Transparency in Coverage Rule

The Transparency in Coverage (TiC) Final Rule was issued by the U.S. Departments of Health and Human Services, Labor, and the Treasury. It requires most health insurance issuers and group health plans to make specific price and cost-sharing information publicly available.

The rule is part of a federal effort to give consumers, researchers, and other stakeholders better insight into the cost of health care services, and to allow for informed decision-making before services are received. It establishes two main requirements:

1. Public Machine-Readable Files

Beginning July 1, 2022, health plans must post standardized, machine-readable files (MRFs) containing the following information:

- **In-Network Rates** – Negotiated rates for all covered items and services with in-network providers.
- **Out-of-Network Allowed Amounts** – Historical billed charges and allowed amounts for services provided by out-of-network providers, based on a 90-day look-back period.
- **Prescription Drug Pricing** – Negotiated rates and historical net prices for all covered prescription drugs. (This portion is delayed pending further federal guidance.)

These files are intended for use by researchers, app developers, and other entities to create consumer-facing tools and perform market analysis. They are updated monthly and must be available to the public without login credentials or other access barriers.

Access Harbor Health's Machine-Readable Files will be available here (coming soon).

2. Consumer Cost-Sharing Information

The rule also requires health plans to provide members with personalized cost-sharing estimates:

- **Phase 1 (effective January 1, 2023):** Estimates must be available for 500 identified "shoppable services," such as common imaging tests, office visits, or outpatient procedures.
- **Phase 2 (effective January 1, 2024):** Estimates must be available for **all** covered items and services.

Harbor Health provides this information through an online self-service tool and will also make it available by phone or in writing upon request. Estimates include:

- Member-specific deductible and out-of-pocket accumulations
  Projected cost-sharing for the requested service
- Pricing for both in-network and out-of-network providers

Purpose of the Rule

The Transparency in Coverage requirements are intended to:

- Help members anticipate their potential costs before receiving care
- Increase competition among providers and health plans by making pricing information available
- Support third-party innovation in creating consumer tools to compare costs and quality

For additional details, visit the Centers for Medicare & Medicaid Services Transparency in Coverage page.