Compliance Overview

Brought to you by: eBenefits Consulting Group, a OneDigital Company

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.

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