A Rule-Based Solution to Opaque Medical Billing in the U.S.

Christopher A. Bobier[1]

1. SAINT MARY'S UNIVERSITY OF MINNESOTA, WINONA, MINNESOTA, USA.

Keywords: Informed Consent, Autonomy, Financial Burden, Healthcare Costs

Abstract: Patients and physicians do not know the cost of medical procedures. Opaque medical billing thus contributes to exorbitant, rising medical costs, burdening the healthcare system and individuals. After criticizing two proposed solutions to the problem of opaque medical billing, I argue that the Centers for Medicare and Medicaid Services should pursue a rule requiring that patients be informed by the physician of a reasonable out-of-pocket expense estimate for non-urgent procedures prior to services rendered.

Imagine you need to buy a car to get to your new job across town. As you walk among the cars at the newly opened auto retailer, deciding which one to buy, you notice something strange — none of the cars have a tag indicating cost. Surprised by this observation, you call the salesperson hovering nearby over, and to your utter amazement, she confesses that she does not know the price of any of the cars! She explains that a computer malware attack deleted the cost of each car before the price tags could be printed and posted, and because cell reception is unreliable in your small town, no one has been able to look up manufacturer costs of the cars. At best she can offer you a broad price range of some but not all of the cars. The good news, however, is that you can drive off the lot today in a new-to-you car if you sign a purchase agreement with a blank spot where the price would ordinarily be: this open price contract guarantees you the car in exchange for a presently undisclosed amount to be paid in the future. Undeterred, in part because you need a car, and in part because you feel like you cannot go to another auto retailer in time, you sign the purchase agreement for a 2018 Toyota Tacoma. Four months later you receive a bill for the car, a bill that exceeded your expectations, along with unexpected bills for a pre-sale servicing fee, a smog check fee, a licensing fee, and a registration fee. You have one month to pay the bills.

The scenario above is unconscionable and yet something very much like it occurs daily in the United States healthcare system. Unlike other services in which costs are known in advance, the cost of medical services is opaque.[1] Patients regularly do not know what they will be charged until after services have been rendered. Physicians themselves are often unaware of the cost of procedures, and even if they knew the total cost, they would find it difficult to know what a procedure would cost for a *particular* patient since different patients have different insurance coverage with different negotiated rates. The result is that patients may opt for a procedure that carries minimal health benefit but significant financial cost, and a physician may push for an expensive procedure without an awareness of the financial burden it may place on the patient.

To remedy the problem of opaque medical billing, some have argued for the need for more transparent pricing in healthcare. Two proposals have gained traction: include out-of-pocket medical costs in informed consent and require insurers and organizations to

Christopher A. Bobier, Ph.D., *is an assistant professor of philosophy specializing in bioethics, animal ethics, and medical ethics at Saint Mary's University of Minnesota.*

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics. DOI: 10.1017/jme.2024.46

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

post prices online. The aim of this paper is to critically assess these proposals. In the first section, I argue that the problem with expanding informed consent is that it is unlikely to succeed in the courts or become part of professional practice. In the second section, I argue that the problem with recent increased price transparency rules at the federal level do not solve the problem because they are ineffective for patients and fail to include physicians in greater awareness of financial burden. For instance, as discussed in section 2 below, although hospitals are required to post payer-negotiated prices for various health services, this has not achieved true transparency for patients: patients do not research pricing beforehand and hospitals have been very good at hiding the lists. Fortunately, a solution is readily available. In the third section, I argue that the Centers for Medicare and Medicaid Services (CMS) should pursue a rule requiring that patients be informed by the physician of a reasonable out-of-pocket expense estimate for non-urgent procedures prior to services rendered.

Unlike other services in which costs are known in advance, the cost of medical services is opaque. Patients regularly do not know what they will be charged until after services have been rendered. Physicians themselves are often unaware of the cost of procedures, and even if they knew the total cost, they would find it difficult to know what a procedure would cost for a particular patient since different patients have different insurance coverage with different negotiated rates. The result is that patients may opt for a procedure that carries minimal health benefit but significant financial cost, and a physician may push for an expensive procedure without an awareness of the financial burden it may place on the patient.

1. Expanding Informed Consent

A proposed solution to the problem of opaque medical billing is to include out-of-pocket expense information in informed consent. This would enable patients and physicians to know beforehand what the financial burden of a proposed procedure will be. Physicians, being better informed of the costs, would be inclined to reduce expensive but unnecessary procedures, while patients would be empowered to make the best medical decision that aligns with their values and desires. Alicia Hall argues that out-of-pocket costs should be included in informed consent on the grounds that the "same considerations" that justify informed consent also justify "a requirement to disclose out-of-pocket costs."[2] Her reasoning is persuasive. A primary motivation for informed consent is a respect for patient autonomy; namely, people have the right to determine what shall and shall not be done to them in light of their desires and beliefs. This right to self-determination requires that enough information be presented so that a person can decide what happens to himself or herself in accordance with his or her personal goals and values: patients get to decide what is best for them, all things considered. While people care about what directly happens to their body, they also care about their finances. A recent report found that more than three quarters of Americans report feeling anxious about their finances and more than half report that finances control their lives.[3] This is not surprising since financial burdens can frustrate one's desires and hopes, frustrate or delay one's life-plan, promote fear and anxiety, strain relationships, and lead to physical distress. Knowledge of what a procedure will cost prior to procedure implementation will help a patient decide in accordance with his or her desires and values, and plan for anticipated financial fallout, just as knowledge of possible physical risks and burdens will help a patient decide and plan. Thus, making an informed choice requires knowing the financial cost of the procedure beforehand. For this reason, Ubel and colleagues conclude that "physicians need to disclose the financial consequences of treatment alternatives just as they inform patients about treatments' side effects."[4]

But informed consent is a legal requirement, a "creature of law" as Gerald Dworkin observes, and the challenge is identifying the legal plausibility of expanding informed consent to including out-of-pocket expenses.[5] United States healthcare law requires physicians to disclose all pertinent information about

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

risks and benefits of a proposed procedure regardless of whether a patients asks, and then, once consent has been granted, perform only that procedure that has been consented to;[6] failure to disclose pertinent risks or failure to abide by what was consented to can lead a patient to recover in tort from the physician. Legal analysis of failure to secure informed consent is grounded in considerations of battery and negligence. Physicians can be charged with battery if they perform a procedure different from the one consented to, exceed the scope of what the patient consented to, or perform a procedure without consent. Physicians can also be held accountable for negligence by failing to disclose important information to patients about a material risk. To establish negligence, the patient must establish four things: (1) the provider had a duty to disclose a material risk; (2) the provider did not disclose the material risk; (3) a reasonable patient would likely not have followed through with the procedure had the material risk been known; and (4) the patient suffered as a result of the undisclosed risk. The courts are split in understanding the physician's duty to disclose, but practically all have accepted that a standard risk-benefit disclosure suffices to mitigate claims of negligence.

Some legal scholars, in agreement with Hall, have argued for an expanded conception of materiality in informed consent, one that may include out-of-pocket costs.[7] The basis for their position is twofold. First, there is the recognition that a prevailing interpretation of materiality in the courts is in terms of a rational patient. Unlike an interpretation of materiality in terms of a professional standard, according to which information is deemed material if it is what a reasonable physician would customarily disclose, the rational patient interpretation posits that information is material if it is what a reasonable patient needs or desires to make an informed choice. This interpretation is grounded in *Canterbury v. Spence* in which the court wrote that "the patient's right of self-decision shapes the boundaries of the duty to reveal."[8] The *Canterbury* court posited that the scope of disclosure is determined by what a reasonable patient needs and expects, specifically, whether a reasonable person would likely "attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."[9] A number of subsequent cases have adopted the rational patient standard.[10] Scholars advocating for an expanded conception of materiality observe that a common lay-understanding of what is relevant to a person's decision-making includes non-medical desiderata: people care about financial risk as much as, if not more so, than unlikely medical risks, risks that are often disclosed in informed consent.

With this interpretative framework in place, the second step of the argument is to note that some courts have interpreted materiality beyond "medically material." There have been some cases in which physician experience or credentials were deemed materially relevant,[11] a case in which physician financial conflict of interest was deemed materially relevant,[12] and a case in which physician health was deemed materially relevant.[13] Other cases involve non-medical interests, such as maintaining fertility,[14] avoiding pregnancy,[15] and even being able to wear high heels,[16] being deemed materially relevant. There are also abortion rules in some states that require third party information be disclosed in informed consent[17] and the Supreme Court in *Planned Parenthood v. Casey* permitted certain disclosures about the impact of an abortion on a fetus.[18] Marc Ginsberg notes that the Eleventh Circuit Court of Appeals in *Silva v. Baptist Health South Florida*, which states that treatment decisions require physician-patient information exchange, is consistent with requiring information about financial costs precisely because patients may view finances as "medically relevant."[19] These cases collectively show that there is room to expand informed consent to include non-medical, possibly financial information.

The issue becomes identifying how to extend materiality to non-medically material information in a principled manner, one that may include out-of-pocket costs but exclude non-relevant information (e.g., physician religious belief). I focus on three accounts with the problem of opaque medical billing in mind. First, Nadia Sawicki suggests that patients should be informed of the medical cost of a procedure when this information is within the physician's knowledge and the information is material to a reasonable patient.[20] For example, if a physician knows of the financial costs of a proposed treatment and a reasonable patient would care about the costs, then the physician ought to disclose this information; but if the physician does not know the financial costs, or they are such that a reasonable patient would not consider them when deliberating, then the physician does not need to disclose such information. There is a problem with this suggestion, however, when it comes to the problem of opaque medical billing, a problem Sawicki observes: "Information about the cost of treatment would be excluded, at least in most practice areas."[21] The reason for this is that many physicians do not know the cost of various treatment options and, even if they did, they could not reasonably inform a particular patient of the out-of-pocket cost due to ignorance of insurance type

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

and coverage. Sawicki's proposal does not require that physicians find out the out-of-pocket costs and then inform patient; rather, it requires disclosing if this information is known, which it often is not.

A second account of how to expand materiality is offered by Christopher Robertson, who argues for the following inclusive test of materiality: "information is material if it is likely to change the decision of a substantial number of patients."[22] On this account, materiality is determined by appeal to what a large number of patients *would do* given certain information. For instance, if many people would not opt for a procedure upon learning of the cost of said procedure, then such financial information is to be considered material. The problem with this account as applied to the problem of opaque medical billing is twofold. First, it does not support a requirement of out-of-pocket costs figuring in informed consent for all procedures, but only the most expensive and unnecessary ones. Yet even less expensive procedures can be burdensome and unanticipated, especially for economically disadvantaged patients. Second, and more importantly, this proposal is unlikely to get us out-of-pocket costs in informed consent because of the power differential at play in the physician-patient relationship. It is well documented that patients tend to defer to their physicians in medical decision-making and feel unknowledgeable about health care.[23] Even if a physician discloses a hefty out-of-pocket cost for a procedure, it may not be the case that a substantial number of patients would act otherwise, for patients may assume that this is the cost of healthcare and there are no viable alternatives. So it is not evident that being made aware of out-of-pocket costs will pass the materiality test Robertson proposes.

A third way of expanding materiality is offered by Robert Gatter, who argues that informed consent should include patient goals: "informed consent doctrine should be expanded to require physicians to make a reasonable inquiry into the subjective treatment goals of each patient they propose to treat."[24] To increase autonomy and decision-making, Gatter reasons, requires physicians to inquire into what a patient would like from treatment. If a physician makes a reasonable effort to ask, and a patient discloses that she would like to retain an active lifestyle, say, then information relevant to this patient desire becomes material (e.g., side effects of immobility). Unfortunately, this account is unlikely to address the problem of opaque medical belling, for Gatter's focus is on treatment outcomes, as his possible list of questions a physician should ask makes clear: "how is your condition affecting your home life, your work, and your major activities outside of work or home?"[25] A focus on how a condition is affecting one's lifestyle does not focus on finances, except, maybe, inasmuch as the condition affects one's ability to work. The focus is in health and medical-related desires, not directly on finances.

Perhaps the preceding misgivings regarding Sawicki's, Robertson's, and Gatter's accounts can be overcome or other accounts of expanded materiality can be offered. It is therefore important to observe a deeper problem for proposals to expand the materiality condition to include out-of-pocket costs — it is unlikely that out-of-pocket costs will be considered material in court or in professional practice.[26] To date, there is no legal precedent for including costs in informed consent, there is no professional rules suggesting as much, and there is a clear precedent for excluding it on grounds that what is material is what is limited to "medically material."[27] In *Canterbury v. Spence*, the case that sets the precedent for a rational patient standard, the court described materiality in informed consent in terms of "the inherent and potential hazards of the proposed treatment,"[28] language that clearly limits materiality to medical risk, and a fair number of courts and legislatures used this language to limit materiality. In *Arato v. Avedon*, the California Supreme Court posited that California law does not impose on physicians an "undefined [duty] to disclose every contingency that might affect the patient's nonmedical 'rights and interests'."[29] In *State v. Presidential Women's Center,* the Florida Supreme Court rejected a proposal to include mention of the social and economic risks of abortion in informed consent forms on the grounds that physicians can only speak on medical matters.[30] In *Whiteside v. Lukson*, a Washington appellate court limited informed consent only to "treatment-related facts,"[31] while in *Felton v. Lovett*, the court defined inherent risks to be disclose as those that "are directly related to the treatment" and excludes information about "non-treatment-specific injuries" such as infection.[32] In *Kaskie v. Wright,* the Pennsylvania Superior Court denied a plaintiff's argument of physician negligence on the grounds that the physician did not inform them of alcoholism;[33] the court reasoned that this would require expanding informed consent beyond its intended boundary, namely, medically material information. These cases, and many more like them, suggest that legally expanding informed consent to include financial burden is bound to be difficult.

Even if informed consent were expanded to include out-of-pocket costs, it is unlikely to benefit patients because it will be difficult to establish that a lack of financial disclosure alone caused compensable injury.[34] To prove physician negligence in an informed consent

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

case, it would need to be established that the patient likely would not have followed through with the procedure had the material risk been known and the patient suffered as a result of the undisclosed risk. Both conditions are monumentally difficult to establish regarding finances. One of the reasons has been explained already, namely, price transparency in informed consent may not influence behavior given the power differential at play in the physician-patient relationship — knowing the out-of-pocket costs beforehand may not influence patient behavior, and post-hoc reasoning ("knowing what I know now") does not show that the patient would have in fact acted differently. Moreover, and more importantly, establishing a causal relationship between the financial burden post-treatment and the patient suffering is nigh well impossible, for there are many possible reasons why a patient may be suffering after a costly treatment. Stress, anxiety, and depression cannot easily be shown to be the direct result of financial burden *alone*.

It is not surprising, therefore, that states and professional organizations limit informed consent to medically material information. Minnesota Statute 144.651, for instance, stipulates that informed consent "shall include the likely medical or major psychological results of treatments and its alternatives,"[35] while Colorado's *Standards for Hospitals and Health Facilities* requires that informed consent forms include "an explanation of the risks and benefits of a treatment or procedure; the probability of success, mortality risks, and serious side effects."[36] The American Medical Association's *Code of Ethics* states that physicians should present information about the "burdens, risks, and expected benefits of all options"[37] related to the proposed treatment. The American College of Surgeons' *Statements on Principles* states that informed consent ought to include the estimated risk of mortality and morbidity along with commonly known complications.[38] The American Academy of Orthopaedic Surgeons' *Position Statement: Shared Physician-Patient Responsibilities* posits that patients ought to be informed of "pertinent medical facts", including "alternative modes of treatment, the objectives, risks and possible complications of such treatment, and the complications and consequences of no treatment."[39]

2. Price Transparency Rules

The ethical argument notwithstanding, it is reasonable to suppose that out-of-pocket costs will not be required in informed consent anytime soon. It is instructive to note therefore that the ethical argument does not necessarily require expanding *informed consent*. Informed consent is one way to promote patient autonomy and decision-making, but there is another way to do this. In this section, I explain the recent push to promote patient autonomy and decision-making through price transparency rules at the federal level. While there have been rules at the state level to promote transparency,[40] I focus on federal rules because of their uniform binding across states and organizations.

Concerned with the burden of rising healthcare costs on the system and individuals, Executive Order 13877, signed into law by then-President Donald J. Trump on June 24, 2019, charged certain federal departments to make medical price information more broadly available to patients. The order empowered the Department of Health and Human Services, Department of the Treasury, and Department of Labor to issue a rule "to require 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."[41] The rationale of the Executive Order was to make transparent the opaque pricing structures to increase informed-decision making among patients, in the hopes that doing so would drive competition and lower costs. The legal justification for Executive Order 13877 is section 1311(e)(3) of the Affordable Care Act, which requires the publication of cost-sharing information of qualified health plan issuers, and section 2715A of the Public Health Services Act, which extends this requirement to non-grandfathered group health plans and health insurance issuers that offer coverage to individuals or groups.[42]

The Centers for Medicare & Medicaid Services (CMS) is charged by the Department of Health and Human Services, and empowered by the Affordable Care Act, to establish rules that promote quality and efficiency, including rules that "may assist consumers and patients in making informed health care decisions."[43] In response to Executive Order 13877, and in accordance with its interpretation of section 1311(e)(3) of the Affordable Care Act and section 2715A of the Public Health Services Act, CMS issued two final rules: Hospital Price Transparency Final Rule and Transparency in Coverage Final Rule. The Hospital Price Transparency Final Rule, which has been upheld in the courts thus far, requires, among other things, hospitals to post their standard charges prominently on a publicly available website and to share payer-specific negotiated prices for health services. The Transparency in Coverage Final Rule, which was issued in accordance with the Department of Labor and Department of the Treasury, requires, among

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

other things, that most private health insurance companies disclose cost-sharing information upon request to a participant, beneficiary, or enrollee (or his or her authorized representative), including an estimate of the individual's cost-sharing liability for covered items or services furnished by a particular provider, as well as publicly report negotiated prices for services. The rationale for these rules is to reduce healthcare costs by empowering patient choice and decision-making.

Although the rules are a necessary step in the right direction, there is compelling reason to think they are not enough to address the problem of opaque medical billing. Pricing tools have been available by insurers for some time, and research shows that patients do not utilize them[44] and that these tools have had little to no effect on out-of-pocket spending.[45] The problem is threefold: patients often remain ignorant of such tools; healthcare is fragmented in a way that makes cost estimates difficult to accurately calculate; and patients tend to not consider healthcare as negotiable or something they can shop around.[46] Indeed, as noted already, given the power-differential at play in the physician-patient relationship, and lack of patient understanding of healthcare, patients regularly adhere to physician recommendation.[47] Regarding the Hospital Price Transparency Final Rule, in particular, hospitals have found innovate ways to hide the charges (or have yet to abide by the rule),[48] and patients who have found the list of charges have found it well-nigh impossible to understand[49] or otherwise incomplete.[50] Pricing information can only be helpful if it is accurate, understandable, and utilized by patients, but so far the available information has been none of these. Furthermore, these rules do not involve physicians in greater awareness of the financial burden of their recommended services. Physicians play a significant role in healthcare decision-making but may remain ignorant of healthcare costs for each patient.[51] If physicians continue to recommend expensive services without being made aware of their cost for patients, we will continue to see expensive services recommended. These problems lead Kullgren and Fendrick to acknowledge that "additional steps are necessary" to improve patient financial wellbeing.[52]

3. A New Rule

There is broad, growing consensus that patients should be provided personalized out-of-pocket costs prior to receiving treatment and that physicians should have cost conversations with patients. The challenge is identifying a way to build in out-of-pocket cost disclosure in the patient visit. Existing price transparency rules have been so far ineffective and expanding informed consent to include something like financial informed consent is unlikely. Fortunately, there is a viable solution, one that I conclude with: CMS pursue a rule that requires that patients be informed by physicians of an out-of-pocket expense estimate for non-urgent procedures prior to services rendered. Rather than let patients find out out-of-pocket expenses on their own, the revised rule would require physicians to avail themselves of pricing tools and other means to provide patients with a good faith estimate of out-of-pocket costs prior to services being rendered. Thus, not only would patients learn of pricing beforehand, so would physicians.

If physicians continue to recommend expensive services without being made aware of their cost for patients, we will continue to see expensive services recommended. These problems lead Kullgren and Fendrick to acknowledge that "additional steps are necessary" to improve patient financial wellbeing.

This rule might involve the following change to healthcare delivery. Patients usually give insurance information to front-desk workers upon arrival, which allows the relevant cost-sharing agreement between the insurer and healthcare organization to be easily accessed. As the physician and patient discuss course(s) of treatment, the physician can use the organization's pricing tool on the exam room computer to give a good faith estimate of what the out-of-pocket costs will be for the patient. All the physician would need is the patient insurance plan and course of treatment. Patients would not be required to provide insurance information for purposes of a cost estimate, of course, and physicians will be trained on how to discuss financial considerations when discussing treatment options. An important benefit of requiring physicians, and not organizations, to offer the good faith estimate is that it allows the *physician* and patient to organically discuss financial well-being when consid-

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

ering treatment options. This would, in theory, stop physicians from seeking expensive but unlikely treatment options. Afterward, the patient may receive quality assessment survey, one question of which may ask whether the provider offered a good faith estimate of what the out-of-pocket costs might be.

The proposed rule is ethically defensible. Respect for patient autonomy and the right to self-determination requires that enough information be presented to the patient so that they can decide what happens to them in accordance with their desires, goals, and values. While people care about what directly happens to their body, they also care about their finances, and so supporting autonomy and self-determination requires the disclosure of out-of-pocket expenses. Moreover, the proposed rule is in line with the Transparency in Coverage Final Rule and Hospital Price Transparency Final Rule, both of which have been successfully defended in the courts thus far and both of which require the publication of cost sharing for patient consideration: the former requires hospitals to post the costs of common procedures, while the latter requires insurers to post cost-sharing prices and even provide cost estimates upon request. However, as I argued above, these rules have thus far failed to achieve what they set out to do, namely, empower patient decision-making and in turn drive down pricing. My proposed rule better aligns with Executive Order 13877, which sought ways to require healthcare providers to "provide or facilitate access to information about expected out-of-pocket costs"[53] prior to receiving care, as well as a stated goal of both rules, namely, to minimize "potential surprises in relation to individual consumers' out-of-pocket costs for health care services."[54] It is much easier to achieve price transparency when physicians are required to provide a good faith estimate of out-of-pocket costs prior to services rendered: while hospitals and other healthcare organizations can hide pricing lists on obscure webpages, CMS can determine whether patients are receiving price estimates from physicians by directly asking them.

It is also worth mentioning that this proposed rule aligns with recent Congressional legislation by extending a certain provision of the No Surprises Act, which Congress passed as part of the Consolidated Appropriations Act of 2021 and President Joseph Biden Jr. signed into law in December of 2020.[55] The No Surprises Act, among other things, allows insured patients to request an advanced explanation of benefits, one that informs of expected out-of-pocket expense, and requires that providers give an uninsured or self-paying consumer "a good faith estimate" of the cost of service when it is scheduled.[56] The Office of Personnel Management, Department of the Treasury, Department of Labor, and Department of Health and Human Services has since issued Interim Final Rules to implement these provisions. The proposed rule I am defending in this paper extends the requirement that providers give an uninsured or self-paying consumer a good faith estimate prior to services rendered to all patients — insured and un-insured. There is thus greater price transparency for patients, and by involving physicians in price awareness, there is better chance that expensive but ineffective medical services are minimized.

It might be argued that the proposed rule would be difficult to implement. On the one hand, it is well-documented that hospitals have found ways to circumvent transparency rules, and on the other hand, physicians may not know a patient's insurance information. Two responses can be offered. First, ethical behavior is often difficult to implement but this is not good reason to not be ethical. Stated differently, that this proposal is hard to operationalize does not show that the ethical argument in its favor is wrong. Second, and more to the point, while practically implementing the proposal would require innovation at the outset, the proposed rule would not be particularly burdensome on physicians and healthcare organizations *beyond* what recent rules and legislation require. This is because healthcare providers have better access to accurate price information than patients do and the pricing infrastructure is already in place: insurers are required to provide out-of-pocket cost estimates to insured patients upon request; hospitals are required to post service prices; uninsured and self-paying consumers receive a good faith estimate of out-of-pocket costs in advance; and health care organizations know what they charge different insurers for various procedures. This proposal acknowledges that providers have, as Wendy Epstein notes, "far superior access to price information than patients."[57] With the organization-specific pricing tool on the exam room computer, a physician need only the patient's insurance plan and possible treatment plan to generate a good faith estimate of out-of-pocket expenses. To be sure, the rule can be phased in over time, by requiring, say, out-of-pocket estimates for the 50 most common procedures in year one and all procedures in year three. This would allow physicians and organizations ample time to implement the practice of sharing pricing information prior to services rendered. Importantly, this rule is easily assessable. For example, a relevant question can be added to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey that CMS uses to issue an overall hospital quality star rating:

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

just as patients are asked to rate the organizations communication about medicines, so they can be asked to rate the provider's communication about out-of-pocket costs.

Conclusion

Price opacity undermines patient autonomy and contributes to rising health care costs in the United States. There is ethical and societal impetus to address the matter, but unless change is required in current practice, providers and patients will continue to remain ignorant of the financial burden of proposed procedures. A federal rule positing that physicians provide a reasonable out-of-pocket cost estimate prior to treatment for non-urgent procedures would promote cost awareness among patients and physicians alike, and—I have argued—be easy to legally justify and implement.

Note

I would like to thank the reviewer for helpful suggestions on the paper.

References

1. W. N. Epstein, "Price Transparency and Incomplete Contracts in Health Care," *Emory Law Journal* 67, no. 1 (2017) 1-58; W. M. Sage, "Regulating through Information: Disclosure Laws and American Health Care," *Columbia Law Review* 99, no. 7 (1999): 1701-1829; G. C. Alexander, et al., "Rethinking Professional Ethics in the Cost-Sharing Era," *The American Journal of Bioethics* 6, no. 4 (2006): 17-22.
2. A. Hall, "Financial Side Effects: Why Patients Should Be Informed of Costs," *The Hastings Center Report* 44, no. 3 (2014), 41-47, at 41; see also K. R. Riggs and P. Ubel, "Overcoming Barriers to Discussing Out-of-Pocket Costs With Patients," *JAMA Internal Medicine* 174 (2014): at 849; P. A Ubel et al., "Full Disclosure-Out-of-Pocket Costs as Side Effects," *New England Journal of Medicine* 369 (2013): 1484, at 1484.
3. A. White, "77% of Americans are Anxious about their Financial Situation — Here's How to Take Control," CNBC (July 21, 2021), *available at* <https://www.cnbc.com/select/how-to-take-control-of-your-finances/> (last visited February 12, 2024).
4. P. Ubel, A. Abernethy, and S. Zafar, "Full Disclosure — Out-of-Pocket Costs as Side Effects," *New England Journal of Medicine* 369, no. 19 (2013): 1484-1486, at 1484.
5. G. Dworkin, *The Theory and Practice of Autonomy* (New York: Cambridge University Press, 1988).
6. For overview of informed consent law, see L. S. Svitak, and M. Morin, "Consent to Medical Treatment: Informed or Misinformed?" *William Mitchell Law Review* 12, no. 3, (1986): 541-578; M. A. Hall and D. Orentlicher, D. *Health Care Law and Ethics in a Nutshell* (4th ed.) (St. Paul, MN: West Publishing Co, 2020); T. Paterick, et al., "Medical Informed Consent: General Considerations for Physicians," *Mayo Clinic Proceedings* 83, no. 3 (2020): 313-319; C. Robertson, "Should Patient Responsibility for Costs Change the Doctor-Patient Relationship?" *Wake Forest Law Review* 50 (2015): 363-380; N. N. Sawicki, "Modernized Informed Consent: Expanding the Boundaries of Materiality," *University of Illinois Law Review* 2016, no. 3 (2016): 821-871; M. D. Ginsberg, "Informed Consent: No Longer Just What the Doctor Ordered? Revisited," *Akron Law Review* 59, no. 1 (2018): 49-196.
7. C. Robertson, "Should Patient Responsibility for Costs Change the Doctor-Patient Relationship?" *Wake Forest Law Review* 50 (2015): 363-380; N. N. Sawicki, "Modernized Informed Consent: Expanding the Boundaries of Materiality," *University of Illinois Law Review* 2016, no. 3 (2016): 821-851; M. D. Ginsberg, "Informed Consent: No Longer Just What the Doctor Ordered? Revisited," *Akron Law Review* 59 (2018): 49-196; T. S. Hall, "Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship," *South Carolina Law Review* 54 (2003): 689, 720–23.
8. *Canterbury v. Spence*, 464 F.2d at 787 (D.C. Cir. 1972).
9. *Canterbury v. Spence*, 464 F.2d at 786-787.
10. See *Largey v. Rothman*, 540 A.2d 504, 508-09 (N.J. 1988); *Wheeldon v. Madison*, 374 N.W.2d 367, 374 (S.D. 1985); *Cross v. Trapp*, 294 S.E.2d 446, 455 (W. Va. 1982); *Wilkinson V. Vesey*, 295 A.2d676,689 (R.I. 1972); *Duffy V. Flagg*, 905 A.2d 15, 20 (Conn. 2006); *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d, 73,79 (N.J. 2002).
11. *Johnson v. Kokemoor*, 545 N.W.2d 495, 497 (Wis. 1996); *DeGenarro v. Tandon*, 873 A.2d 191, 200 (Conn. App. Ct. 2005); *Barriocanal v. Gibbs*, 697 A.2d 1169, 1172 (Del. 1997).
12. *Moore v. Regents of the Univ. of Cal.*, 793 P.2D 479,483 (Cal. 1990).
13. *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993).
14. *Redford v. United Stated*, Civ. No. 89-2324 (CRR), 1992 WL 84898 (D.D.C. Apr. 10 1992).
15. *Hartke v. McKelway*, 707 F.2d 1544 (D.C. Cir. 1983).
16. *Hartman v. D'Ambrosia*, 665 So. 2d.1206 (La. Ct. App. 1995).
17. S.D. CODIFIED LAWS § 34-23A-10.1; KAN. STAT. ANN. §§ 65-6709(b)(5), 65-6710; N.D. CENT. CODE ANN. § 14-02.1-02; *Planned Parenthood Minn. v. Rounds*, 375 F. Supp. 2d 881, 887 (D.S.D. 2005).
18. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).
19. Ginsberg, *supra* note 6.
20. Sawicki, *supra* note 6, at 869.
21. Sawicki, supra note 6, 826.
22. Robertson, supra note 6, at 373.
23. W. Levinson, A. Kao, A. Kuby, and R.A. Thisted, "Not all Patients want to Participate in Decision Making," *Journal of General Internal Medicine* 15, no. 1 (2013): 46-50.
24. R. Gatter, "Informed Consent Law and the Forgotten Duty of Physician Inquiry," *Loyola University Chicago Law Journal* 31 (2000): 557, 579.
25. *Id.*
26. *Id.*
27. Sawicki observes that legal scholars have "concluded that, with very rare exceptions, the physician's duty only extends to disclosure of medically material facts" (833); and Robertson writes that the courts have largely "focused on the risks of treatment." (371)
28. *Canterbury*, 464 F.2d at 787.
29. *Areto v. Avedon*, 858 P.2d 609.
30. *State v. Presidential Women's Center* 937 SO.2w 114 (Fla. 2006).
31. *Whiteside v. Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997).
32. *Felton v. Lovett*, 388 S.W.3d 656, 662 (Tex. 2012).
33. *Kaskie v. Wright*, 589 A.2d.
34. Epstein, supra note 1, at 58; see also J. H. Krause, "Reconceptualizing Informed Consent in an Era of Health Care Cost Containment," *Iowa Law Review* 85 (1999): 261, 317.
35. Minnesota Statute 144.651
36. Department of Public Health and Environment, Standards for Hospitals and Health Facilities, 6 CCR 1011-1, 6.6.1b2.
37. Code of Medical Ethics Opinion 2.1.1
38. American College of Surgeons' *Statements on Principles* II.a., *available at* <https://www.facs.org/about-acs/statements/statements-on-principles/> (last visited april 9, 2024).
39. American Academy of Orthopedic Surgeons, *Position Statement: Shared Physician-Patient Responsibilities, available at* <https://www.aaos.org/globalassets/about/position-

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press

statements/1182-shared-physician-patient-communication.pdf> (last visited February 12, 2024).
40. See ARIZ. REV. STAT. ANN. § 36-125.05 (2016); ARK. CODE ANN. §§ 20-7-301–07 (West 2011); CAL. HEALTH & SAFETY CODE §§ 1339.55, .56, .58, .585 (West 2016); COLO. REV. STAT. ANN. § 6-20-101 (West 2016); DEL. CODE ANN. tit. 16, §§ 2001–2009 (West 2013); FLA. STAT. § 381.026 (West Supp. 2017); 20 ILL. COMP. STAT. ANN. 2215/4-2(d)(6)&(7) (West 2015).
41. Federal Register (2019) *Improving Price and Quality Transparency in American Healthcare To Put Patients First* Sect. 3b, *available at* <https://www.federalregister.gov/documents/2019/06/27/2019-13945/improving-price-and-quality-transparency-in-american-healthcare-to-put-patients-first> (last visited February 12, 2024).
42. Centers for Medicare & Medicaid Services (CMS) (2022d) Affordable Care Act Implementation FAQs – Set 15, *available at* <https://www.cms.gov/CCIIO/Resources/Fact-Sheets andFAQs/aca_implementation_faqs15#:~:text=Section%202715A%20of%20the%20PHS,through%20an%20Exchange%20shall%20only> (last visited February 12, 2024).
43. Social Security Act, 1890(b)(7)(B), *available at* <https://www.ssa.gov/OP_Home/ssact/title18/1890.htm> (last visited February 12, 2024).
44. J. T. Kullgren, et al., "Consumer Behaviors Among Individuals Enrolled in High-Deductible Health Plans in the United States," *JAMA Internal Medicine* 178, no. 3 (2018): 424-426.
45. S. Desai et al., "Association Between Availability of a Price Transparency Tool and Outpatient Spending," *JAMA* 315, no. 17 (2016):1874-1881; S. Desai, et al., "Offering a Price Transparency Tool did not Reduce Overall Spending Among California Public Employees and Retirees," *Health Affairs (Millwood)* 36, no. 8 (2017): 1401-1407.
46. J. Kullgren and M. Fendrick, "The Price Will Be Right—How to Help Patients and Providers Benefit from the New CMS Transparency Rule," *JAMA Health Forum* 2, no. 2 (2021): e210102; S. M. Desai, S. Shambhu, and A. Mehrotra, "Online Advertising Increased New Hampshire Residents' Use of Provider Price Tool But Not Use of Lower-Price Providers," *Health Affairs (Millwood)* 40, no. 3 (2021): 521-528.
47. S. Glied "Price Transparency — Promise and Peril," *JAMA* 325, no. 15 (2021):1496–1497.
48. M. Henderson and M. Mouslim, "Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule," *Health Affairs Blog* (2021), https://doi.org/10.1377/hblog20210311.899634.
49. L. Gustafsson and S. Bishop "Hospital Price Transparency: Making It Useful for Patients," *To the Point (blog)*, Commonwealth Fund, https://doi.org/10.26099/qacm-j392.
50. M. Horný, P.R. Shafer, and S. B. Dusetzina, "Concordance of Disclosed Hospital Prices With Total Reimbursements for Hospital-Based Care Among Commercially Insured Patients in the US," *JAMA Network Open* 4, no. 12 (2021): e2137390.
51. E. J. Emanuel and A. Diana, "Considering the Future of Price Transparency Initiatives — Information Alone is not Sufficient," *JAMA Network Open* 4, no. 12 (2021): e2137566.
52. Kullgren and Fendrick, *supra* note 46.
53. Federal Register, "Improving Price and Quality Transparency in American Healthcare To Put Patients First" (2019), Sect. 3b, *available at* <https://www.federalregister.gov/documents/2019/06/27/2019-13945/improving-price-and-quality-transparency-in-american-healthcare-to-put-patients-first> (last visited February 12, 2024).
54. See <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf> (last visited February 12, 2024).
55. Centers for Medicare & Medicaid Services (CMS) "No Surprises: Understand your Rights Against Surprise Medical Bills," (2022), available at <https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills> (last visited February 12, 2024); Kaiser Family Foundation (KFF) "Surprise Medical Bills: New Protections for Consumers Take Effect in 2022," (2021), available at <https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/> (last visited February 12, 2024).
56. Centers for Medicare & Medicaid Services (CMS), "Surprise Billing & Protecting Consumers," *available at* <https://www.cms.gov/nosurprises/Ending-Surprise-Medical-Bills> (last visited February 12, 2024).
57. Epstein, *supra* note 1, at 7.

The Journal of Law, Medicine & Ethics, 52 (2024): 22-30. © The Author(s), 2024. Published by Cambridge University Press on behalf of American Society of Law, Medicine & Ethics.

https://doi.org/10.1017/jme.2024.46 Published online by Cambridge University Press