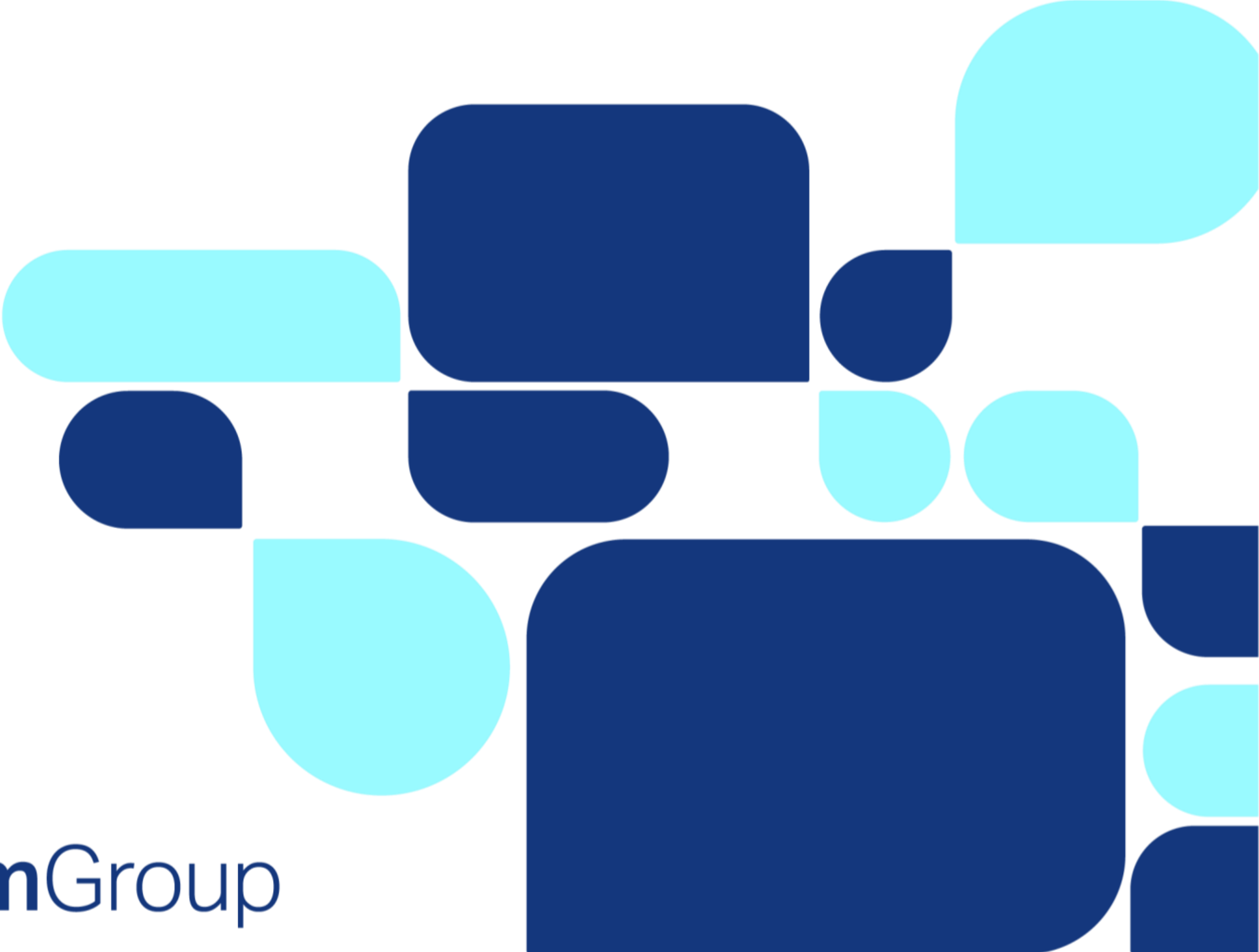
Compliance Guide: Transparency in Coverage Rule



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Purpose of this Compliance Guide 2

What Is It? 2

What is Required? 2

Publicly Available Machine-Readable Files 2

Consumer Price Transparency Tool 3

Effective Date Timeline 3

Which Plans Must Comply? 4

What Plans Are Excluded? 4

Enforcement & Penalties for Noncompliance 4

Value Beyond Compliance 5

Checklist for Self-Funded Clients 5

Additional Resources 6

Purpose of this Compliance Guide

The purpose of this compliance guide is to provide you, the self-funded plan sponsor, with information and resources to assist in navigating the new requirements under the Transparency in Coverage final rule. The manual includes detailed information covering the requirements as well as an easy checklist that can be utilized to help you prepare.

What Is It?

The Transparency in Coverage (TIC)[1] final rule was released by HHS, DOL and the Treasury Department on October 29, 2020. The requirements were issued in response to President's Trump executive order on *Improving Price and Quality Transparency in American Healthcare to Put Patients First*. The goal of the TIC rules is to make it easy for consumers to find accurate pricing information related to their healthcare. Over the next four years, the TIC rules along the No Surprises Act, will drastically change healthcare price transparency. The regulations place the responsibility on providers, health systems, health insurers, and health plans to share detailed pricing information to the public and personalized to members.

What is Required?

Publicly Available Machine-Readable Files

Health insurers and health plans are required to make available to the public, three (3) machine-readable files that detail information on the costs of covered items and services:

1. ***In-network negotiated rates*** for all covered items and services;
2. ***Historical allowed amounts,*** billed charges, and payments to ***out-of-network providers*** for all covered items and services;
3. ***In-network negotiated rates and historical net prices for prescription drugs*** by health insurer/health plan at pharmacy location level.

The publicly available website must be accessible free of charge and cannot require the user to establish a user account or submit any personal identifying information. The website cannot require a password or other credentials.

[1] Transparency in Coverage Final Rule

Files must be updated monthly.

This FAQ published on April 19, 2022 clarified that for plans or services provided under a “percentage-of-billed charges” where an exact dollar amount cannot be determined for those items or services prospectively, the plan is permitted to report the applicable percentage of payment.

In addition, the FAQ permits the plan to utilize open text fields to describe the applicable formula, variables, methodology or other information where the arrangement is not supported by the specified schema.

Consumer Price Transparency Tool

Health insurers and health plans must create online consumer tools that personalize information regarding a member’s cost-sharing responsibility for covered items and services, including prescription drugs:

- Permit members to search based on billing code,service description, provider name and geographic location;
- Allow members to compare costs across both in-network and out-of-network providers;
- Inform members of accumulated year-to-date deductible and other-out-of-pocket expenditures;
- List any factors that impact cost such as service location or drug dosage; and
- Provide cost estimates in paper format at a member’s request.

The online consumer price transparency tool must be an internet-based tool that provides real time, accurate estimates of a member’s cost-sharing liability for covered items, services and prescription drugs from different providers.

Effective Date Timeline

July 1, 2022: Machine-readable data files for in-network negotiated rates and historical data for out-of-network providers.

January 1, 2023: Online Consumer Price Comparison Tool that includes 500 specific shoppable items and services identified here:

January 1, 2024: Online Consumer Price Comparison Tool that includes all covered items and services.

Delayed Pending Rulemaking: Machine-readable data files for in-network negotiated rates and historic net prices for prescription drugs.

Which Plans Must Comply?

The final rules apply to all individual health plans and all group health plans regardless of their size or funding arrangement. This includes non-ERISA self-funded group health plans, subject to certain exceptions.

What Plans Are Excluded?

- Grandfathered Plans
- Excepted Benefits (e.g., standalone vision, dental)
- Retiree Only Plans
- Short-Term Limited Duration Plans
- FSA, HRA, HSA
- Medicare
- Medicaid

Enforcement & Penalties for Noncompliance

Potential Penalties: High

Although the final rule does not reflect specific penalties for noncompliance, rulemaking authority comes from the Affordable Care Act (ACA) and the Public Health Service Act (PHSA). Violations are subject to $100 a day penalty for each affected individual.

For example, for a 200 employee group, the maximum penalty (though unlikely in practice) for a year of noncompliance could be $7.3 Million per year.

- 200 Employees X $100 per day penalty X 365 days per year

Insured Plans: The Department of Health and Human Services (HHS). However, the states have primary enforcement authority.

ERISA Plans: The Department of Labor (DOL) has primary enforcement authority over group health plans subject to ERISA.

Value Beyond Compliance

Making cost information available online may meet the new federal requirements, but changing the way members find, evaluate and utilize healthcare requires more. These new transparency regulations create opportunities to have discussions with members about the value of knowing and understanding the cost of a healthcare provider or service, but they fail to address the importance of quality, experience, convenience and personal preferences. Things that equally influence an often emotional decision making process. In fact, studies show that the availability of price transparency with no additional information, may actually steer members to choose higher-priced care. But, as we know, higher price does not always equal higher quality.

When evaluating solutions and strategies to help meet these new requirements, it's important to think beyond just compliance. Find solutions and partners who will help empower members to implement real changes in the way they make healthcare decisions. Use this opportunity to re-engage members, educate them on the importance of evaluating their healthcare options and how they can make significant improvements in their overall healthcare navigation experience. Combining transparency with full population engagement, personalization, and high-touch offerings, creates a healthcare navigation experience that saves costs.

The new regulations are a step in the right direction, building a foundation for future changes as the journey to full transparency and reducing healthcare spending continues.

Checklist for Self-Funded Clients

- [ ] Talk to your broker or consultant to understand how these regulations might impact your plan design and overall healthcare costs.
- [ ] Develop a strategic plan and explore solution partners who can help you meet your compliance obligations.
- [ ] Talk to your Third-Party Administrator (TPA) and other solution partners currently servicing your plan. They may already offer solutions that can be integrated into your plan.
- [ ] When evaluating a potential third-party vendor, consider their ability to support the required public data files and online tools. Consider how many different sources of data exist and how those will be collected, aggregated and updated.
- [ ] Determine if the solution partner(s) you have chosen expects to provide these services in-house or utilize outside subcontractors.

- Review contract language with solution partners. Ensure that services to be provided are explicitly outlined and that the contract indemnifies the plan sponsor if the solution partner does not fulfill their contractual obligations.

Additional Resources

RESOURCE	WEB ADDRESS
Tri Agency FAQ 40	https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf
Transparency in Coverage Final Rule	https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
Tri Agency FAQ 53	https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-53.pdf
List of 500 items and services required for 2023 tool	https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage#page-72182
UnitedHealthcare TIC FAQ	https://www.uhc.com/content/dam/uhcdotcom/en/HealthReform/PDF/Provisions/reform-external-transparancy-FAQs.pdf
Anthem TIC FAQ	https://static1.squarespace.com/static/5e7f4ea99327941b94452bfb/t/626a9173f18809067e694bb6/1651151220021/ABS_CAA_TIC_Client_FAQ+_APR22.pdf

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