CHEAT SHEET

for health plans and payers

The Transparency in Coverage Rule

What US health plan leaders need to know about compliance

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Key takeaways

- On October 29, 2020, CMS finalized its transparency rule for payers, expanding on its push toward increased competition and consumerism across the health care industry in the hopes of driving down costs.
- Payers are required to publish negotiated rates with providers and pharmacies and out-of-network charges by July 1, 2022, and create an online cost-sharing estimation tool for members by January 1, 2023.
- Payers should expect that the rule will have implications regarding rate negotiations, payer-consumer relations, and market disruption from newly available information.

What is it?

CMS finalized a suite of policies at the end of 2020 in the latest iteration of its push toward greater transparency in health care. On October 29, 2020, CMS finalized its Transparency in Coverage Rule for payers. This complements the Hospital Price Transparency Rule requiring providers to disclose payer-identified negotiated rates. Payers will have to create out-of-pocket cost estimator tools for their members and publish negotiated rates with providers and pharmacies.

By equipping patients with pricing and quality information, CMS hopes to create a marketplace for services where patients can "shop" for high-value, low-cost care. With access to personalized out-of-pocket estimates for covered procedures, health plan members can make more informed choices and better plan their medical spending. Additionally, CMS amended medical loss ratio calculations, allowing payers to classify "shared savings payments," or incentive payments to members who select lower-cost providers, as medical expenses.

CMS intends for other stakeholders, including payers, providers, and third parties, to use and analyze pricing data as well. By requiring this information be publicly available in machine-readable files, CMS hopes to even the playing field during payer-provider negotiations and shift leverage away from large plans and health systems. However, It's unclear whether the rule's intended effects of increasing competition during rate negotiation and boosting consumerism in the market will drive down health care costs as proponents of price transparency predict. Stakeholders across the industry have argued that rate transparency, rather than lowering prices, will increase costs across the health care system by creating a pricing floor for services. By driving up the rates that providers want from payers, the transparency rule may limit payers' ability to negotiate for lower rates in their provider networks.

Why does it matter?

This new rule from CMS for transparency from payers, coming out concurrently with a similar rule for hospitals, aims to help consumers choose services at least partly based on transparent prices. However, both payers and providers have been outspoken in their opposition to these transparency rules, and payers have raised concerns about the impacts of this rule on the future of the industry.

Concerns from Payers

Technological compliance may require substantial initial investment.

To disclose their prices to consumers, payers will need to collate data from a variety of different internal systems. Maintenance of and updates to these systems working together will require plans' time, staff, and funding.

Public disclosure of rates may transform rate negotiations.

With payer-specific negotiated rates being published, providers will have access to in-network rates, out-of-network rates, and initial provider charges to payers. This new information may prompt a shift in what metrics are evaluated when negotiating payer-provider contracts. Depending on which players hold more negotiating power in certain markets, revised negotiation tactics can lead to demands for rate changes. Anticipating these new strategies may not be enough to maintain previously established leverage when restructuring contracts.

Market disruptors may hinder tactics to improve member guidance.

Under the new rule, payers can incentivize members to choose low-cost, high-value care through shared savings payments and count these payments towards their medical loss ratio (MLR). However, while payers can take advantage of the revised MLR formula to improve member decisions, technology vendors looking to take foothold in the health industry may disrupt this relationship. These disruptors may be able to mine the data publicly released by payers and repackage it to market directly to consumers. If apps can deliver a favorable user experience to members, they may jeopardize payers' role in member engagement.

How does it work?

Payers must comply with the new rule through two main requirements:

1) Publishing three machine-readable files containing negotiated rates with providers
2) Implementing an online self-service tool providing cost-sharing estimates to consumers

The table below describes the three separate machine-readable files that payers must publicly release by July 1, 2022, as dictated by the first requirement. CMS will delay enforcement of the prescription drug file until it issues further rulemaking.

In-Network Rate File	Allowed Amount File	Prescription Drug File
Negotiated rates for in-network providers	Historical payments to and charges from out-of-network providers	Negotiated rates and historical net prices for in-network prescription drugs

All three files must include names and identifiers of each coverage option and billing codes, and each file must be updated monthly.

Payers also must provide cost-sharing estimates at the request of an enrollee through an online self-service tool or in paper form at consumer request beginning January 1, 2023. The estimates should include personalized out-of-pocket costs and underlying negotiated rates for all covered items and services, including prescriptions. The online tool must also be a searchable platform allowing consumers to find negotiated rates for 500 “shoppable” services selected by CMS. The tool must provide real-time cost-sharing data and allow the consumer to search results by billing code, descriptive term, and provider identity. Consumers should be able to refine results by geographic proximity to in-network providers and the amount of cost-sharing liability.

Conversations you should be having

01 Evaluate whether your current technology strategy includes a plan for the data overhaul that compliance will require.

02 Determine whether you will partner with a vendor to ensure clinical and pricing data complies with CMS requirements.

03 Establish a communication strategy to engage with members on what information and services will become available to them after the July 1, 2021, deadline.

04 Anticipate how providers in your network will use newly available information during rate negotiations.

05 Consider how third-party apps will analyze and display pricing information and what effects they will have on your member engagement strategy and larger business goals.

These conversations will help payers amend their strategies to meet compliance deadlines and prepare for potential impacts on the market.

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