COMPLIANCE ALERT

Machine-Readable TiC File Requirement Is Looming

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Quick Facts

- Group health plans and issuers are now required to make publicly available a machine-readable file (MRF) disclosing information about costs, covered items and services starting on July 1, 2022.
- Additional requirements for prescription drug data and cost transparency tools are coming in the future.
- MRFs must contain specific information, follow a specific format and be posted on a publicly accessible website.
- Both fully insured and self-funded plan sponsors must comply with the requirements and will need to lean heavily on their carriers and third-party administrators (TPAs) for compliance assistance.

Background

In recent years, multiple new laws and regulations have been passed with the intent of making certain health plan information more accessible to health plan participants and the public. In November 2020, the Centers for Medicare and Medicare Services (CMS) finalized the **Transparency in Coverage Final Rules** (TiC) and in December 2020, President Trump signed into the law the Consolidated Appropriations Act of 2021 (CAA), both of which required group health plans to make certain health plan disclosures and in many cases had overlapping requirements.

The TiC requires group health plans and issuers to make available to the public, a machine-readable file disclosing certain information about plan costs for covered items and services. Additionally, plans and issuers must create an online cost-estimator tool, customized for plan participants. Starting January 1, 2023, the cost transparency tool must disclose costs for 500 specific items and services, and starting January 1, 2024, for all items, services and prescription drugs covered by the health plan.

In August 2021, the Department of Labor, the Department of Health and Human Services, and the Treasury Department (collectively "the Departments") jointly issued a **frequently asked question** (FAQ) document addressing the overlap of the regulations and providing additional guidance. On April 19, 2022, the Departments released another set of **FAQs** providing technical guidance on MRFs and providing two safe harbors for group health plans and issuers who use alternative payment arrangements.

Machine-Readable Files

As part of the TiC, non-grandfathered group health plans and insurance issuers must make available to the public three separate machine-readable files (MRFs) related to:

- Negotiated rates for all covered items and services between the plan or issuer and in-network providers.
- Historical payments to, and billed charges from, out-of-network (OON) providers. For privacy purposes, historical payments must have a minimum of twenty entries.
- Detailed network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The MRF requirement was originally effective on January 1, 2022, but the August FAQ guidance delayed the date for the in-network and out-of-network data to be provided until July 1, 2022, and delayed data for prescription drugs indefinitely pending additional guidance.

Content to Disclose

Starting July 1, 2022, plans and issuers must create two files, one for in-network items and services and one for out-of-network items and services. The files must conform to specific format requirements and follow schemas set forth on the **CMS GitHub website**. The files must be posted on a publicly accessible website and updated monthly. Note that the files must be posted on a publicly accessible website, not a company intranet site because the intent is not to disclose the information only to employees but to make the information publicly available.

In-Network

The in-network MRF must contain the following information:

Name or Identifier for Each Plan Option

The MRF must contain the name and identifier for each plan option or coverage offered by a group health plan or insurer. For the identifier, plans and insurers must use the name and the 14-digit Health Insurance Oversight System (HIOS) identifier. Alternatively, a plan may use the 5-digit HIOS identifier, or the Employer Identification Number (EIN) if the plan does not have a HIOS identifier.

Billing Code

The MRF must include the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier used by a plan or insurer. If a covered item or service does not have a corresponding code, then a plan is permitted to choose its indicator or another method to communicate that there is no corresponding code.

Applicable Rates

The MRF in-network file must contain negotiated rates or comparable amounts for each covered item or service furnished by in-network providers. Plans that do not use negotiated rates should disclose derived amounts. Plans that use underlying fee schedule rates should include the fee schedule in addition to negotiated rates and derived amounts. Applicable rates and items or services that are part of a bundled payment arrangement should be shown as dollar amounts.

Out-of-Network

The out-of-network MRF must contain the following information:

Name or Identifier for Each Plan Option

The MRF must contain the name and identifier for each plan option or coverage offered by a group health plan or insurer. For the identifier, plans and insurers must use the name and the 14-digit HIOS

identifier. Alternatively, a plan may use the 5-digit HIOS identifier, or the EIN if the plan does not have a HIOS identifier.

Billing Code

The MRF must include the CPT code, the HCPCS code, the DRG code, the NDC, or other common payer identifier used by a plan or insurer. If a covered item or service does not have a corresponding code, then a plan is permitted to choose its indicator or another method to communicate that there is no corresponding code.

Allowed Amount

Plans must include out-of-network allowed amounts and billed charges for items and services furnished by out-of-network providers during the 90-day period beginning 180 days before the publication of the MRF. Because of privacy concerns, data on claims for items and services should be omitted when there are less than 20 different claims for the item or service. Allowed amounts must be reflected as dollar amounts. The plan or insurer must disclose the aggregate of the actual amount the plan or insurer paid to the out-of-network provider, and the plan participant's cost-share.

Safe Harbor Requirement

On April 19, 2022, the Departments released a set of **FAQs** to provide clarity on the pricing disclosures required by MRFs starting on July 1, 2022. In the FAQs, the Departments provide a safe harbor for payment arrangements where a specific dollar amount cannot be determined. In the case of a percentage-of-billed-charges arrangement, where a dollar amount cannot be assigned for an in-network item or service, the group health plan or issuer may provide a percentage in place of a dollar amount. In the case of an alternative reimbursement arrangement, if the **reporting schema** does not support the arrangement or requires additional information to describe the nature of the arrangement, the group health plan or issuer may provide a description of the reimbursement arrangement. Plans or issuers should provide a description of the formula, variables, methodology or other necessary information to describe the arrangement.

Publishing the Disclosure

The files must be made available as machine-readable files, which 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." The regulations require each file to use a specific format, comply with specific technical guidance and follow schemas set forth on the **CMS GitHub website**. MRFs must be accessible to the public, at no cost and cannot require user access, passwords or other credentials such as name or email address. MRFs must be updated monthly and state the date on which when they were most recently updated.

Employer Compliance

Starting July 1, 2022, group health plans and issuers must provide the MRFs publicly and will need to rely heavily on insurance carriers and TPAs for compliance assistance. Fully insured plans should be able to rely on carriers to comply. Fully insured plan sponsors should discuss the requirements with their carrier and ensure there is a written agreement in place with the carrier for compliance. Self-funded plan sponsors are responsible for compliance but will need to rely on the TPA for assistance. Self-funded plan sponsors should contact TPAs to inquire about what steps the TPA is taking to create an MRF and provide the file to the plan sponsor to post on a publicly accessible site. All plan sponsors are encouraged to seek guidance from ERISA counsel if they anticipate not being able to comply with the requirements on the July 1, 2022, deadline.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.

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