Estimating the Burden of the Proposed Transparency in Coverage Rule

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I. EXECUTIVE SUMMARY

Driven by concerns about health care expenditures and the difficulties individuals encounter in obtaining information in advance about the cost of health care goods and services, the Administration has proposed a new "Transparency in Coverage" rule (TCR). These regulations would require two things from carriers offering health plans: (1 a consumer tool that allows carrier members to prospectively identify their specific out-of-pocket (OOP) cost for any health care services or goods covered by their health carrier; and (2 two publicly-available machine-readable data files. One of these files (the Negotiated Rate File) lists negotiated prices for all covered goods and services for all health care providers in the insurance carrier's network. The other file (the Allowed Amount File) reports the amount that the insurer has historically paid for covered items and services delivered by providers not included in the carrier's network.

The economic issues involved in transparency in health care coverage have been discussed in academic literature, and there are many important financial and economic issues related to transparency that we do not consider here. Among these are the potential impact of disclosing confidentially negotiated rates for hospital and provider payment; economic implications for the cost and quality of care resulting from releasing negotiated rates between providers and payors; potential legal costs; and customer experience issues arising from a regulatory approach that potentially conflicts with existing market driven efforts. This paper is focused on assessing the administrative and operational costs of implementation that are likely to be incurred by covered private carriers if the current proposed regulations are finalized without any changes.

The Proposed Rule was published by the Department of the Treasury, Department of Labor and Department of Health and Human Services (the Departments) in the *Federal Register* and includes estimated compliance costs. We have been asked to assess the costs insurers are likely to encounter and to compare those to the cost estimates in the *Federal Register*. In order to assess those costs, we conducted interviews with representatives of 18 insurance companies representing approximately 78 million members, describing the carrier requirements and asking them to provide initial estimates of the cost of establishing the tools and data files described in the regulations. The vast majority of these carriers (94.4%) already offer a consumer price transparency tool, providing OOP cost information on an average of 1,011 items and services.

Through our interviews, we found that insurance companies anticipate a much greater burden for establishing and maintaining the tool and the data files required by the regulation, by a factor of about 26, than is estimated in the Proposed Rule. The table below summarizes the results of our interviews.

Tool element	OMB cost estimate	Carrier cost estimate average	Carrier cost estimate range
Set up web-based consumer price tool (full build)	$221,029	$5,528,000	$1,000,000 to $15,000,000
Set up negotiated rate file	$107,905	$2,139,167	$85,000 to $10,000,000
Set up allowed amount file	$117,757	$1,071,167	$42,000 to $5,000,000
Annual maintenance of web-based consumer price tool	$13,141	$3,784,375	$375,000 to $10,000,000
Annual maintenance of negotiated rate file	$36,022	$467,000	$15,000 to $1,000,000
Annual maintenance of allowed amount file	$14,698	$643,000	$15,000 to $1,500,000
Total	$510,552	$13,632,708	-

In view of the fact that carriers are of widely varying sizes, have different levels of experience and have engaged in different levels of analysis of the impact of these newly proposed regulations, there are differences in the extent to which carriers have evaluated the costs and feasibility of complying with the regulations. The carriers also make different assumptions about the degree of support from vendors or trade associations that affect their perception of the administrative and operational costs of implementation.

Primary Conclusions:

- Carriers we interviewed anticipated the implementation costs of the TCR requirements to be substantially larger than the costs estimated by the Departments. Although the responses we received vary in their precision, the total estimated cost of complying with the proposed rule (including set-up and annual maintenance) as estimated by the carriers was $13.6 million, more than 26 times the estimate produced by the Departments.
    - The average of the estimated set-up costs provided by carriers was approximately $8.74 million, while the Departments' estimated set-up costs totaled $447,000, assuming the carrier needed to build a complete consumer tool.[1]
    - The difference in the estimates of annual maintenance costs is quite significant. The Departments estimated that the annual maintenance costs for the consumer price tool would be about $13,000, but the average of the carriers' estimates was $3.8 million, about 288 times higher. The annual maintenance costs for the two machine-readable files were also viewed as significantly more costly by the carriers.
- Carriers viewed the Consumer Search Tool as much more expensive (by a factor of more than twenty-five) to operationalize than estimated by the Departments. Although most of the carriers we spoke with have an existing consumer facing tool meeting many of the required elements of the TCR, several carriers expressed significant concern about the cost and feasibility of complying with the requirements as

[1] As discussed below, the Departments estimated that the set-up cost for a partial build of a consumer tool was $55,260.

written. Importantly, many respondents indicated that the detailed specifications of the requirements may necessitate a complete rebuild of their consumer tool. Key concerns include:

  - As written, the TCR references providing pre-service estimates of *all* services (discrete or bundled) that would be covered. This requires a carrier to essentially engage in a mock claim adjudication which can be highly complex depending on the goods or services involved.
  - This requirement involves costly and complex integration of benefits that are not uniformly maintained within existing systems. Pharmacy benefits, benefits provided through third-party administrators, medical management requirements, visit limits and allowed out-of-network benefits were key elements of concern.
  - There seems to be a core set of functions for a core set of services that the majority of respondents report having currently. These include the ability for members to: (1 learn about their OOP costs for certain items and services; (2 search for items and services by provider and by descriptive terms; and (3 filter and sort by geography, OOP costs, and distance. The carriers we interviewed typically focus on "shoppable" and commonly utilized items and services (or in some cases, procedures and bundles). In our sample, consumer tools currently provide OOP cost information on an average of 1011 items and services.[2]
  - The requirement does not appear to recognize the unavoidable uncertainty in defining and pre-determining the precise services that may be provided in a given care setting. This uncertainty greatly complicates providing precise estimates of cost in many settings. One knee replacement, or one child birth, will not be the same as others, for example. It will be difficult to communicate to customers what the cost of their precise experience will be in any matter in which there is a need for provider decisions and adjustment to medical circumstances that cannot be known in advance. Some respondents indicated that inputs from providers such as diagnosis codes may be necessary to reflect the degree of precision specified in the rules.
  - Multiple respondents indicated that they have existing business strategies focused on increasing cost transparency for members in a way that enhances the consumer experience. They have concerns that certain TCR requirements are inconsistent with those strategies and would require changes in customer service priorities that they see as detrimental to care and the customer experience.

- Carriers viewed the Negotiated Rate File as much more costly to implement (by a factor of approximately twenty) than estimated by the Departments. Carriers estimated set-up costs surpassing $2 million, on average. Annual maintenance costs were also estimated to be much higher at $467,000, about 13 times higher than the Departments' estimate. While not quantifiable, some respondents indicated that certain aspects of this portion of the Proposed Rule are not feasible. For example, they noted that negotiated rates for performance-based (quality-adjusted) and experience-based (risk-adjusted) contracts can only be calculated ex-post and would not necessarily reflect rates going forward.
- Generally, we found that interview respondents shared consistent concerns about the high cost and significant complexity associated with producing the Allowed Amount File. While no carrier had carefully evaluated the cost of publishing such a file, carriers estimated set-up costs of over $1 million (about nine times higher than estimated by the Departments) and annual maintenance costs of $643,000 (44 times higher than the Departments' estimate). In addition, some respondents expressed concerns about maintaining HIPAA protections because of the small numbers of claims associated with particular services and out-of-network providers.

[2] One interviewed carrier does not have a consumer tool; the average was calculated including zero for that carrier. Among the carriers that do have a consumer tool, the number of items and services for which OOP cost information is provided ranges from 148 to approximately 1600.

II. OVERVIEW AND SCOPE

On Nov. 15, 2019, the Departments of Health and Human Services (HHS), Treasury, and Labor released a proposed "Transparency in Coverage" rule (TCR).[3] On Nov. 27, 2019, TCR was posted in the *Federal Register* and the Departments are seeking comments by 5 p.m. on Jan. 29, 2020.[4]

Bates White was asked by the Blue Cross Blue Shield Association (BCBSA) and America's Health Insurance Plans (AHIP) to conduct an analysis of the feasibility and costs of implementing necessary changes under the proposed rule. This report summarizes the results of that evaluation, which was conducted by interviewing representatives of 18 carriers that are members of BCBSA and AHIP. We refer to these interview respondents as "carriers" throughout. Efforts were made to include carriers with a wide range of characteristics, such that our sample is roughly representative of all carriers offering a variety of health insurance coverages.

The carriers we interviewed span the range of small to large insurers. Our interview respondents cover a total of more than 78 million lives in the U.S. and range from a low of under 300,000 to a high of more than 25 million covered lives per carrier. Interviewed carriers included both national and individual state carriers and offered a variety of coverage designs including group and individual coverage in a variety of formats in both the private and public sectors.

Each interview was scheduled for one hour. In view of the relatively short time since the Proposed Rule was released, most carriers have not undertaken formal cost estimation analyses and have not formally begun implementing system changes or negotiating with third parties regarding system and data upgrades. Thus, the figures reported here represent the carriers' best approximations of the operational costs involved in implementing the new regulations at this time and should be interpreted as preliminary estimates that are subject to change. Carriers emphasized that their estimates are based on the assumption that no major unforeseen problems occur. Thus, their estimates are believed to be conservative and could be significantly higher, especially for those aspects of the Proposed Rule for which feasibility is not assured. Further, carriers were asked to describe the feasibility and costs associated with implementing the Proposed Rule as it currently stands, despite the fact they expect certain elements of the regulations to be clarified, modified or eliminated.

This report: (1 summarizes the current state of BCBSA and AHIP carriers' price transparency efforts and evaluates the feasibility of meeting specific requirements of TCR within one year of when it is finalized; (2 compares the cost estimates provided by carriers with those calculated by the Departments; and (3 identifies areas in which the carriers interviewed believe the Departments' estimates appear to be reasonable, understated, overstated or incomplete. A complete analysis of the economic implications of the Proposed Rule, such as the potential impact on the prices carriers negotiate with hospitals and practitioners, is beyond the scope of this report, which only considers the administrative and operational challenges involved in compliance.

The remainder of this report is organized as follows.

- Section III describes the requirements imposed by TCR on all health insurance issuers and Third Party Administrators (TPAs) and then summarizes the Departments' estimates of the incremental burden associated with these requirements.
- Section IV reviews the *Federal Register* estimates of the burden imposed by the TCR rule.
- Section V begins by summarizing the state of existing web-based consumer tools among the carriers interviewed—outlining specific TCR requirements that would require additional investment. Then, before getting into cost estimates, we summarize existential issues that are introduced by specific TCR

[3] U.S. Department of Health & Human Services, "Trump Administration Announces Historic Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans," news release, Nov. 15, 2019, *available at* https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html

[4] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65464

requirements. The section concludes by presenting cost estimates provided by carriers and compares these estimates with those provided by the Departments for the average carrier.

- Section VI details our conclusions.

III. PROPOSED TCR REQUIREMENTS

TCR imposes three significant requirements. Group health carriers and health insurers must: (1 develop, build and maintain an internet-based consumer self-service tool that makes cost-sharing information available to plan members; (2 make publicly available a machine-readable Negotiated Rate File; and (3 make publicly available a machine-readable Allowed Amount File.[5] If unchanged in the Final Rule, these requirements will go into effect for plan years beginning one year after the rule is finalized.[6]

III.A. Consumer-facing Search Tool

The consumer self-service tool would require carriers to provide covered individuals with cost and eligibility information before receiving services. The tool is required to have the following features:

- Calculate OOP costs for all items and services defined as: all encounters, procedures, medical tests, supplies, drugs, durable medical equipment and fees (including facility fees), for which a provider charges a patient in connection with the provision of healthcare.
- Estimate allowed amounts and a plan member's cost-sharing liability for all out-of-network items and services, by provider, using historical claims data.
- Ability for plan members to search for items and services by provider, billing code or descriptive terms, and by any other factor necessary for determining the cost sharing amount.
- Ability for plan members to filter and sort by geographic proximity, OOP costs and distance.
- Communicate progress towards both individual and family deductibles and out-of-pocket maximums.
- Communicate medical management prerequisites for services to be covered.
- Provide estimates based on provider tier.
- Communicate applicable visit limits and deductibles in real time.
- Provide all of the information from the web-based consumer tool on paper, within two days, upon request.[7]

III.B. Negotiated Rate File

The regulations require all carriers to produce a machine-readable file provided in the public domain that includes negotiated rates for each covered item or service furnished by in-network providers. Data in this file is to be expressed as a dollar amount associated with the provider's National Provider Identifier (NPI). If the carrier or issuer uses a bundled payment rate, the carrier must identify the items included in each bundle of services by the relevant code.[8]

This file "must be posted on a public internet site with unrestricted access and must be updated monthly."[9] The purpose of this tool is to allow third parties to access up-to-date price and cost information across different carriers. While the file would not be in a format conducive to use by consumers, it would be useable by parties developing cost-comparison tools and other applications of use to consumers and would also become publicly

[5] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65469-65470
[6] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65516
[7] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65471-65474
[8] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65479
[9] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65507

available to all carriers and providers. The data in the file would also be useable by health services researchers and others analyzing the performance of the U.S. health care system.

III.C. Allowed Amount File

Carriers are also required to produce and maintain a publicly available machine-readable file that provides amounts payable for covered items or services associated with particular out-of-network providers. These data are to be calculated by assessing historical cost during the 90-day period that begins 180 days before the publication date of the Allowed Amount File. Amounts are to be expressed as a dollar amount and are to be associated with the provider's NPI. This amount would include the carrier's paid portion and the plan member's share of costs.[10]

This file must be published and updated similarly to the Negotiated Rate File. As with the Negotiated Rate File, this information would generally not be in a format conducive to use by typical consumers, but it would be useable by third parties for similar purposes to those described for the Negotiated Rate File.

[10] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65480

IV. *FEDERAL REGISTER* ESTIMATES OF BURDEN

As required by the Paperwork Reduction Act of 1995, the Departments have included estimates of the burden of complying with the regulation because of Executive Order 12866 which was then reviewed by the Office of Management and Budget (OMB).[11] The Departments assessed that approximately 1,754 issuers and 205 TPAs will be affected by TCR.[12] In addition, the Departments provided estimates of the number of labor hours and costs necessary for a carrier to establish and maintain the tools and files required by the proposed regulations. These estimates are broken down into set-up and maintenance costs by requirement and summarized in Figure 1 as the average burden per health insurance issuer.[13]

In order to generate estimates of cost, the Departments estimate the average number of labor hours necessary to comply with the proposed regulation, by occupation/level. Then, the Departments use wage data from the Bureau of Labor Statistics (BLS) to map these labor hour estimates to a cost estimate.[14] Additionally, the Departments assume for a partial build that existing systems would already have operational capabilities that meet approximately 75 percent of the requirements in the Proposed Rule and, thus, the burden of a partial build would be 25 percent of a full build.

The Departments estimate that set-up for a web-based consumer tool will cost health insurance issuers an average of $221,029 for a full build and $55,260 for a partial build. The asserted burden in terms of labor hours (underlying the cost estimates) are 2,508 (1.2 FTEs) and 815 (.39 FTEs) for the full and partial builds, respectively.[15]

The rate files are also estimated to impose a moderate burden on health insurance issuers. Set-up for the Negotiated Rate File is estimated to cost health insurance issuers $107,905, on average, with a labor burden of 1,190 hours (.57 FTEs). Set-up for the Allowed Amount File is estimated to cost health insurance issuers $117,757, on average, with a labor burden of 1,290 hours (.62 FTEs). Thus, the Departments estimate the rate files required by TCR to be the larger burden of the Proposed Rule if a given health insurance issuer already has a partial build of their web-based consumer tool.

Annual maintenance of the web-based consumer price tool is estimated to cost health insurance issuers $13,141, on average, with a burden of 145 hours (.07 FTEs). Maintenance of the Negotiated Rate File is estimated to cost health insurance issuers $36,022, on average, with a labor burden of 360 hours (0.17 FTEs). Maintenance of the Allowed Amount File is estimated to cost health insurance issuers $117,757, on average, with a labor burden of 1,290 hours (.62 FTEs).

Apart from building and maintaining the web-based tool and the two rate files, the Departments included two other burden estimates: (1 Training customer service representatives on the consumer price tool was estimated to require 20 hours (with a cost of $701); and (2 Accepting and fulfilling requests for a mailed disclosure on an annual basis (labor, printing and materials) was estimated to require 15 hours annually (with a cost of $547).

As we will describe in the next section, these amounts are significantly lower than our sample of carriers anticipate. For several companies, implementing the requirements as they are currently described seems infeasible within the time frame envisioned. For others, the feasibility of implementation has not been assessed, but upon considering the requirements, the cost appears very large, “a whole new ballgame,” as one representative characterized it.

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[11] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p.65491
[12] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65500-65502
[13] For simplicity, we use the term “health insurance issuer” to describe one of the 1,959 issuers and TPAs the Departments had in mind while estimating costs.
[14] Mean wage estimates by occupation/level include a 100 percent increase for fringe benefits and overhead.
[15] An FTE is assumed to work 2,080 hours a year.

Figure 1: The Departments' estimates of burden associated with Proposed TCR

Requirement	Total cost per carrier	Burden per carrier (hours)
Set up for web-based consumer price tool—complete build	$221,029	2,508
Set up for web-based consumer price tool—partial build	$55,260	815
Train customer service representatives for consumer price tool	$701	20
Set up negotiated rate file	$107,905	1,190
Set up allowed amount file	$117,757	1,290
Total set up (complete build)	$447,392	5,008
Total set up (partial build)	$281,623	3,315
Annual maintenance of web-based consumer price tool	$13,141	145
Annual maintenance of negotiated rate file	$36,022	360
Annual maintenance of allowed amount file	$14,698	156
Accept and fulfill requests for a mailed disclosure on an annual basis (labor, printing and materials)	$547	15
Total annual maintenance	$64,408	676

Source: Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019) p. 65491-65551 Notes: The Proposed Rule was published by the Department of the Treasury, Department of Labor and Department of Health and Human Services (The Departments) in the Federal Register and includes estimated compliance costs. Estimates are rounded to the nearest dollar and are provided per respondent (n=1959) where a respondent is an issuer or TPA.

V. BURDEN ASSESSED FROM INTERVIEWS

V.A. Current State of Carriers' Web-based Tools and Concerns about Certain TCR Requirements

Prior to estimating the burden of complying with TCR requirements, we assessed the state of carriers' web-based price transparency tools, if any exists. We also captured commentary on the feasibility of complying with specific TCR requirements in the timeframe in the Proposed Rule. Figure 2 summarizes carriers' responses.

Figure 2: Current state of carriers' web-based consumer tools

Functionality of current consumer tool	Percentage of carriers	Number of responses
Calculate OOP costs for certain items and services	94.4%	18
Calculate OOP costs for all items and services	0.0%	18
Estimate allowed amounts and a plan member's cost-sharing liability for all out-of-network items and services, by provider, using historical claims data.	0.0%	18
Ability for plan members to search for items and services by provider	85.7%	14
Ability for plan members to search for items and services by descriptive terms	86.7%	15
Ability for plan members to search for items and services by billing code	12.5%	16
Ability for plan members to filter and sort by geography, OOP costs and distance	84.6%	13
Communicate medical management prerequisites for services to be covered.	5.9%	17
Provide estimates based on provider tier.	22.2%	9
Communicate deductibles in real time.	46.7%	15
Communicate applicable visit limits in real time.	6.3%	16
Provide all of the information from the web-based consumer tool on paper, upon request	23.1%	13

Notes: The table above summarizes the current state of carriers' web-based consumer tools. We report the percentage of carriers offering a tool with a given functionality required by the proposed regulations and the number of respondents for each. Given that we had a limited amount of time in each interview, we did not get to ask each carrier about each functionality. In some cases, the interviewee was not sure whether the tool included certain functionalities.

V.A.1. Largest Burdens

We found that 94 percent of carriers have some sort of web-based tool for calculating a plan member's OOP costs for *certain* items and services. One takeaway from our interviews is that reporting OOP costs for *all* covered items and services poses the greatest challenge for the majority of carriers and does not provide meaningful and actionable data to the consumer. Currently, the average number of items and services for which OOP costs are provided is 1,011, with a maximum of approximately 1,600.[16] The carriers we interviewed typically focus on "shoppable" and commonly utilized items and services (or in some cases, procedures and bundles), which are more helpful to consumers.

The proposed regulations define all items and services as: "all encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees), for which a provider charges a patient in connection with the provision of healthcare."[17] The proposed regulations also mention codes, including Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and Diagnosis-Related Group (DRG) codes. This requirement is daunting because it encompasses a very large number of potential services. One respondent said, "There are over 15 thousand codes. It would be an astronomical effort to include all services." In fact, there are more than 94,000 codes – 77,559 ICD-10-PCS and 16,448 HCPCS (includes CPT) – covering institutional inpatient, outpatient and professional claims. This does not include all of the codes connected with drugs and medical devices.

Additionally, users must be able to "search for cost-sharing information for covered items and services by billing code, or by descriptive term, per the user's request."[18] Many carriers currently allow plan members to search for items and services by provider and by descriptive terms (86 percent and 87 percent of respondents, respectively) yet not by billing code (13 percent of respondents). Apart from the efforts to develop these capabilities, concerns were raised about how consumer experience would be affected. It is unclear to many respondents how their consumer tools can remain user-friendly while also including all items and services and the corresponding billing codes. Relatedly, many health care services are subject to decision-making and judgement calls at the point of care, and it is virtually impossible to know in advance what a provider and patient may elect to do as information about a condition is revealed. In discussing this requirement, one respondent said, "a knee replacement is not a knee replacement," elaborating that the costs can vary depending on characteristics unique to the patient, which are hard to anticipate. With minor variations, this sentiment was repeated consistently. A condition requiring a bundle of services is hard to determine in advance, so providing a prospective determination of coverage and cost is very difficult.

The requirements to provide integrated information about medical management requirements, visit limits and, to a lesser extent, deductibles were also cited as significant burdens for carriers. The vast majority of carriers do not have these first two features integrated in their consumer tool today (6 percent include medical management requirements, 6 percent include visit limits, and 47 percent include deductibles). Regarding communicating applicable visit limitations, one respondent mentioned, "It would be quite a heavy lift because it's not stored in a numeric format." Complex information on benefits can vary depending on the carrier and service, and we found that it is typically not integrated with the OOP cost estimates among the carriers interviewed. It would be a large effort to integrate this information on the back-end and then make it user-friendly on the front-end.

Some respondents suggested that there would be substantial barriers in obtaining permission to disclose prescription prices, for example, from third parties (such as pharmacy benefit managers), while others seemed to believe they could satisfy the requirement by simply passing a customer over to the pharmacy administration website for such information without directly providing it themselves.

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[16] Some carriers reported the number of procedures, bundles, or treatment categories so what we summarize as an "item or service" is not necessarily as granular as the proposed regulations would like.
[17] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65471
[18] Transparency in Coverage, 84 Fed. Reg. 229 (November 27, 2019). p. 65501

Providing users' cost-sharing liability for out-of-network (OON) allowed amounts was another big concern for carriers we interviewed. First, this is not something that any carriers we interviewed provide in their consumer tools today. Some respondents emphasized that historical allowed amounts with OON providers are not necessarily reflective of future cost information because carriers do not have contracts with OON providers. Thus, respondents felt that it was a risk to use historical allowed amounts in the consumer tool as an estimate, since it may be unreliable. Other respondents mentioned that it is hard to track down information on OON providers, even if they do have claims data. One respondent offered that this could potentially conflict with a current state regulation related to listing OON providers in directories.

Currently, none of the carriers we interviewed have a web-based tool anywhere close to satisfying the stated requirements of the consumer tool. Putting all of the requirements together, carriers likened the proposed regulations to mock claim adjudication. Yet, these regulations take mock claim adjudication one step further because this information would have to be user-friendly and searchable.

V.A.2. Additional Concerns

Although not uniform, a tendency among the smaller carriers we interviewed was to assume that a third-party vendor would understand the regulations and would provide an IT solution to implement necessary changes. As the details of the TCR were discussed, these carriers tended to express serious concern about the feasibility of implementation within the required length of time.

A related concern was that certain carriers employ "rental networks" which are those that provide coverage for certain services in a network arrangement rather than by individual provider. Such networks may not provide visibility to the contracting carrier of the actual rates paid for specific services within the network. Carveout networks, where an employer carves out pharmacy or mental health to a separate vendor, could also create complicated compliance issues for employer plans. Carriers expressed concern that their ability to comply with the regulation would be inconsistent with business relationships such as rental networks or carveouts.

Additionally, providing information from the web-based consumer tool on paper, upon request, seemed feasible to most carriers, but is not a feature of most tools currently (23 percent of those interviewed currently have capability). However, many carriers expressed concerns about the requirement to perform this task within two business days.

V.B. Cost Estimates

Figure 3 summarizes carriers' responses about the incremental burden imposed by the proposed regulations, analogous to how the Departments' estimates are summarized in Figure 1.

Figure 3: Cost estimates from carriers interviewed

Requirement	Average cost per carrier	Minimum	Maximum	Responses
Set up web-based consumer price tool	$5,528,000	$1,000,000	$15,000,000	15
Set up negotiated rate file	$2,139,167	$85,000	$10,000,000	6
Set up allowed amount file	$1,071,167	$42,000	$5,000,000	6
Total setup	$8,738,333	-	-	-
Annual maintenance of web-based consumer price tool	$3,784,375	$375,000	$10,000,000	8
Annual maintenance of negotiated rate file	$467,000	$15,000	$1,000,000	6
Annual maintenance of allowed amount file	$643,000	$15,000	$1,500,000	5
Total annual maintenance	$4,894,375	-	-	-

Notes: This Figure summarizes cost estimates provided by the carriers we interviewed. When a range of costs were given, we took the mean. If only a minimum or maximum was given, we just used that number. We conservatively assumed that a statement that a task would cost seven figures meant $1 million rather than a larger seven figure number, and that an estimate of eight figures meant $10 million rather than a larger eight figure number. If multiple ranges were added together, we took the average of each range and then summed these amounts. We also asked about the burden in terms of labor time, but the responses were harder to map to a precise number of hours or FTEs. For example, we received responses such as, “30 people would work on the project part time from multiple divisions.” Given the information we have, it is not possible to translate such responses into estimates of labor burdens.

The Consumer Search Tool was seen as much more expensive to operationalize than estimated by the Departments. Estimates of the cost averaged about $5.53 million compared to the Departments’ estimate of $221,029. This is more than 25 times what the Departments estimated as the cost for a full build of the consumer tool. Although most of the carriers we spoke with have an existing consumer-facing tool meeting many of the required elements of the TCR, several carriers expressed significant concern about the cost and feasibility of complying with the requirements as written. Multiple respondents indicated that the requirements may necessitate a complete rebuild of their consumer tool. The costs seem to be driven by two main factors: (1 the need to effectively adjudicate the claim – before it actually happens – to provide estimates for every conceivable type of medical item or service while integrating this information with various benefits; and (2 condensing all of this detail into a user-friendly format for use by enrollees, which is a considerable and possibly even infeasible challenge, as currently proposed. Many carriers indicated that, as currently worded, the proposed regulations would be more costly than implementing real-time claims adjudication, in which the claim for the medical service is adjudicated at the time the service is provided.

Given the complexities of the consumer tool, as proposed, carriers interviewed estimated the annual maintenance costs to be, on average, about $3.78 million (although fewer carriers had an estimate for maintenance costs). The Departments, by contrast, estimated an average cost of only $13,000 for annual maintenance of the consumer tool. One respondent elaborated that, “maintaining the tool would take a dedicated department.” As codes are updated and new procedures are introduced, the tool would have to be kept up to date.

The Negotiated Rate File similarly was seen as much more costly to implement (again by a factor of around twenty) than estimated by the Departments. Carriers estimated set-up costs surpassing $2 million, on average. While not quantifiable, some respondents indicated that certain aspects of this portion of the Proposed Rule are not feasible. Specifically, they noted that negotiated rates for performance-based (quality-adjusted) and experience-based (risk-adjusted) contracts can only be calculated ex-post and would not necessarily reflect rates going forward. While beyond the scope of this paper, carriers also expressed concerns that went beyond operational costs. In particular, some carriers expressed substantial concern about the confidentiality of the information that would be required to be made public in this file as well as concerns about the potential complications such disclosure poses for their negotiations with providers.

There was less agreement and understanding about the costs and complexities of generating the rate files, given that these are entirely new ideas. Estimates for setting up the Negotiated Rate File (approximately $2.14 million) and setting up the Allowed Amount File (approximately $1.07 million), both significantly exceeded the Departments' estimates of $107,905 to set up the Negotiated Rate File and $117,757 to set up the Allowed Amount File. Carriers interviewed estimated the annual costs of maintaining the Negotiated Rate File and the Allowed Amount File at $467,000 and $643,000, respectively. Both of these maintenance estimates surpassed the Departments' set-up estimates for the same files. Given the unprecedented requirement and lack of carrier experience, it was difficult for carriers to estimate these potential costs.

For the Allowed Amount File, some respondents expressed concerns about maintaining HIPAA protections because of the small numbers of claims associated with particular services and out-of-network providers. Others expressed that most carrier members used in-network services, and, thus, there would be "holes" in the file generated using historical data from a narrow period of time. Another carrier mentioned that, "it's difficult to get demographic/directory information from OON providers."

Given the short window of commenting on the proposed regulation, we were not able to estimate the impact of all of the potential implications regarding the public release of negotiated prices or additional costs to carriers beyond the operational costs of setting up these files. These implications could be significant, including the potential for increased payment rates to providers, increasing healthcare costs. Such implications merit further analysis.

VI. CONCLUSIONS

Through a targeted interview process with 18 carriers that are generally representative of the private health insurance industry in the U.S., we evaluated the feasibility and operational cost imposed on carriers of implementing the TCR transparency requirements recently proposed by the Departments. Importantly, we did not consider the broader economic and financial implications of disclosing payment rates that have been negotiated between hospitals and health care providers, and insurance carriers. That analysis is beyond the scope of this paper, but could have a significant impact on health care cost and quality.

We found that while most carriers are still working to digest the impact these regulations will have on their businesses, we did obtain high-level estimates of the cost of implementing the regulation's primary requirements from a meaningful number of respondents. The responses cover a wide range that reflect the differences in the carriers themselves, their different states of readiness for developing tools called for in the regulations, and different perceptions and understanding of what the regulations will require.

Despite the wide range of estimates, the clearest result we have is that the interview respondents view the proposed regulations as far more costly and disruptive than is reflected in the Departments' published estimates. A consistent theme was that carriers are steadily moving in the direction of providing more information and tools to their members to increase transparency about the cost of care based on customer experience research. There is concern that the regulations, as written, would not only impose substantial cost, but that they would also most likely result in tools that are less useful to consumers.

Our primary observations are as follows:

- The Consumer Search Tool was seen as a much more costly and disruptive element to implement than was estimated by the Departments. Based on interviews, there is a range of potential costs for implementing the Consumer Search Tool – all of which are significantly higher than the agencies' estimates. Although most of the carriers we spoke with have an existing consumer-facing tool meeting many of the required elements of the TCR, several carriers expressed severe concern about the cost and feasibility of implementing the requirements as written. Multiple respondents indicated that the requirements may necessitate a complete rebuild of their consumer tool. Key concerns include:
    - As written, the TCR references providing pre-service estimates of *all* services (discrete or bundled) that would be covered. This requires a carrier to essentially engage in a mock claim adjudication which can be highly complex depending on the goods or services involved.
    - This requirement also requires costly and complex integration of benefits that are not uniformly maintained within existing systems. Pharmacy benefits, benefits provided through third-party administrators, medical management requirements, visit limits and allowed out-of-network benefits were key elements of concern.
    - There seems to be a core set of functions for a core set of services that the majority of respondents report having currently. These include the ability for members to: (1 learn about their OOP costs for some items and services; (2 search for items and services by provider and by descriptive terms; and (3 filter and sort by geography, OOP costs and distance. Currently, the average number of items and services for which OOP costs are provided is 1,011, with a maximum of approximately 1,600. The carriers we interviewed typically focus on "shoppable" and commonly utilized items and services (or in some cases, procedures and bundles).
    - The requirement does not appear to recognize the unavoidable uncertainty in defining and pre-determining the precise services that may be provided in a given care setting. This uncertainty greatly complicates providing precise estimates of cost in many settings. One knee replacement, or one child birth, will not be the same as others, for example. It would be difficult to communicate to customers what the cost of their precise experience would be in any matter in which there is a

need for provider choice and adjustment to medical circumstances that cannot be known in advance. Some respondents indicated that inputs from providers such as diagnosis codes may be necessary to reflect the degree of precision specified in the rules.

- Multiple respondents indicated that they have existing business strategies focused on increasing cost transparency for members in a way that enhances the consumer experience. They have concerns that certain TCR requirements are inconsistent with those strategies and would require changes in customer service priorities that they see as detrimental to care and the customer experience.

- Carriers viewed the Negotiated Rate File as much more costly to implement (by a factor of approximately twenty) than estimated by the Departments. Carriers estimated set-up costs surpassing $2 million, on average. While not quantifiable, some respondents indicated that certain aspects of this portion of the Proposed Rule are not feasible. Specifically, they noted that negotiated rates for performance based (quality-adjusted) and experience based (risk-adjusted) contracts can only be calculated ex-post and would not necessarily reflect rates going forward.

- Generally, we found that interview respondents shared consistent concerns about the high cost and significant complexity associated with producing an Out-of-Network Allowed Amount File. While no carrier had carefully evaluated the cost of publishing such a file, carriers estimated set-up costs of over $1 million (about nine times higher than estimated by the Departments). In addition, some respondents expressed concerns about maintaining HIPAA protections because of the small numbers of claims associated with particular services and out-of-network providers.

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