Turquoise Health

Price *Transparency* Impact Report

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2025

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Foreword

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In our first Impact Report in 2022, we predicted that the initial phase of price transparency adoption would be a five-year journey. Now, in that fifth year, it feels like the appropriate time to take stock. Price transparency reporting has reached near-universal levels. What once felt like a bold experiment has matured into a core component of the healthcare billing industry and served as the foundation of a new ecosystem. The same payers and providers that were once reluctant to participate now rely on transparency data as an essential tool for negotiation and market intelligence.

In many ways, 2025 has been the most active year yet in the short history of price transparency regulation. From the Executive Order in February to hospital schema updates in July and payer schema updates in October, the government has acted with renewed vigor. Price transparency has entered a new phase of maturation, with recent regulatory updates focused on improving the accuracy and reliability of data. The conversation has evolved from “Can we make price transparency happen?” to “How accurate can we make it?”

With baseline compliance now nearly universal, our focus has shifted to raising the data quality and utility. At Turquoise, we are publishing our detailed Payer Transparency Scores for the first time, revealing which payer files are complete and which fall short. We are encouraged to see that many of the large payers are already doing an excellent job of reporting, but work remains in some areas. Reporting on data quality is complex, and our approach will continue to evolve. This is an area where we welcome collaboration and feedback from across the industry as we all work toward accurate, actionable pricing data for patients.

It’s not just regulators who have been busy. For our data engineering team, 2025 has also been our most consequential year. The question we hear most often about price transparency data is “How do I know if the rates are accurate?” We’ve built a system called Clear Rates that finally answers that question. Clear Rates integrates payer and hospital transparency data with claims data, Medicare benchmarks, and other reference sources. Through statistical evaluation across these datasets, we can determine the most trustworthy price for any healthcare service. This approach lets us fill in gaps and flag inaccurate rates. Every data point is fully traceable to the sources, and all of our calculations are visible to the user.

Despite the progress, the impact of price transparency has been a two-sided story. The industry now depends on this data, yet patients have not felt the same level of direct benefit. Our mission is to eliminate the financial complexity of healthcare. That means every patient should have instant access to guaranteed pricing of their entire bill. Simple estimates of billing codes aren't enough. The burden of creating a shoppable healthcare experience was never intended to become patients' responsibility.

As we enter this next phase of price transparency, we are refocusing on the patient. Much progress has been made, and more is on the way, but patients need to see that progress firsthand. The regulation has provided the framework to deliver patient-centered, simple, upfront pricing, and now it's time to deliver it.

Transparently yours,

Adam Geitgey
Co-Founder & CTO, Turquoise Health

01

The *2025* Legislative Landscape

As we near the five year mark of the publication of the first wave of hospital machine-readable files (MRFs), it remains evident that price transparency is incredibly important. There are more entities than ever before reporting on MRF data quality, completeness, and accuracy. The push to transform price transparency data into something usable for patients as consumers continues and is bolstered by legislative backing.

And despite some policy clunkiness, which we'll go into more detail on further on in the report, there seems to be industry alignment that MRF data in a vacuum is not sufficiently making prices more transparent until patients can reasonably understand the cost of shoppable care upfront, without needing a PhD in the revenue cycle or claims processing. Calls for improved accountability and enforcement of entities publishing MRFs come from all corners of the industry. It's an exciting time to be focused on eliminating the financial complexity of healthcare!

Hospital Rules and Laws

As the saying goes, the only constant is change. That rings as true as ever in the policy world of price transparency. These past few years, change has come in waves for hospitals adhering to the ever-evolving price transparency requirements. 2024 was relatively quiet regarding specific final rule updates, and the most notable change was the required hospital MRF schemas.

In 2025, by contrast, there has been a whirlwind of new required and proposed changes. On February 25, 2025, President Trump signed an Executive Order (EO) that required The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services (The Departments) to fulfill the following directives within 90 days:

- Require the disclosure of the actual prices of items and services, not estimates;
- Issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans; and
- Issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.

What followed that EO was a flurry of activity on May 22, 2025 that coalesced into a Press Release from The Departments detailing four main areas of focus:

1. Updated hospital price transparency guidance around algorithm pricing
2. A Request for Information (RFI) seeking feedback regarding hospital MRF completeness and accuracy
3. A second RFI seeking feedback regarding prescription drug price disclosure requirements
4. Updated Transparency in Coverage (TiC) FAQs that announced a new schema for payer MRFs

Turquoise, alongside many others in the industry, responded to both RFIs and developed new processes around the changes to hospital MRFs. Some elements of the May 22 rollout felt disjointed and open-ended. For example, there was no explicit enforcement date for the updated hospital price transparency guidance. The RFI submission process differed noticeably between the two RFIs. Even the timing of each individual mandate or announcement occurred prior to the full press release launch.

And then, as hospitals were still actively working to maintain compliance with the May 22 guidance, more change came. On July 15, The Centers for Medicare and Medicaid Services (CMS) issued yet another new proposed rule that included detailed requirements changing the hospital MRF landscape for the second time in 2025. The proposed rule focused on attestation language, percentile allowed amount reporting, and laying clearer guidelines for using 835 transaction data to calculate algorithm-based allowed amounts. At the time of publication, that proposed rule has yet to be finalized as CMS reviews submissions from the open comment window. Turquoise responded with a number of thoughts and, similar to the May 22 guidance, noted a lack of specificity and clarity around the constant changes to allowed amount reporting.

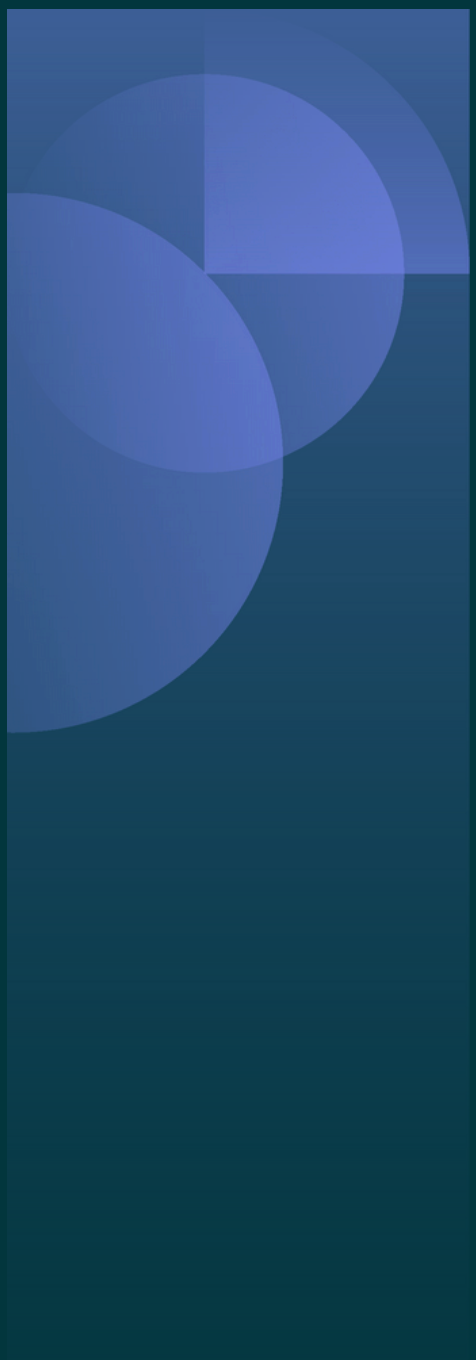
Payer Rules and Laws

After multiple years of no additional requirements or updates to TiC, change finally came to the payer policy landscape in October 2025. Specifically, on October 1, on the heels of the EO, CMS' TiC GitHub repository was updated with the schema version 2.0 requirements. The changes are tactical and point to a longer road of continual improvement in the data displayed in payer MRFs. This will be the first time payer MRF generation teams will have to meaningfully study the requirements, make process changes, and run new quality assurance checks since establishing a process based on the first TiC schemas. Notably, the October 1 updates did not include a due date for the third Prescription Drug file, which remains on hold indefinitely.

02

The State of *Price Transparency*

Researchers, start ups, patient advocacy groups, and government entities have spent the last several years studying data trends, accuracy, and completeness in hospital MRFs. Doing the same type of comprehensive analysis in payer files; however, has proven challenging. The main hurdles to overcome are not surprising to anyone who's spent some time parsing, or even simply downloading, payer MRFs.



Payers

Hurdles to Assessing Payer MRFs at Scale

1. Payers must include both hospital and non-hospital rates.
2. While hospital rates are bound by the directive to include MRF data on items and services located in a chargemaster, payers are bound by the broad directive to include "all items and services." Hospitals must also include bundled services, like MS-DRGs or soft-coded CPTs, but that list of required MRF line items pales in comparison to the idea of reporting on a non-quantifiable "all" directive. Particularly through the lens of the first challenge listed above, imagine adding rates for every free standing ambulatory surgery center (ASC), laboratory, and imaging center into the mix alongside hospital data.
3. Payers often have national, regional, or statewide networks, and within TiC, there is no explicit requirement making payers identify which posted files correspond to specific networks. This challenge is compounded by the fact that payers maintain large fee schedules that serve as the foundation for negotiated rates for a number of providers, hospitals, or health systems.

That same list of challenges is applicable to the teams creating and maintaining payer MRFs. It's no easy feat to efficiently and comprehensively report all items and services, and yet, more than three years after the files first came online, we are consistently seeing useful and comprehensive data posted in payer files. How much data does that entail? **Currently, we track monthly MRF posting across 219 payers**. It's difficult to assign an exact number of how many payers should be posting rates, given larger payers sometimes post files for smaller subsidiary payers.

Transparency in Coverage spends time defining the types of rates and providers that must be in files. Specifically,

> *…the final rules define in-network provider to mean any provider of items and services with which the plan or issuer, or a third-party for a plan or issuer, has a contract setting forth the terms under which a covered item or service may be provided to a participant, beneficiary, or enrollee. The Departments broadened this definition to clarify that* ***even where a provider and a plan or issuer have a limited rate agreement of some kind, or a rate agreement covering DME, those providers should be considered in-network providers for purposes of the final rules.*** *Additionally, if a plan or issuer enters into a contract or has such payment arrangements, then* ***the pricing information for the specific covered items or services subject to that contract or payment arrangement are required to be disclosed as part of the internet self service tool and machine-readable files.***

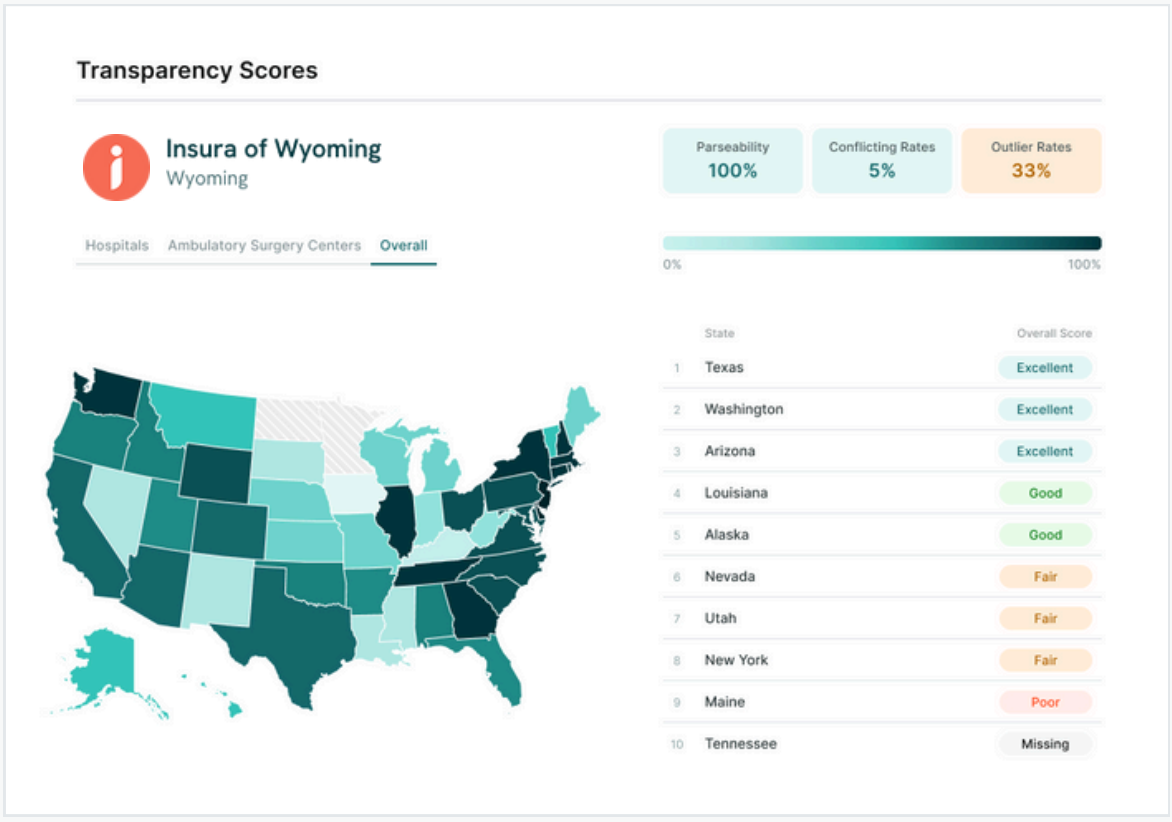
With that definition in mind, there are likely other small or subsidiary payers posting rates, though it's difficult to confidently state a specific total expected payer file number. We are constantly in pursuit of newly posted files. Our data users often ask about data ingested from specific payers, and that feedback helps bolster our confidence that the majority of covered lives and rates are represented in the 219 files (and counting!) that we track each month.

Introducing Turquoise Health Payer Transparency Scores

Turquoise Health, alongside many others in the industry, has deployed countless hours, technical resources, and subject matter experts to payer MRF parsing and analysis since the files first came out in 2022. Today, payer MRFs are generally seen as a massive swath of data in need of wrangling. Our goal is to ensure the payer files are useful as a crucial resource to help eliminate the financial complexity of healthcare.

To help accomplish that goal, we have released our Payer Transparency Scores.

We have assigned scores to the top 97 payers to date, and the number will continue to rise as development continues. By publishing these scores, our goal is to shift the payer MRF conversation from "what files and rates are posted?" to "what files and rates are complete, accurate, and useful?"



The scores are useful for any interested stakeholder—from journalists and researchers, to providers, payers, life sciences companies, the government, and employers—looking to understand how insurers are performing on transparency. The scores are intended to be an efficient and succinct reflection of where gaps remain and where the highest quality data exists. Payers can use the scores to improve the quality and accuracy of their own files, exploring performance on an individual hospital/ASC basis.

It's a helpful approach to view all presented MRF data points through two lenses:

- Following TiC mandates
- Utility in the creation of an accurate patient estimate.

The interactive dashboard containing these scores is accessible here and updated monthly to coincide with mandated monthly file refreshes. We add payers to the dashboard every month and have focused this first wave of scores on the largest payers that impact the most covered lives.

We have extensively documented our methodology, processes, and overall approach and welcome feedback on how to best iterate and improve the scoring process. We believe payer file scores are essential to the industry because payers have yet to be closely monitored for accuracy and completeness. **It's also important to remember that Turquoise Health is not the arbiter of compliance or enforcement of TiC files.** According to the final rule, "states will generally be the primary enforcers" and the Department of Health and Human Services (HHS) will assume jurisdiction over payer compliance if they determine that "a state has failed to substantially enforce the requirements." **Only the states or HHS can review a payer MRF and deem it compliant or noncompliant.** At the time of publication, no payer files have been publicly identified by HHS as noncompliant.

The price transparency landscape is maturing, and because TiC hasn't evolved in years, the challenge is to prevent payer MRFs from stagnating. Payer Transparency Scores create a platform to raise the floor of payer data quality and instill accountability for payers doing their part to help create clear understanding of the cost of care.

Understanding payer scores

Ratings are assigned to each category, provider, and state based on the underlying score. Scores are meant to help viewers understand what files and rates are complete, accurate, and useful.

As such, we use the following nomenclature to score each payer:

Excellent	Good	Fair	Poor	Missing
Complete, high-quality, usable.	Usable, with some gaps.	Noticeable gaps that limit analysis.	More incomplete than complete.	No data reported.

Themes From The Payer Transparency Scores

The process of creating, reviewing, and iterating on comprehensive Payer Transparency Scores led us to notice a few common patterns and areas for improvement across many payers. There are three focal points that we believe, if mitigated or fixed, would most significantly improve the quality of MRF data as a whole. We'll dig into each focus area below.

Conflicting Rates

We define conflicting rates as **records where a single service has multiple, distinct rates reported, with no discernible way to differentiate between them.** Thus, the user has difficulty ascertaining which of the conflicting rates is the true negotiated rate. That conflict is familiar to users of payer MRF data and erodes both file usability and confidence in the data.

> *Of all the areas for improvement within the payer files, conflicting rates is the most pervasive. Thus, conflicting rates serve as a focal point within our scoring logic because of the damage they do to file size, credibility, and overall utility of payer MRF data.*

29% of scored payers have >50% conflicting rates

Of the 97 payers we have scored to date, 28 of those payers have at least 50% of the rates in file marked as conflicting in our Transparency Payer Scores.

Some instances of conflicting rates would be resolved with additional changes to the TiC schema. For example, there is no field in the schema to identify the specific location of a rate. That means that if a payer contracts under one specific EIN or a small handful of NPIs, but the rates differ by state, the code and provider combination appearing for each state would be flagged as a conflicting rate. But the addition of a location field would mitigate these instances by allowing any users of the data to clearly identify instances where code-specific rates vary by state when the correctly reported EIN or NPI remains the same.

Payers With > 50% Conflicting Rates

Payer name	% of total rates that conflict
WellSense Health Plan	100%
Healthfirst NY	99%
PreferredOne	99%
UHA Health Insurance	94%
Molina Healthcare	93%
Blue Cross Blue Shield of Maryland & DC (CareFirst)	86%
EmblemHealth	85%
CDPHP	84%
PacificSource	82%
Group Health Cooperative-SCW	81%
Quartz	81%
Blue Cross Blue Shield of New Jersey (Horizon)	74%
Blue Cross Blue Shield of Texas	73%
Oscar Health	73%
Priority Health	72%
Sanford Health Plan	71%
Kaiser Permanente	70%
Hometown Health	63%
Blue Cross Blue Shield of Nebraska	62%
Innovation Health Insurance Company	61%
Sutter Health Plus	60%
LifeWise Health Plan	60%
Blue Cross Blue Shield of Rhode Island	57%
Fallon Community Health Plan	57%
Aetna	57%
Harvard Pilgrim Health Care	56%
SelectHealth	52%
Blue Cross Blue Shield of Pennsylvania (Capital Blue Cross)	52%

Outlier Rates

Here we focus on the percentage of rates that were deemed outliers, or rates that appear statistically too high or too low compared to the average rate. Common examples of outlier rates include reporting $0.01 for a high-acuity service, like an organ transplant, or reporting $100,000 for a routine blood draw.

Though outliers are not as prevalent in the data as conflicting rates, they are commonly featured in reports of price transparency data quality. For example, many articles and studies online point to the wide range of potential costs for delivery or orthopedic surgery. The visibility into a harmfully wide range of negotiated rates highlights the importance of eliminating outliers, which played a factor into why we included them in our scoring methodology.

Defining An "Outlier"

Conflicting rates plague the dataset more often than outlier rates, but when we do see these outlier rates, they often fall into a few different categories. Our outlier definition varies based on the reported negotiated rate type within the MRF and can be seen below:

- If the reported `negotiated_type` = 'per diem' and:
  - `rate` > IPPS Medicare rate / IPPS's geometric LOS * 10
  - `rate` < IPPS Medicare rate / IPPS's geometric LOS
- If the reported `negotiated_type` = 'percentage' and the `rate` > 100
- If the reported `negotiated_type` is one of 'derived','fee schedule',or 'negotiated' and `rate` > $500 and:
  - `negotiated_rate` < 10% or > 1,000% of the applicable Medicare rate (using IPPS, OPPS, or ASC pricers)
- If the reported `negotiated_type` is one of 'derived','fee schedule',or 'negotiated' and `rate` ≤ $500 and:
  - `negotiated_rate` < 10% or > 5,000% of the applicable Medicare rate (using IPPS, OPPS, or ASC pricers)
- If `billing_code_type` is 'HCPCS' or 'APC' and `negotiated_type` is one of 'derived', 'fee schedule',or 'negotiated' and `negotiated_rate` > $500,000
- If `billing_code_type` = 'MS-DRG' and `negotiated_type` is one of 'derived', 'fee schedule', or 'negotiated' and `negotiated_rate` > $2.5M
- If OP Surgical Revenue Codes (360 or 361) are reported with any `negotiated_type` except 'percentage'.

In our years studying payer MRFs, we've come to expect outlier rates in virtually every file. The files are extremely complex, which means creating outlier detection logic is also complex. A robust outlier detection system must have a built in margin for error to flag false positive outliers while also keeping in mind that, in any data set, a true 5th percentile and 95th percentile data point does exist. There are accurate and extremely high dollar negotiated rates just as there are accurate and extremely low dollar negotiated rates. The balance Turquoise aims to strike is constantly reviewing the results of our outlier detection to distinguish real high or low rates from erroneous high or low rates.

6% of payers have >15% outlier rates, 4% have >25%

Keeping those nuances in mind, some payers have MRF generation processes, controls, and quality assurance methods in place that result in posting definitively fewer outlier rates than other payers. Thus, the presence of a noticeable amount of outliers affect file quality, and subsequently appear in our Payer Transparency Scores. Overall though, the statistics show that many payers have a small percentage of Outlier rates, but very few have it as a systemic problem. Only six of the 97 payers we scored have >15% outlier rates, and an even smaller bucket (four) have >25% outlier rates.

Payers with Outlier Rates

Payer name	% of total rates flagged as outliers
Capital Health Plan	48%
MVP Health Care	34%
Blue Cross Blue Shield of Tennessee	29%
Innovation Health Insurance Company	23%
Aetna	16%
Oscar Health	16%

Our work shows that the top area at risk for outliers is payers posting dollar values for surgeries billed in revenue codes 360 and 361. 90% of outliers are surgical HCPCS that fall outside the reasonable bounds when we use Medicare's Outpatient Prospective Payment System (OPPS) rates as the benchmark. As an example, we located an instance where a commercial payer reported a facility-specific rate of $1,903.60 for a minor procedure, CPT 11719, which is used to report trimming any number of nondystrophic nails. The Medicare rate for this same code at the same facility is $70.00.

The rate difference for that nail trimming procedure doesn't seem glaringly stark, but if we look at a higher-acuity, and thus more costly, surgery, the difference becomes a lot more obvious. We located a reported rate of $66,845.00 for a hospital-specific instance of CPT 61050, which represents a cervical spinal puncture without injection. And although a spinal puncture is more resource-intensive procedure than a nail trimming, the reported Medicare rate is $349.32 for this facility. That Medicare rate, alongside the fact that the facility-specific median commercial rate is $2,456.00, indicates $66,845.00 is an outlier (19,000% of the Medicare rate).

Parsability

Parsability is defined as the percent of files Turquoise was able to ingest from each specific payer in each specific month. That metric, alongside conflicting and outlier rates, is equally essential to measure when gauging file quality. Not only does it serve as a barometer of a file's overall schema health, it also serves as a way to assess a payer's good faith efforts to adhere to price transparency mandates.

> *Parsability is a key dimension for gauging a payer's good faith efforts to adhere to price transparency mandates.*

The Turquoise data pipelines are able to consistently ingest all compliant files from each payer each month. That efficacy means that if our process is unable to parse a file, it typically points to a root cause problem with a specific file or website that houses the specific file. As the months since go-live in 2022 have passed, we run into fewer parsing issues. But there are still payers that are somewhat consistent in creating parsing challenges for any user looking to ingest their data on a consistent, month-over-month basis.

94% of payers were highly parsable

Of the 219 files (across 97 payers) we mentioned earlier in the report, we have successfully parsed and ingested data 206 of them, or 94%. The 6% we were not able to parse may be non-compliant files or malfunctioning links a user is unable to access. We download and parse files monthly, and notably, four of the payers who scored < 50% maintained that low score over three consecutive months. That means if our data team happened to attempt to download a file and our system or the payer's URL glitched temporarily, the following month the issue would likely remedy itself and the payer would fall off the low parsability score list. In this case, a quarter's worth of a low score indicates a payer should consider attempting to download and parse their own files to confirm what technical fixes they could make to prevent parsing errors.

Payers with <50% files parsed

Payer	% Files Parsed
UHA Health Insurance	49%
Denver Health Medical Plan Inc.	40%
Centivo	16%
Physicians Health Plan of Northern Indiana	0%

It's encouraging to see so many payers maintaining MRFs that users can locate and parse. There do not appear to be many malicious efforts to hide files so stakeholders cannot find them, and payers overall are posting files without broken links and without parsing blockers.

National Payers are Performing at a High Level

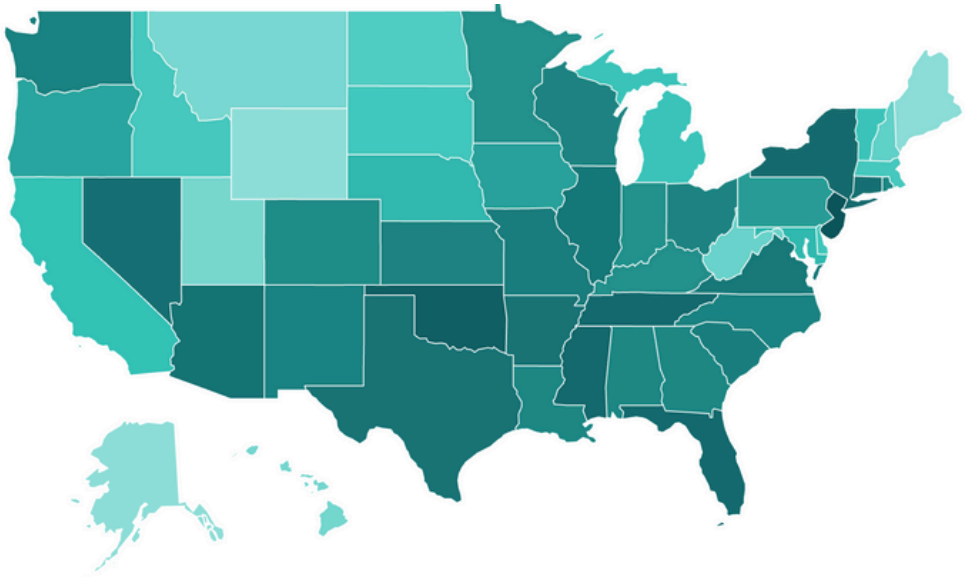
Of the 97 payers we have scored to date, we found national payers were generally performing at a high level. Their conflicting rates, outliers, and parsability scores combined with the total data coverage in their MRFs indicates that while there remain areas for improvement, their comprehensive negotiated rate data is available and accurate.

United Healthcare - Hospital & ASC Scores

Parsability
99%

Conflicting Rates
6%

Outlier Rates
3%

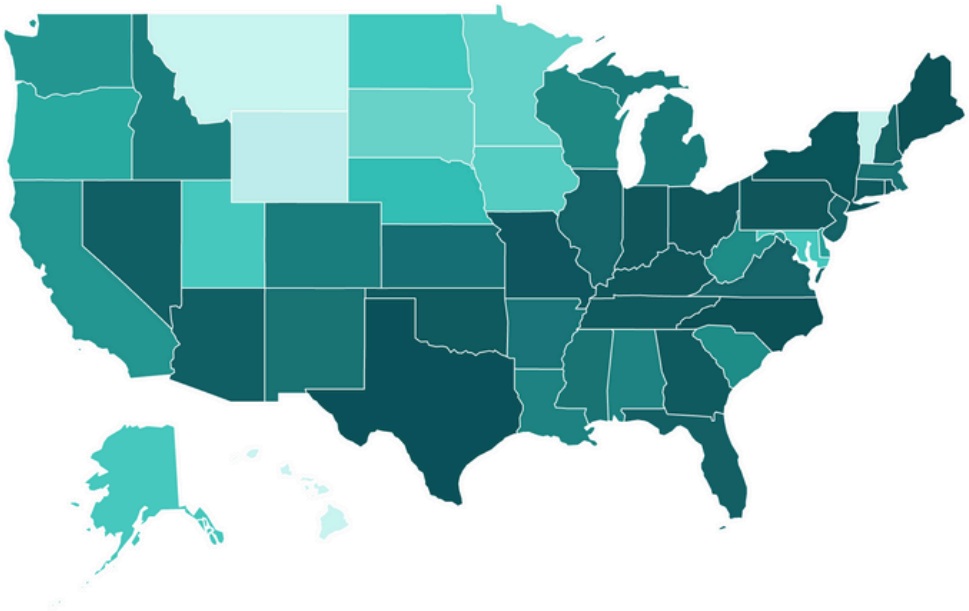


Aetna - Hospital & ASC Scores

Parsability
99%

Conflicting Rates
57%

Outlier Rates
16%

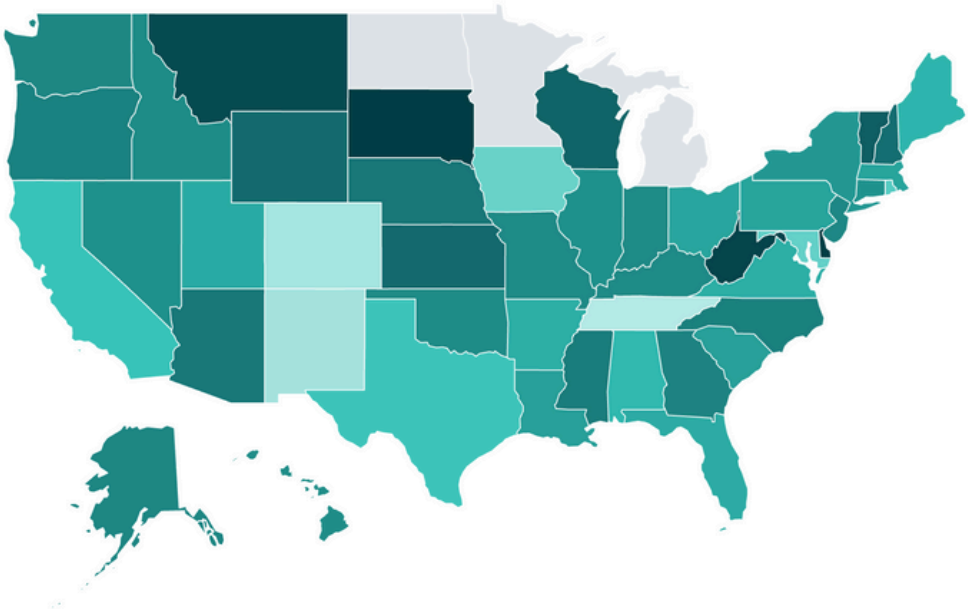


Cigna - Hospital & ASC Scores

Parsability
100%

Conflicting Rates
6%

Outlier Rates
4%

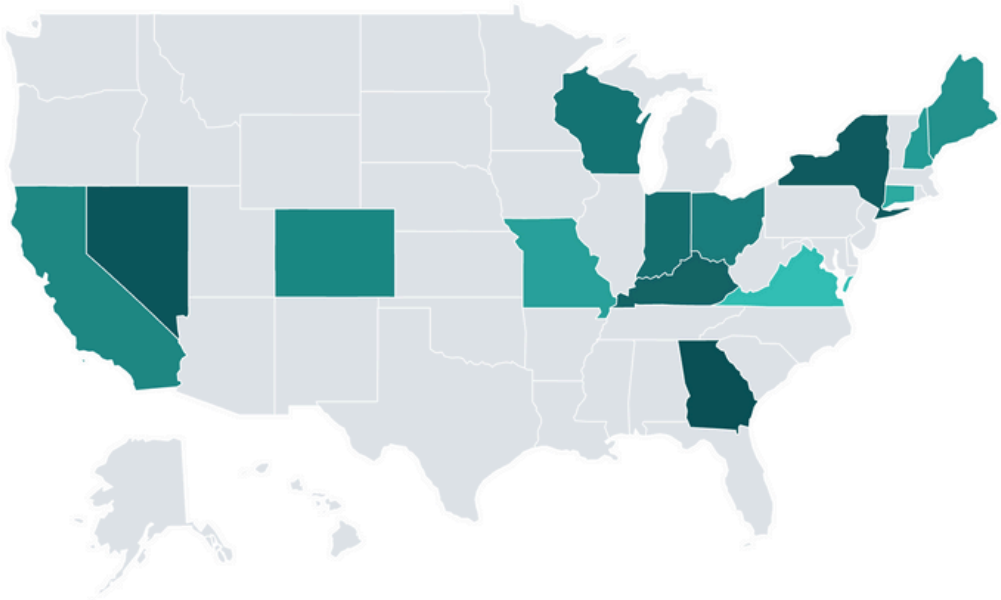


Anthem* - Hospital & ASC Scores

Parsability
87%

Conflicting Rates
16%

Outlier Rates
3%

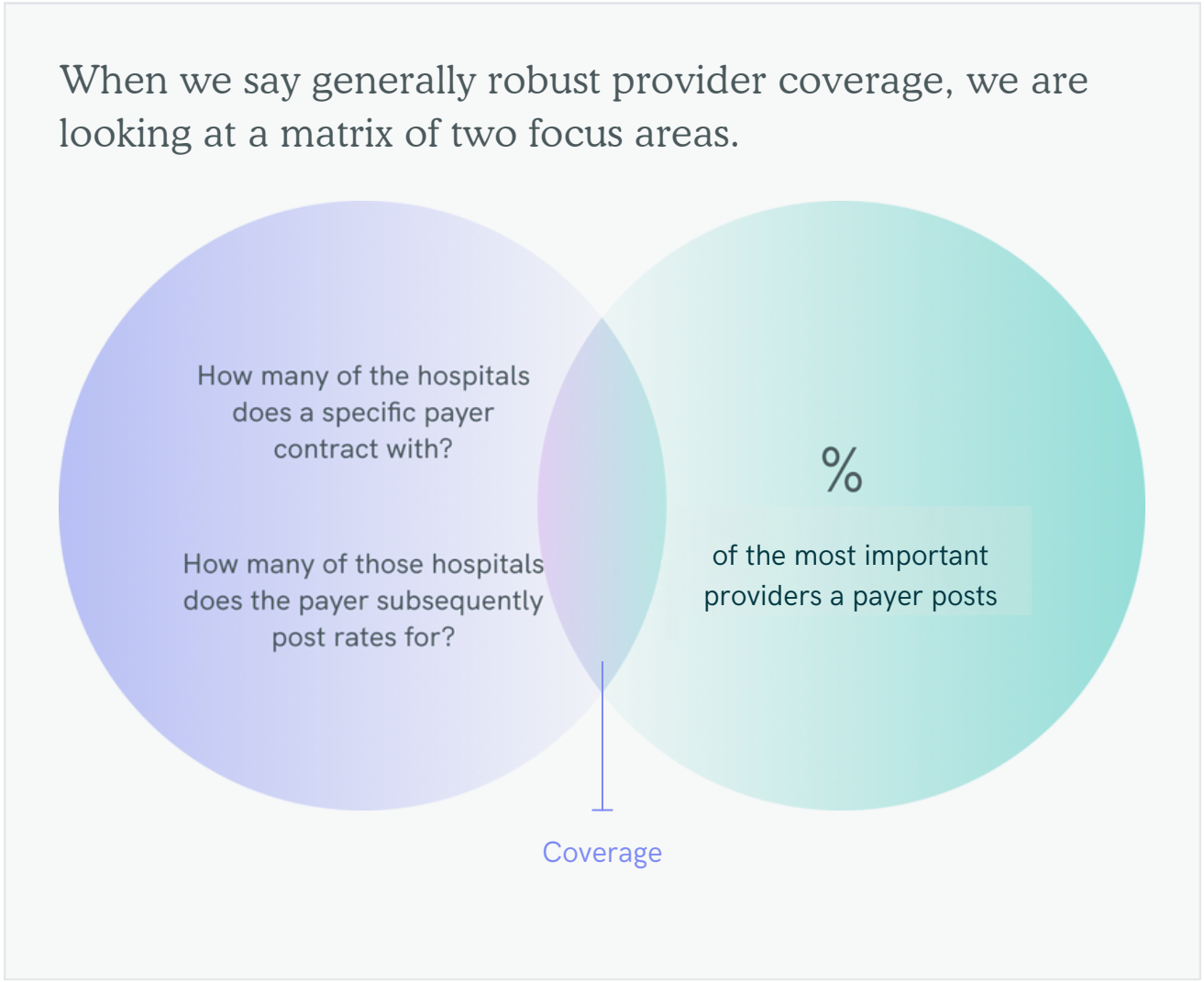


**While Anthem is a national payer, it operates as an independent Blue Cross Blue Shield licensee in select states. Additional state-specific Blue Cross rates are detailed later in the report.*

Provider Coverage

As part of the process of reviewing payer data and creating a visual representation of quality and availability, we picked up on a trend when assessing coverage gaps. For nationwide payers, hospital provider coverage is generally robust. Larger payers tend to have the financial, technical, and personnel resources to most effectively manage MRFs and their overall coverage is better as a result. As the map graphics in the coming pages indicate, smaller regional or state-specific payers may not have access to the same amount of resources, which can translate into lower MRF quality.

When we say generally robust provider coverage, we are looking at a matrix of two focus areas. First, how many of the hospitals does a specific payer contract with, and how many of those hospitals does the payer subsequently post rates for? Next, what percentage of the most important providers are payers posting?



The Appendix shows the full list of the average percentage of providers posted for each of the four major payers for the first focus area mentioned on the previous page: United Healthcare, Aetna, Cigna, and Anthem.

To define the second focus area, important providers, we use a scoring methodology that weights hospitals by their Net Patient Revenue (NPR). This approach is beneficial to price transparency because posting complete rates for a major hospital that accounts for 40% of the NPR in a state impacts the industry's ability to understand the cost of care when compared to posting rates for a small Critical Access Hospital treating an underserved or at-risk community. We therefore weight the payer's state coverage score to more heavily emphasize the presence of high NPR hospitals.

We also studied the quality of ASC rates within payer files. These rates are not typically present in hospital MRFs, so high-quality ASC data from payer MRFs is a gold mine for understanding the cost of care in a lower-acuity setting.

Here's how the national payers performed in reporting hospital rates, ASC rates, and the percentage of NPR they each included. Notably, no national payer received a Poor score for their reported rates for major hospitals.

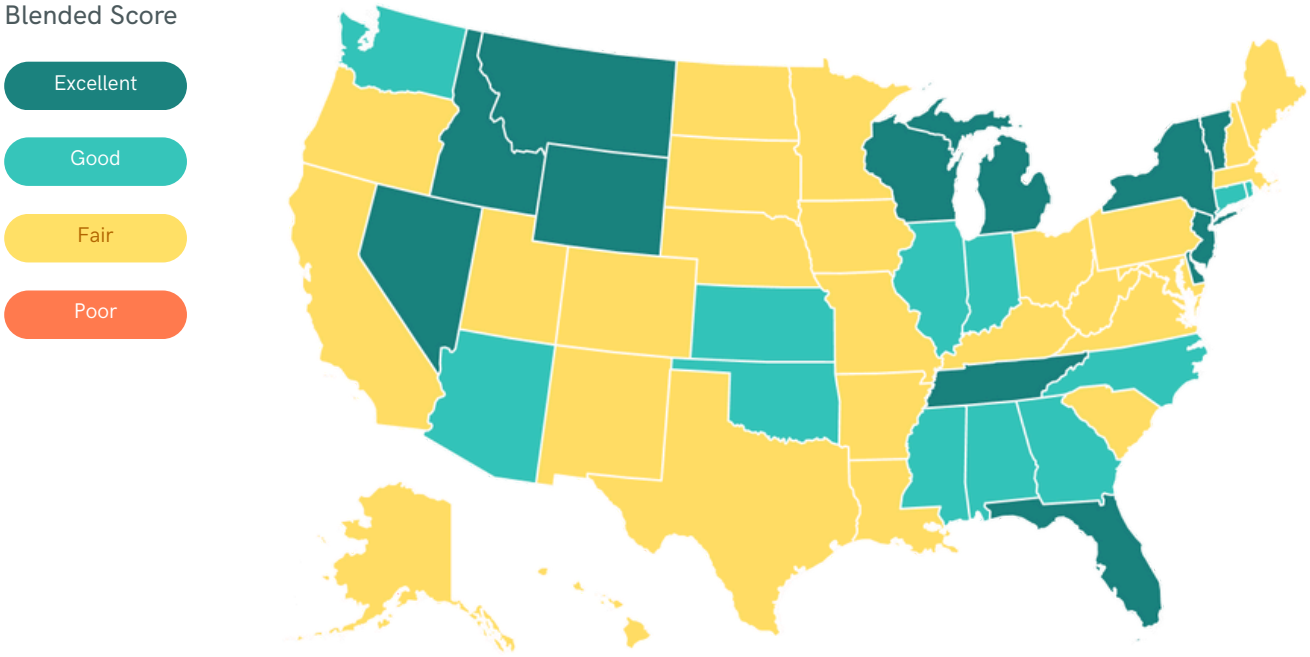
Payer	Hospital Score	ASC Score	% NPR Share
United Healthcare	Good	Excellent	95%
Anthem	Good	Excellent	88%
cigna healthcare	Fair	Excellent	85%
aetna	Fair	Fair	91%

Aetna scores the lowest of the national payers, even though their percent of NPR share is very healthy, primarily due to the number of conflicting rates (multiple rates for the same provider and code combination) present in their MRFs.

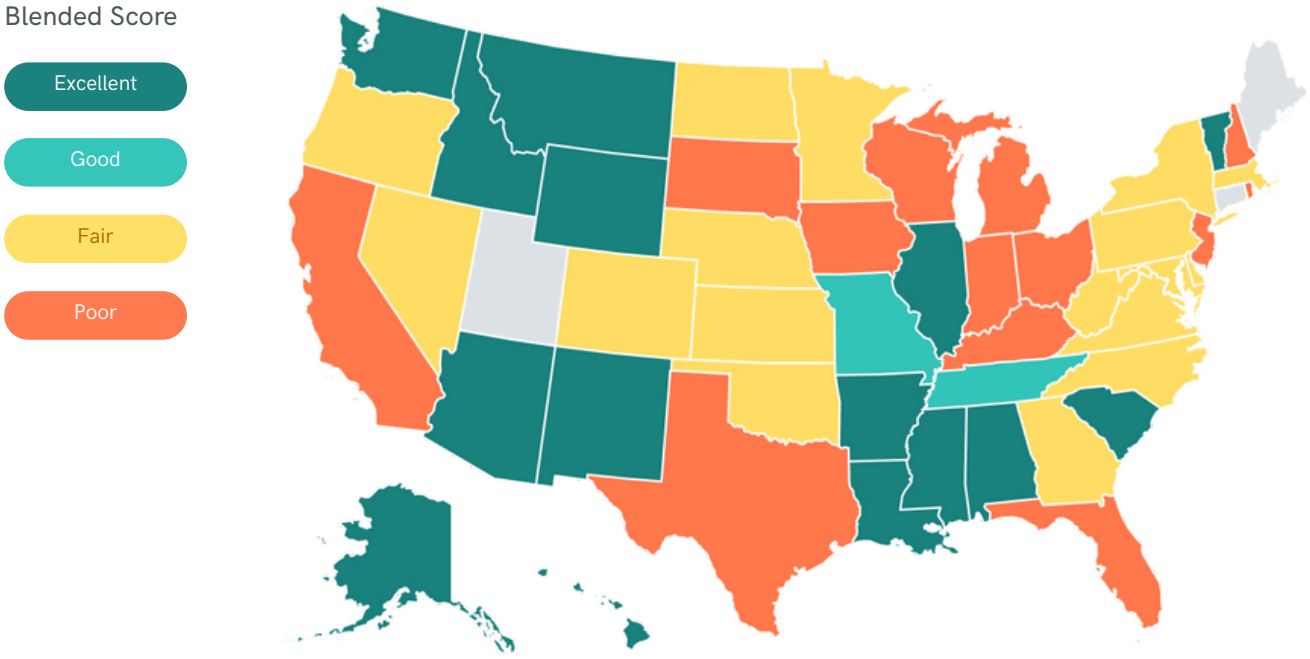
We have observed there could be a number of root causes, such as:

- A billing code can theoretically qualify for multiple provisions and therefore multiple rates in a contract. That ambiguity translates into:
  - confusion over how to best report a rate when a surgical contract has discounted rate logic depending on if multiple procedures occur in a single episode of care.
  - payers choosing to post an "all other" rate designed to cover any items or services not explicitly carved out in a contract in addition to posting the actual negotiated actual rate.
- A payer assigns a billing class at the provider level and not the rate level, which leads to conflicting rates that appear to be both for institutional and physician services.

If we map out what the national payer provider NPR coverage looks like across states, we get the following visual:



The coverage quality drops when we start looking at the regional or state payer level:



Blue Cross Blue Shield State-Specific Payer Scores

Blue Cross is known to have state-specific payers and rates as well, so we can see how those fared in a more granular detail vs looking at Anthem at the national level.

Payer	Hospital Rank	ASC Rank	% NPR Share
Blue Cross Blue Shield of Vermont	Excellent	Excellent	100%
Blue Cross Blue Shield of North Dakota	Excellent	Excellent	100%
Blue Cross of Idaho	Excellent	Excellent	100%
Blue Cross Blue Shield of Illinois	Excellent	Excellent	99%
Wellmark Blue Cross Blue Shield	Excellent	Excellent	99%
Blue Cross Blue Shield of Alabama	Excellent	Excellent	99%
Blue Cross Blue Shield of Louisiana	Excellent	Excellent	99%
Blue Cross Blue Shield of Mississippi	Excellent	Excellent	99%
Blue Cross Blue Shield of Wyoming	Excellent	Excellent	98%
Premera Blue Cross	Excellent	Excellent	96%
Blue Cross Blue Shield of Minnesota	Excellent	Excellent	91%
Regence Blue Cross Blue Shield	Excellent	Excellent	83%
Blue Cross Blue Shield of Arizona	Excellent	Excellent	83%
Blue Cross Blue Shield of Michigan	Excellent	Excellent	81%
Blue Cross Blue Shield of South Carolina	Excellent	Excellent	80%
Blue Cross Blue Shield of Hawaii	Good	Excellent	100%
Blue Cross Blue Shield of Massachusetts	Good	Excellent	98%
Blue Cross Blue Shield of Tennessee	Good	Excellent	95%
Blue Shield of California	Good	Excellent	86%
Blue Cross Blue Shield of Montana	Excellent	Fair	100%
Blue Cross Blue Shield of Texas	Fair	Excellent	97%
Blue Cross Blue Shield of New Mexico	Excellent	Fair	96%
Blue Cross Blue Shield of New York (Excellus)	Fair	Excellent	87%
Blue Cross Blue Shield of Nebraska	Good	Fair	99%
Blue Cross Blue Shield of Arkansas	Excellent	Poor	96%
Blue Cross Blue Shield of Kansas	Good	Good	55%
Blue Cross Blue Shield of Florida (Florida Blue)	Poor	Excellent	65%
Blue Cross Blue Shield of Kansas City	Good	Poor	95%
Blue Cross Blue Shield of New Jersey (Horizon)	Fair	Fair	93%
Blue Cross Blue Shield of North Carolina	Fair	Fair	77%
Blue Cross Blue Shield of Rhode Island	Poor	Good	74%
Highmark Blue Cross Blue Shield	Fair	Poor	95%
Blue Cross Blue Shield of Pennsylvania (Independence)	Fair	Poor	94%
Blue Cross Blue Shield of Pennsylvania (Capital Blue Cross)	Fair	Fair	51%
Blue Cross Blue Shield of Oklahoma	Fair	Poor	81%
Blue Cross Blue Shield of Maryland & DC (CareFirst)	Missing	Poor	0%

A note on validating rates across payer and hospital MRFs

To address that drop in quality mentioned and make price transparency data usable across the nation, we merge the MRF files reported by hospitals and by payers into a dataset we call Clear Rates (more about this on pg. 35). This unified dataset is made possible by Turquoise's approach to creating canonical entities in our pipelines, such that the myriad ways payers and providers are represented in each other's files can be normalized against the best representation of each entity.

For example, some hospitals will represent UnitedHealthCare as United, others as UHC, and some as United Health Care. When constructing our underlying data engine, Turquoise maps all of these unique representations to the proper and singular entity, which enables us to de-duplicate rates, fill in gaps with data from payer MRFs that might be missing from hospital files (and vice versa), and provide rich insights into how often payers and hospitals report the same rates for the same services.

Code Coverage

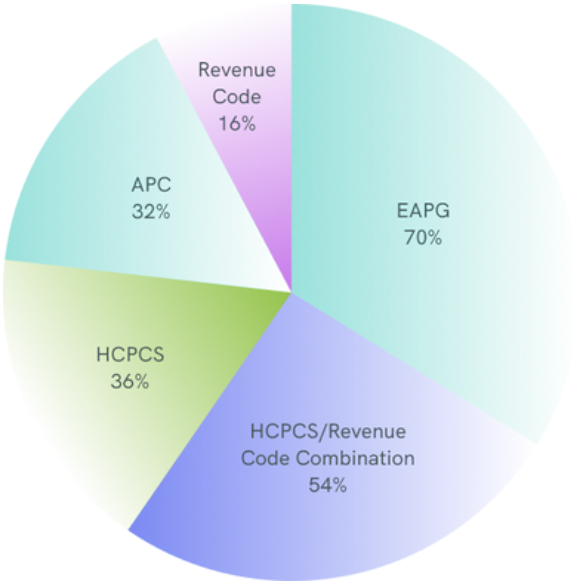
As the visuals on the previous pages confirm, overall provider coverage is comprehensive within the payer MRFs. The primary opportunity to address and improve missing coverage is at the code level.

> *When we dug into gaps in code coverage, we discovered that, although it may seem obvious, simplified contracts and code types typically yielded higher scores.*

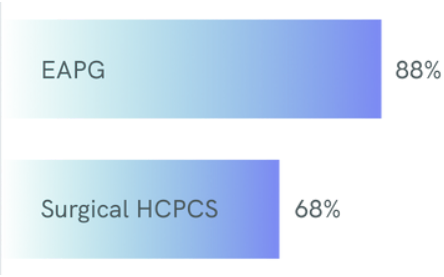
As Vi Moore noted in Footloose, "Simple elegance is something to strive for." That is as true in payer MRFs as it is in fashion. The difference in simple versus complex contracts is not drastic through the lens of Payer Transparency Score correlation, but it is notable when looking at MRF data through the lens of using it to power patient estimate tools (PETs). More on those PETs later in the report, but for now, let's look further into outpatient rates as an example.

Payers that only post negotiated rates for Enhanced Ambulatory Patient Groupers (EAPGs) are performing the best: their average coverage score of 70% puts them generally in the Excellent category. EAPGs offer a simple, bundled approach to codifying clinical services rendered and that type of code is the easiest to accurately report.

Code Types Reported



The same holds true for ASC rates:



Generally, this points to the idea that the more granular the code type, the more challenging it is to report full code coverage in an MRF. Simpler, bundled codes translate into MRF code coverage that is easier to post, easier to interpret, and typically yields a modest increase in the Payer Transparency Score.

03

A Call to *Collaboration*

When we first released our hospital scorecards in 2022, we heard from many hospitals and health systems that spent time digging into the specifics of our scoring methodology and providing feedback to keep us honest. We anticipate the same exchanges with payers and are actively in discussion with a number of payer MRF generation teams. We view that dialogue as vital to our ability to host a fair and trustworthy source to highlight where MRFs excel and where improvements can be made. We welcome any feedback on our processes and are committed to continually improving the scoring process, updating our methodology, and maintaining a data-driven approach to MRF comparison and benchmarking.

For any feedback or comments on Payer Transparency Scores, please reach out here.

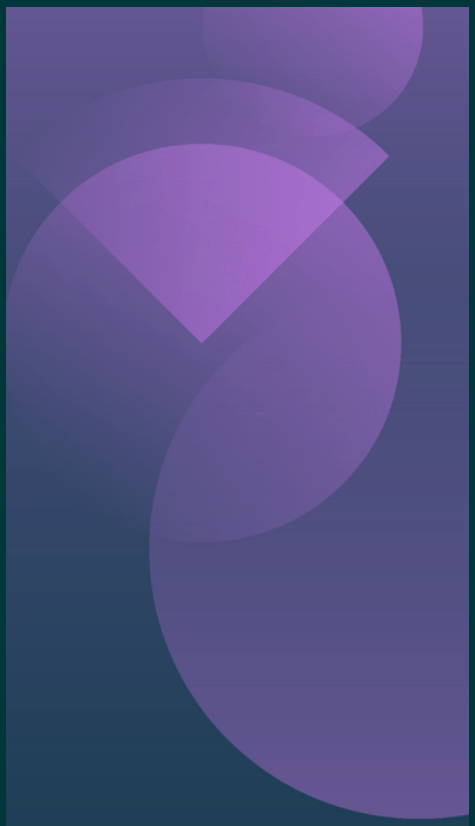
04

The Next Stage of *Price Transparency*

To talk about what's next for price transparency, we must first talk about 2025's numerous opportunities to respond to RFIs and submit public comments regarding future improvements within the price transparency rules and laws. Across all of our submitted responses, our aim was to consistently emphasize that true price transparency can and should simplify healthcare's financial complexity and empower patients to understand and compare costs before receiving care. That goal can be accomplished through clearer, standardized, and interoperable data frameworks—especially for MRFs and PETs—that enable accuracy, consistency, and usability across hospitals, payers, and prescription drug reporting. We are eager to see alignment in updated guidance, enforcement timelines, and organized schemas across all rules and laws.

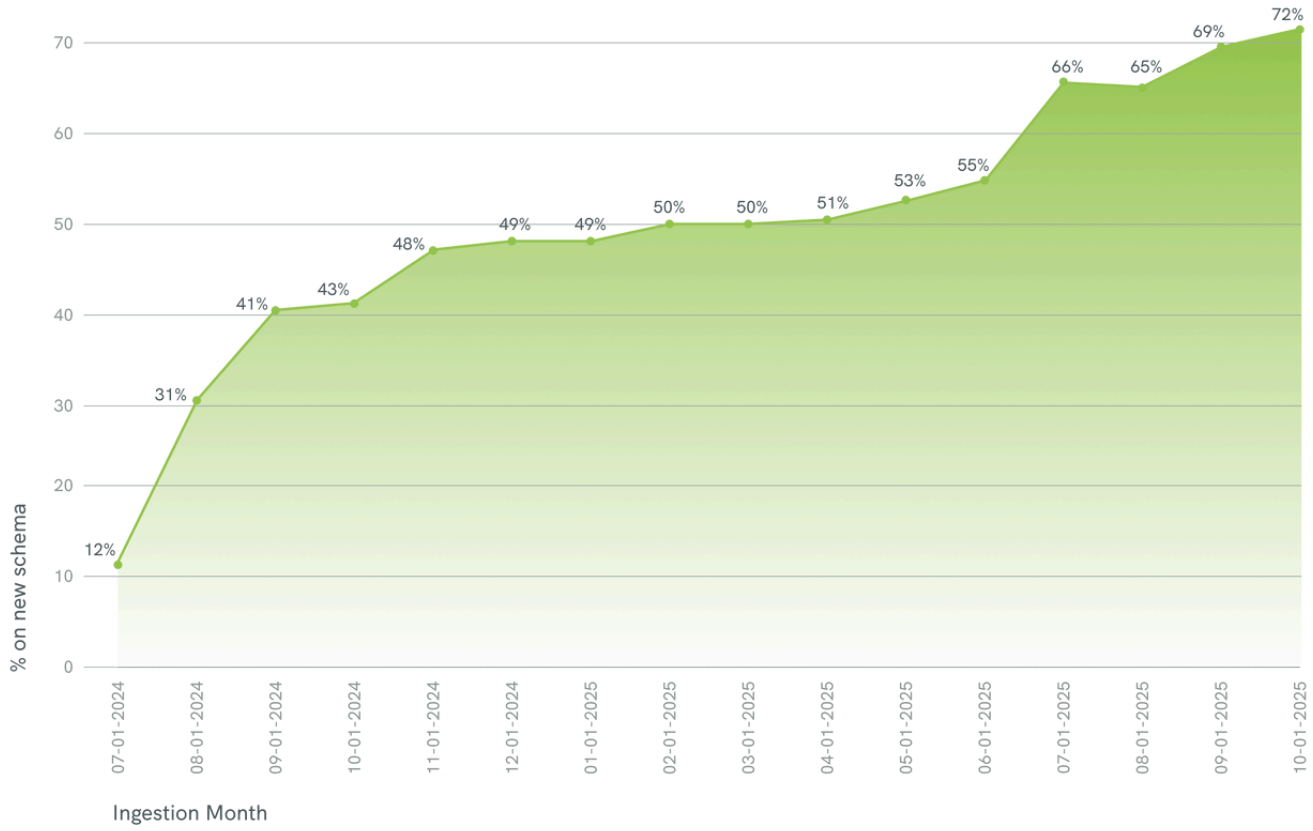
Beyond the minutiae of data reporting, Turquoise used the public comments to lay a clear vision that looks ahead to a world where transparency fuels a patient-first, technology-driven healthcare economy. Between our approach to Clear Rates and additional information around contract language, as we'll explore further, the next stage of price transparency looks like transforming static regulatory data into functional tools that foster trust, efficiency, and meaningful competition across the healthcare system.

In the coming pages we highlight a few core areas that are not meaningfully reported in today's price transparency landscape but that, if made available, could be force multipliers in getting us to that future state.



Hospitals

Across the country, hospitals adopted the new CMS schema requirements that went into effect on 7/1/2024. As is typical with new requirements, we observed a month-over-month trend of an increasing number of hospitals updating their files to the new schema. While adoption has started to plateau, as of October 2025, just short of 75% of hospital files pass the CMS file validator checks specifically focused on schema adoption.



Given the changes to hospital MRF requirements, the measure of completeness and accuracy has evolved significantly since Turquoise last published Hospital Price Transparency Scores. As such, we're hard at work updating our hospital scoring methodology to reflect the most up-to-date requirements and will be publishing those scores in 2026. We plan to release a subsequent Impact Report highlighting the results of our new approach to hospital scores.

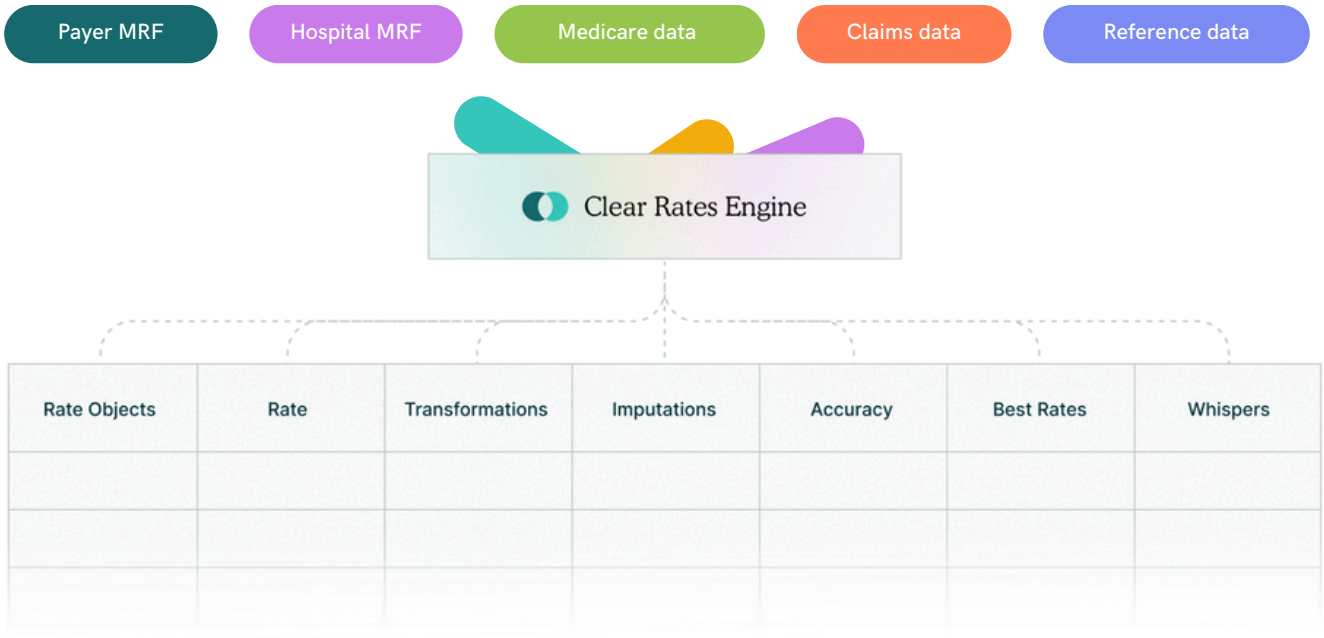
Data Utility at Turquoise

With all the work we're doing on creating robust hospital and payer data scoring methodologies, the goal isn't just improved data for the sake of increasing access to price transparency. The data has been accessible for years now, and, despite its well-documented imperfections, it's become an embedded cornerstone for payers, providers, brokers, pharmaceutical manufacturers, and consultants to use in their daily workflows.

In tandem with the granular work required to create and maintain MRF scores, we've also changed the way Turquoise Health data users ascertain negotiated rates for specific items or services. The earliest question data users asked in 2021 when the hospital data first went live was, "How do I know if the rates are accurate?" Over time, other data sets, including payer MRFs, have come online and supported a process to identify a singular trustworthy rate. From our perspective, up-leveling MRF data means the ability to seamlessly pull from a number of different data sets to confidently and definitively understand the actual cost of an item or service.

As mentioned earlier in the report, Turquoise recently launched our precision pricing engine, Clear Rates. It uses all of data sources as inputs and delivers a single, transparent rate for every payer/provider and network/billing code combination. Clear Rates eliminates conflicting and duplicate rates, scores the quality and confidence in accuracy for every rate, and blends claims and Medicare reference data to fill in gaps, provide benchmarks, and identify outliers.

More precisely, we use advanced statistical methods and inference to de-duplicate, fill in gaps, and surface the most accurate rate that analysts can rely on. Each rate is scored based on Turquoise's confidence level, derived from how many sources the rate was positively validated against, and rates that represent non-case-rate billing arrangements (such as per diem reimbursement, and percent of charge arrangements) are converted to real world equivalent rates using additional elements like average length of stay and billed charges. Finally, every data element that is considered in the creation of Clear Rates is logged in the dataset itself, so users can see the rate's native location, such as a payer MRF or Medicare reference data. This approach enables users to access a single platform with the broadest coverage across codes and gaps. That same platform also surfaces rates that are scored for accuracy, easily benchmarked against Medicare or claims data references, and are fully traceable.



Creating a singular rate to power the engine is based on a number of different processes

Ingestion

The benefit of using the multiple data sources is that we can more confidently capture every available rate for each provider-payer-code combination.

Previously, if a rate was missing in payer or hospital MRFs, the industry was stuck with a knowledge gap.

Transformation

The process to transform rates includes converting percentages to dollars, applying DRG crosswalks, calculating per diem extensions, and normalizing across different contract methodologies. Not all rates need to be transformed, but when they do, we are able to address the "comparing apples to oranges" conundrum that's plagued the industry for years.

Imputation

For missing rates, Clear Rates uses intelligent modeling based on observed patterns. For example, if 18 out of 25 DRG codes show the same base rate when normalized by CMS weights, we can reliably impute the missing 7 codes using that same pattern.

Scoring

Each rate receives a confidence score based on data quality, source reliability, benchmark alignment, and historical consistency. This adds an element of integrity to the surfaced rates so users can take rates at face value or spend additional time understanding the nuances behind a specific rate in question.

Rate Selection

All this work leads to the selection of the single best rate from all available options (original, transformed, or imputed) based on the highest accuracy score

The logic includes which rate to surface in the event of a tie.

Traceability

The notes fields in hospital and payer MRFs were previously the best place to try and understand the rate creation process. However, there's an element of needing MRF teams to show their work that remained missing. Our focus on traceability works to combat that, and every final rate maintains complete lineage. We show the exact calculation, methodology, and original source file used to arrive at the best rate.

Stop-Loss/Outlier Reporting

An important distinction here is that the term “outliers” in this section is different from the use of “outlier” in the previous payer MRF section. Here we focus on improvement opportunities specifically regarding stop-loss language and other methods of reimbursement for high-acuity care. The standard reimbursement methods often found in MRFs (case rates, fee schedules, per diems, and percent of billed charges) do not typically fully disclose outlier reimbursement. These methods miss reporting on over $100 billion in outlier costs[1]. Stop-loss language for outlier cases is variable and complex, as seen in the two examples below:

Example A: First-Dollar Stop-Loss

Stop-Loss rate applies to any admission (excluding Trauma and Burn) where billed charges reach or exceed the threshold in the rate sheet, including charges for Exclusion items (threshold may vary by facility), in lieu of the negotiated MSDRG or Per Diem rates.

Stop-Loss Threshold: $412,000
Stop-Loss % of Charge: 57.0%

Example B: Second-Dollar Stop-Loss

When the Eligible Billed Charges for a single inpatient admission exceed the Second Dollar Stop-Loss Threshold of $260,000 (excluding professional fees, implants billed separately, and excluded services as defined in Exhibit A), reimbursement shall convert from the applicable DRG or Per Diem methodology to the Second Dollar Stop-Loss methodology as follows:

The first $260,000 in Eligible Billed Charges shall be reimbursed per the applicable DRG or Per Diem methodology; and Eligible Billed Charges above $260,000 shall be reimbursed at 80% of billed charges.

In order to more comprehensively report negotiated rates that include outlier reimbursement, there are two regulatory approaches that could increase the presence of stop-loss language in MRFs:

1. The government could require full contractual free-text disclosure of "Inpatient Stop-Loss and other Outlier provisions" at the provider, Payer, and Plan level in both Hospital Price Transparency (HPT) and TiC files, even if these provisions are not triggered by a billing code for an Item or Service.
2. For complex algorithms that are attached to an Item or Service billing code, the government can reinforce the requirement to place the full contractual free-text of the algorithm in the notes (TiC) or algorithm (HPT) section of the in-network MRFs.

Stop-Loss Reporting for Hospitals

There are three permitted formats for HPT MRFs: CSV Tall, CSV wide and JSON. Our recommendation for CSV files follows the precedence of Modifier treatment, meaning the hospital would be placing Stop-Loss and Outlier as a row with no item or service billing code attached. With Modifiers as the guide, record level disclosure could occur as follows:

- Adding "outlier" as a valid value for "standard charge methodology"
- Requiring disclosure of the full text of the outlier provision in `standard_charge|negotiated_algorithm`
- Requiring Github clarity that `standard_charge|methodology` type "outlier" does not require presence of a billing code
- Modifying the MRF validator tool so as to not require an estimated allowed amount when "standard charge methodology" is outlier

For JSON MRFs, we recommend use of the existing `general_contract_provisions` field as it already accommodates payer and plan. We do not recommend `general_contract_provisions` in the CSV format as hospitals may omit or provide mismatched payer and plan information from the items and services record.

We consider this to be the most straightforward way to require disclosure of stop-loss provisions, but enforcement would need to be increased (see below). We would only add a new `provision_name` field to the `general_contract_provisions` object. This allows users to quickly identify outlier provisions from others.

Enforcement should also include making sure that payers and plans disclosed in `general_contract_provisions` match exactly the payers and plans included in `payers_information` object.

1.Outlier estimate derived from three sources: HHS Outlier payments[1], Segal SHAPE claims[2], and Turquoise Health contracts and claims. Scaled to national spend using CMS NHE[3] and Dieleman et al[4]. Source inputs combined via equal-weighted average to reduce bias from any single source.

1. https://oig.hhs.gov/documents/evaluation/2959/OEI-06-10-00520-Complete%20Report.pdf
2. https://www.segalco.com/consulting-insights/medical-stop-loss-premiums-increase-nearly-10-percent
3. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected
4. https://jamanetwork.com/journals/jama/fullarticle/2830568

The pros of this approach to hospital price transparency disclosure of Outlier:

- Minimal burden for providers
- Does not require an additional MRF or addendum file
- Maintains fidelity to Payer, Plan and Provider which is required for proper disclosure of Stop Loss, but does not require the attachment to a billing_code for an item or service
- Easy to enforce computationally:
    - Look for the presence of Outlier for all Payer / Plan combinations and filling in of required fields. If there are no entries with "outlier" methodology, throw a warning in the HPT validator tool.

Stop-Loss Reporting for Payers in the In-Network File

In TiC, we centered on the CSTM-ALL code type as precedent for record level disclosure where a standard billing code does not need to be present. Leaning on this precedent, we suggest:

In the In Network file, in the **in_network** object:

- **billing_code_type** = "CSTM-ALL"
- **billing_code** = "outlier"
- In the **negotiated_prices** object:
    - **negotiated_type**: "outlier" [Needs to be added as a valid value via Github]
    - **additional_information**: Text of the outlier clause [additional_information would be made a required field when **negotiated_type** = "outlier"]

There are a number of benefits to this approach:

- Minimal burden for payers
- Does not require an additional MRF or addendum file or new fields
- Maintains fidelity to Payer, Plan and Provider which is required in MRF
- Easy to enforce computationally:
    - Look for the presence of Outlier for all Payer / Plan combinations and filling in of required fields. If there are no entries with "outlier" negotiated_type, throw at least a warning in the MRF validator

Meaningfully Moving the Needle on Accurate Patient Estimate Fulfillment

You may have read up to this point and wondered what net benefits, if any, payer scores and clarity around accurate negotiated rate reporting have to help achieve the broader goals of price transparency. Why extrapolate the best rate at all? Notably, one of the Executive Order's areas of focus was on actual prices as opposed to estimates. As the May 22 guidance showed, most of The Departments' efforts to fulfill this requirement specifically targeted hospital MRFs. In-network rates are paid using a number of different provisions, like case rates, per diems, or a percentage of claim charges. If an algorithm is required to display a dollar value of the cost of care, CMS has created additional requirements for Estimated Allowed Amount reporting.

And yet, despite laser focus on algorithm-based pricing in hospital MRFs, there's a key area that's been conspicuously absent from most legislation this year: enforcement of patient estimate requirements. Estimates are a part of both final rules in the form of requirements for PETs. They're also a major part of The No Surprises Act (NSA), which governs a number of elements of the patient healthcare financial transaction, including requirements around Good Faith Estimates (GFEs) for uninsured or cash pay patients and Advanced Explanation of Benefits (AEOBs) for insured patients.

> *Should it matter that PETs and the NSA were not included in this summer's wave of updates? Unequivocally, yes.* ***By nature, MRFs are exactly as stated: machine-readable. Patients, on the other hand, justifiably benefit from a solution that is human-readable.*** *The burden of creating a shoppable healthcare experience was never intended to become patients' responsibility. Patients, even when they work in the revenue cycle or have managed care experience, cannot reasonably be expected to bundle rates or calculate algorithms on their own. Instead, that burden should be on innovators, health plans, and providers. TiC specifically noted that one of the main reasons to post rates was to* ***open the door for subject matter experts to transform MRFs into "products, research, and market oversight and reforms that will ultimately benefit consumers."***

The current PET landscape could use some improvement. For starters, hospitals are not required to maintain a PET if they post a shoppable services MRF instead. But in the event a provider does have an estimate tool of some sort and patients have attempted to navigate it, more than likely the experience has been at best, rudimentary, and at worst, cumbersome and frustrating. The PET experience often ends with a message telling the user to call the provider to get the requested information. And, if the PET does offer a price, it's often in the form of a range that's wildly variable, like an estimate of between $100 and $5,000. This is inherently unhelpful and in fact may be a driver in patients deciding to put off care if they fear the cost may be too expensive.

What does a reliable, credible PET look like? At Turquoise, our belief is that when displaying an estimated price for a service that is rendered as a part of an encounter and billed alongside multiple services and fees on a claim, it is critical to factor in any potential ancillary, professional, and optional items and services. The Turquoise PET includes Standard Service Packages (SSPs), our open license bundling methodology, to deliver comprehensive price estimates to patients that more closely reflect what they can expect to see billed on a claim.

To accompany an inclusive price and an itemized list of the services included, PETs should include educational content to empower patients with the requisite data, presented in the clear, non-clinical language patients need to have informed conversations with providers and their billing teams about the total expected cost of care. To ultimately empower patients as consumers, a reliable, credible PET should be robust and clear enough to support a productive conversation with the patient's care team.

Creating Standard Contracts

At the end of the day, all of the negotiated rate data published in MRFs is natively located within payer/provider contracts. The conversation around MRFs is incomplete without the full picture of not just dollar-value rates but the definitions, language, and rules of engagement that also exist in contractual base agreements, amendments, or payer policy documentation. What is the appeal limit? What is the claims adjustment limit? Is there prompt pay language? How can the claims adjudication process flow smoothly and in a way that eases administrative burden on both payers and providers?

To that end, Turquoise believes commercial contracting Preferred, Acceptable, Discouraged, Unacceptable (PADU) standards can and should be developed so hospitals and payers are able to best understand region-specific benchmarks around contract terms. In the same way that a standardized, simplified contract leads to simplified MRF reporting, a standardized, simplified menu of contract terms can lead to simplified claims adjudication. So what's the hold up? Contract terms are not required for publication in the same way negotiated rates are, so there's no way to know what the market is. For many entities, these non-rate elements of the contract are seen as a competitive advantage, but there are more efficiencies to be gained by standardizing terms when the aim is to eliminate the financial complexity of healthcare and reduce administrative waste.

Turquoise Health is interested in industry responses to creating a Preferred, Acceptable, Discouraged, Unacceptable (PADU) library to best understand contract terms in a way that mirrors MRF benchmarks. It's another way both sides of the negotiating table can show up with the same source of truth information. This type of repository can and should exist to better support payers, providers, and self-funded employers actively looking to ensure their contracts are in line with industry standard. If you are interested in getting involved in the creation of this PADU library, we encourage you to send us a note directly at patients@turquoise.health.

In Conclusion

We're eager to hear all thoughts and comments on this Impact Report, our Payer Transparency Scores, and the state of price transparency legislation. How, if at all, has your organization's use of transparency data evolved over the years? Where do you see opportunities to improve the patient's financial experience?

Let us know, as we would love to feature new use cases in forthcoming reports. **Drop us a line, here.**

Appendix

To view the detailed data behind our Analysis, **click here**.