MarshMcLennan Agency

Employer Playbook: Transparency in Coverage

Countdown to price transparency compliance

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Introduction

Using this playbook

A proactive guide

This Playbook is a living document designed to guide MMA clients one step at a time through the complex nature of the extensive and transformative new Transparency in Coverage rules. This is the first of three planned playbook releases over the next few months. Each release will focus on the most burning priority along the rule's deadlines. Right now, that it is the machine-readable file requirements beginning to take effect July 1, 2022.

✓ What is the playbook?

A reference guide of the key information, planning steps and resources to support you in being compliant ready.

✓ Why should I use the playbook?

These are complicated rules to implement. Being proactive can minimize your non-compliance risk and surface new opportunities for plan design changes.

✓ Who is the playbook for?

HR, Benefits, and Compliance leaders looking for a simple blueprint on what to do and when to comply with the new federal requirements. Self-insured employers shoulder the most significant burden of liability, but there are still key actions for fully-insureds to be aware of.

✓ When should I use the playbook?

Now! The first effective date of July 1 is around the corner! At this stage, self-insureds, specifically, should get acquainted to the new rule and operationalize the steps to be compliant.

Warmup: Transparency in Coverage

Before you embark on compliance activities, it’s important to get familiar with the Transparency in Coverage (TiC) requirements.

Warmup: What is Transparency in Coverage?

In October 2020, HHS, Labor, and Treasury issued the groundbreaking “Transparency in Coverage” Final Rule (TiC), which requires plan sponsors of self-insured plans and fully-insured group health plans to disclose extensive price and cost-sharing information in a set of two different required data disclosures: public disclosures and plan participant disclosures.

These rules will be implemented in phases, over the course of about three years, beginning with the public posting of pricing data (known as the “machine-readable files” or “MRFs”) and progressing to a more personalized transparency experience for plan members in 2023 and 2024 through deployment of an advance cost estimate tool or health care “shopping tool” for plan members.

What the new transparency rules hope to accomplish:

- ✓ Empower, inform and incentivize action from consumers
- ✓ Shine light on hidden business arrangements between payers and providers
- ✓ Expose real-time pricing information and out-of-pocket liability
- ✓ Create a foundation of pricing data standards
- ✓ Enable comparison shopping
- ✓ Stabilize and reduce the price of health care services
- ✓ Establish a market-driven health care system

Warmup: Who must comply with the rules?

The following plan types must comply:

- Non-grandfathered group health plans, including employer-sponsored plans
- Multiemployer plans (e.g. Taft-Hartley plans)
- Multiple employer plans (e.g. association plans)
- Non-federal governmental plans (e.g. municipalities)

The rules do NOT apply to:

- Grandfathered plans
- Excepted benefits (e.g. onsite medical clinics, employee assistance programs)
- Account-based plans (e.g. health reimbursement arrangements, health FSAs)

The exclusions mean the rules primarily apply to medical and prescription drug benefits.

Transparency in Coverage applies to **all size employers**, including small groups less than 50 employees.

Penalties and enforcement:

Transparency in Coverage has bipartisan support, so it is unlikely the rules will go away. Although there are some discrepancies around requirements, “Good Faith” compliance should be pursued pending regulatory details.

- States are the primary enforcer for **fully-insured group health plans** with HHS as back-up.
- DOL is the primary enforcer of **self-insured plans**. DOL recently announced an initiative to add 100 investigators – a sign that increased enforcement is in store.
- There are steep penalties of $100 per plan member per day.

“Good Faith” compliance best practices:

- ✓ Know the rules and how to approach your plan
- ✓ Designate price transparency point of contact(s)
- ✓ Create a well-documented compliance strategy if you are self-insured
- ✓ Be clear on your abilities to execute your strategy prior to the deadline

Warmup: Burden of liability

Fully-insured plans:

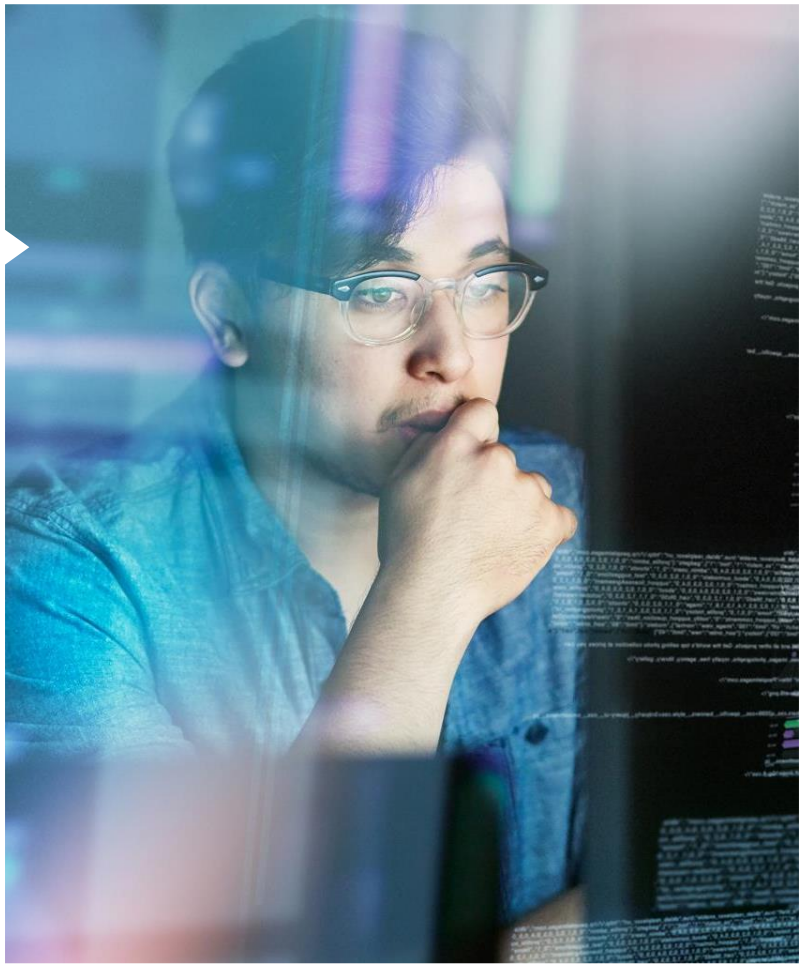
Fully-insured employers can delegate performance and compliance. Typically, the insurer will contractually assume sole responsibility for required data disclosures, meaning the plan has no liability. However, this is not a guarantee. **Fully-insured employers should make sure to have a written agreement in place with their insurer to ensure both sides are in agreement about who will be taking responsibility for data disclosure.** If you don't do this, the employer/plan sponsor could have liability.

Self-insured plans:

Self-insured employers can delegate compliance performance but not the compliance obligation. The plan/plan sponsor is responsible for complying with the Transparency in Coverage rules. **Self-insured plans may contract with a TPA to provide the disclosures.** Employers should review contract agreements to ensure there are appropriate representations and indemnification provisions in place.

Level-funded, minimum premium plans:

In most cases, **a level-funded plan is self-insured and a minimum premium plan is fully-insured**. If you are unsure, the carrier/TPA can tell you if the plan is filed as a fully-insured policy in one or more states. If no, the plan is considered self-insured.



Warmup: What are the key phases and scope?

Phase 1: Document
January 1, 2022 *(enforcement delayed to July 1, 2022)*

Create public machine-readable files (MRFs) that display in-network rates, out-of-network allowed amounts, and prescription drug pricing.[1]

- *Plan years beginning from 1/1/22-6/30/22 must begin disclosing the first MRF (medical) by July 1, 2022*
- *Plan years beginning on or after 7/1/22 must begin disclosing by the end of the month in which the plan year begins*

Phase 2: Personalize
January 1, 2023

Offer an internet-based, advanced cost estimate tool, with that provides personalized, out-of-pocket cost estimates and other price-related data for 500 pre-determined items and services.

Phase 3: Expand
January 1, 2024

Expand the internet-based advanced cost estimate tool to include cost-estimates for all covered items, services and prescription drugs.

Quality data is not part of the mandatory disclosures in the rules.

1) Negotiated rates and historic net prices for drugs file delayed pending further guidance 2) CMS data schema specifications: https://github.com/CMSgov/price-transparency-guide

Warmup: What are the key phases and scope?

First focus: phase 1 MRFs

Let's preview the MRF requirements. This should give you a sense of the twists and turns that often unfold in the generation of these complex, data files which are ushering in new ways to manage and process health care pricing data. We will further unpack **MRFs and pathways to compliance in *Part 3: Game Time.***

In-network negotiated rate files: Rates for items and services of all contracted providers need to be included. If a plan uses leased networks, MRF format allows URL links. Each listed rate should be associated with a National Provider Identifier (NPI), Tax ID Number (TIN), and Place of Service Code for each provider and the last date of the contract term or expiration date. If a plan uses a standard fee-for-service model or other reimbursement arrangements, the primary billing code and total cost for the bundle must be identified in the file, as well as the list of services included.

Out-of-network allowed amount files: These have many of the same basic data elements listed above. Where they are different is only historical payments for providers with more than 20 claims in the first 90 of the preceding 180 days need to be included in this file.

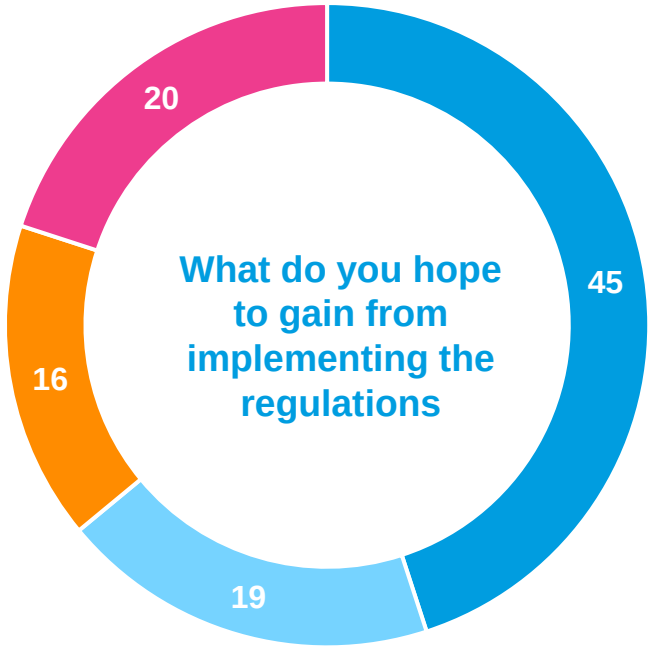
Warmup: Employer sentiments

How employers are viewing the rules

Self-insured employer members of the *Employer Health Innovation Roundtable*[1] polled during meetings in fall 2021 generally favored the rule—or at least the principle behind it—but responses vary on preparation and progress toward compliance, as well as predictions for impact. Polling results and conversations revealed several insights and sentiments on Transparency in Coverage Rule.

Paths, partners and costs

A majority of benefits leaders who weighed in aren't looking much beyond July 1. Employer attendees were asked which of their vendors they consider responsible for helping them meet the required medical and pharmacy components. The overwhelming majority specified their health plan, TPA, pharmacy benefit manager (PBM) and consultant. ERISA Counsel and internal compliance departments were also mentioned. Only 6.6 percent said "Other Benefit Vendor." In response to the question who is paying for it, those who had discussed with a PBM, TPA or consultant implied that the costs are considerable. It is unlikely the average TPA will be able to incur these costs and it was assumed TPAs were already looking at outside pricing transparency vendors to subscribe to.



- **A: Better access to information/data transparency**
- **B: Lower health care costs**
- **C: Identifying *bad actors* in the system**
- **D: A more competitive health care system (10%)**
  Easy to interpret data (5%), Employee/member engagement (5%)

1) Research and white paper by EHIR & Rx Savings: https://rxss.com/ehir-transparency/

Pre-game: Employer compliance

The most important action for employers to take at this time is to ensure that any agreements you have with your insurer/TPA specify who will provide the information for, update, and host the machine-readable files. The following pages unpack key considerations for your compliance planning.

Pre-game: How do we meet the requirements?

Remaining compliant will be a considerable undertaking and requires partnering with an MMA benefits consultant who is skillful in breaking down the big picture and finer details of navigating TPA/insurer relationships. As previously explained, **fully-insured employers** can largely rely on their insurer to satisfy the requirements; a safe harbor is available for sponsors of fully-insured health plans if there is a written agreement with the insurer. **There is no similar relief for self-insured plans**. While many self-insured employers will contract with a TPA or ASO to furnish the advance cost estimate tool and machine-readable files, vendors will undoubtedly charge additional fees, so a budget and corresponding action plan are essential. At this stage, **self-insured employers should be out of the learning period and operationalizing compliance.**

Pathways to compliance:

Reach out to your insurer/TPA representative to fully understand their implementation plan, requirements and timeline. Don't just assume your insurer/TPA will comply.

- **Fully-Insureds:** Ensure you have a written agreement in place with your insurer.
- **Self-Insureds:**
  - ✓ Review your current plan year TPA contract to see if there is any language specific to transparency rules *(unlikely)*
  - ✓ Understand thoroughly additional TPA fee schedules
  - ✓ Decide whether to contractually delegate compliance "performance" to the TPA *(we generally recommend yes in all cases)*
  - ✓ Discuss with your legal counsel appropriate compliance representation language and ensure all contracts including data use/BAA/NDAs are reviewed
  - ✓ Negotiate indemnification protection from any compliance failures by the TPA *(highly recommended)* if the existing indemnification language is insufficient.

Under basic contract principles, a written statement from the insurer/TPA that it will handle one or more transparency items and that does so without objection by the employer should constitute a written agreement between the parties Please save the correspondence.

Pre-game: FAQs

Will the regulations be delayed?

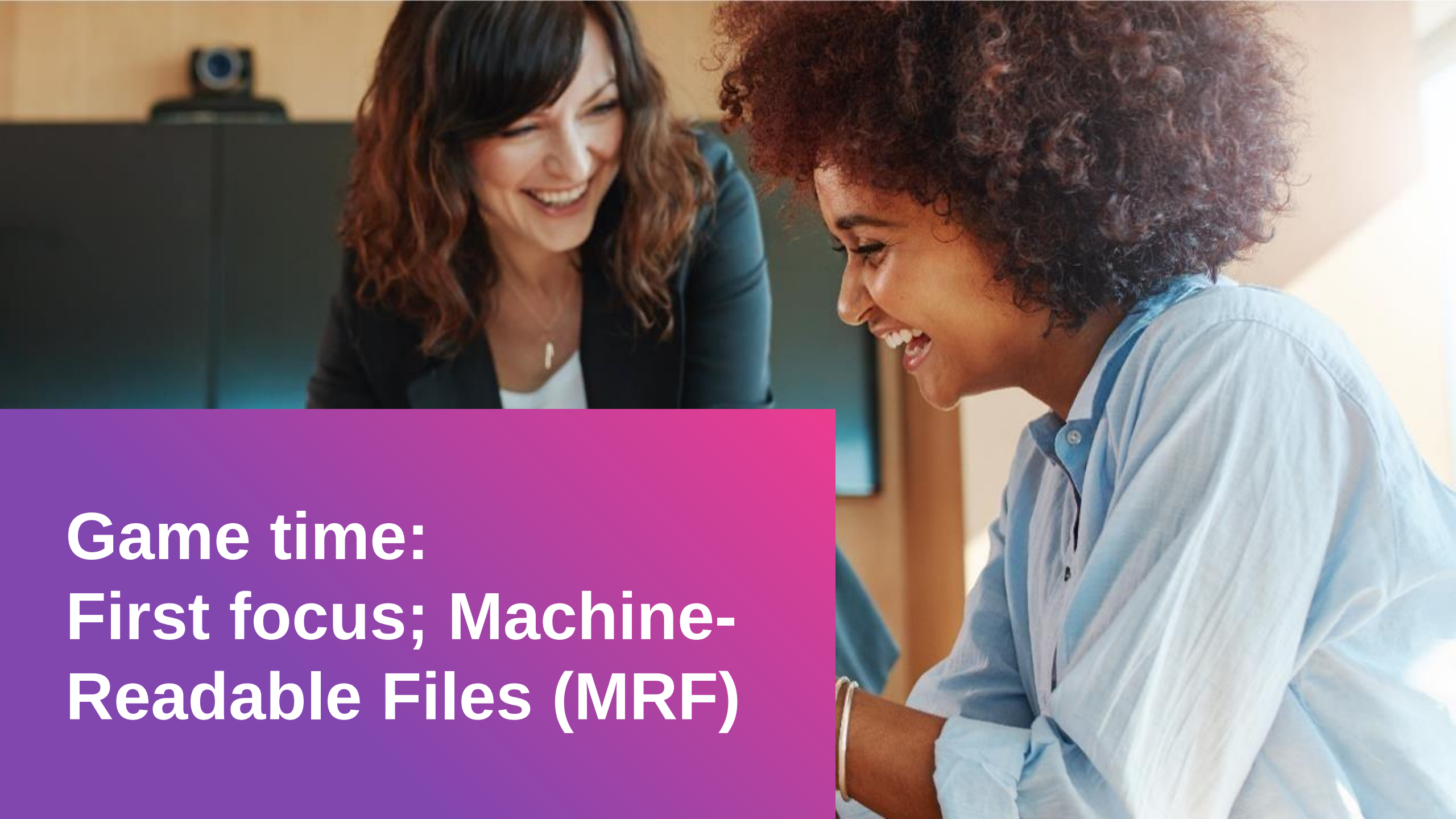
While there is still speculation about what will and won't happen, CMS continues to signal that the July 1st effective date for publicly disclosing in-network rates and out-of-network allowed amounts is STILL on track.

Is the market ready?

Employers are overwhelmed trying to figure out how to be compliant. Price transparency is a big deal and the manner in which insurers and self-insured employers are required to disclose this information – for example, through *machine-readable files* – is generally new to the industry. The bottom line is stakeholders are taking compliance seriously, but they continue to struggle to comply due to some practical and operational issues.

What is keeping people up at night?

Currently, it's discrepancies around the machine-readable files and how certain information should be input and then getting that data. TPAs and their self-insured customers are struggling with how to comply if they cannot access the necessary pricing data from a medical provider or the owner of a provider network. There are also open questions regarding unique plan designs and reimbursement arrangements. What about carve-outs? How will Rx drug data be integrated? etc.



Game time:
First focus; Machine-Readable Files (MRF)

Game time: Focus MRFs

What do we need to know about MRFs?

Plans and insurers must create two files: **one to disclose in-network provider rates and another to disclose out-of-network allowed amounts and billed charges for covered items and services.** The prescription drug file has been delayed until further notice so is not due July 1 with the other two files. Both files must be machine-readable, meaning they must conform to non-proprietary, open standard format such as XML or JSON and be available via HTTPS. Formats such as PDF or DOCX are not acceptable file formats**. MRFs must be updated monthly and indicate a date of most recent update.** As a general matter, the information in the machine-readable files will be meaningless to the average person. The purpose of the MRFs are to allow application software and analytics companies to ingest and create useful products and services that can be leveraged to manage health care costs.

- *Plan years beginning from 1/1/22-6/30/22 must begin disclosing the first MRF (medical) by July 1, 2022*
- *Plan years beginning on or after 7/1/22 must begin disclosing by the end of the month your plan year begins*

Steps employers can take:

- ✓ **Determine whether you or the TPA will host the MRFs.** Insurers will host for fully-insured plans but be aware of exactly where your MRF will be posted (see the next bullet). Insurers are sending out notices outlining how to access them and any associated action items.
- ✓ **Self-Insured employers must provide a link to the MRF file on their own public-facing website not intranet** (generally recommend the MRF link appear within one click from your main landing page).
- ✓ **If an insurer for a fully-insured plan accepts performance/compliance by agreement**, we interpret the rule to mean that the employer does not have to host the MRFs or post a link to the MRFs on the insurer's website.
- ✓ **Provide and/or confirm certain data elements to the insurer/TPA.**
- ✓ **Ensure self-insured service agreements indicate the TPA will update on a monthly basis and continue to host MRFs through the end of the current calendar year.**

Game time: FAQs

Is there a hub of technical guidance?

Yes, the technical implementation guide can be found here. The current MRF format was introduced on March 1. It contained last-minute schema changes: additional rate types (i.e. percentage can now be used when you don't know a charge amount), additional custom billing codes were added and increased flexibility with provider references and usage of the table of contents. The files are large and the intent is to lessen the cost and complexity of storage and access. CMS has indicated future changes will come to the data schema, but when future releases will occur is unknown.

Have MRF FAQs been put out by CMS?

Yes, on April 19, 2022, the Administration released new FAQs specific to the machine-readable files. According the FAQs the Administration will provide an enforcement safe harbor when plans using alternative reimbursement arrangements cannot accurately derive a specific dollar amount until after the service is rendered, for example, in percent-of-billed charges contract arrangements. In such cases, the plan can list the formula, methodology or other information about how the rate would be derived, instead of a specific dollar amount.

Do the insurers have information on their website?

Yes, the large, national health plan carriers (BlueCross BlueShield, UnitedHealthcare, Cigna, Humana and Anthem) have FAQs on their public websites with information about their approach to the Transparency in Coverage rules. For example, click here for UnitedHealthcare's FAQs.

Game time: Key takeaways

Key action steps for employers

Fully-insured employers should make sure they have a written agreement in place to ensure their legal responsibility has shifted to the insurer.

Self-insured employers should ensure that any agreements they have with their TPA **specify who** will provide the information for, update, and host the machine-readable files for the public disclosure requirement and determine any indemnity provisions or other protections if the TPA fails to satisfy the rules.

Data currency for employers?

The interesting question right now is how actionable the MRF information may be. No one knows yet. Additionally, some health care stakeholders have voiced skepticism that transparency will only lower costs, speculating that it may instead lead to a race to the middle and also raise rates for those with “better deals.”

Quality data

Quality data is not part of the mandatory disclosures in these rules. Identifying what constitutes quality has been difficult for industry experts. There are a number of organizations dedicated to coming up with a uniform definition of quality that is acceptable to all industry stakeholders. But, that is still a work in progress. Having said that, reporting quality data is the next big frontier in transparency. The federal departments want to add a quality component to the Transparency in Coverage Rule while issuers, plans, TPAs are pushing hard for an industry-standard on what constitutes quality.

Post-game – What’s next

Post-game: Resources

Advance cost estimate tool guide

The advance cost estimate tool component of the Transparency in Coverage rules is the most complicated piece to implement. The next release of this playbook in June will support you by breaking down the requirements, arming you with the most up-to-date guidance and market information as well as pathways for you to meet the requirements.

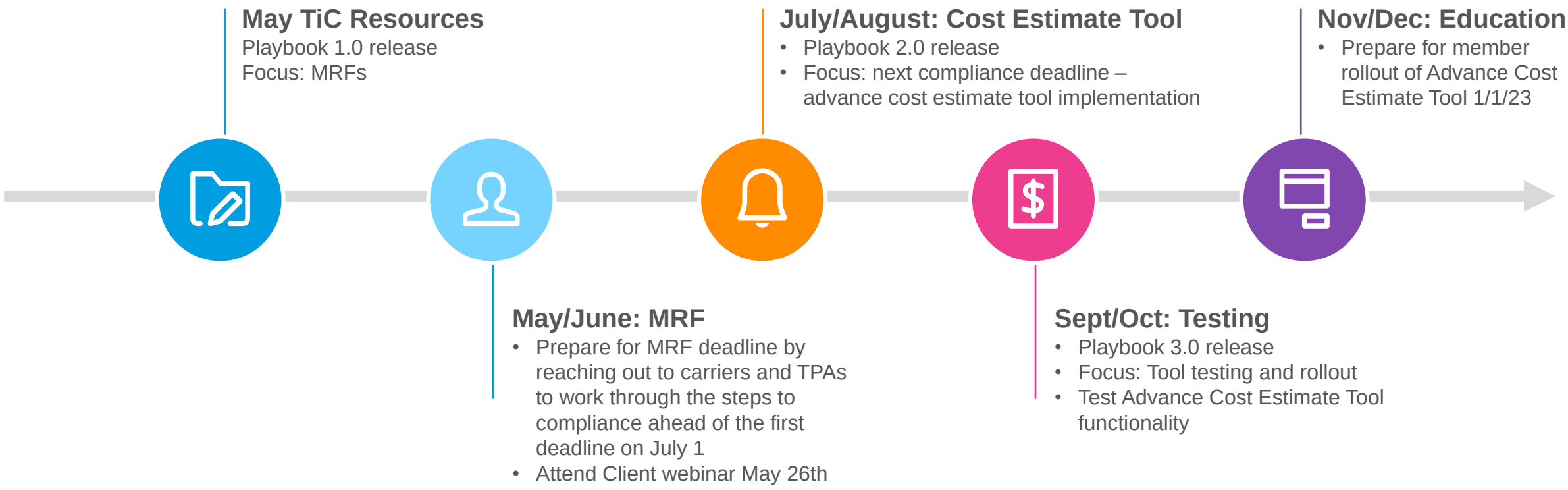
MMA resources & support

Contact your local MMA Representative

Join our client webinar on May 26th, 2pm EDT – Register here

Post-game: When can I expect future playbook updates?

MMA has you covered with the most up-to-date information and resources to advance your readiness plan.



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