The Transparency in Coverage Participant Disclosure Requirements Go into Effect on January 1, 2023

By Seth Capper

A lot of attention has been given in recent months to the public disclosure (i.e., machine-readable file) requirements under the "Transparency in Coverage" ("TiC") regulations, which went into effect on July 1, 2022, and the CAA's pharmacy reporting requirements, the first reports for which are due on December 27, 2022. In addition, we also wanted to remind plan sponsors about the TiC's participant disclosure requirements, which go into effect, in part, on January 1, 2023.

Pursuant to the TiC regulations, group health plans and health insurance issuers must disclose cost-sharing information to participants, beneficiaries, and enrollees upon request in paper form, and such information must be made available on an internet-based, self-service tool that includes certain search capabilities. An initial list of 500 items and services (as determined by the agencies) must be available on the internet-based self-service tool for plan years that begin on or after January 1, 2023. The remaining items and services must be available through these self- service tools for plan years that begin on or after January 1, 2024. The **regulations** include a detailed explanation of the cost-sharing information that must be disclosed, which includes the following:

- The participant's estimated cost-sharing liability for a requested covered item or service, calculated based on the following information:
    - Accumulated amounts (i.e., the amount of financial responsibility that a participant has incurred at the time the request for cost-sharing information is made, with respect to a deductible and/or an out-of-pocket limit). To the extent a plan or issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits, or hours covered in a defined time period) independent of individual medical necessity determinations, this includes amounts that have accrued toward the cumulative treatment limitation.
    - The in-network rate for such item or service, comprised of (i) the negotiated rate (i.e., the amount the plan or issuer has contractually agreed to pay), expressed as a dollar amount, and (ii) the underlying fee schedule rate (i.e., the rate from a particular in- network provider that the plan or issuer uses to determine a participant's cost-sharing liability), expressed as a dollar amount, but only if it is different from the negotiated rate.
    - If the request for cost-sharing information is for a covered item or service furnished by an out-of- network provider, the out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount the plan or issuer will pay for the requested covered item or service.

- If the requested item or service is subject to a bundled payment arrangement, a list of the items and services included in the bundled payment arrangement for which cost-sharing information is being disclosed.

- If applicable, notification that coverage of a specific item or service is subject to a prerequisite (i.e., concurrent review, prior authorization, and step-therapy or fail-first protocols).

- A disclosure notice that includes: balance billing provisions; a statement regarding possible variations in actual charges versus estimates; a statement that the estimated cost- sharing liability is not a guarantee; a statement disclosing the application of copayment assistance and/or third-party payments to deductibles and out-of-pocket maximums; for preventive services, a statement that an in-network item or service may not be subject to cost-sharing if billed as a preventive service if the plan or issuer cannot determine whether the request is for a preventive or non-preventive item or service; and any other information deemed appropriate.

A **model notice** is available on the DOL's website. For fully insured plans, the plan may satisfy the TiC's participant disclosure requirements (and no longer be liable) if the plan requires the issuer to meet the requirements on its behalf pursuant to a written agreement. While self-funded plans can contract with their TPAs or other third parties to provide the disclosures, and include indemnification provisions in such contracts, the self-funded plans still must monitor the TPAs because such plans will remain liable for the disclosure requirements if the TPA or other third party fails to comply.

Note that the TiC's participant disclosure requirements do not apply to (i) grandfathered group health plans, (ii) excepted benefits (e.g., limited-scope dental or vision offered under separate policies, many EAPs, and fixed indemnity plans), (iii) account-based plans (e.g., HRAs and many gap/bridge plans), (iv) short-term limited- duration insurance, or (v) retiree-only plans.