

SURPRISE BILLING PROTECTIONS, PRICE TRANSPARENCY, AND FINANCIAL ASSISTANCE POLICIES IN TENNESSEE HOSPITALS

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The Tennessee Health Care Campaign (THCC) is a statewide nonprofit agency that has, since 1989, worked to ensure that all Tennesseans have equitable access to quality, affordable healthcare through public education, its advocacy efforts, and the provision of enrollment services in TennCare, Medicare, and Marketplace plans.

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EXECUTIVE SUMMARY

The Tennessee Health Care Campaign (THCC) advocates for equitable access to quality and affordable healthcare for all Tennesseans. This report is a follow-up to an initial survey conducted in late 2023 to assess how well Tennessee hospitals were implementing the consumer notification requirements of the federal **No Surprises Act** and **Hospital Price Transparency Rule**. The initial survey, **Implementation of The No Surprises Act Consumer Notifications Study**¹, also noted whether hospitals had posted information about their financial assistance policies.

This follow-up survey was conducted in the summer of 2025. THCC collected data from the websites of 108 hospitals across Tennessee. The survey evaluated the completeness of patient-facing information regarding (1) patients' rights to be protected from balance billing by out-of-network providers; (2) the ability of consumers to collect comparable cost information on shoppable hospital services, and (3) the accessibility and clarity of information about hospital financial assistance policies.

As illustrated by the figures on the following pages, THCC found that there were substantive improvements in the accessibility and completeness of information about the **No Surprises Act** protections from balance billing and the right of patients to receive advance notification of good faith estimates of the cost of elective care. Information about how an uninsured patient could dispute an excessive bill also increased. Information was, however, provided in multiple languages only 25% of the time.

The Price Transparency Rule requires hospitals to post the costs of common procedures in a consumer-friendly format to encourage consumers to shop for care. All but three hospitals complied. Ninety-six percent (96%) of hospitals chose a cost-estimator tool to convey pricing information. While the ease of using these tools also improved, the tools continued to include lengthy disclaimers that not all facility and provider costs might be included. They also revealed a wide variation in prices for the same procedure, even within a single hospital system.

Most hospitals provide some information about their **financial assistance policies** on their websites, as required by state and federal law, but the information varies in completeness and clarity about the eligibility criteria, the application processes differ, and there is a wide range in the amount of discounted care offered among hospital systems.

Recommendations include:

- **Enacting balance billing protections for ground ambulance services, a gap in the federal *No Surprises Act* that states need to fill.**
- **Providing quality of care data and standardizing pricing estimates so consumers can compare the full costs of needed services among hospitals.**
- **Identifying strategies to improve hospital financial assistance to medically-indigent Tennesseans and to mitigate their medical debt.**

¹ Tennessee Health Care Campaign (March 2024). *Implementation of The No Surprises Act Consumer Notification Study*. https://www.tnhealthcarecampaign.org/files/ugd/0f9062_1fdd82ec323741f7a6fd14b01af9e69d.pdf

BACKGROUND ON CONSUMER RIGHTS TO PROTECTIONS FROM SURPRISE BILLING, PRICE TRANSPARENCY AND FINANCIAL ASSISTANCE

PROTECTIONS FROM BALANCE BILLING

The ***Affordable Care and Patient Protection Act (ACA)*** in 2010 prohibited insurance companies from excluding coverage for pre-existing conditions, capped the percentage of insurance company administrative costs that could be covered by premiums, and helped subsidize the cost of health insurance for low and middle-income citizens and legal residents who were not insured through their employers. The ***ACA*** also enabled states to expand their Medicaid programs to all adult citizens and legal residents ages 19-64 earning under 100% of federal poverty guidelines, an option that Tennessee has not yet adopted for its TennCare program.

One issue that still plagued insured consumers was what came to be known as "surprise" medical bills. These surprise bills resulted from the way insurance companies structure their policies. Insurers negotiate discounted rates with in-network providers. Insurance plans also set a deductible amount that the enrollee needs to pay before the insurer starts to cover the cost of care. When the deductible is reached, insurers also charge a co-payment rate for services received from in-network providers, usually 10-40% of the negotiated or allowable price, depending on the terms of the policy. Co-payment rates for out-of-network providers in most insurance plans, if offered at all, are much higher, with enrollees needing to cover 50-80% of what the insurer pays. When out-of-network providers billed an insured patient, they would accept the allowable amount the insurer would pay them, but then also bill the patient the balance between what the insurer paid and the full undiscounted amount of their charges, a practice known as "balance billing." These surprise or balance bills occurred frequently in medical emergencies, when an ambulance—not knowing an injured person's insurance status—took a patient to a hospital that was out-of-network. Surprise bills also came from physicians who practiced at in-network hospitals but did not participate in the same insurance networks as the hospitals.

In 2020, the bipartisan ***No Surprises Act (NSA)***, championed by U.S. Senator Lamar Alexander of Tennessee and Senator Patty Murray of Washington, was passed to correct the balance-billing issue, especially in emergency cases. The ***NSA***, effective in January 2022, did the following:

- **Restricted the practice of surprise balance billing by out-of-network providers in emergency situations and when insured patients seek nonemergency care at in-network hospitals and ambulatory care facilities, and for air ambulance services.** Regulation of balance billing of ground ambulance services would be left up to the states.
- **Required insurers to update provider network information every 90 days and to honor the network information available to consumers at the time of service.** Insured patients would not be liable for out-of-network rates if a provider's status was incorrectly listed.

- **Established a right for patients to receive a good faith estimate of a patient's medical bills at least three days in advance of scheduled procedures.** Uninsured patients should already be receiving good faith estimates of costs for scheduled procedures from the hospitals three days in advance of the procedures. Although the **NSA** has been in effect for over five years, at the time of this report's publication, CMS has not yet released rules regarding providing estimates to insured patients. When that rulemaking is finalized, insured patients should receive Advanced Estimate of Benefits (AEOBS) from their insurance providers for scheduled procedures.
- **Created a federally-mediated procedure to resolve cost and coverage disputes between providers and insurers without involving the patient.** Uninsured patients now also have a right to contest their final bill if it exceeds the estimate by more than \$400 through a mediated dispute resolution process.

RIGHT TO PRICE TRANSPARENCY

The **ACA** also sought to provide consumers with better information about the costs of healthcare before they arranged elective procedures. It fostered improved price transparency to promote competition, helping to hold down the rising costs of healthcare. The **ACA** authorized the Centers for Medicare and Medicaid Services (CMS) to issue consumer-oriented regulations on hospital price transparency. It was not until November 2019 that CMS issued its initial **Hospital Price Transparency Rule (HPTTR)**, which became effective in January 2021.²

The rule initially required hospitals to post pricing information in two formats:

1. A machine-readable spreadsheet detailing the codes and charges for all billable services. Hospitals were required to list five elements of their pricing: the gross charges, the discounted cash prices (what a self-paying patient would be charged), the minimum and maximum negotiated prices with insurance carriers, and the specific negotiated charges with each in-network insurance carrier that contracted with that hospital.
2. A consumer-friendly list of the cost of 300 or more shoppable procedures to facilitate the consumer's ability to compare the costs of care among different hospitals that include the elements listed above. Hospitals were also allowed to use a cost-estimator tool that was specific to a patient's insurance coverage, which would provide an estimate of the cost under their coverage plan, but would not disclose the minimum and maximum charges.

In 2019, the Tennessee General Assembly also passed legislation on price transparency, the **Right to Shop Act**.³ This act facilitated the ability of insured consumers to shop for services by

² Centers for Medicare and Medicaid. (Accessed 5/22/2026). Hospital Price Transparency. <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency>

³ Tennessee General Assembly. (Accessed 4/2/2026). *The Tennessee Right to Shop Act*. <https://publications.tnsosfiles.com/acts/111/pub/pc0407.pdf>

requiring private insurance carriers to provide enrollees with information on provider costs *and* quality within their insurance networks. The act also enabled insurers to implement incentive programs to reward enrollees who chose lower-cost, high-quality healthcare providers within their networks.

RIGHT TO FINANCIAL ASSISTANCE

In exchange for not being taxed, nonprofit hospitals have long been expected to provide commensurate benefits to the communities they serve, often but not always in the form of charity care. The **ACA** required nonprofit hospitals to conduct community health needs assessments every three years to identify unmet health needs and to develop implementation strategies to address them. The **ACA** also required nonprofits to have financial assistance policies (FAPs) posted on their websites and within the hospitals. Those policies were required to include clear statements of eligibility criteria and of how costs of care will be calculated and discounted.

There is also a federal requirement that nonprofit hospitals use reasonable efforts to evaluate a patient's eligibility for financial assistance before pursuing collection procedures through third parties. Nonprofit hospitals, under federal law, cannot charge individuals eligible for financial assistance more than the "Amounts Generally Billed (AGB)" for emergencies or other medically-necessary care. Internal Revenue Service code 501(r) also requires nonprofit hospitals to:

- Give patients at least 240 days (about eight months) to apply after they get bills;
- Give patients chances to fix incomplete applications;
- Pause sending bills to collections while they are reviewing aid applications and
- Send patients letters with the final decisions and reasons.⁴

These federal requirements regarding FAPs do not apply to for-profit hospitals. Also, independent physician groups may bill separately and are not obligated to follow a given hospital's FAP. Tennessee state law (Tenn. Code Annotated (TCA) § 68-1-109(2) also requires hospitals to post concise statements of their charity-care policies and the factors the hospital considers in assessing a person's ability to pay.⁵ The code defines "medical indigence" as a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not necessarily limited to a defined percent of the Federal Poverty Guidelines. It also specifies that in determining indigency the provider should consider liabilities, income and expenses, only those assets convertible to cash and unnecessary for the patient's daily living, and extenuating circumstances that may impact the patient's financial status (TCA § 68-1-109(2)(A)(ii)).

⁴ Internal Revenue Service. (Accessed 4/10/2026). Section 501[®] reporting. <https://www.irs.gov/charities-non-profits/section-501r-reporting>

⁵ FindLaw. (Accessed 4/10/2026). Title 68: Health, Safety, and Environmental Protection. <https://codes.findlaw.com/tn/title-68-health-safety-and-environmental-protection/tn-code-sect-68-1-109.html>

Tennessee regulations also specify a limit (175% of the cost of the services) that uninsured patients, regardless of income, can be billed for services⁶.

KEY FINDINGS OF 2023 SURVEY

Health services researchers initially found poor consumer awareness about the **NSA** and poor compliance with the **Hospital Price Transparency Rule** in the first years of implementation.^{7,8} THCC chose in 2023 to participate in a national survey conducted by Families USA, a national non-profit health advocacy organization, to assess how well hospitals were complying with the **NSA** rights and hospital charges. Because at the time of our survey between 564,452 and 783,700 Tennesseans were estimated to be uninsured,⁹ THCC also chose to look at whether uninsured consumers had access to each hospital's **financial assistance policies (FAPs)**.

THCC's first survey, conducted between October 2023 and January 2024, included 105 general hospitals but did not include psychiatric hospitals, women's or children's hospitals, rehabilitation hospitals, or other specialty hospitals). THCC found:

- **While 90% of Tennessee hospitals did have some information about the NSA posted on websites, that information was difficult to find. Only 57% had the information clearly linked to websites on billing or pricing.**
- **When hospitals informed consumers about their right to a good faith estimate of the cost of nonemergency care, they were also told that uninsured patients had the right to dispute a bill that was more than \$400 over a good faith estimate only 65% of the time.**
- **Websites did not always inform consumers that they could contact the Tennessee Department of Commerce and Insurance (TDCI) with questions, or that TDCI provides mediation services for consumers who have problems with their insurers.**
- **Ninety-one percent (91%) of Tennessee hospitals complied with the Hospital Price Transparency Rule provision to post a link on the hospital's home page to a machine-readable file of charges and negotiated prices, as well as a consumer-friendly listing of 300 shoppable services.**
- **The most common consumer-friendly pricing format used was a patient cost-estimation tool, intended to streamline consumers' ability to shop for care. THCC**

⁶ Tennessee Department of Health. (Accessed 4/2/2026). <https://www.tn.gov/health/health-program-areas/statistics/health-data/jar.html>

⁷ Kirzinger A, Kearney A, Stokes M, Hamel L, Brodie M. (March 2022). Economic Concerns and Health Policy, The ACA, and Views of Long-term Care Facilities. *Kaiser Family Foundation*. <https://www.kff.org/health-costs/kff-health-tracking-poll-march-2022/>

⁸ Jiang JX, Krishnan R, Bai G. Price. (2023). Transparency in Hospitals—Current Research and Future Directions. *JAMA Net Open*. 6(1):e2249588.

⁹ Quittmeyer, R. (Oct. 2022). *Tennesseans Without Health Insurance*. Office of the Comptroller. <https://comptroller.tn.gov/content/dam/cot/orea/advancedsearch/2022/Tennesseanswithouthealthinsurancelegislativebrief.pdf>

found that these tools varied significantly in ease of use. Disclaimers indicated that some tools excluded certain costs, so it was difficult to compare prices between hospitals. There were large variations in charges to uninsured patients as well.

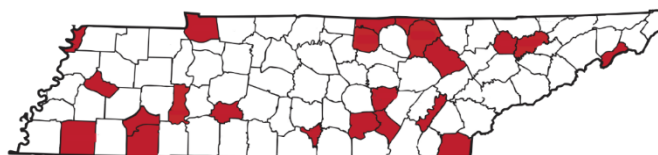
- **Most hospitals (88%) provided information about their financial-assistance policies on their websites. The policies appeared to differ substantially, but THCC’s initial survey did not explore this in detail.**

THCC hoped a second survey would show improvements in the accessibility and usefulness of information about protections from balance billing, the cost of care, and financial assistance and planned to repeat the survey in 2025. A 2024 poll by KFF found most Americans (78%) still knew little or nothing about their **NSA** consumer protections.¹⁰ THCC also hoped a second survey would increase consumers’ awareness of their rights to balance billing protections and to receive good faith estimates of the cost of their needed health services.

During the COVID pandemic, **ACA** Marketplace plan premium tax credits for low-income families were enhanced, and caps on premiums were extended to middle and high-income families. These enhancements enabled an additional 400,000 Tennesseans to enroll in **ACA** Marketplace plans between 2021 and 2025. Marketplace enrollment data for 2025 indicate that 95% of Tennesseans who were insured through **ACA** Marketplace plans earned less than 400% of the federal poverty level and relied on these subsidies. Failure to extend enhancements past 2025 are expected to result in increased numbers of uninsured Tennesseans, with some projections as high as 250,000. Another 24,000 TennCare enrollees may also lose coverage due to changes in verification procedures recently made.¹¹ These impacts make it even more important to understand how hospitals provide financial assistance, which the second survey examined in more detail.

In the second survey, THCC examined the websites of 108 hospitals across the state, including women’s hospitals. As in our first study, the current study did not cover children’s hospitals, psychiatric hospitals, or rehabilitation hospitals. THCC completed this survey in September 2025.

Figure 1. Map of Tennessee counties with (white) and without (red) a medical hospital as of December 2025. Prepared by Tennessee Health Care Campaign



¹⁰ Amin K, Pestaina K, Cox C. (March 2024). What resources are available for privately insured patients who get surprise balance bills? *Kaiser Family Foundation*. <https://www.kff.org/health-costs/what-resources-are-available-for-privately-insured-patients-who-get-surprise-balance-bills/>

¹¹ Burns A, Ortalicza J, Lo J, Rae M, Cox C. (August 2025). How Will The 2025 Reconciliation Law Affect The Uninsured Rate In Each State? *Kaiser Family Foundation*. <https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/>

KEY FINDINGS OF 2025 SURVEY

NO SURPRISES ACT (NSA)

Table 1 summarizes some of the improvements noted in how hospitals communicated information about the **NSA** to consumers. In 2025, hospitals were doing a more consistent job of prominently posting information on their websites about balance-billing protections, the costs of care, and the rights of uninsured patients to good faith estimates. In this second survey, we also investigated whether hospitals conveyed **NSA** information in languages other than English. Only 25% of hospitals did so.

Table 1. Sample Questions and Results for NSA Implementation, 2023-2025

SURVEY QUESTION	2023 Result	2025 Result
What percentage of hospitals posted any information about balance billing protections of the <i>No Surprises Act</i> on their billing information webpages?	57%	91%
What percentage of hospitals posted information about the right of uninsured patients to request resolution of a disputed bill if their charges were more than \$400 above a good faith estimate of the cost of their care?	65%	91%

Hospitals are required to post contact information for the Centers for Medicare and Medicaid (CMS) **No Surprises** help desk. The help desk is the entity an insured patient would contact if they received a bill from an out-of-network provider or an uninsured patient would contact to dispute a bill. In 2025, THCC researchers found that 93% of hospitals provided some form of CMS contact information for consumers with questions or complaints. Specifically, 85% of the hospitals provided both the phone number and website link for the help desk, 7% provided the phone number only, and 1% provided the website only.

THCC also examined whether hospitals posted information on how to contact the Tennessee Department of Commerce and Insurance (TDCI). While TDCI does not have an official role in dispute resolution regarding the amount an insurer pays out-of-network providers, it does have responsibility for informing consumers about the **NSA** and helping them navigate other issues with their insurance companies. If an insurance company denies a claim for services provided during a hospital stay for example, the TDCI Consumer Insurance Services Division can mediate between the consumer and the insurance company. In 2024, more than \$17.54 million in restitution was

paid back to consumers through TDCI's mediation and restitution efforts.¹² THCC found that only 73% of hospitals mentioned the role of TDCI in supporting consumers and provided information on how to contact the agency.

HOSPITAL PRICE TRANSPARENCY

In THCC's 2023 survey, conducted two years after the **Hospital Price Transparency Rule (HPTTR)** became effective, about 8.5% of hospitals had not yet incorporated price transparency information on their websites. In 2025, 99.5% of hospitals had a link to some price transparency information on their homepages, as required by the rule. The rule also stipulated that price information should be made available in two forms:

- (1) Machine-readable files listing hospital charges, as well as negotiated prices with insurers
- (2) Consumer-friendly formats such as lists or cost-estimator tools for at least 300 commonly-performed procedures.

As in our first survey, THCC found that much of the price transparency information provided remains difficult for most consumers to use. Nonetheless, there were improvements.

Machine-readable files were intended to provide transparency about the variation in pricing discounts negotiated by commercial insurance companies that contract with the hospitals for in-network services. They also disclose the rate that hospitals usually bill uninsured patients. Eighty-three percent (83%) of hospitals in THCC's second survey provided these files. These complex, large datasets were not intended for consumer use, but for analysis by entities such as health services researchers or large employers that provide coverage for their employees. However, these files reveal important insights into hospital billing practices for consumers.

Health researchers have found, for example, that the maximum price of a service charged to one commercial plan could be more than three times higher than the minimum price charged to another commercial plan in the same hospital. Researchers also found that while nearly half of hospitals provided a discounted rate to self-pay patients that was below the median charge to commercial payers, the remainder of hospitals charged self-pay patients more.¹³ Large corporate health systems have also been found to charge significantly more than smaller, independent hospitals, a practice thought to be driving the healthcare affordability crisis.¹⁴

¹² Tennessee Department of Commerce and Insurance. (2025, August 5). *TDCI: Over 47.9 million returned to Tennesseans so far in 2025*.

<https://www.tn.gov/commerce/news/2025/8/5/tdci--over--7-9-million--returned-to-tennesseans-so-far-in-2025.html>

¹³ Jiang JX, Krishnan R, Bai G. Price Transparency in Hospitals—Current Research and Future Directions. *JAMA New Open*. 2023;6(1):e2249588.

¹⁴ Tripoli SA, Camaliche A, Plotke A, Chang N. Big Systems, Bigger Profits: Consumers are Paying the Price of Corporate Hospital Power. Families USA. (May 2026). <https://familiesusa.org/resources/big-systems-bigger-profits-consumers-are-paying-the-price-of-corporate-hospital-power/>

Consumer-friendly listings for 300 common procedures were intended to enable consumers to shop for procedures they needed by providing information about what that care would cost before they scheduled procedures with a given hospital or provider. Hospitals could post a subset of their machine-readable file containing pricing for 300 of the most common procedures and services provided at their facility or provide a cost-estimator tool. These cost-estimator tools request information on whether a consumer is uninsured or insured. If insured, the tools ask for specifics about the insurance company and plan type, copayment rates and deductible status. The tools also often require detailed descriptions or codes for the treatment that will be needed. Between our first and second surveys, these tools became more accessible to potential patients and easier to use if those specifics could be provided. We were unable to find any information on consumer pricing for only three hospitals. In our latest survey, while some hospitals provided this consumer-friendly information in more than one format, 96% of the compliant hospitals were using cost-estimator tools to convey pricing information to consumers.

Table 2. Number of Applied Consumer-Friendly Price Estimator Tools

Consumer-friendly formats used	Number
Cost-estimator tool	101
Another format	40

While these estimator tools help insured consumers understand what portion of the cost of care they would be responsible for out of pocket, they do not provide the comparative information on prices negotiated with other major insurers that would be found in the listing format. All these tools also include often lengthy disclaimers to explain that the costs provided may not accurately reflect full facility or provider charges. Hospitals are increasingly contracting with, rather than employing, specialty physician practices, including emergency-room physicians; cardiologists; surgeons' radiologists and hospitalists, which may bill separately.¹⁵ Hospitals also may use disparate practices to determine service pricing, such as by the day, by the service or bundled payments to arrive at their costs, but these practices are not transparent to consumers. As noted earlier, CMS rule-making delays mean that as of the publication date of this report hospitals are not yet required to provide insured consumers a specific good faith estimate before receiving care. For these reasons it can still be difficult to accurately compare costs and shop for services, which is the stated purpose of price transparency efforts.

To illustrate this concern, we offer two examples. In THCC's 2023 survey, volunteers requested estimates for an uninsured patient seeking information on the costs of the standard Current Procedural Terminology (CPT) code for "knee arthroscopy with meniscus surgery" [CPT Code 29881] from seven randomly-selected hospitals. One hospital made the cost-estimator tool

¹⁵ Rosenthal, E. (2025, July 18). Surprise Medical Bills Were Supposed To Be A Thing of the Past. Surprise—They're Not. *KFF Health News*. <https://kffhealthnews.org/news/article/no-surprises-act-bills-keep-coming-health-insurance-cms-networks-emergency-care/>

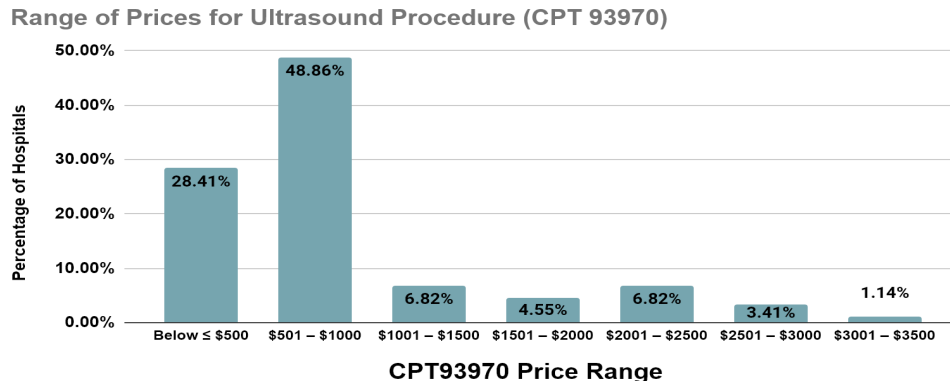
available only to already-registered patients. Two hospitals required that consumers speak with someone in the finance office before being provided with the estimate. A third hospital did not have knee surgery listed among its searchable procedures. As shown in Table 3, for the four remaining hospitals, THCC volunteers found disparate prices ranging from \$2,912 to \$39,880, with self-pay patient discounts ranging from 0% to 75%.

Table 3. Prices for Knee Arthroscopy with Meniscus Surgery (CPT 29881) in 2023

Knee Arthroscopy with Meniscus Surgery (CPT 29881)	Hospital A	Hospital B	Hospital C	Hospital D
Total Cost	\$39,880.00	\$26,369.00	\$17,243.00	\$2,912.00
Self-pay discount	\$27,118.00	None noted	\$12,932.00	\$1,340.00
Patient cost estimate	\$12,762.00	\$26,369.00	\$4,310.00	\$1,572.00

In THCC’s 2025 survey, researchers selected the cost of a common diagnostic procedure — a complete bilateral duplex scan of extremity veins for an uninsured patient with CPT Code 93970 — and surveyed each hospital to compare what an uninsured consumer would be billed. Twenty hospitals did not include this procedure in their shoppable lists. The variation in pricing for a self-pay patient among the remaining hospitals for the same procedure is shown in Figure 2. Estimated costs ranged from a low of \$227 to a high of \$3,488.

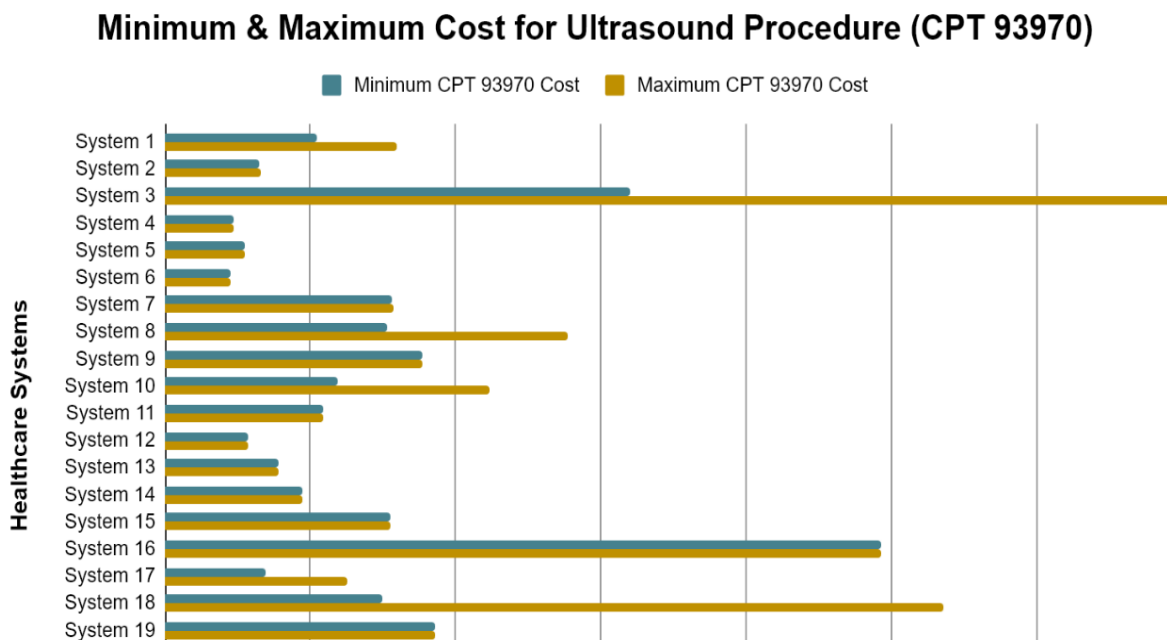
Figure 2. Range of Prices for Ultrasound Procedure (CPT 93970)



We also looked at whether the prices charged to uninsured patients for this selected procedure varied *within* the 20 major hospital systems that now own and/or operate most hospitals in Tennessee. The price of this procedure was consistent within half of the systems (10) but varied within the other half. As shown in Figure 3, prices ranged from \$750 to \$2,681 in one hospital system and from \$1,603 to \$3,488 in another. It was unclear whether the discrepancies were due to differences in self-pay patient discounts, the type of instrumentation used in the procedures, network status of technicians doing the procedure and physicians interpreting the results, or something else, but the differences were greater than expected.

Our study is not the only one to find large variations in the cost of care among Tennessee hospitals. Two additional studies of Tennessee hospital compliance with the **HPTR** were recently published in peer-reviewed journals. The researchers found considerable variability in the pricing of diagnostic testing, as well as problems with compliance with specifics of the rule, which our survey did not examine.¹⁶ A second article by the same authors confirmed wide pricing variability in laboratory tests as well and identified correlating factors that might explain the differences¹⁷, including regional economic factors and for-profit versus nonprofit status. The National Academy for State Health Policy (NASHP) has recently released a Hospital Cost Tool Dashboard to provide state policymakers and researchers with analytical insights into how much hospitals spend on patient care services, and how such costs relate to the hospital charges (list prices) and actual prices paid by health plans¹⁸. The dashboard reports a range of cost-to-charge percentages from a low of 90% for a county-owned rural hospital to 1300% for an urban for-profit hospital in Tennessee.

Figure 3. Minimum and maximum cost for ultrasound procedure CPT 93970 within major health systems. These findings are based on cost-estimator tools sampled in August 2025. Health



¹⁶ Hart SA, Khan A, Booth GS, Wiencek JR. (November 2024). Tennessee hospital noncompliance with price transparency legislation for eight common laboratory tests. *Am J Clin Pathol.* 162(5):450-454.
<https://pubmed.ncbi.nlm.nih.gov/38733607/>.

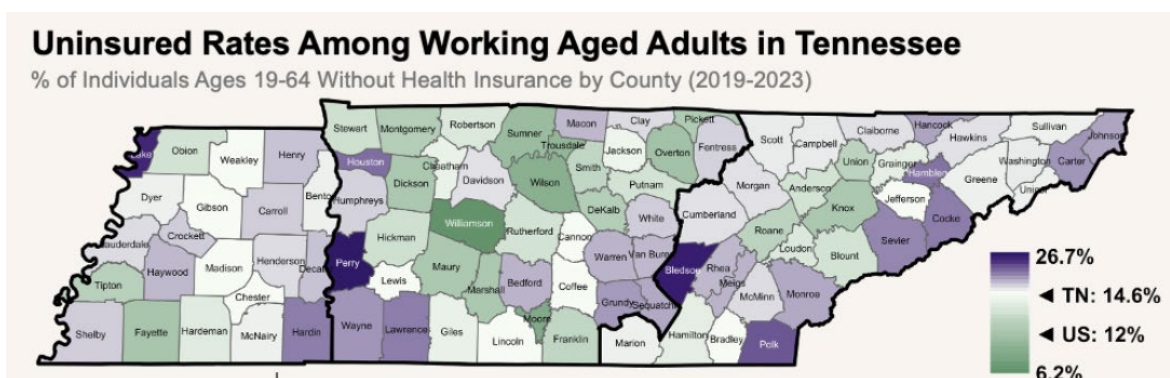
¹⁷ Hart SA, Khan A, Booth GS, Wiencek JR. (May 2025). Price Variability of Eight Common Laboratory Tests across All Licensed Tennessee Hospitals, *Journal of Applied Laboratory Medicine*, Volume 10, Issue 3: 731–737.
<https://doi.org/10.1093/jalm/jfae167>.

¹⁸ National Academy for State Health Policy. (Accessed 4/17/2026) Hospital cost Tool Dashboard.
<https://tool.nashp.org/>

FINANCIAL ASSISTANCE POLICIES (FAPs)

In 2024, The Sycamore Institute estimated that 690,000 Tennesseans were uninsured, with the uninsured rate varying by income, as illustrated in the chart below.¹⁹ Of these, at least 95,000 were in the coverage gap created by the state's failure to extend Medicaid to all adults earning under 138% of the federal poverty level (FPL), an expansion enabled by the **ACA** since 2014.²⁰ As noted above, due to recent federal policy changes affecting Marketplace plans, Medicare and Medicaid, it is expected that several hundred thousand more Tennesseans may become uninsured.

Figure 4. Tennessee's uninsured rate by county.
[2023 Income, Poverty, Health Insurance Coverage, and Education in Tennessee's 95 Counties <https://sycamoretn.org/2023-income-poverty-insurance-education/>]



People without health insurance are more likely to forgo preventive care and chronic disease management for conditions that require medical specialists. When uninsured people do seek care, they are more often seeking care for an urgent or emergent condition requiring hospitalization. Delays can result in a higher burden of medical debt for families and add to hospitals' uncompensated care costs. High rates of uncompensated care are a key factor motivating hospitals to increase charges for insured patients, to close relatively unprofitable lines of care (e.g., obstetric care) or to close altogether.

THCC found that 10 hospitals in our survey did not have an FAP posted. Another 16 hospitals did not specify an income limit for financial assistance eligibility on their websites. While some hospitals evaluate financial need on a case-by-case basis, most hospitals use some percentage of the federal poverty level (FPL) to determine eligibility for charity or discounted care, although other

¹⁹ 2024 Census Data on Education, Income, Health Insurance, and Housing in Tennessee https://sycamoretn.org/2025-income-poverty-insurance/?utm_source=newsletter&utm_medium=email&utm_content=%20U.S.%20Census%20data&utm_campaign=scoop. (Accessed 10/27/25).

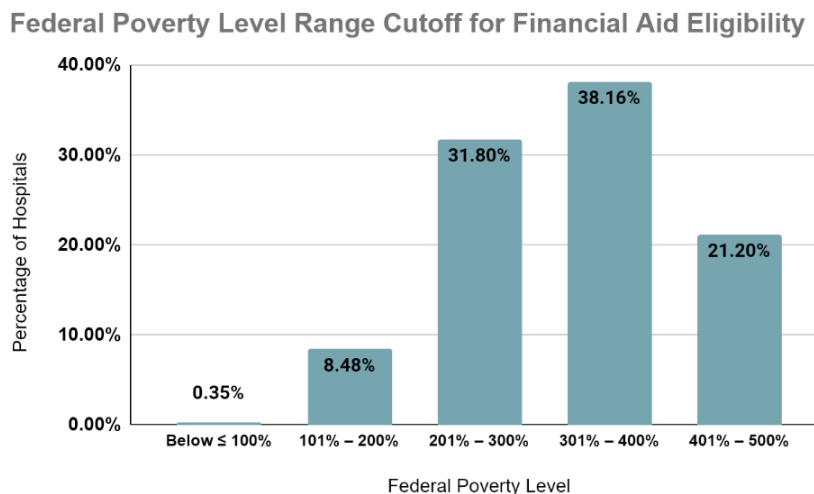
²⁰ Center for Budget and Policy Priorities. (Accessed 3/13/2026). The Medicaid Coverage Gap in Tennessee. <https://www.cbpp.org/sites/default/files/4-3-24health-factsheet-tn.pdf>

metrics are available that may be more accurate. For example, ALICE (Asset Limited, Income Constrained, Employed) is used by United Ways across the country. In 2023, based on the Federal Poverty Level (FPL), 14% of Tennessee households were living in poverty. According to the ALICE measure, in that same year, 44% of Tennessee households were deemed financially insecure.²¹

Nearly all hospitals—nonprofit and for-profit —provide full charity care to patients below 100% of the FPL who are not otherwise eligible for Medicaid, Medicare or other federal benefits. However, several hospital systems provide full charity care up to 250%-300% of the FPL. Several FAPs also consider the actual cost of emergency and medically necessary care relative to a patient’s yearly household income and provide charity care for catastrophic expenses, regardless of FPL status.

Hospital FAPs usually also apply discounts on a sliding scale for uninsured patients not eligible for charity care, up to an income cutoff that varies between 200%-500% of the FPL, as shown in Figure 5. The sliding scales differ across hospitals. (For example, one hospital might offer a 40% discount to people earning between 300% and 400% of the FPL, whereas another hospital might offer a 20% discount.) Since baseline hospital charges for the same procedure can vary significantly among hospitals, with one hospital charging a self-pay patient two to three times what another hospital might charge before any discounts are applied, it is difficult to compare the relative value of FAPs without a more in-depth review.

Figure 5. Upper limit of FPL range for financial assistance



²¹United Ways of Tennessee. (Accessed 1/23/26) Do You Know Alice? <https://www.uwtn.org/alice>

DISCUSSION

Given the anticipated rise in the number of uninsured in coming years, as well as the increases in premiums, deductibles and out-of-pocket maximums that are being predicted for insured Americans, it is increasingly important that our state make every effort it can to protect Tennesseans from all surprise medical bills, increase the ability of all healthcare consumers (insured, underinsured, and uninsured) to find affordable, quality care, and minimize the impact of medical indigency and medical debt.

In terms of minimizing surprise medical bills, THCC realizes that posting consumer protection information on websites alone does not guarantee that consumers will review this information before arranging their care. The **NSA** requires hospitals to document that they provide good faith estimates to *uninsured* patients before scheduled procedures. However, as noted above, CMS has not yet established the start date for providing Advanced Explanation of Benefits with cost estimates to *insured* patients. Our Congressional delegation should use its influence with CMS to accelerate that process.

Another piece of unfinished business under the **NSA** is the regulation of balance billing by out-of-network ground ambulance services. Although air ambulance services are prohibited from balance billing by the federal legislation, Congress could not reach consensus on how to deal with ground ambulance services. Emergency Medical Services (EMS) have traditionally been developed and coordinated at the local county level with oversight and regulation by states. While EMS services were originally considered a public service, like fire or police protection, these services are now provided by a mix of public, private, nonprofit and for-profit providers, and regulations vary state to state. The **NSA** established the Advisory Committee on Ground Ambulances and Patient Billing to make recommendations on how to extend balance billing protections to ground ambulances. The committee issued its recommendations in 2024.²² The committee recommended that Congress establish guidelines to cap patient copayment amounts and establish reasonable reimbursement rates for use by self-financed employer-based health insurance coverage (ERISA) plans and encouraged states to move forward with similar guidance for insurance plans regulated by state insurance agencies.

To date, 22 states have passed regulations to fill this gap.²³ During the 114th Tennessee General Assembly (2025-2026), legislation prohibiting balance billing by ground ambulances for both emergency transport to a hospital and transfers between hospitals for medically-necessary interventions was proposed. The bill passed unanimously in the state House of Representatives

²² Ground Ambulance and Patient Billing Advisory Committee. (2024, March 24). Report on Prevention of Out-of-Network Ground Ambulance Emergency Services Balance Billing. <https://www.cms.gov/files/document/report-advisory-committee-ground-ambulance-and-patient-billing.pdf>

²³ Harden-Stein, M. (2026, February 5). Expanding the No Surprises Act to Protect Consumers from Surprise Ambulance Bills: Map of State Laws. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/maps-and-interactives/expanding-no-surprises-act-protect-consumers-surprise-ambulance>

but failed in the Senate Commerce and Labor Committee due in part to objections from insurers. It is our hope that this legislation will be reintroduced in 2027.

While compliance with the posting requirements of the **Hospital Price Transparency Rule** is improving, our study shows that, given the variation in hospital methods and the caveats associated with the estimates being provided to consumers, the ability to comparison shop is still very questionable. The Patient Rights Advocacy organization has aggregated hospital pricing website links from every state on a dashboard to make it easier for consumers to access and compare.²⁴ Several states (Colorado; Indiana; Nevada; Ohio and Oklahoma) also aggregate the data from all the hospitals in their state and have created online tools that make price comparisons among hospitals easier.

The cost of care is an ongoing and growing concern, but it is not the only factor consumers consider in choosing a source of care. A Tennessee Advisory Commission on Intergovernmental Relations (TACIR) study commissioned in support of the **Tennessee Right to Shop Act of 2019** affirms that patients' relationships with their doctors, and the perceived quality of providers and services, are as important as cost.²⁵ The **Right to Shop Act** requires insurance carriers to implement programs that enable enrollees to compare the costs and *quality* of care from different providers. However, it does not address how to provide quality of care information to uninsured Tennesseans.

While consumers may associate higher prices with higher quality for many goods and services, health services research studies have found that this is not always the case with healthcare. Medicare has tracked indicators of hospital healthcare quality on its Healthcare Quality Initiative website for decades and created a star rating system based on outcome data. These indicators include complication rates during hospitalization, readmission rates after discharge, nursing staffing ratios, condition-specific outcomes and patient satisfaction surveys.²⁶ *U.S. News & World Report* has used this data for decades to rank hospitals by quality of care in its annual "Best Hospitals" edition.²⁷ In the interest of quality transparency, hospitals could also provide links or information about quality indicators on their websites so that potential patients can take these factors into account when planning care.

The notion of comparative shopping for healthcare also assumes that insured consumers have choices of conveniently located hospitals within their health insurance networks, but that is not always the case for Tennesseans. Our state has seen the highest rate of hospital closures per population in the nation²⁸. The Center for Health Care Quality and Payment Reform's January 2026

²⁴ PatientRightsAdvocate.org. (Accessed 4/17/26). Hospital Price Files Finder. <https://hospitalpricingfiles.org/>.

²⁵ Tennessee Advisory Commission on Intergovernmental Relations. (December 2020). Cost Savings of Right to Shop Programs. https://www.tn.gov/content/dam/tn/tacir/2020publications/2020_RightToShop.pdf

²⁶ Centers for Medicare and Medicaid. (Accessed 4/17/26). Find & compare providers near you. <https://www.medicare.gov/care-compare/>.

²⁷ US News & World Report. (Accessed 4/17/26). Best Hospitals. <https://health.usnews.com/best-hospitals>

²⁸ Tennessee Health Care Campaign. (March 2021). *Rural Hospital Closures*. https://63841a6a-3be1-4bfe-9a63-aa1fdb00c66b.filesusr.com/ugd/0f9062_d2c5a097a9124ffc84ee29b28200e975.pdf

report on rural hospitals at risk of closure indicates that another 13 of Tennessee's rural hospitals are at immediate risk of closure.²⁹ In an effort to stay open, some hospitals have had to close necessary but not always profitable service lines. At the time of this report there are 19 counties in our state without any hospital or emergency room, and 30 counties lacking obstetrical providers. Tennessee is also addressing provider shortages that exist in mental health and dental care.

Commercial health insurers are offering increasingly more narrow provider networks in efforts claimed to lower costs in both employer and individual coverage markets. Consolidation among hospital systems and among insurance companies is further limiting consumer choices in many areas of our state. For example, there is only one healthcare system operating in 8 northeast Tennessee counties.³⁰ Only seniors enrolled in standard Medicare plans currently have access to unrestricted networks of providers. While not the focus of this report, it is important that state government continues to evaluate the network adequacy of insurance coverage being offered by commercial insurers and provide incentives to providers to locate in areas of need.

Given the anticipated increase in uninsured in coming years, Tennessee should also evaluate strategies to improve hospital **financial assistance policies** and to alleviate medical debt. Even with steep discounts, uninsured families and insured families with high-deductible plans struggle to pay their bills after hospitalization. The resulting medical debt not only impacts a family's credit report rating, which can reduce their ability to obtain loans for homes or business and, in some cases, limit career advancement, but also deters many families from seeking further medical care. Before the COVID-19 pandemic, approximately one in four Tennessee households (24%) had some level of medical debt on their credit reports, ranging from 10% in wealthier counties to 43% in economically-distressed counties.³¹ Just recently, a national charity, Undue Medical Debt, took the extraordinary step of purchasing \$1.2 million in medical debt on behalf of 73,000 of the most indebted Tennesseans.³² Nevertheless, substantial medical debt remains, and will continue to threaten uninsured and underinsured families. A 2025 survey of over 1,300 Tennesseans conducted by the HealthCare Value Hub found that 74% experienced at least one healthcare affordability burden in the past year, 76% worry about affording healthcare in the future, and 72% delayed or went without healthcare due to cost concerns in the past year.³³

²⁹ Center for Healthcare Quality & Payment Reform. (January 2026). Rural Hospitals at Risk of Closure. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

³⁰ Kelman, B. (June 3, 2025). Ballard Health Hospital Monopoly Underperformed. Then Tennessee Lowered the Bar. *KFF Health News*. <https://kffhealthnews.org/news/article/ballad-health-copa-hospital-monopoly-underperformed-tennessee-lowered-standards-public-health-benefit-appalachia/>

³¹ Spears, M and Melton C. (May 2019). Medical Debt in Tennessee: Who Has It and Why Does It Matter? The Sycamore Institute. <https://sycamoretn.org/medical-debt-tennessee/>

³² Warren, B. (August 14, 2025). This nonprofit is wiping medical debt for 73K Tennesseans. Here's How. *The Tennessean*. https://www.tennessean.com/story/news/health/2025/08/14/undue-nonprofit-tennessee-medical-debt/85528190007/?gnt-cfr=1&gca-cat=p&gca-uir=false&gca-epti=z115346p119250c119250u003846e009300v115346&gca-ft=257&gca-ds=sophi&sltsgmt=0154_E

³³ Healthcare Value Hub. (2025). Tennessee Consumer Healthcare Experience State Survey. *Altarum's Healthcare Value Hub. Tennessee – Healthcare Value Hub*

Strategies for mitigating medical debt need to be pursued at the federal and state level. The outgoing Biden administration issued a federal rule in early January 2025 that would have prevented credit-rating agencies from including medical debt in consumer credit ratings, but it was rescinded by the current administration before it was implemented.

Many states are also seeking approaches to control future medical debt. These include:

- Setting a requirement that all hospitals (not just nonprofits) provide financial assistance to uninsured patients with low incomes (e.g. between 250% to 500% of the FPL).
- Limiting what uninsured patients can be charged to the Medicaid payment rate in that state, to the standard Medicare reimbursement rate, or to the lowest negotiated commercial rate, rather than to a percentage of a hospital's charge.
- Requiring hospitals to offer financial assistance to both insured and uninsured patients if their out-of-pocket expenses exceed a percentage (e.g. 10%) of their household income.

Several states have also taken legislative steps to reduce the impact of existing medical debt on their residents. For example, North Carolina, which recently expanded its Medicaid program to cover all adults earning under 138% of the FPL, is also incentivizing hospitals to forgive the patient debt remaining on its books in return for higher Medicaid reimbursement rates. Other state strategies include limiting the amount of debt collected monthly to a reasonable percentage of a household's income (e.g., 2-4%), prohibiting hospitals from sending medical debt to collection agencies, and preventing medical debt from impacting a patient's credit rating.³⁴

Negotiating debt payments is complex, and many families may need technical help to navigate it. Hospitals should make their patients aware of resources that are available. For example, Hamilton County General Sessions Court is piloting an online medical portal to aid consumers in resolving medical debt issues outside of the legal system.³⁵ A listing of additional resources that may be helpful to families in negotiating medical debt was compiled by the Tennessee Justice Center³⁶. THCC is also currently partnering with Undue Medical Debt and organizations in Tennessee counties to raise funds to excuse additional medical debt for their low-income residents.³⁷

³⁴ Spears, M. (October 2019). Medical Debt in Tennessee: 12 Options for State Policy Makers. <https://sycamoretn.org/medical-debt-policy-options/>

³⁵ Hamilton County General Sessions Court. (Accessed May 2, 2026) Online Medical Debt Resolution. <https://cii2.courtinnovations.com/TNMEDEBT>

³⁶ Tennessee Justice Center. (Accessed May 2, 2026) Medical Debt Help. <https://www.tnjustice.org/medical-debt>

³⁷ Tennessee Health Care Campaign <https://www.tnhealthcarecampaign.org/>

RECOMMENDATIONS

While many of the issues discussed in this report need to be addressed at the federal level, the recommendations below can be considered by our state legislature or enacted voluntarily by hospital systems.

- **Enact legislation to extend balance-billing protections to ground ambulance services.**
- **Increase access to affordable health insurance coverage for low-income Tennesseans not currently eligible for TennCare.**
- **Define statewide expectations for charity care, discounted care, and overall community benefit that hospitals operating in our state should provide their communities.**
- **Evaluate whether TennCare reimbursement and state-directed payments to hospitals providing uncompensated care are fair and adequate.**
- **Implement strategies to mitigate the impact of medical debt on families.**
- **Improve hospital price transparency by standardizing cost-estimator tools and aggregating Tennessee hospital pricing data to facilitate cost comparisons**
- **Provide written information about hospital financial assistance policies to patients with billing statements and about medical debt negotiation services to patients behind in payments.**
- **Provide access to Medicare quality-of-care metrics on hospital websites.**
- **Provide information about the role of the Tennessee Department of Commerce and Insurance (TDCI) in providing mediation for consumers experiencing problems with their insurance coverage on hospital websites.**

If you are interested in learning more about THCC's work or have a story to share about your own experiences obtaining affordable care in Tennessee, please reach out to THCC staff at info@tnhealthcarecampaign.org.