SVI) scores³¹. Due to its success, the program has been extended for four more years until 2026. Maryland is the only state that enforces a uniform rate-setting payment model regulated by the HSCRC. It does not matter who the insurer is or what hospital you get services from, the pricing will be close to uniform. When paired with financial incentives in higher quality outcomes, greater revenue is a result of reducing avoidable utilization. Providers are more concerned with keeping their patient populations healthy and out of the hospital³².

Moving forward, the Federal Government is implementing a new state TCOC model called the All-Payer Health Equity Approaches and Development (AHEAD) Model³³. Maryland will serve as the first state to undergo the demonstration in 2026, lasting until 2034. Two other cohorts of states will start their implementation phase in 2027. These states are Connecticut, Hawaii, Vermont, and New York. Through the AHEAD model, CMS hopes to improve the total health of the population and lower healthcare costs for consumers. They aim to do so by improving primary care, preventative services, and care coordination to address social drivers of health.

Maryland is a unique state that prioritizes policy and innovation. Since the 1970s, Maryland has been using their state waiver to improve healthcare delivery for their residents, constantly aiming to better their health outcomes. The uptake of an all-payer system is unlikely, but possible to be transplanted to other states due to the politics and values of other states. With the pending AHEAD model, we will have to wait to see how it plays out in more states in the coming years.

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33. *Concept for Image on Page 1 was drafted by author and initial image was generated using DALLE image generation tool. Image produced by Open AI DALL-E was edited with direction of author before being used in its final form.*