601 S. Gaines St.
P.O. Box 2181
Little Rock, AR 72203-2181
arkansasbluecross.com

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Transparency rule – Machine-readable files update

The federal **Transparency in Coverage final rule** (CMS-9915-F), jointly issued in October 2020 by the Department of Health and Human Services (HHS), the Department of Labor and the Department of the Treasury, contains many requirements that have implications for health insurers, health plans, healthcare providers and consumers.

- ## Machine-readable files – nonpharmacy

  One provision in the Transparency of Cost Rule[1] requires nongrandfathered group health plans and health insurance issuers in the individual and group markets to disclose certain pricing information in publicly available **machine-readable files** posted to a website. These machine-readable files can be used by payers, consultants and groups for visibility of costs across the healthcare financing and delivery system. These files must contain:
  - In-network negotiated rates with healthcare providers
  - Historical payments to out-of-network healthcare providers (including out-of-network healthcare providers' billed charges)

  These machine-readable file requirements are applicable for **plan years/policy years** beginning on or after **January 1, 2022**.

  Arkansas Blue Cross and our affected affiliates will update machine-readable files monthly, in JSON (JavaScript Object Notation) format.

  Arkansas Blue Cross and Blue Shield and its affiliates (BlueAdvantage Administrators of Arkansas and Health Advantage) will make these files publicly available for **fully insured health plans** and **self-funded groups** via the corresponding affiliate's website:
  - **Arkansas Blue Cross** – arkbluecross.com/mrf
  - **Health Advantage** – healthadvantage-hmo.com/mrf
  - **BlueAdvantage Administrators** – blueadvantagearkansas.com/mrf

  [1] *85 FR 72158 (Nov. 12, 2020)*

  Self-funded groups should make the link that corresponds to their health plan publicly available on their own websites.

- ## Machine-readable file – pharmacy

  Enforcement of the requirement that plans and issuers must publish **machine-readable file related to prescription drugs** has been deferred, while federal regulators decide whether the prescription drug machine-readable file requirement remains appropriate. In the meantime, groups would be well-advised to work with their pharmacy benefit manager to be prepared to meet this requirement, in the event it is eventually enforced.

- ## Consumer price comparison tool

  The rules also require plans and issuers to make price comparison information available to participants, beneficiaries and enrollees through an internet-based self-service tool and in paper form, upon request.[2]
  This information must be available for plan/policy years beginning on or after:
  - **January 1, 2023** – for the **500 items** and services identified in **Table 1** in the preamble to the final rules.[3]
  - **January 1, 2024** – for **all other** covered items and services.[4]

  [2] *26 CFR 54.9815-2715A2(b), 29 CFR 2590.715-2715A2(b), and 45 CFR 147.211(b).*
  [3] *85 FR 72158, 72182 (Nov. 12, 2020).*
  [4] *26 CFR 54.9815-2715A2(c)(1), 29 CFR 2590.715-2715A2(c)(1), and 45 CFR 147.211(c)(1)*

In-network file layout	
Field Name	**Description**
Billing Code	The code used by a plan or issuer or its in-network providers to identify health care items or services for purposes of billing, adjudicating and paying claims for a covered item or service.
Billing Code Type	Common billing code types. Please see a list of the currently allowed codes at the bottom of this document.
Billing Code Type Version	There might be versions associated with the billing_code_type. For example, Medicare's current (as of 5/24/21) MS-DRG version is 37.2.
Bundled Codes	This is an array of bundle code objects. This array contains all the different codes in a bundle if bundle is selected for negotiation_arrangement.
Covered Service	This is an array of covered services objects. This array contains all the different codes in a capitation arrangement if capitation is selected for negotiation arrangement.
Description	Brief description of the item/service.
Entity Name	The legal name of the entity publishing the machine-readable file.
Entity Type	The type of entity that is publishing the machine-readable file (a group health plan, health insurance issuer, or a third party with which the plan or issuer has contracted to provide the required information, such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor).
Expiration Date	The date in which the agreement for the negotiated_price based on the negotiated_type ends. Date must be in an ISO 8601 format (e.g. YYYY-MM-DD). See additional notes.
In-Network	An array of in-network object types.
Last Updated On	The date in which the file was last updated. Date must be in an ISO 8601 format (e.g. YYYY-MM-DD).
Market Type	Allowed values: "group" and "individual".
Name	This is name of the item/service that is offered.
Negotiated Price	The negotiated price object defines information about the type of negotiated rate as well as the dollar amount of the negotiated rate.
Negotiated Rate	The dollar amount based on the negotiation_type.
Negotiated Rates	This is an array of negotiated rate details object types.
Negotiated Type	There are a few ways in which negotiated rates can happen. Allowed values: "negotiated", "derived", and "fee schedule". See additional notes.
Plan ID	The 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN)for each plan or coverage offered by a plan or issuer.
Plan ID Type	Allowed values: "EIN" and "HIOS".
Plan Name	The plan name and name of plan sponsor and/or insurance company.
Providers	An array of individual (type 1) provider identification numbers (NPI).
Tax Identification Number	The unique identification number issued either by the Social Security Administration or by the Internal Revenue Service (IRS).
Version	The version of the schema for the produced information.

Out-of-network file layout	
Field Name	**Description**
Allowed Amount	The allowed amount must be reported as the actual dollar amount the plan or issuer paid to the out-of-network provider for a particular covered item or service, plus the participant's, beneficiary's, or enrollee's share of the cost. See additional notes.
Billed Charge	The total dollar amount charges for an item or service billed to a plan or issuer by an out-of-network provider.
Billing Code	The billing_code_type code for the item/service
Billing Code Type	Common billing code types. Please see a list of the currently allowed codes at the bottom of this document.
Billing Code Type Version	There might be versions associated with the billing_code_type. For example, Medicare's current (as of 5/24/21) MS-DRG version is 37.2
Description	Brief description of the item or service. In the case of items and services that are associated with common billing codes (such as the HCPCS codes), the codes' associated short text description may be provided. In the case of NDCs for prescription drugs, the plain language description must be the proprietary and nonproprietary names assigned to the NDC by the FDA.
Entity Name	The legal name of the entity publishing the machine-readable file.
Entity Type	The type of entity that is publishing the machine-readable file (a group health plan, health insurance issuer, or a third party with which the plan or issuer has contracted to provide the required information, such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor).
Last Updated On	The date the file was last updated. Date must be in an ISO 8601 format (e.g. YYYY-MM-DD)
Market Type	Allowed values: "group" or "individual".
Name	The name of each item or service for which the costs are payable, in whole or in part, under the terms of the plan or coverage.
National Provider Identifier	An array of provider identification numbers (NPI)
Out Of Network	An array of out-of-network object types.
Payments	An array of out-of-network payments objects.
Place of Service Code	The CMS-maintained two-digit code that is placed on a professional claim to indicate the setting in which a service was provided.
Plan ID	The 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN), for each coverage option offered by a plan or issuer.

***Important note**: While Arkansas Blue Cross and Blue Shield strives to be helpful, we **do not provide legal or regulatory advice or services to third parties**. If groups have questions about whether or how a law or regulation applies to their health plan, they **should consult with their own legal counsel**. We can provide background information and offer our business perspective where we believe it would be helpful – but **not** legal, regulatory or compliance advice. It is also important to remember that much of the **responsibility** for complying with these measures **rests with the group health plan**. Arkansas Blue Cross and its affiliates will continue to perform all functions for which we are presently responsible and any functions the new measures require of us. We will ensure that compliance is achieved for all functions for which we are responsible, and we will provide data and support to group health plans, where desired and permissible.*

These provisions are very complex and nuanced. Please feel free to reach out your group marketing representative or email your inquiries directly to federalregulations@arkbluecross.com.