Fact sheet

Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F)

Oct 29, 2020 Affordable Care Act, Policy, Quality

The Transparency in Coverage final rule released today by the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments) delivers on President Trump's executive order on Improving Price and Quality Transparency in American Healthcare to Put Patients First.[1] This final rule is a historic step toward putting health care price information in the hands of consumers and other stakeholders, advancing the Administration's goal to ensure consumers are empowered with the critical information they need to make informed health care decisions.

The requirements in this rule will give consumers the tools needed to access pricing information through their health plans. This rule builds upon previous actions the Administration has taken to increase price transparency by giving patients access to hospital pricing information. The Administration has already finalized requirements for hospitals to disclose their standard charges, including negotiated rates with third-party payers. The requirements in the Transparency in Coverage final rule will reduce the secrecy behind health care pricing with the goal of bringing greater competition to the private health care industry.

For too long, Americans have been in the dark about the cost of their health care until after they obtain services and receive a bill. This rule will require most group health plans, and health insurance issuers in the group and individual market to disclose price and cost-sharing information to participants, beneficiaries, and enrollees. The Departments are finalizing a requirement to give consumers real-time, personalized access to cost-sharing information, including an estimate of their cost-sharing liability, through an internet based self-service tool. This requirement will empower consumers to shop and compare costs between specific providers before receiving care. Through this final rule, plans and issuers will also be required to disclose on a public website their in-network negotiated rates, billed charges and allowed amounts paid for out-of-network providers, and the negotiated rate and historical net price for prescription drugs. Making this information available to the public will drive innovation, support informed, price-conscious decision-making, and promote competition in the health care industry.

Making Health Care Price Information Accessible for Consumers

This final rule includes two approaches to make health care price information accessible to consumers and other stakeholders, allowing for easy comparison-shopping.

- First, most non-grandfathered group health plans[2] and health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make available to participants, beneficiaries and enrollees (or their authorized representative) personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request. For the first time, most consumers will be able to get real-time and accurate estimates of their cost-sharing liability for health care items and services from different providers in real time, allowing them to both understand how costs for covered health care items and services are determined by their plan, and also shop and compare health care costs before receiving care. An initial list of 500 shoppable services as determined by the Departments will be required to be available via the internet based self-service tool for plan years that begin on or after January 1, 2023. The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.
- Second, most non-grandfathered group health plans or health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers, three separate machine-readable files that include detailed pricing information. The first file will show negotiated rates for all covered items and services between the plan or issuer and in-network providers. The second file will show both the historical payments to, and billed charges from, out-of-network providers. Historical payments must have a minimum of twenty entries in order to protect consumer privacy. And finally, the third file will detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level. Plans and issuers will display these data files in a standardized format and will provide monthly updates. This data will provide opportunities for detailed research studies, data analysis, and offer third party developers and innovators the ability to create private sector solutions to help drive additional price comparison and consumerism in the health care market. These files are required to be made public for plan years that begin on or after January 1, 2022.

In this rule, HHS will also allow issuers that empower and incentivize consumers through plans that include provisions encouraging consumers to shop for services from lower-cost, higher-value providers, and that share the resulting savings with consumers, to take credit for such “shared savings” payments in their medical loss ratio (MLR) calculations. HHS will allow this to ensure that issuers would not be required to pay MLR rebates based on a plan

allow this to ensure that issuers would not be required to pay MLR rebates based on a plan design that would provide a benefit to consumers that is not currently captured in any existing MLR revenue or expense category. HHS believes this change will preserve the statutorily-required value that consumers receive for coverage under the MLR program, while encouraging issuers to offer new or different value-based plan designs that support competition and consumer engagement in the healthcare market.

The final rule can be found here: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf

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[1] https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

[2] Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of PPACA, and that are only subject to certain provisions of PPACA, as long as they maintain status as grandfathered health plans under the applicable rules. Under section 1251 of PPACA, section 2715A of the PHS Act does not apply to grandfathered health plans. This rule would not apply to grandfathered health plans (as defined in 26 CFR 54.9815-1251, 29 CFR 2590.715-1251, 45 CFR 147.140).