HEALTH CARE OVERVIEW

Transparency in Health Coverage

New transparency in coverage requirements apply to group health plans and health insurers in the individual and group markets. These rules require plans and issuers to disclose certain price and cost information to participants, beneficiaries and enrollees.

These provisions only apply to non-grandfathered coverage, including both insured and self-insured group health plan sponsors. The requirements take effect in three phases, as follows:

- **Jan. 1, 2022:** Detailed pricing information must generally be made public for plan years beginning on or after Jan. 1, 2022.
- **Jan. 1, 2023:** A list of 500 shoppable services must be available via the internet-based self-service tool for plan years beginning on or after Jan. 1, 2023.
- **Jan. 1, 2024:** A list of the remainder of all items and services is required for plan years beginning on or after Jan. 1, 2024.

LINKS AND RESOURCES

- On Oct. 29, 2020, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) issued a final rule regarding transparency in coverage.
- Transparency in coverage FAQs were released on Aug. 20, 2021.

Participant Disclosures

- Plans and issuers are required to disclose personalized price and cost-sharing information to participants, beneficiaries and enrollees (or their authorized representative).
- An initial list of 500 shoppable services is required for plan years beginning on or after Jan. 1, 2023.
- The remainder of all items and services is required for plan years beginning on or after Jan. 1, 2024.

Machine-readable Files

- Plans and issuers are required to make publicly available three machine-readable files that include detailed pricing information.
- The Departments have deferred enforcement of some of these requirements due to the enactment of the CAA, as it includes potentially overlapping requirements.

Transparency in Coverage Requirements

The Transparency in Coverage Final Rules (TiC Final Rules) require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose certain information. The final rule includes two approaches to make health care price information accessible to consumers and other stakeholders, allowing for easy comparison shopping.

Participant, Beneficiary and Enrollee Disclosures

First, most non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to disclose personalized price and cost-sharing information to participants, beneficiaries and enrollees (or their authorized representatives). Specifically, plans and issuers must provide **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.

- An initial list of **500 shoppable services**, as determined by the Departments, is required to be available via the internet based self-service tool for plan years that begin on or after Jan. 1, 2023.
- A list of the **remainder of all items and services** will be required for these self-service tools for plan years that begin on or after Jan. 1, 2024.

Machine-readable Files

Second, most non-grandfathered group health plans or health insurance issuers offering non-grandfathered health insurance coverage in the individual and group markets will be required to make available to the public (including stakeholders such as consumers, researchers, employers and third-party developers) three separate machine-readable files that include detailed pricing information.

- The first file must show negotiated rates for all covered items and services between the plan or issuer and in-network providers;
- The second file must show both the historical payments to, and billed charges from, out-of-network providers (historical payments must have a minimum of 20 entries in order to protect consumer privacy); and
- The third file must detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

Plans and issuers will display these data files in a standardized format and provide monthly updates.

These machine-readable files are required to be made public for plan years that begin on or after **Jan. 1, 2022**. However, the Departments reserved enforcement discretion in their FAQs to apply the following two exceptions:

1. Under the first exception, the Departments will **defer enforcement of the machine-readable files requirement relating to prescription drug pricing** pending further rulemaking. Following the enactment of the Consolidated Appropriations Act, 2021 (CAA)—which imposes potentially duplicative and overlapping reporting requirements for prescription drugs—the Departments are currently considering whether the prescription drug machine-readable file requirement remains appropriate.

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2. Under the second exception, the Department will **defer enforcement of the requirement to publish the remaining machine-readable files until July 1, 2022**. On July 1, 2022, the Departments intend to begin enforcing the requirement that plans and issuers publicly disclose information related to in-network rates and out-of-network allowed amounts and billed charges for plan years (in the individual market, policy years) beginning on or after Jan. 1, 2022. For 2022 plan years and policy years beginning subsequent to July 1, 2022, plans and issuers should thus post the machine-readable files in the month in which the plan year (in the individual market, policy year) begins, consistent with the applicability provision of the TiC Final Rules.

HHS encourages states that are primary enforcers of these requirements with regard to issuers to take a similar enforcement approach, and will not determine that a state is failing to substantially enforce this requirement if it takes this approach.

MLR "Shared Savings" Credits

The TiC Final Rules also allow issuers that share savings with consumers resulting from plan provisions encouraging consumers to shop for services from lower-cost, higher-value providers, to take credit for those "shared savings" payments in their medical loss ratio (MLR) calculations. This is intended to ensure that issuers would not be required to pay MLR rebates based on a plan design that would provide a benefit to consumers that is not currently captured in any existing MLR revenue or expense category.

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