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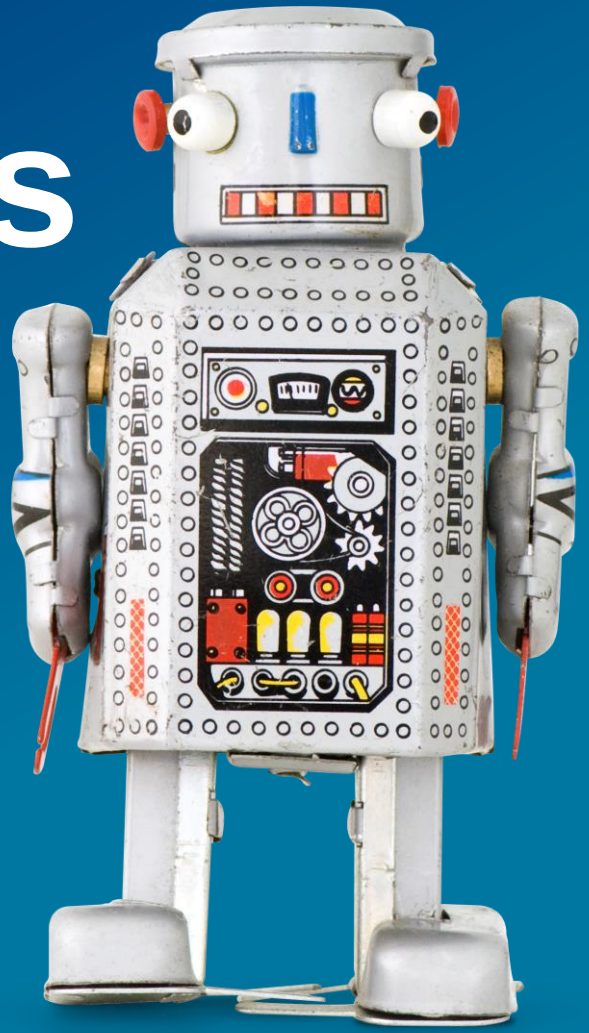
What employers need to know…

Machine-readable files



May 4, 2022

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Healthcare price transparency

Regulatory overview

New transparency requirements aim to address wide price variations, reduce healthcare waste, and help individuals make informed choices

Effective January 1, 2021

Hospital requirements to make standard charges public

- Comprehensive machine-readable file
- Display of shoppable services

Effective 2022-2024

Group health plan/insurer requirements to disclose out-of-pocket costs, negotiated rates

- Post publicly available machine-readable files
- Provide “self-service” tool

Healthcare price transparency

Regulatory overview

Machine-readable files

Plan years beginning 2022

Post publicly 2 machine readable files[1]:

- Negotiated in-network provider rates *(7/1/22 enforcement delay)*
- Historic out-of-network allowed amount and billed amount *(7/1/22 enforcement delay)*

Group health plans must disclose extensive price and cost-sharing information beginning in 2022

Price Comparison/Self-service Tool

Plan years beginning 2023

Provide online self-service tool with estimated cost-sharing liability (and other information) for 500 items and services. CAA requirements are likely to be incorporated.

Plan years beginning 2024

Provide online self-service tool with estimated cost-sharing liability (and other information) for all covered items and services, including Rx drugs.

1) Negotiated rates and historic net prices for drugs file delayed pending further guidance

2) The requirements apply to all nongrandfathered group health plans and insurers regardless of size. Does not apply to: retiree only plans, HRAs, excepted benefits, expat plans, STLDI

Machine-readable files

General

Group health plans must provide information for all covered items and services in two areas:

- Negotiated in-network provider rates
- Historic out-of-network allowed amount and billed amount

The machine-readable files must be made publicly accessible on an internet site.

- The allowed out-of-network amount MRF may be hosted on a third-party website, but the plan's website would need to provide a link to the other site
- The rules do not say whether a third-party website could also host the in-network rate MRF

The MRFs must be updated monthly and indicate the date of the most recent update.

- The rules do not indicate how long records will need to be retained. The plan may need to assume responsibility or rely on the TPA/carrier for record retention

Consider where to post the machine-readable files and/or URL links and how to update.

Machine-readable files

Format

- A machine-readable file is defined as “a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost”.
  - Examples that meet the definition include, but not limited to: JSON, XML, YAML
  - Examples that do not meet the definition: PDF, XLS/XLSX
- The files must be made available via HTTPS

Files will contain **massive amounts** of raw data (e.g., 60-120 million lines).

Machine-readable files

Data elements

In-network rates, including negotiated rates

- Name and identifier (e.g., HIOS, EIN)
- Billing code
- Applicable rates
  - Associated with the NPI, TIN, and place-of-service code for each provider
  - Associated with the last date of the contract term for the rate
  - Notated when a reimbursement arrangement other than fee-for-service applies (such as a capitation or bundled-payment arrangement)

Out-of-network allowed amounts

- Name and identifier (e.g., HIOS, EIN)
- Billing code
- Unique out-of-network allowed amounts and billed charges
  - Data may be aggregated
  - Covered items and services furnished during the 90-day period that began 180 days prior to the file's publication date
  - Associated with the NPI, TIN, and place-of-service code for each provider
  - Reflected as a dollar amount

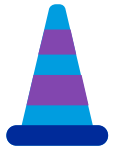
CMS posted the final schema (Version 1.0) on **March 1, 2022.**

Machine-readable files

Accessibility

Publically available

Files must be made available without restrictions that would impede the re-use of information.



No barriers

Files must not require a username, password, or request personal information for accessing data.

Free of charge

Files must be posted publically without charge.

Discoverable

Files must allow for search engine discoverability.

The goal is to **improve competition and flatten increases** in the cost of health care. Getting there may be hard…

- Machine-readable files will have raw data that won't be understandable to most employees.
- Data will likely be aggregated and analyzed, allowing employers to be better informed when negotiating for benefits and services.
- New enforcement of anticompetitive behaviors in health care is possible.

Machine-readable files

Communication

Employers should consider including pop-up language regarding purpose of files and how to properly open files.

This sample language is intended to be posted with the machine-readable file links/URLs. Employers should review and modify the drafted language to include their plan-specific and business policy information (as applicable). Consultation with legal counsel is recommended.

The Transparency in Coverage Final Rules require certain group health plans to disclose on a public website information regarding in-network provider rates and historical out-of-network allowed amounts and billed charges for covered items and services in two separate machine-readable files (MRFs). The MRFs for the benefit package options under the *[insert Plan name—as included on the governing ERISA plan document and related Form 5500]* are linked below:

[Insert filenames / URLs here]

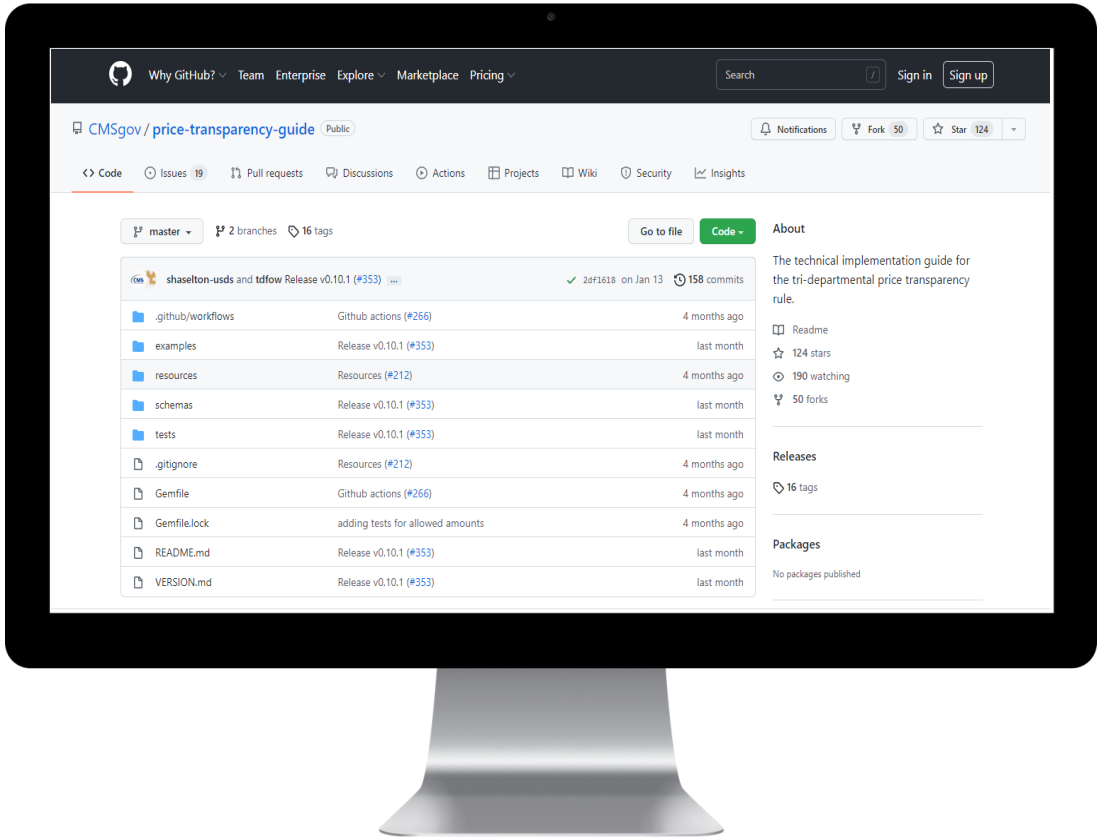
Machine-readable files

Technical implementation

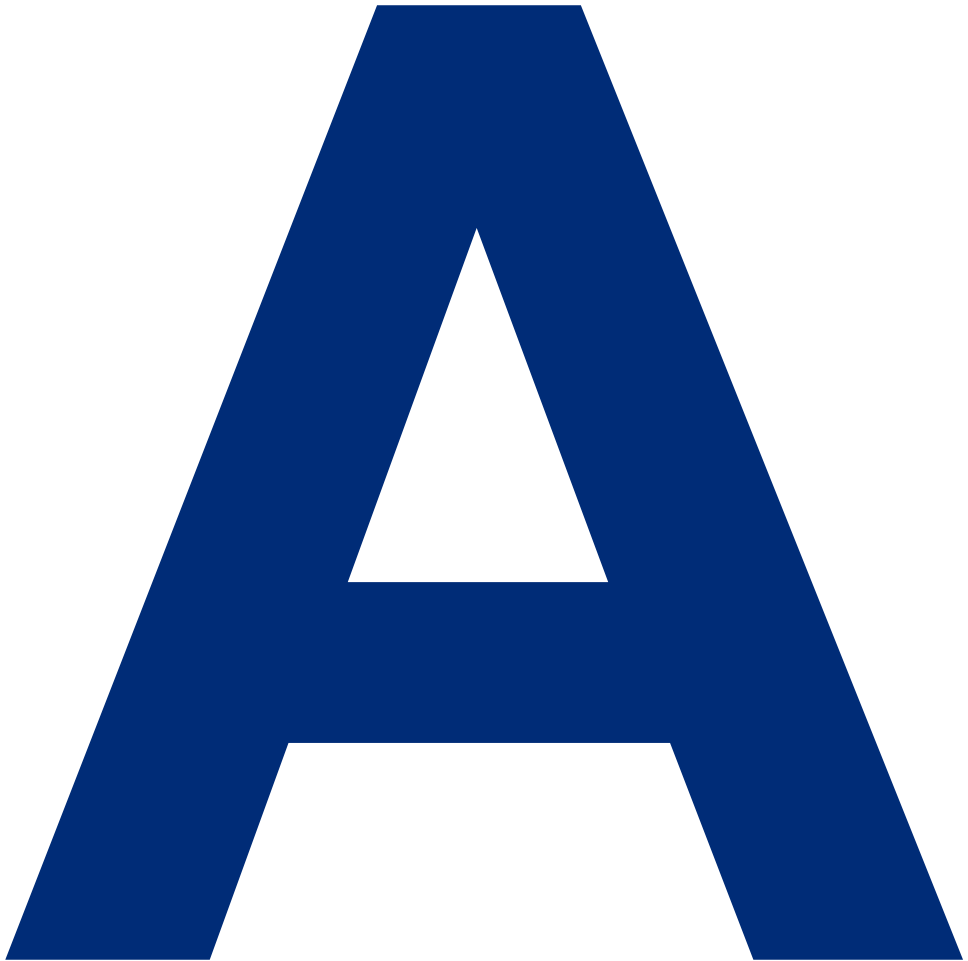
Technical implementation guide for the machine-readable files: https://github.com/CMSgov/price-transparency-guide.

Developers are able to collaborate, learn, and keep up-to-date on the development and implementation of the requirements on GitHub.

Additional schema versions may become available after March 1, 2022. Files conforming to schema Version 1.0 would be considered compliant.



Appendix



Machine-readable files

In-network rates, including negotiated rates — enforcement delayed to July 1

Plans and issuers must disclose negotiated rates through the in-network rate MRF.

- The negotiated rate is the amount that a plan or an issuer has contractually agreed to pay — whether directly or indirectly through a TPA or PBM — to an in-network provider for covered items and services.
- The in-network MRF must include for each coverage option:
  - ***Name and identifier*:** the Health Insurance Oversight System (HIOS) identifier or the employer identification number (EIN) if the HIOS identifier is not available
  - ***Billing code:*** the billing code (the National Drug Code (NDC) for prescription drugs) and a plain language description of each covered item or service
  - ***Applicable rates:*** dollar amounts for all applicable rates, including negotiated rates, underlying fee schedule or derived amounts, or if rates can be adjusted for a particular enrollee, the base rate
- If a plan doesn't use negotiated rates for provider reimbursements, it should disclose derived amounts, if calculated in the normal course of business (e.g., for capitated arrangements).
  - A derived amount is the price a plan assigns to an item or service for internal accounting

Machine-readable files

In-network rates, including negotiated rates — enforcement delayed to July 1

- If a plan uses underlying fee-schedule rates to calculate cost sharing, the files must provide those rates in addition to the negotiated or derived rates.
- Rates must be:
  - Associated with the national provider identifier (NPI), taxpayer identification number (TIN) and
  - Place-of-service code for each in-network provider
  - Associated with the last date of the contract term for the rate
  - Notated when a reimbursement arrangement other than fee-for-service applies (such as a capitation or bundled-payment arrangement)

Bundled rates and other alternative payment models.

- In-network rates disclosed in the machine-readable files must include any items or services covered by a bundled-payment arrangement (e.g., for diagnostic imaging).
  - This type of arrangement pays a provider a single payment for all covered items and services provided to a patient for a specific treatment or procedure.
- These requirements apply to other alternative payment models as well, such as referenced-based pricing, direct primary care, capitated arrangements and value-based arrangements.

Machine-readable files

Out-of-network allowed amounts — enforcement delayed to July 1

Plans and issuers must disclose out-of-network allowed amounts through the allowed amount MRF.

- The out-of-network allowed amount is the maximum a plan will pay for a covered item or service furnished by an out-of-network provider.
- The MRF must include unique out-of-network allowed amounts and billed charges for covered items and services furnished during the 90-day period that began 180 days prior to the file's publication date.
  - A plan must exclude data involving fewer than 20 different claims for a particular item or service. The rules don't require disclosing any information that would violate applicable privacy laws.
  - A plan may use aggregate data (collected from multiple plans or issuers) under certain circumstances.
- Each unique out-of-network allowed amount must be:
  - Reflected as a dollar amount
  - Associated with the NPI, TIN and place-of-service code for each out-of-network provider

Example:

An out-of-network provider submits 25 claims to a plan for an item. The 25 claims have three different billed charges ($100, $150 and $200) and two different allowed amounts ($50 and $150). The plan should have one entry for each of the six unique combinations of billed charges and allowed amounts submitted by the provider:

- Entry A has a billed charge of $100 and an allowed amount of $50.
- Entry B has a billed charge of $150 and an allowed amount of $50.
- Entry C has a billed charge of $200 and an allowed amount of $50.
- Entry D has a billed charge of $100 and an allowed amount of $150.
- Entry E has a billed charge of $150 and an allowed amount of $150.
- Entry F has a billed charge of $200 and an allowed amount of $150.

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