TREXIN INSIGHT PAPER

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TRANSPARENCY IN COVERAGE COMPLIANCE

Health plan timelines.

The Transparency in Coverage final rule, released by the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury, creates a framework of requirements for healthcare payers and providers to make pricing information available to the public. The goal is to create access for consumers to compare what their out-of-pocket expenses will be, allowing them to make cost-conscious evaluations of their healthcare needs and options. Healthcare providers have begun to meet their requirements and now, as payers prepare to comply with the Transparency in Coverage final rule, it is important to consider some of the challenges to be met in doing so. The new requirements only apply to health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets and non-grandfathered group health plans.

Over the next three years increasing levels of information will be required to be made available to the public.

- Starting for plan years beginning on January 1, 2022, **three machine-readable files** in a non-proprietary, open format will be required to be updated monthly specific to each plan or issuers:
    - The first machine-readable files will disclose information related to **in-network rates**.
    - The second file will detail the **allowed amounts** inclusive of billed charges from and historical payments to **out-of-network providers**.
    - The third file will detail **in-network rates and historical prices for all covered prescription drugs**, at the pharmacy location level.
    - **UPDATE:** CMS updated the Transparency in Coverage ruling in August 2021, deferring enforcement of the first and second machine readable files to July 1st, 2022. Meanwhile, enforcement of the third file has been deferred pending further rulemaking.
- On January 1, 2023, plan participant specific disclosures are required and must be provided, starting with **specific cost estimates for 500 services** outlined by Centers for Medicare and Medicaid Services (CMS).
- And finally, on January 1, 2024, **pricing information for ALL provided services** must be made available. The participant specific disclosures are required to be in plain language and will need to be available both via online tools as well as a paper mailing within two business days.

While this may seem like a simple requirement, it's execution can be anything but. Many payers use home-grown systems and technologies and synthesizing the requisite data into publicly accessible files can be a difficult task. More challenging still are the questions of how the very act of disclosure, of making this information publicly available, can affect the healthcare market and business strategy moving forward for payers.

An additional component of the Transparency in Coverage final rule includes changes to the Medical Loss Ratio (MLR) program. The MLR was introduced in the Affordable Care Act and required plans to provide a rebate back to plan membership if a proportion of premium revenue was spent on clinical services and quality-improvement activities. The Final Rule updates the MLR program rules to allow payers to receive credit in their MLR calculations for savings they share with membership that result from the membership shopping for, and receiving care from, lower-cost, higher-value providers. Beginning in the 2020 MLR reporting year, these shared savings payments made by an issuer to an enrollee will be factored into a payer's MLR calculation. This change provides an incentive for payers to engage in additional

administrative investments to drive healthcare transparency and reduce costs.

When the pricing is made available via cost estimation tools, consumers may have access to where to secure the lowest-cost option for healthcare, but not of the context on quality. This information has the potential to create an overemphasis on price when consumers evaluate their medical needs. As payers begin preparing to comply with the Transparency in Coverage final rule, an evaluation of their go-to-market strategy will be of paramount importance to ensure that their business goals are aligned as the landscape changes. Payers are in the business of negotiating provider pricing with a degree of flexibility depending on the specific circumstance. Pricing information has historically been considered confidential and proprietary so changes will need to be made to the confidentiality provisions of any service agreements, for example with pharmacy benefit managers or hospital systems. The cost to develop and build the required internet based self-service tools and machine readable files as well as training staff to respond to member inquiries is the apparent (or obvious) cost, but the larger financial impact will be in how payers navigate go-to-market strategy when pricing is more transparent.

These are the sorts of issues and considerations that are essential to consider over the next few years, as we move towards a greater level of public access to healthcare pricing information. In meeting the requirements and expectations of the Transparency in Coverage final rule, the goal is to provide a better overall result for consumers and stakeholders. Accomplishing that means navigating the challenges to the current business model to ensure that payers are able to continue to provide excellent services to their membership.

For more information on the changes and requirements of Transparency in Coverage, and how Trexin Consulting can help, both in the implementing of them and in navigating the challenges resulting from them, please click here.

This TIP was written by Trexin's Healthcare Practice Lead, Neil Rolland. Neil welcomes comments and discussion on this topic and can be reached at neil.rolland@trexin.com.