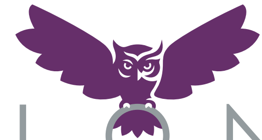

Planning Guide

Ensuring Compliance with the No Surprises Act and Transparency in Coverage Rule

Understanding, Assessing, and Selecting the Best Compliance Solution

TALONhealthtech.com

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TALON™

Executive Summary

The Transparency in Coverage Rule, when combined with the No Surprises Act, both which took effect on January 1st, 2022, puts health care price information directly into the hands of consumers, ensuring they are empowered with the critical information they need to make informed health care decisions. Groups that do not comply with the rule can face a fine of $100 per affected member per day, or an estimated $250,000 per day for an employer with 1,000 employees, going back to the original date of non-compliance.

Under the Transparency in Coverage Rule (TiC), Employer-sponsored Group Health Plans and Health Insurance Issuers must make their Negotiated Rate, Allowed Amount, and Prescription Drug files* publicly available using a standardized format. Each mandate also requires an internet-based self-service tool be made available to participants, beneficiaries, and enrollees providing personalized out-of-pocket-cost information, and the underlying negotiated rates for covered health care items and services, including prescription drugs*.

The TiC Rule outlines a two-phase rollout for the internet-based self-service tool. In phase 1, 500 items and services identified by federal Departments must be made available by January 1, 2023. In phase 2, all items and services must be shoppable by January 1, 2024. **The No Surprises Act, however, accelerated the legal requirement that all items and services be shoppable on a self-service tool, which must show patient out-of-pocket (OOP) responsibility as of January 1, 2022, with enforcement taking effect January 1, 2023.**

Harness the new healthcare marketplace with

Mobile-First Shopping
Reduce plan participant out-of-pocket costs (and overall health plan expenditures).

Plan Advisory Support
Built-in next-generation tools to educate, incentivize and reward healthcare consumerism.

Automatically Generate Required Machine-Readable Files
Ensure employer group compliance.

*Pending further comment and rulemaking.

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Understanding, Assessing, and Selecting the Best Compliance Solution

The No Surprises Act protects participants from surprise medical bills that could arise from Out-of-Network (OON) emergency care, and certain ancillary services provided by OON providers, with the participant being required to pay only the in-network cost-sharing amount, which is applied to their deductible and out-of-pocket maximums under the Plan. In most situations, providers can not "balance bill" participants. Further, the employer plan or the insurer must send participants an advanced explanation of benefits (AEOB)* at least 1 business day before such service is to be furnished, but not later than 3 business days after the date of scheduling. In short, the No Surprises Act and the Transparency in Coverage Rule will disrupt and transform how patients identify, consider, and navigate their healthcare journey.

TALON's Next Generation Platform and Tools

On the day the Transparency in Coverage Rule was finalized, most existing healthcare price transparency tools became obsolete. Legacy tools with legacy architectures become noncompliant when real prices and patient out-of-pocket responsibilities must be displayed rapidly and accurately to comply with the Rule. It is therefore necessary to identify a solution which provides accurate negotiated rates to the consumer in a fully individualized user experience that supports consumers' essential information needs at the time when healthcare purchase decisions are being considered and made. In development since 2014, TALON was the only platform demonstrated to the federal government's Health Policy Team who had been tasked with developing the Transparency in Coverage Rule. **TALON's platform was then used as the model upon which the new federal mandates are based. As a result, TALON has emerged as the leading compliance solution for the Transparency in Coverage Rule and the No Surprises Act.**

*Pending further comment and rulemaking.

No Surprise Shopping
TALON's Encounter Pricing™*

MAINE MEDICAL PARTNERS
Nuclear Stress Test

Encounter Estimate

Procedure Name	Likelihood	Weighted Price
Nuclear Stress Test	100%	$788.00
Professional Fee	100%	$153.00
Cardiovascular Stress Test: Interpretation & Report Only	87%	$24.48
Cardiovascular Stress Test: Supervision Only	73%	$31.52
Typical Other Costs		$104.26
	Encounter Estimate:	**$1,101.26**

Notes

The **Encounter Estimate** is the full cost of the primary procedure plus the full cost of the associated procedures multiplied by their respective 'likelihood' amounts. Where Carriers or Plans have provided Machine Readable Files, In-network and Out of Network amounts from those files will be used in these estimates. When MRF pricing is not available, prices used in the calculation are median prices. These specific calculations are based on 500+ records for this specific provider performing this specific procedure.

*Shows what is typically charged by provider.
Patient's real charge could be over $2,100 more.

Surprise Shopping
Other Vender Tools*

NUCLEAR STRESS TEST

Procedure Estimate Calculated using these procedures

Procedure Name	Likelihood	Weighted Price
NUCLEAR STRESS TEST	100%	$1,662
PROFESSIONAL FEE	100%	$95
	Procedure Estimate	$1,757

*Per Machine Readable File Rates,
Only shows the Nuclear Stress Test at $1,662.

Employer-sponsored plans that do not **comply** with the rule face a fine of $100 per member per day, or an estimated $87,000 per enrolled employee per year.

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TALON's Next Generation Platform and Tools (continued)

The TALON platform leverages extensive data sources, scalable architecture, and machine learning algorithms to amass a data warehouse currently comprised of over 3.8 billion claims. This includes not only allowed amounts paid from insurers and payers to providers for specific procedures, but also added depth of knowledge of what individual providers typically bill within each encounter. TALON's system continuously updates the claims data warehouse and, along with contracted pricing file feeds from partners, leverages its massive scale to produce detailed, accurate machine-readable files with predictive and actual negotiated rates. Access to this comprehensive pricing data is provided to plan participants through **MyMedicalShopper**™, a robust yet simple-to-use shopping function within the TALON application, or through a wide variety of powered by TALON third-party subscriber portals. The result is a turnkey solution that secures compliance with the key price transparency elements of the Transparency in Coverage Rule and the No Surprises Act.

Goals of the Transparency in Coverage Rule include to:

- **Establish a market-driven healthcare system**
- **Enable comparison shopping**
- **Expose real-time pricing information and out-of-pocket liability**
- **Stabilize and reduce the price of health care services**
- **Empower, inform, and incentivize action from consumers**

TALON's **Encounter Pricing**™ identifies additional procedures billed in conjunction with the primary procedure as a patient evaluates different providers for a test or service. This unique feature eliminates most notorious "surprise billing" experiences. TALON's **Retrospective Shopping**™ applies machine learning through claims processing to analyze missed savings opportunities accrued by the participant who received care at a higher cost provider. Such results can later be presented to participants to encourage more deliberate shopping behavior and reduce unnecessary out-of-pocket costs and overall wasteful plan expenditures. Finally, to increase engagement and incent consumerism, TALON offers its patented **MyMedicalRewards**™ system through which participants may receive rewards for smart healthcare consumerism. These rewards can extend through the plan year and can be earned even after the consumer's deductible or out-of-pocket maximum are reached. This promotes effective and efficient healthcare decision-making throughout the entirety of the year. These rewards can be added seamlessly to participants' HSAs, HRAs or delivered as eGift cards.

TALON's platform can immediately bring organizations to full compliance with the Transparency in Coverage Rule and No Surprises Act and relieve organizations of concerns regarding solutions that can only promise to deliver. We hope that the following guide offers a comprehensive framework and the regulatory literacy your organization requires to make informed decisions related to the Transparency in Coverage Rule and No Surprises Act.

HealthValueAwards
Presented by ValidationInstitute
2020
Winner

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PART 1 Impact of the Federal Mandates

Overview: Transparency in Coverage Rule

The 2010 Affordable Care Act ("ACA") represented a profound effort to democratize health insurance, improve healthcare access, and increase market competition. The ACA's major provisions have resulted in a significant reduction in the number and percentage of people without health insurance and was surely a step in the right direction towards healthcare cost containment and market competition.

Acknowledging that patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care, Executive Order 13877, promoting price transparency in healthcare, was signed in June 2019. Its purpose was to *"enhance the ability of patients to choose the healthcare that is best for them. To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance."* The order further noted that *"shoppable services make up a significant share of the healthcare market, which means that increasing transparency among these services will have a broad effect on increasing competition in the healthcare system."*

The order directed the Department of Health and Human Services (HHS) to draft a new rule that would require hospitals to disclose the prices that patients and insurers pay in "an easy-to-read, patient-friendly format". The new rule would also "require health care providers and insurers to provide patients with information about the out-of-pocket costs they'll face before they receive health care services."

The order's logic is simple and direct. Healthcare consumers must be given access to information that is relevant and necessary for their healthcare purchase decisions, mirroring the process of other types of purchases in consumer-centric markets. The order applies appropriate pressure upon the industry to function more like a consumer-directed market, where price, quality, and convenience are major factors in driving market behavior.

In October 2020, the Departments of Health and Human Services, Labor, Treasury, and CMS issued its "Transparency in Coverage" final Rule (TiC), which requires most employer-sponsored group health plans and commercial health insurance issuers offering group and individual coverage to disclose price and cost-sharing information to participants, beneficiaries, and enrollees, in advance. Patients, as healthcare consumers, must be provided with accurate estimates of any out-of-pocket costs they must pay to meet their plan's deductible, co-pay, or co-insurance requirements. The rule allows patients to gain access to essential purchasing information (e. g., price, network guidance, etc.) in a standardized manner, allowing for easy comparisons, and empowering consumers to "shop" and compare costs between specific providers before receiving care.

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- These rules do not apply to excepted benefits (such as vision or dental), retiree-only plans, or grandfathered plans.
- **Employers that do not comply will face a fine of $100 per member per day, or approximately $87,000 per enrolled employee per year.**

The goals of the Rule include to:

- Establish a market-driven healthcare system
- Enable comparison shopping
- Expose real-time pricing information and out-of-pocket liability
- Stabilize and reduce the price of health care services
- Empower, inform, and incentivize action from consumers

As of January 1, 2022, Employer-sponsored Group Health Plans and Health Insurance Issuers must now make the following three **machine-readable files** publicly available:

- **Negotiated Rate File** — All applicable rates (negotiated rates and fee schedules) with in-network providers
- **Allowed Amount File** — Data outlining the historical allowed amounts for covered items and services provided by non-participating providers
- **Prescription Drug File*** — Negotiated rates and historical net prices for prescription drugs furnished by in-network providers

Additionally, the three machine-readable files must use a standardized format. This information must be updated no less than monthly and be made available on the plan's website free of charge. Finally, access cannot require a user account or otherwise require the individual to submit personal identifying information.

The purpose of the machine-readable files requirement is to allow application software and analytics companies to ingest and create useful products and services to help manage healthcare costs. While the law went into effect on January 1, 2022, the administration has announced that after July 1, 2022 it will begin **levying fines against employers that have not fully complied with this requirement.**

Self-Service Tool

Employers and Health Issuers must make available to participants, beneficiaries, and enrollees (or their authorized representative) the following:

- Personalized out-of-pocket-cost information, and the underlying negotiated rates for all covered health care items and services, including prescription drugs*, through an internet-based self-service tool and in paper form upon request.

Unlike the machine-readable files, the self-service tool requirement of the TIC rule may be introduced over two phases:

1. For all plan/policy years beginning on or after January 1, 2023 – Plans and issuers must make cost-sharing information available for 500 items and services identified in the Rule
2. For all plan/policy years beginning on or after January 1, 2024–The same requirement imposed as of 1/1/23, but for ALL services, items, and prescription drugs*

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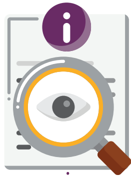
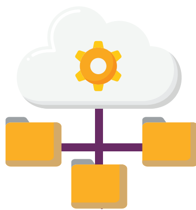
212
Million
U.S. consumers to receive price transparency tools



2022
Transparency in Coverage
regulations went into effect



3
Machine-Readable Files*
updated monthly as required by law

Overview:
The No Surprises Act

On December 27, 2020, the Consolidated Appropriations Act of 2021 was signed into law. Included in this legislation is the No Surprises Act (Act), which became effective January 1, 2022. The act was born from concern for patients who often faced financial ruin by "surprise medical bills" perceived to be arbitrarily received months after receiving procedures believed to be included as covered medical expenses. The Act represents an additional historic step toward putting health care price information in the hands of consumers, ensuring they are empowered with the critical information they need to make informed health care decisions.

Additional consumer guidance, like the availability of a new *Advanced Explanation of Benefit* (AEOB)*, is also required by the Act.

*Pending further comment and rulemaking.

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Price Comparison Tool

A Plan must offer price comparison guidance by phone and make available on the Plan website a price comparison tool that allows a Plan enrollee to compare the amount of cost-sharing that an individual would be responsible for paying with respect to a specific item or service — considering plan year, geographic region, and participating providers.

Advanced Explanation of Benefits (AEOB) for Scheduled Services*

The AEOB represents a significant step for consumer protection in healthcare. Patients must now be provided with a good faith estimate of their out-of-pocket exposure prior to receiving care. The AEOB must be made available at least one business day before services are to be furnished, but no later than three days after being scheduled.

The AEOB must include:

- A list of services and their billed amounts provided by the provider
- The network status of the providers and facilities
- Good faith estimates of the payments received by the providers or facilities based on the billing and diagnostic codes
- Good faith estimates of the health plan's payment amount
- A good faith estimate of the patient cost sharing amount
- A good faith estimate of the amounts the enrollee has incurred toward meeting the limit of financial responsibility under their health plan
- In the case of a service subject to medical management techniques (e.g., prior authorization), a disclaimer that the service is subject to medical management
- A disclaimer that the information is only an estimate and subject to change

*Delayed past 1/1/2022, pending further comment and rule-making.

Compliance with the Transparency in Coverage Rule and the No Surprises Act requires effort and coordination among plan sponsors, medical insurance carriers, self-funded plan administrators, entities offering medical networks to self-funded plan sponsors, and many other stakeholders to manage and implement the various new processes and requirements mandated in the regulations.

Business Impacts of Non-Compliance

Benefits advisors who provide ill-informed guidance regarding these compliance requirements may quickly lose the trust of their employer group clients, leading to lost business. Likewise, TPAs, ASOs, and carriers who either can't provide, or delay in providing, the required machine-readable files or a compliant cost-comparison shopping tool may lose the confidence of their employer group customers.

11/2019

Transparency in Coverage Rule Proposed

10/2020

Final Regulations Transparency in Coverage Rule

1/1/2022

Transparency in Coverage Rule in effect

7/1/2022

Transparency in Coverage Rule Enforced

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PART 2

Breaking Down the Key Requirements

Transparency in Coverage Rule — Non-Tool Functionality

Functionality	Required Dates				TALON's Capability
Transparency in Coverage - Non-Tool Functionality	**1/1/22**	**7/1/22**	**1/1/23**	**1/1/24**	**1/1/22**
Three Machine-Readable Files (Public Accessible)	✓	✓			✓
In-network Negotiated, Underlying Fee Schedule and Derived Rates for All Services	✓	✓			✓
Out-of-network Historical Allowed Amounts for All Services	✓	✓			✓
Prescription Drug Negotiated and Historical Net Prices	✓		✓†		✓
Files Updated at least Monthly	✓	✓			✓
HIOS Identifier or EIN to Identify the Plan	✓	✓			✓
CPT, HCPCS, NDC, DRG, or Other Code for each Item or Service	✓	✓			✓
NPI, TIN, and Place of Service Code for each Provider	✓	✓			✓
Last Date of Price Validity	✓	✓			✓
Notation of Capitated or Bundled Payment Arrangements	✓	✓			✓

✓ Regulatory requirement and enforcement date

✓ Enforcement date occurring after regulatory requirement date (blue check)

† TALON estimated based on updated Department guidance

Transparency in Coverage - Non-Tool Functionality

Employer-Sponsored Plans and Health Insurance Issuers

As of January 1st, 2022, Employer-Sponsored Group Health Plans and Health Insurance Issuers must provide the following three machine-readable files:

- Negotiated rates for all covered items and services between the plan or issuer and in-network providers
- Historical payments to and billed charges from out-of-network providers
- In-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level*

These three machine-readable files serve as a foundation for innovative solutions providers to furnish members with previously unavailable pricing information, allowing healthcare consumers to easily compare costs and estimate of any out-of-pocket expense they will have to pay. The files must use a standardized format, be updated no less frequently than monthly and be publicly accessible and free of charge, without restrictions.

> Groups that do not comply with the rule will face a fine of $100 per member per day, or an estimated $87,000 per enrolled employee per year.

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Functionality	Required Dates			TALON's Capability
Transparency in Coverage - Tool Functionality	**1/1/22**	**1/1/23**	**1/1/24**	**1/1/22**
Internet Based Self-service Tool		✓		✓
Mail, Fax, and Telephone Pricing Inquiries		✓		✓
500 Searchable Items & Services		✓		✓
All Searchable Items & Services			✓	✓
All Searchable Prescription Drugs			✓	✓
Search by CPT Code or Descriptive Term		✓		✓
Coverage of all code types and bundled payment arrangements			✓	✓
Refine and Reorder by Geography and Cost-sharing Amount		✓		✓
Search by Facility		✓		✓
Search by Individual Provider		✓		✓
In- and Out-of-network Indicator		✓		✓
Show In-Network Underlying Negotiated Rates		✓		✓
Show In-Network Out-of-pocket Cost-sharing Information		✓		✓
Show Out-of-network Allowed Amount & Out-of-pocket Cost-sharing Information		✓		✓
Show Accumulator Balances at the Time of Search		✓		✓
For Bundled Payment Arrangements:				
Support of Custom Care Bundles and Price Negotiations		✓		✓
Ability to Enumerate Allowed and Cost-sharing Amounts for each Component, if Necessary		✓		✓
Notifications of Potential for $0 Cost-sharing Amounts for Preventive Care			✓	✓
Tracking of Accumulator Amounts		✓		✓
Deductible & Out-of-pocket		✓		✓
Tracking Limits on Care & Pre-requisites to Care		✓		✓
Accurate Network Mappings to Show In-network Providers		✓		✓
Required Disclaimers		✓		✓
Support of Disclosures by Mail		✓		✓

Transparency in Coverage - Tool Functionality

Self-Service Tool

Employer groups and health insurers must also provide a self-service tool for enrollees to obtain personalized out-of-pocket cost estimates. The self-service tool informs employees of their cost-sharing amount according to their plan design and assists them in comparison-shopping before receiving medical care. Similar to the machine-readable files requirement, there are certain data elements that must be included, which are included in this Tool Functionality Table.

Unlike the machine-readable files requirement, the self-service tool may be introduced in two phases:

By 1/1/23 – Information for 500 items and services identified in the Rule:

Make available to participants, beneficiaries, and enrollees (or their authorized representative) personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs*, through an internet-based self-service tool and in paper form upon request.

By 1/1/24 – The same requirement imposed as of 1/1/23, but for ALL services, items, and prescription drugs*. However, the No Surprise Act requires elements of the self-service tool deployed on January 1, 2022.

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No Surprise Act

Functionality	Required Dates			TALON's Capability
No Surprises Act - Tool Functionality	**1/1/22**	**1/1/23**	**1/1/24**	**1/1/22**
Price Comparison Guidance by Telephone (Support)	✓	✓		✓
Web-based Price Comparison Tool	✓	✓		✓
Search Any Specific Item or Service Across In-network Providers	✓	✓		✓
Individual Cost-sharing Amount (Out-of-pocket)	✓	✓		✓
No Surprises Act - Non-tool Functionality				
Supply of Recognized & Qualifying Payment Amounts to:				
Support Out-of-network Emergency Billing	✓			✓
Dispute Resolution Process	✓			✓
Negotiations with Air Ambulances	✓			✓
Advanced Explanation of Benefits (Pre-EOB Delivered to Patient Before Date of Service)	✓	✓†		✓
Provider Directories (Public Website)	✓			✓*
Contact Information and Network Membership Verified each 90 Days	✓			✓*
Updates Sent by Providers Reflected within 2 Business Days	✓			✓*
Must Respond to Provider Network Status Request by Telephone, Electronic, Mail within One Day	✓			✓*
Directory Info Includes Name, Address, Specialty, Telephone, and Digital Contact Info	✓			✓*
Pharmacy Benefit and Drug Cost Reporting	✓	✓		✓
Air Ambulance Reporting to HHS and Department of Treasury	✓			✓

✓ Statutory requirement and enforcement date ✓ Enforcement date occurring after statutory requirement date
* Also available on our Self-service Tool (MyMedicalShopper™) † TALON estimated based on updated Department guidance

Price Comparison Tool

Plan issuers must offer price comparison guidance by phone and make available on the Plan website a price comparison tool that allows a Plan enrollee to compare the amount of cost-sharing that an individual would be responsible for paying with respect to a specific item or service — factoring in plan year, geographic region, and participating providers.

Provider Directories

Plans must ensure that their in-network directories are reliable and up to date and that participants can access the directory online or by phone. A process for verifying the accuracy of the provider information included in the directory at least every 90 days must include a procedure in place for removing a provider or facility if unable to verify the provider or facility information.

If a participant requests information via phone regarding whether a provider is in-network, response in writing (or electronically if preferred by the participant) is required within one business day and a record of this communication must be maintained for at least two years.

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Preventing Surprise Medical Billing (Applies to plan years beginning on and after January 1, 2022)

Participants are protected from surprise medical bills that could arise from Out-of-Network (OON) emergency care and certain ancillary services provided by OON providers.

For these services, a participant is required to pay only the in-network cost-sharing amount, known as qualified payment amount (QPA), which must be applied to the participant's health plan deductible and out-of-pocket maximums.

Providers can not "balance bill" or collect the differences from participants, except in cases where a notice and consent is allowed for certain non-emergency services.

Advanced Explanation of Benefits (AEOB)*

The employer-sponsored health plan or issuer must send participants an AEOB before scheduled care. In most cases, this AEOB is due at least one business days before such service is to be furnished, but not later than three businesses days after the date of such scheduling.

Functionality	Responsibility				
No Surprises Act - Non-TALON Requirements	**TALON**	**Issuers**	**Plans**	**Providers**	**Gov't**
Coverage of Emergency Services and Services by Non-participating Individuals					
Without prior authorization		✓	✓		
Whether with a participating or non-participating provider		✓	✓		
At a cost sharing amount not more than the amount paid to a participating provider		✓	✓		
Evaluate State All-Payer Model Agreements, state laws, and qualifying payment amounts		✓	✓		
Record such cost-sharing amount against accumulators as if it were incurred in network		✓	✓		
Sends initial notice of denial or payment for the services within 30 days		✓	✓		
Provider requirements regarding surprise medical billing					
May not balance bill patient for costs above their cost-sharing amount				✓	
Must always treat ancillary services charges as if from a participating provider				✓	
Pre-requisites to out-of-network-cost sharing in covered situations				✓	
Issue notice showing participating alternatives, a list of expected services and their charges				✓	
Obtain consent without duress on the part of the patient (reasonable time to decide)				✓	
Publish disclosure of requirements and prohibitions on providers to their website				✓	
Requirements specific to air ambulances				✓	
Negotiation of final payment amount & IDR process					
Notify other party to start open negotiation phase within 30 days of receiving initial payment		✓	✓	✓	
Notify other part within 4 days following open negotiation to begin IRD process, if necessary		✓	✓	✓	
Select an IDR entity within 3 days of beginning the IDR process		✓	✓	✓	
Adhere to the binding determination of the IDR entity		✓	✓	✓	
Non-favored bid to pay the IDR entity for their services		✓	✓	✓	
Both parties to pay HHS for participating in the IDR process, without respect to IDR outcome		✓	✓	✓	

*Pending further comment and rulemaking.

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Functionality	Responsibility				
No Surprises Act - Non-TALON Requirements	**TALON**	**Issuers**	**Plans**	**Providers**	**Gov't**
Removal of gag clauses from payer-provider contracts		✓	✓	✓	
Ensure continuity of care after termination of participating status, change in terms of service		✓	✓	✓	
Allow selection of any available primary care physician (paediatric and adult)		✓	✓		
Direct Access to gynaecological care without PCP referral or oversight		✓	✓		
Publish deductible and out-of-pocket coverage limits on health cards		✓	✓		
Comparative analysis of NQTL for plans with mental health and substance abuse coverage		✓	✓		
APCD grants, mandatory access for research, reporting					✓
Pharmacy Benefit and Drug Cost Reporting					
50 costliest, most frequent, and highest cost growth prescription drugs		✓	✓		
Health care service costs broken down by provider type		✓	✓		
Average monthly premium paid by the individual and employer, separately		✓	✓		
Effect of fees and rebates paid by drug manufacturers to the plan on plan premiums		✓	✓		
Audits, Reports & Committees					
Submission of annual report on air ambulance services to HHS by providers				✓	
Ensure qualifying payment amounts are properly calculated					✓
Submission of comprehensive report on air ambulances to HHS					✓
Publish report on the effects of the Act on providers, plans, access to care, and cost of care					✓
Publish report on adequacy of provider networks					✓
Publish annual report on IDR process					✓
Issue a rule to implement protections for discrimination against providers in plan networks					✓
Provide an external review process to be used by health plan enrollees after failed appeals to plans					✓
Convene APCD Advisory Committee					✓
Convene Ground Ambulance Patient Billing Advisory Committee					✓
Convene Advisory Committee on Air Ambulance Quality and Patient Safety					✓
General enforcement of Act by appropriate federal body					✓

Goals of the Transparency in Coverage Rule include to:

- **Establish a market-driven healthcare system**
- **Enable comparison shopping**
- **Expose real-time pricing information and out-of-pocket liability**
- **Stabilize and reduce the price of health care services**
- **Empower, inform, and incentivize action from consumers**

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PART 3

Selecting the Right Compliance Solution

The day the *Transparency in Coverage Rule* was finalized was the day that most existing healthcare price transparency tools became obsolete. For instance, the options to adjust Medicare prices to estimate costs, or to work from data use agreements with carriers restricting pricing displays to "fair prices" (or presented as ranges with green, yellow, red, or $, $$, $$$ or other symbols), are non-compliant under the new mandate. As a result, many traditional solutions and tools with legacy architectures will fail to meet the compliance requirements. Simply adding new displays without having built a scalable architecture and infrastructure will far from suffice when fully considering the magnitude and complexities of the Rule's requirements.

It is sensible (if not imperative) to identify a compliant, next generation solution that provides accurate, actual negotiated rates to the consumer in a fully individualized user experience, supporting their essential information needs when healthcare purchase decisions are made; a solution that meets the complex functional requirements of the government mandates supporting, encouraging, and enabling healthcare consumerism. Such functional requirements include:

1. **Fully Scalable Cloud-based Solution:** The solution must scale to perform intense batch and real-time computational requirements as well as the Electronic Data Interchange (EDI) and Application Programming Interface (API) communications required for each individual comparison search. It must make accurate pricing information available with minimal processing delays at the user display interface across potentially millions of subscribers with the performance of a fully automatic and load-balanced cloud-based server architecture. To support the billions of raw data points that must be available for comparison searches and computations, pipelined batch processing and real-time customized user displays, high-speed cloud-based storage, and database technologies must be properly leveraged.

TALON Consultation

Speak with one of our experts to learn how TALON can help your group take flight.

TALONhealthtech.com

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2. **Mobile-First Application Design:** The new-generation pricing transparency tool must provide a responsive web-based application experience with full adaptation layers supporting an unlimited number of mobile phones, tablets, and web browsers. It's not enough to create user apps in the Apple App store and Google Play. A fully responsive mobile first web app design should be used with appropriate device adaptation to allow a universally engaging experience across all devices and browsers.
3. **Patient Eligibility and Demographics:** The system must be fully integrated with eligibility and demographics feeds using EDI and APIs. For a system to be scalable and engaging to users, it is necessary that new subscribers are added and welcomed to the system and initial use under full automation. The transparency system must seamlessly integrate with appropriate companion systems to keep the eligibility and information on dependents fully synchronized for additions and removals of participants.
4. **Plan Design/Definition Parameters:** The system must be fully integrated with plan design/definition parameter feeds using EDI and APIs. If the system doesn't have knowledge of the plan designs and current accumulator and consumption status for each member, it is not possible to determine patient out-of-pocket responsibility without untenable (and non-compliant) delays when comparison shopping for a procedure that might return dozens of provider and facility options.
5. **Claims Feeds:** The system must be fully integrated with claims feeds using EDI and APIs. This is needed to assure that as providers modify the mixtures of procedure codes used to bill against primary procedure names, the system can produce shopping estimates that capture all the key component costs most likely to be billed to the patient and plan.
6. **Upstream Negotiated Pricing Feeds:** The system must be fully integrated with upstream negotiated pricing feeds using EDI and APIs. This is required to assure that the system maintains the integrity of the required machine-readable files and that those updated prices are instantly used in the appropriate shopping price calculations for the real-time displays of the self-service tool.
7. **Carrier/Payer Network Accuracy:** The transparency system must be carrier/payer network agnostic but at the same time be carrier/payer network specific. This is to say that the architecture of the systems database and user display technologies should have been developed to show very specific carrier/payer network negotiated rates but be able to switch between payers seamlessly and only display prices associated with the appropriate payer.
8. **Integrated Flexible Savings Reward System:** A flexible shared savings rewards system should be fully integrated with claims handling and EDI to tax advantaged account reconciliation systems, payroll, and eGift card reward partners. To create consumer incentive and to influence price shopping behaviors in all varieties of health plan designs and throughout the subscriber's annual medical services consumption journey, a highly flexible reward system should be put in place that allows multiple reward scenarios to be stacked, defined, and available for each plan option.

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The Complexity of Displaying Subscriber-Specific Prices

The Transparency in Coverage Rule requires health insurers and employer group plans to provide complete and accurate pricing information in the form of a consumer-facing price comparison **shopping tool** and two **machine-readable files** (MRF). Price data must be complete, accurate, and updated no less frequently than monthly.

For the machine-readable files (MRFs) requirement, the intent of the law is to have one negotiated rate for each procedure-provider pair, which would be subscriber-specific, based on their personal summary of benefits. This requirement is a monumental information technology challenge, and a foundational component in support of the price comparison shopping tool requirement. TALON's machine learning and price multiplexing automatically outputs the MRFs per the original intent of the law. The following high-level diagram illustrates the multi-step data and process flow that must be managed on a continuous basis.

Machine Learning and Price Multiplexing Program Flows

Simplified flow

In an April 22' announcement by CMS, in order to accommodate the monumental information technology challenge burdening many stakeholders within the industry to create subscriber-specific one negotiated rate for each procedure-provider pair, CMS added a Table of Contents approach. This allowed for the machine-readable files to reference URLs that direct to the publicly accessible location of each Independent MRF and capture the different plan data for download. Though a simpler approach, it pushes the massively complex technical work down the road with regards to the requirements of the price comparison shopping platform. In order to implement in accordance with the intent of the law, only one negotiated rate for each procedure-provider pair can be displayed during a subscriber specific search, in accordance with their summary of benefits and previous healthcare utilization. The table of contents approach cannot fulfill this requirement.

Finally, price data must be organized into 3 categories of price records:

1. **In-Network Negotiated Rates** with provider-specific rates for all contracted providers
2. **Out-Of-Network Allowed Amounts** for covered OON provider services and prescriptions
3. **In-Network Negotiated Prescription Drugs*** with rates and codes for covered medications

These files must be publicly available in a standard data interchange format and published monthly to the public. The same price data must be continuously available for consumers to easily access via the comparison-shopping tool.

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PART 4 Implementing a TALON Solution

TALON is **your solution** for price transparency & consumerism in healthcare. We've built the ultimate suite of software services designed to fulfill the requirements of the Transparency in Coverage Rule and No Surprises Act. TALON is your partner to solve all price transparency needs for every user in the benefits ecosystem, all without disruption or distraction.

Hidden Variations for In-Network Procedure Prices
(negotiated discount, same procedure, different providers)

BOSTON (50 Mile Radius)			
Procedure	**Low Price**	**High Price**	**Variation**
Diagnostic Colonoscopy	$665	$2,593	390%
MRI Lower Joint	$470	$2,056	437%
Ultrasound of Neck	$144	$640	444%
Rotator Cuff Repair	$2,536	$12,140	478%
Nuclear Stress Test	$600	$3,055	509%
Chest X-Ray	$32	$323	1009%
Thyroid Stimulating Hormone	$14	$169	1207%
ER Visit	$129	$1,564	1212%
Cholesterol Screening	$12	$153	1275%

The Average Employer is **Overspending by 41%** Due to Hidden In-Network Variations

Our Vision is

To create and supply America's market-driven healthcare system

Our Mission is

To educate, empower, and incentivize the American healthcare consumer

At the time the Transparency in Coverage rule was originally published, TALON's basic platform itself complied with nearly all the requirements of the Rule, as it had been the model from which the Rule was derived.

As a result, TALON has emerged as the leading solution for compliance with the No Surprises Act and the Transparency in Coverage Rule.

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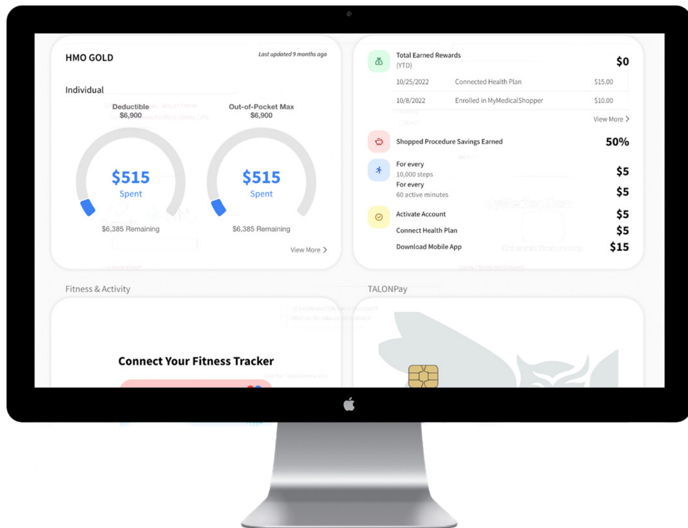
TALON's Optional Expandable Platform

"Everything you need at your fingertips", with ability to embed in TPA's own portals on a Widget/Tile basis



HealthValueAwards

Presented by **ValidationInstitute**

2020 Winner

TALON's technology and services were recognized by the Validation Institute as the recipient of the *2020 Health Value Award for Price Transparency*. The Validation Institute is dedicated to providing unbiased, data-driven insights on health care solutions and services by validating performance claims made by solutions providers and educating purchasers to drive transparency in the marketplace and maximize cost-savings.

In this section, we present TALON's essential compliance capabilities, key architectural components, and technology innovations that makes compliance possible, and – in fact – beneficial – for advisors, TPAs, carriers, employers, and their plan participants.

TALON Technology & Services

By combining extensive data sources with the use of machine learning algorithms, TALON has amassed a data warehouse of over 3.7B annual claims. Our data includes the allowed amounts paid from insurers and payers to providers for specific procedures. Additionally, through continuous refinement of machine learning models and statistical analyses, TALON has developed added depth of knowledge concerning what specific providers typically charge above and beyond basic procedures.

At the heart of TALON's scalable architecture is a machine learning system that aggregates data feeds from multiple sources. Our system continuously updates the claims data warehouse and leverages this massive database alongside contracted rate files and feeds to produce detailed, accurate machine-readable files with predictive and actual negotiated rates.

TALON has the unique ability to ingest multiple rate information data feeds from network partners, PBM partners, RBP partners, bundled payments partners/ providers, and direct contract providers and extract pricing data which is then processed and audited by TALON's rules engines and organized to present price data on a per-employer group and per plan basis to ensure display of only one valid price for each provider of each specific service.

TALON's auditing and cleansing process includes a series of quality checks to ensure data is in the proper format and contains accurate medical billing codes (e.g., diagnostic, procedure, treatment, prescription, etc.). One of TALON's key capabilities, Encounter Pricing™, which is explained in greater detail later in this guide, is an output of TALON's auditing and validation process. This then allows users to engage in 'apples-to-apples' comparison shopping. TALON has mastered this extremely complex process through modern machine learning algorithms and statistical analyses and can confidently identify trends and anomalies across a massive volume of data that is constantly in motion.

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Plan participants access this comprehensive pricing data through **MyMedicalShopper**™, a sophisticated yet easy-to-use mobile application that enables health care consumers to perform comparison shopping. This tool is designed as "Mobile First."

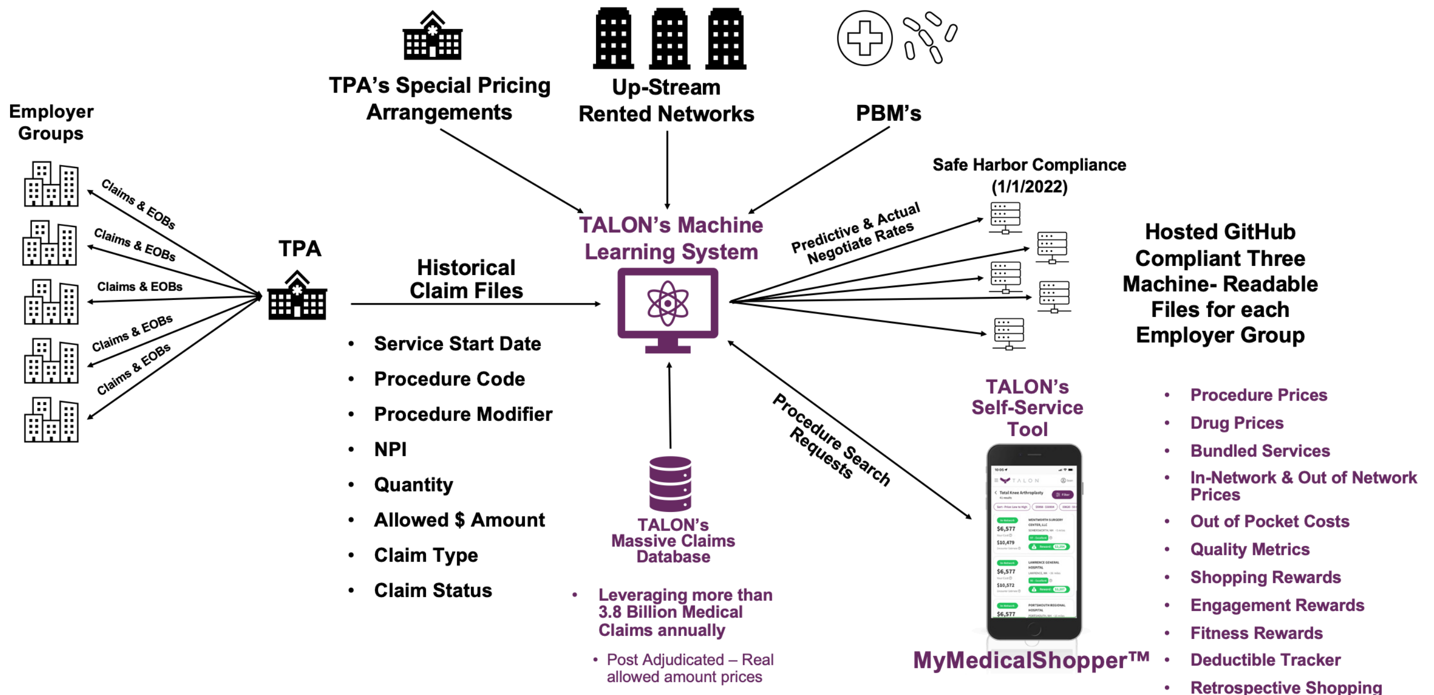
The result is a turnkey solution that provides compliance with both the *Transparency in Coverage Rule* and the *No Surprises Act*.

Since its inception in 2014, TALON has been producing standard format file structures to expose the hidden prices for procedures and bundled services. TALON has gained unparalleled expertise during this time in parsing complex non-standard historical claims files and negotiated rate payer arrangement files from the multitude of TPA and carrier networks and value-added pricing arrangements that TALON has engaged. This puts TALON's machine learning system in an unrivaled position regarding the auto-creation of Machine-Readable Files and provision the cost-comparison shopping tool supporting ongoing *Transparency in Coverage* rule compliance requirements.

To fully support the No Surprises Act's **AEOB** requirement, TALON's platform includes an AEOB module with a portal extension for Provider data ingestion along with user digital displays and an API output to our partner integrations for customized printing, stuffing and mailing.

Achieving Compliance

Utilizing Retrospective Processing



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TALON's software architecture and machine learning system was designed from the outset to support true price transparency and served as the model for the Transparency in Coverage Rule to empower healthcare consumerism and increase participant choice.

Also supporting the No Surprises Act through our machine learning system, TALON's Encounter Pricing ™ presents additional, ancillary healthcare procedures often added to primary procedures by different providers. Without this visibility, participants are often unaware of the thousands of dollars that may be additional out-of-pocket exposure. TALON's unique methods reduce such surprise shopping experiences.

Surprise Shopping
Other Vender Tools*

NUCLEAR STRESS TEST

Procedure Estimate Calculated using these procedures

Procedure Name	Likelihood	Weighted Price
NUCLEAR STRESS TEST	100%	**$1,662**
PROFESSIONAL FEE	100%	**$95**
	Procedure Estimate	**$1,757**

*Per Machine Readable File Rates,
Only shows the Nuclear Stress Test at $1,662.

No Surprise Shopping
TALON's Encounter Pricing™*

Encounter Estimate

Procedure Name	Likelihood	Weighted Price
Nuclear Stress Test	100%	$788.00
Professional Fee	100%	$153.00
Cardiovascular Stress Test: Interpretation & Report Only	87%	$24.48
Cardiovascular Stress Test: Supervision Only	73%	$31.52
Typical Other Costs		$104.26
	Encounter Estimate:	**$1,101.26**

Notes

The **Encounter Estimate** is the full cost of the primary procedure plus the full cost of the associated procedures multiplied by their respective 'likelihood' amounts. Where Carriers or Plans have provided Machine Readable Files, In-network and Out of Network amounts from those files will be used in these estimates. When MRF pricing is not available, prices used in the calculation are median prices. These specific calculations are based on 500+ records for this specific provider performing this specific procedure.

*Shows what is typically charged by provider.
Patient's real charge could be over $2,100 more.

For years, TALON has ingested and analyzed billions of claims in-depth and presented historical summaries to participants. We have successfully applied this learning to enhance our analyses and highlight the missed savings opportunities that participants accrue when selecting higher cost providers. Through TALON's **Retrospective Shopping**™, each claim is optionally re-shopped by the system, identifying up to three local providers that could have provided the same set of services at a lower price. This information can be presented to plan participants to encourage better shopping behavior, reduce wasteful out-of-pocket spending, and contain overall plan expenditures.

< Back 4/7/2022

Missed Savings Opportunities

BRIDGTON HOSPITAL
BRIDGTON, ME ~35 miles
Estimated Price **$94.97**

BRIDGTON HOSPITAL
BRIDGTON, ME ~35 miles
Estimated Price **$209.95**

You could have saved up to **$136** by shopping for care!
Shop Now >

Pharmacy 9/17/2021

COSTCO #1227

COSTCO #1227
959461484506456320
John Doe

Your Responsibility **$0.00**
Billed Amount $9.09
Allowed Amount $9.09

Hide Claim Details

Procedure	Billed	Allowed	Deductible	Coinsurance	Copay	Not Covered
OLMESARTAN MEDOXOMIL	$9.09	$9.09	$0.00	$0.00	-	-

Medical 6/16/2021

PORTSMOUTH HOSPITAL
9876543210
John Doe

Your Responsibility **$363.86**
Billed Amount $528.75
Allowed Amount $424.29

Hide Claim Details

Procedure	Billed	Allowed	Deductible	Coinsurance	Copay	Not Covered
Management of hospital discharge during the day (more than 30 minutes)	$270.00	$215.81	$215.81	$0.00	$0.00	$0.00
Hospital care for an additional complication (up to 35 minute bedside visits, 1 per day)	$258.75	$208.48	$148.05	$0.00	$0.00	$0.00

Retrospective Shopping Tool

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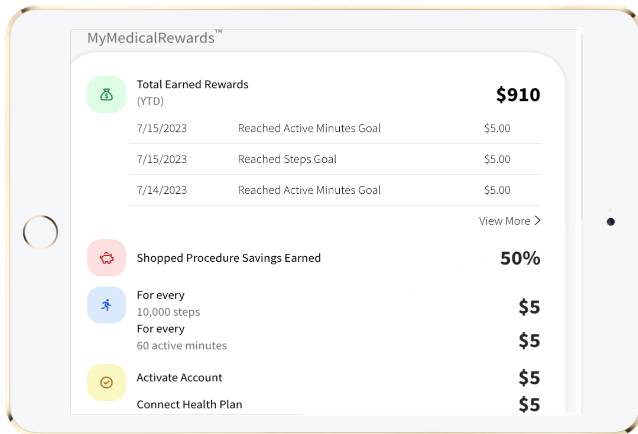
TALON has learned that Price Transparency alone may not drive significant healthcare cost reductions. Increased engagement and consumerism are key ingredients in influencing consumer's buying behavior. In response, TALON created the patented rewards system, **MyMedicalRewards™**, through which participants receive rewards incentives for smart healthcare consumerism, platform engagement, and fitness.

MyMedicalRewards™ extends throughout the plan year and can apply beyond the consumer's deductible and out-of-pocket maximum. These rewards can be seamlessly added to participants' HSAs, HRAs, and debit cards through integrations with TALON and the administer of the users' tax-advantaged accounts.

MyMedicalRewards™

User Experience



Shopping Rewards

- Shop for care using the TALON platform, and earn rewards for choosing to receive care at low-cost providers.

Engagement Rewards

- Earn rewards for activating your account, connecting your health plan (for those not auto connected), and/or download the mobile app

Fitness Rewards

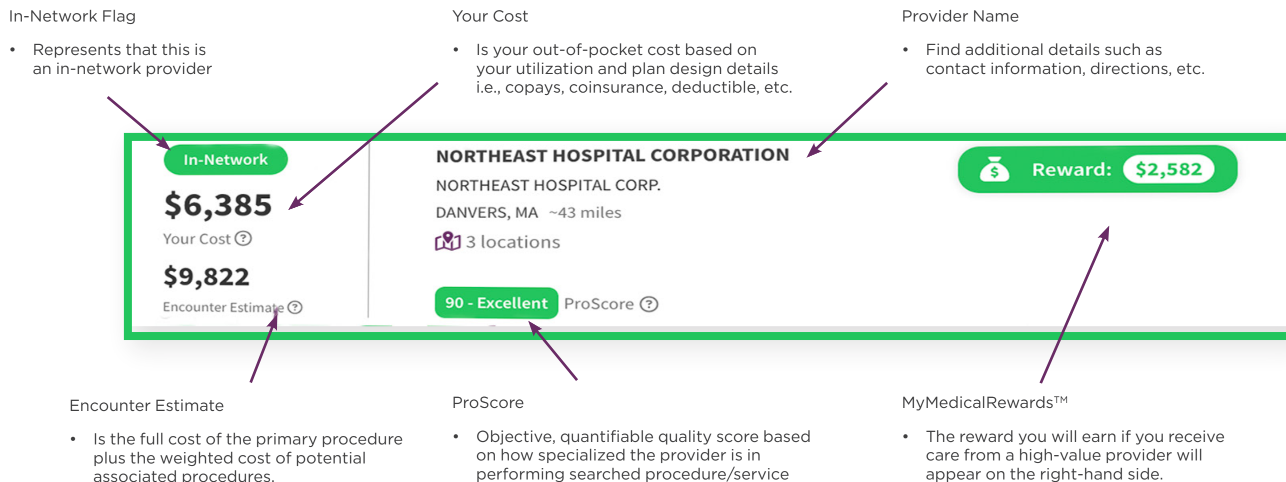
- Connect your preferred fitness device/app to your TALON account and earn rewards when you hit your goals

Use TALON's full web application with subscribers or leverage TALON's "SSO to Widget" functionality allowing any function to be integrated, providing a unified user experience in third-party portal environments. This includes the ability for full customization, aligning common look and feel into existing environments.

TALON provides clear visibility of In-Network/Out-of-Network provider status, integrated reward opportunities, proprietary quality score at the procedure/provider level, facility/provider searches, Google Map integration, out-of-pocket costs, and Encounter Pricing.

TALON's MyMedicalShopper™

Comparison shopping tool is the Gold Standard for detailed True Price Transparency



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A comprehensive **Administrative Console** for advisory and support staff that includes the ability to capture and record every participant interaction within the platform to better understand participant behavior and provide data for troubleshooting or dispute settlement.

Driving down cost in the healthcare market requires more than price transparency. Increased healthcare consumerism is essential to drive participant engagement, where employees are incented throughout the plan year to navigate to low-cost, high-value care, regardless of where they are in their deductible. TALON offers a comprehensive, patented toolset to ensure and promote such behavior, while also helping payers, brokers, and advisors delight and retain their customers and grow their business.

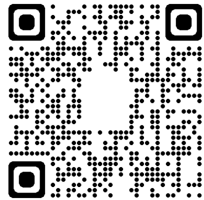
TALON's Advisor Dashboard toolset includes:

Claims Hindsight™

Consumer Interest Calculator™

SPARC™ Plan Analysis

Take flight.



Download the full WHITE PAPER and schedule a consultation with our experts at **www.TALONhealthtech.com**

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Key Take-Aways

01
The Transparency in Coverage Rule and No Surprises Act contain bold, transformative regulations that set a new course in healthcare consumerism.

02
As of 1/1/22, these new federal mandates require most commercial group health plans, and commercial health insurance issuers to disclose price and cost-sharing information by producing plan-specific Machine-Readable Files (MRFs). Enforcement of substantial fines for non-compliance will begin as early as 7/1/22.

03
As of 1/1/22, these new federal mandates require most commercial group health plans, and commercial health insurance issuers to provide a self-service tool for enrollees to obtain personalized out-of-pocket cost estimates. Enforcement of substantial fines for non-compliance will begin as early as 1/1/23.

04
Groups that do not comply can face fines of **$100 per plan member** per day or an estimated **$87,000 per enrolled employee** per year.

05
TALON has deep expertise in dealing with the substantial complexities of automating the ongoing creation of Machine-Readable Files (MRFs) that must be updated no less frequently than monthly.

06
TALON's **MyMedicalShopper**™ served as the model upon which the new federal mandates are based.

07
Through its **Retrospective Shopping**™ every subscriber claim is optionally re-shopped against TALON's massive pricing database through a machine learning system identifying up to three providers in the local area that could have provided the same set of services at a lower price.

08
Other TALON tools and services include **MyMedicalRewards**™ to incent consumerism, white label branding options, and Administrative Console to better support and understand participant behaviors.

09
Immediate and seamless compliance offers enormous competitive advantage delighting channel partners, employer clients, and plan participants.

Harness the new healthcare marketplace with

Mobile-First Shopping
Reduce plan participant out-of-pocket costs (and overall health plan expenditures).

Plan Advisory Support
Built-in next-generation tools to educate, incentivize and reward healthcare consumerism.

Automatically Generate Required Machine-Readable Files
Ensure employer group compliance.

*Pending further comment and rulemaking.

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The Time to Act is NOW

TALON has created **true free market healthcare** capabilities for all. We enable payers, providers, groups, and individuals with a platform to freely shop for healthcare and effectively removes surprise costs. Our bottom line is protecting yours. We enable you to be prepared to abide by the guidelines established under the Transparency in Coverage Rule & No Surprises Act and educate and empower all parties we serve along the way.

Here are two easy ways to get started:

REQUEST A DISCOVERY ASSESSMENT

TALON routinely conducts assessments to understand the unique requirements of your environment, and tailor a solution to meet your needs. Utilize the QR Code above or follow the link below to schedule your assessment with one of our compliance experts.

SCHEDULE A DEMONSTRATION

If you are interested in viewing a demonstration of TALONs software solution, we are happy to present the platform to your team. Follow the link below to schedule a demonstration.

TALONhealthtech.com

Sales: 603-292-3020