

# Cost Transparency:

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500 Ways Benefits Will Get More Personal



# Game Changer

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After years of remaining buried beneath red tape, a federal mandate issued in late 2020 seeks to at last bring U.S. health care costs into the light of day. Published jointly by three federal agencies, the final [Transparency in Coverage Rule](#), aims to allow Americans to more accurately predict their health care costs by helping them find and filter care providers and lab services within their network and location, and with respect to the amounts paid toward their deductible and out-of-pocket maximum.

## **It's personal. And it's a game changer.**

With effective dates staggered across a three-year period, the new regulation methodically peels back the curtain that has obscured the personal and macro-economics of health care for decades. And for benefits professionals, **there's never been a better opportunity to increase employees' engagement** in their health care and pharmacy benefits.





# We've All Experienced It

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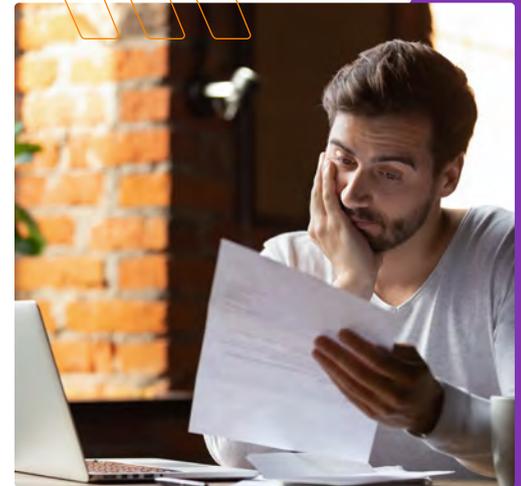
Nearly everyone in the health care ecosystem has felt frustration at the lack of cost transparency. When asked how much something will cost, providers tell patients to check with their plan. We all know urgent care is less expensive than the emergency room, but by how much? Network status is available through benefits platforms and plan websites, but employees will be the first to say it isn't consistently accurate.

**And surprise billing? Let's not even go there.**

As a benefits professional, you've been told the answer is "health care consumerism." By putting the purchasing power in the hands of employees through high-deductible health plans and other cost-shifting arrangements, employees will make more informed health care decisions.

**Or so the theory goes.**

There's just one problem. **It's incredibly difficult—if not impossible—to predict** how much anyone will pay for a particular health care service under a specific plan, in a specific ZIP code, with a specific provider or lab and with respect to one's current deductible and out-of-pocket max accumulations.





# The Rule

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Published jointly by the U.S. Departments of Health and Human Services, Treasury, and Labor, the final Transparency in Coverage Rule requires **group health plans and insurance issuers to make two key types of disclosures**:

**Disclosures to the Public:** For plans with effective dates beginning on or after July 1, 2022, plans and issuers must publicly disclose health care pricing online and update it monthly. The pricing information must include:

- In-network provider **negotiated rates** for covered items and services
- Historical data of **billed and allowed amounts** for covered items or services furnished by out-of-network providers, labs, and pharmacies
- Negotiated rates and **historical net prices** for in-network prescription drugs (deferred pending further ruling)

**Disclosures to Plan Participants:** Plans and issuers must provide certain personalized cost-sharing information to participants and beneficiaries in advance and upon request through an online self-service tool related to:

- 500 of the most **“shoppable” health care services** and items (effective Jan. 1, 2023)
- **All covered health care services**, items and prescription drugs (effective Jan. 1, 2024)





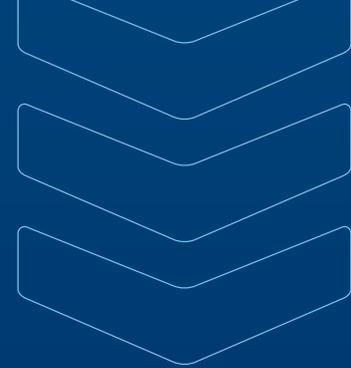
# The 500 Shoppable Services

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Whether it's a knee surgery, a tonsillectomy, or the removal of a plantar wart, most people understand the importance of shopping around when time permits. Like any other purchase, we want the **right provider to deliver the right service at the right value.**

**But with health care, this has never been easy.**

For even the most empowered health care consumers, calculating their remaining deductible, double checking their out-of-pocket max and calling various providers takes time and energy. Oftentimes, they simply settle for the one with the earliest availability, which does a **disservice to both patient and plan.**



**Given these barriers, regulators compiled a list of 500 "shoppable" health care services and items. In developing the list, researchers considered:**

- **Non-urgent** (i.e., planned) procedures
- The **most frequently performed** services and items
- Services with the most significant **cost variability**





# The Timeline

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Fortunately, the effective dates for the varying degrees of transparency and technological implications outlined in the rule are staggered. Here are the high-level requirements\* for plans and issuers during each phase. **For plan years beginning on or after:**

## July 1, 2022

### Publicly disclose:

- Negotiated rates for in-network providers
- Historical allowed amounts for out-of-network providers

## Jan. 1, 2023

### Disclose to participants via an online self-service tool:

Personalized cost-sharing information and negotiated rates for the identified 500 'shoppable' services

## Jan. 1, 2024

### Disclose to participants via an online self-service tool:

All covered health care items and services





# The Self-Service Tool

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When the first part of the rule goes into effect on July 1, 2022, the public disclosure of previously proprietary information will likely result in healthier competition among plans and health care providers. That's good, but the truly exciting part is the availability of a **self-service tool** slated for plans with effective dates of Jan. 1, 2023, and later.

In helping employees make the most optimal health care decisions based on their unique circumstances, the second part of the rule—the disclosures to plan participants—represents the biggest **employee engagement opportunity** employers have had in decades.

**It literally puts everything at their fingertips.**

**According to the rule, group health plans and issuers must provide their employees with an online self-service tool that:**

- Allows plan participants to look at costs on a **code-by-code** and **provider-by-provider** basis
- Includes real-time **cost accumulators**, such as how much members have accrued toward their deductible, out-of-pocket maximum, etc.
- Distinguishes between in-network negotiated rates and **out-of-network allowed amounts**
- Makes these details available **online whenever** the member needs them





## Obligation Or Opportunity?

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Benefits professionals are well-versed in compliance issues and often regard them as **obligations that yield few, if any, opportunities** to improve benefits cost-effectiveness or overall benefits strategy. And yes, the new rule outlines the penalties for non-compliance. Group health plans and issuers who fail to adhere to these disclosures can face a fine or an excise tax of \$100 per person per day per violation.

**But this is one mandate where the potential opportunities far outweigh the burden of the obligation.**

- Encouraging employees to seek in-network care can reduce employers' health care spend by 3%
- Up to **27% of U.S. emergency room visits** can be managed in physician offices, clinics and urgent care centers, saving \$4.4 billion annually
- Nearly 1 in 5 inpatient admissions includes a claim from an out-of-network provider
- Nearly 45% of Americans have received a "surprise bill" for services they were unprepared for
- Employees will be better able to gauge their health care spending for the year and take advantage of FSAs and HSAs to fund their upcoming expenses tax-free





# But Wait, There's More: The No Surprises Act

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The No Surprises Act, introduced in late 2020, generated a lot of buzz among benefits professionals. Aimed at **protecting patients from surprise medical bills** in situations where they have little or no control over who provides their care (e.g., services provided by out-of-network providers at in-network facilities or special services like air ambulances), this rare piece of bipartisan, bicameral legislation was a long time in the making.

## Hence the headlines.

In the context of cost transparency, the No Surprises Act is critical to the new rule's success. Disclosing costs to plan participants by itself means little if they can still get surprise-billed for thousands more than they were expecting. With the two regulations combined, **participants can be confident** they won't receive bills beyond those amounts, as long as they go to in-network facilities.

## The implication for employers with self-funded plans is two-fold:

- Those who provide easy access to cost transparency information can better educate their employees and **build confidence** in their benefits selections prior to annual enrollment.
- Those who start educating their employees now about the transparency tools that will be available to them between 2022 and 2024 make a strong case for **retention**, financial security and employer empathy.





# Six Next Steps For Employers

While compliance with the transparency rule may seem daunting, it helps for employers to **break down the requirements and delegate compliance responsibilities** among their various service providers.

**These six steps can help focus their efforts:**

- 1 Work the clock.** These changes are going into effect now. Make sure you're up to date with these [Labor Department resources](#).
- 2 Take inventory.** Determine which plans are subject to the new rule. For now, vision, dental, EAPs, FSAs, fixed indemnity hospital, specified disease coverage, grandfathered, retiree medical, and certain account-based plans are exempt.
- 3 Delegate.** Assess which compliance aspects to assign to insurance issuers and which to contract to third parties.
- 4 Document.** Carefully outline which parties are responsible for compliance.
- 5 Budget.** Issuers and TPAs will undoubtedly pass along certain compliance costs.
- 6 Show and tell.** Ensure sufficient time for beta testing the online tools, as well as informing employees about their ability to maximize benefits decision-making and cost savings.



# Ready To Learn More?

Employees can enjoy a seamless experience, from enrollment to provider lookup with **MyChoice® Find a Provider**.

Learn more about this  
Transparency in Coverage solution.



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