# COMPLIANCE OVERVIEW

# Health Care Transparency: Posting Machine-readable Files

The Transparency in Coverage Final Rules (TiC Final Rules) require group health plans and health insurance issuers to disclose on a public website detailed pricing information in **three separate machine-readable files (MRFs)**. Specifically, the following information must be disclosed:

- **First file:** In-network provider negotiated rates for covered items and services (the "**In-network Rate File**");
- **Second file:** Historical payments to and billed charges from out-of-network providers (the "**Allowed Amount File**"); and
- **Third file:** In-network negotiated rates and historical net prices for covered prescription drugs (the "**Prescription Drug File**").

The files must be publicly available and accessible free of charge without any restrictions. Most employers will rely on their insurance carriers and third-party administrators (TPAs) to provide the MRFs.

## Enforcement Dates

- MRF requirements were generally applicable for **plan years beginning on or after Jan. 1, 2022**.
- Federal agencies deferred enforcement of the first and second MRFs related to disclosing in-network and out-of-network data until **July 1, 2022.**
- Enforcement of the third MRF relating to prescription drugs was **temporarily delayed**. FAQs from Sept. 27, 2023, announced the end of the enforcement delay. Future guidance will specify an implementation timeline for this MRF.

## Covered Plans

- The rules apply to group health plans and health insurance issuers in the individual and group markets.
- The rules **are not applicable** to grandfathered plans, excepted benefits and account-based plans, such as HRAs, FSAs and HSAs.

## Machine-readable Files (MRFs)

The In-network Rates, Allowed Amounts, and Prescription Drug Files must be disclosed as machine-readable files. The TiC Final Rules define ''**machine-readable file**'' 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 lost semantic meaning. This ensures the MRF can be imported or read by a computer system without those processes resulting in alterations to the ways data and commands are presented in the file.

The Final Rules require each MRF to use a nonproprietary, open format that will be identified in technical implementation guidance—for example, JavaScript Object Notation (JSON), Extensible Markup Language (XML) or Comma Separate Value(s) (CSV). A PDF file would not meet this definition due to its proprietary nature.

**A plan or issuer's file will be acceptable so long as it:**

1. Includes all **required data elements** mandatory for the respective file (that is, all applicable rates in the In-network Rate File, allowed amounts and billed charges in the Allowed Amounts File, and negotiated rates and historical net process in the Prescription Drug File); and
2. Is **formatted** in a manner consistent with technical implementation guidance.

## Nonduplication Rule

The TiC Final Rules anticipate that plan sponsors will rely on their carriers or service providers, such as TPAs for self-insured plans, to satisfy the MRF disclosure requirements. Accordingly, the TiC Final Rules include a special rule to streamline the provision of the required disclosures and avoid unnecessary duplication. The special rule has different implications depending on the type of plan:

- **Fully insured plans:** A fully insured group health plan satisfies the MRF requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and issuer. **Accordingly, if a plan sponsor and an issuer enter into a written agreement under which the issuer agrees to provide the information required and the issuer fails to provide full or timely information, then the issuer, not the plan, has violated the TiC Final Rules' disclosure requirements.**
- **Self-insured plans:** A self-insured group health may satisfy the MRF requirements by entering into a written agreement under which another party (such as a TPA or health care claims clearinghouse) will make public the required information. But, the plan must monitor the other party to ensure the entity is providing the required disclosures. **It is ultimately the responsibility of the plan to ensure that the third party provides the required information.**

***Website Posting***

Department FAQs from August 2022 clarify that nothing in the TiC Final Rules requires plans to create their own website for the purposes of providing a link to a location where the MRFs are publicly available, where:

- The group health plan does not have its own public website; or
- The plan sponsor (e.g., the employer) maintains a public website, but the group health plan sponsored by the employer does not.

**Instead, a plan may satisfy the MRF disclosure requirements by entering into a written agreement under which a service provider (such as a TPA) posts the MRFs on its public website on behalf of the plan.** To the extent a service provider posts the required information on its public website on behalf of a plan, the plan satisfies the requirements with respect to posting the information on a public website if the service provider makes the information available in the required manner, regardless of whether the group health plan has a public website. **In the case of aggregated "Allowed Amounts" files, however, the plan must post a link to the file hosted by the service provider on the plan's own website, if the plan maintains a public website.**

Notwithstanding this clarification, if a plan enters into an agreement under which a service provider agrees to post the MRFs on its public website on behalf of the plan, and the service provider fails to do so, the plan violates the MRF disclosure requirements.

## Content Elements for All MRFs

The following content elements are required to be included in the three MRFs:

- **Name and identifier for each coverage option:** Plans and issuers must include their Health Insurance Oversight System (HIOS) ID at the 14-digit product level. If the plan or issuer does not have a HIOS ID at the plan or product level, the plan or issuer must use the HIOS ID at the five-digit issuer level. If a plan or issuer does not have a HIOS ID, it must use its EIN.
- **Billing codes:** This includes a Current Procedural Terminology (CPT) code, a Healthcare Common Procedure Coding System (HCPCS) code, a Diagnosis Related Group (DRG), a National Drug Code (NDC) or another common payer identifier used by a plan or issuer (for example, a hospital revenue code). In the case of prescription drugs, plans may only use the NDC as the billing code type. Plain language descriptions of the billing codes must also be provided.
- **In-network applicable amounts, out-of-network allowed amounts, or negotiated rates and historical net prices for prescription drugs:** This will depend on the type of file (in-network amounts for the In-Network Rate File, allowed amounts and historical billed charges for the Allowed Amount File, or negotiated rates and historical net prices for the Prescription Drug File). For all MRFs, the specific pricing information within each file must be associated with the provider's national provider identifier, tax identification number and a Place of Service Code, although the provider's name is not required to be included. Historical payments must have a minimum of 20 entries to protect consumer privacy.

**Timing:** Plans and issuers must update the information required to be included in each MRF on a **monthly basis** to ensure it remains accurate and must clearly indicate the date the files were most recently updated. According to CMS guidance (in the form of a technical clarification Q&A), federal agencies consider "monthly" to refer to reasonably consistent periods of approximately 30 days, but are not specifying a particular day of the month.

**Retention:** CMS has stated that the TiC final rules do not include a retention requirement for the MRFs. However, federal agencies recommend that group health plans and health insurance issuers maintain prior months' MRFs to demonstrate compliance, especially considering their duty to comply with requirements under other applicable federal laws (including requirements governing the accessibility, privacy, or security of information, or those governing the ability of properly authorized representatives to access participant, beneficiary, or enrollee information held by plans and issuers). In addition, states may have their own requirements related to retention that would apply to certain health insurance plans and issuers.

## Technical Guidance

The Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) have provided technical guidance for plans and issuers to assist in developing the MRFs.

***GitHub Implementation Guidance***

The Departments' technical implementation guidance is available online through **GitHub**, a website and cloud-based service that helps developers store and manage their code as well as track and control changes to their code. The Departments' goal in using GitHub is to facilitate a collaborative effort that allows plans and issuers to meet the public disclosure requirements of the TiC Final Rules while addressing their unique IT system, issuer and plan attributes.

To the extent a plan or issuer's unique attributes (for example, IT system, plan benefit design or reimbursement model) are not addressed sufficiently through the technical implementation guidance, the Departments intend to provide targeted technical assistance to ensure all plans and issuers are able to meet their public disclosure requirements. The technical implementation guidance will provide instructions on obtaining this technical assistance should the need arise.

The guidance hosted on GitHub will include a file's repository set of "**schemas**," which are descriptions of how the data should be organized and arranged. **Plans and issuers will be able to access the GitHub schemas at any time and collaborate with the Departments in real-time.**

***Enforcement Safe Harbor for In-Network Rates***

On April 19, 2022, the Departments issued FAQs providing an **enforcement safe harbor** for in-network rates that are not expressed as a dollar amount:

- For contractual arrangements under which a plan or issuer agrees to pay an in-network provider a percentage of billed charges and is not able to assign a dollar amount to an item or service prior to a bill being generated, plans and issuers **may report a percentage number in lieu of a dollar amount**.
- For situations in which alternative reimbursement arrangements are not supported by the schema, or in instances where the contractual arrangement requires the submission of additional information to describe the nature of the negotiated rate, **plans and issuers may disclose in an open text field a description of the formula, variables, methodology or other information necessary to understand the arrangement**.
- The Departments FAQs from Sept. 27, 2023, rescind this safe harbor, stating that the Departments did not intend to provide a categorical exception to the MRF posting requirements. The FAQs clarify that whether a plan or issuer can comply with the requirement to disclose certain rates as dollar amounts is a fact-specific determination. Thus, the Departments intend to exercise enforcement discretion with respect to this requirement on a case-by-case basis.

# Links and Resources

- TiC Final Rules
- FAQ guidance from August 2021 temporarily delaying the requirement to post the Prescription Drug File
- FAQ guidance from April 2022 providing an enforcement safe harbor for in-network rates that are not expressed as a dollar amount
- FAQ guidance from September 2023 ending certain enforcement relief for providing the MRFs

*Source: U.S. Department of Labor*