Requirement to Post Machine-readable Files Begins July 1, 2022

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**")—this particular MRF requirement is ***delayed*** until further notice.

The files must be publicly available and accessible free of charge without any restrictions.

Action Steps

Most employers will rely on their insurance carriers and third-party administrators (TPAs) to provide the MRFs. The TiC Final Rules allow fully-insured employers to shift legal responsibility for the MRFs to their carriers if this arrangement is described in a written agreement. Self-insured employers can use their TPAs (or other service providers) for the MRFs if this is set forth in a written agreement. Still, these employers remain legally liable for compliance under the TiC Final Rules.

The TiC Final Rules suggest that self-insured employers may be required to post a link on their websites to where the MRFs are publicly available, but this is not clearly addressed in the Final Rules. Additional guidance from federal agencies on this topic would be helpful.

Employers should confirm that written agreements addressing MRFs are in place with their carriers and TPAs and that these files will be available by the applicable deadline.

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:

- 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
- 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 will satisfy 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.** Unfortunately, while the TiC Final Rules suggest that plan sponsors using the nonduplication rule may be required to provide a link on their websites to the location where the MRFs are publicly available, this is unclear. Additional guidance from federal agencies on this topic would be helpful.

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.

Technical Guidance

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

GitHub Implementation Guidance

The Departments' technical implementation guidance will be 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.**

April 2022 Technical Guidance

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**. Documentation specific to the format requirements for percentage-of-billed-charges arrangements can be found here.
- 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.** Documentation specific to the use of the open text field can be found here.

According to the Departments, they will monitor the implementation of the MRF requirements and may revisit this safe harbor in the future. In addition, this safe harbor will not apply to a particular alternative reimbursement arrangement if the Departments determine the particular arrangement can sufficiently disclose a dollar amount. The Departments encourage the continued utilization of GitHub to submit suggestions on ways the schema should support alternative reimbursement arrangements.

Source: U.S. Department of Labor

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Compliance Update

Date: May 25, 2022

2nd Quarter 2022 Compliance Updates

The massive regulations over the past few years, designed to provide greater consumer protections for employees and their families, continue to place new and costly responsibilities on plans in 2022 and beyond. Auxiant is committed to making it easier for you to meet the new compliance requirements timely through our framework of customized solutions. We've highlighted with ACTION ITEM below those areas for which Auxiant will need a response from you. This does not represent all plan action required by the rules.

Here, we cover recently issued guidance impacting group health plans, which include:

1) **Telehealth for High Deductible Health Plans – Extension of First Dollar Coverage Exemption**;
   ACTION ITEM: For HDHPs wanting to continue first dollar telemedicine benefits under the 2022 extension, determine how you want to address the gap issue.
2) **Colonoscopy Coverage – Preventive Care Changes**.
   ACTION ITEM: For grandfathered plans, alert us if you'd like to opt-in.

As well as updates on implementation strategies in these areas:

a) **Negotiation and IDR under the No Surprises Act** – Plan Sponsor Options;
   ACTION ITEM: For Auxiant managed NSA claims, alert us if you want to apply negotiation thresholds or increase payments upon appeal. The default is to "stand on the data."
b) **Machine Readable Files – Upcoming Enforcement Deadline**; and
c) **Mental Health Parity – NQTL Comparative Analysis Reminder**.

First Dollar Coverage of Telehealth for High Deductible Health Plans

Generally, a qualified high deductible health plan (HDHP) may not provide benefits for any year until the deductible is met unless under the limited exception for providing preventive care benefits. In response to COVID-19, plan sponsors were allowed to temporarily offer first dollar telehealth services. The most recent update has created a gap making this difficult to administer.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act expanded the preventive care safe harbor for HDHPs to include telehealth services applicable for plan years beginning on or before December 31, 2021. The recently passed 2022 Consolidated Appropriations Act extends the relief for first dollar coverage of telehealth services, but only for the months of April 2022 through December 2022. So, for example, there would be no relief for calendar year plans from January 1, 2022 through March 31, 2022. A July 1st plan would be subject to the extended relief from the Consolidated Appropriations Act from July 1, 2022 through December 31, 2022 but would be without relief from January 1, 2023 through June 30, 2023 unless there is an extension by subsequent legislation.

In a HDHP, telemedicine can be provided prior to the deductible being met if the participant is required to pay the fair market value of the telemedicine visit. Determining how participants pay when telemedicine is received though a plan vendor such as HealthJoy or Teladoc is a plan sponsor decision. There is no published authority on what fair market value equates to, but we have seen consult fees for vendor services up to $65 per service. A plan paying benefits out of alignment with the IRS' HDHP rules could invalidate participant HSAs and create adverse tax consequences for employees.

As a reminder, the Families First Coronavirus Response Act (FFCRA) generally requires group health plans provide benefits for certain items and services related to diagnostic testing for the detection or the diagnosis of COVID-19 during the continuing emergency period. This coverage must be provided without imposing any cost-sharing requirement. Items and services furnished to an individual (*including telehealth visits*) that results in an order for or administration of an in vitro diagnostic product will be covered in a HDHP prior to the deductible being met and without cost sharing so long as appropriately billed by the provider and will not result in a violation of the HDHP first dollar coverage requirement.

Changes to Required Colonoscopy Coverage

On January 10, 2022 the Departments issued colonoscopy coverage changes. Plans must cover and not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive-stool based screening test or direct visualization screening test for colorectal cancer for certain individuals as described in the United States Preventive Services Task Force recommendation. This goes into effect for plan years on or after June 1, 2022. Without this change, any follow up colonoscopy would likely be considered diagnostic and not paid as preventive. Claims will be processed as preventive so long as coded appropriately. Grandfathered health plans are exempt from this requirement. If you would like to voluntarily adopt this change as part of your 2023 renewal process on a grandfathered plan, please contact your account manager.

Plan Sponsor Options Regarding Negotiation and Independent Dispute Resolution of the No Surprises Act

When Auxiant is managing the open negotiation and independent dispute resolution (IDR) processes, we have implemented a default decision to "stand on the data" for all claims. This means no further amount will be offered above the qualifying payment amount (QPA) and provider engagement will be limited to explaining the initial QPA payment. However, each step is fully customizable to your preferences. A plan may offer additional payment to the provider during the open negotiation period on a claim-by-claim basis so long as we are timely notified of your decision. Another option is to put in place prospective negotiation thresholds and/or minimum claim amounts. At this time, no stop loss carriers have authorized blanket negotiation thresholds.

For claims entering IDR, plans will have another opportunity to adjust the offer amount. Carriers have yet to confirm their intention to cover IDR fees and payment amounts resulting from IDR decisions. We expect more information throughout 2022 as everyone becomes more accustomed to the NSA processes.

These options and statements do not apply to plans utilizing a reference-based pricing partner unless you have coordinated a process with us and your partner to opt-in to the Auxiant solution.

Machine Readable Files

Included in the February 2021 Auxiant Insights update was a comprehensive summary of the Transparency in Coverage Rules. We also sent a detailed machine readable file (MRF) update earlier this month.

Auxiant has made significant progress toward obtaining and hosting MRFs. Early in 2021, Auxiant formed a working group comprising more than 20 network partners which hosts regular meetings centered on joint implementation efforts. We have gone to great lengths to assist networks as they create the MRFs and we test and prepare to host them. At this time, we have received three network test files and expect more as we near the enforcement date. However, several networks are in jeopardy of not providing a file by 7/1/22. Through our vendor, we will provide a single out-of-network MRF for the standard option which we expect to be posted by the deadline. Like the network files, this will not include plan specific data. Plans with unique repricing mechanisms, such as referenced based pricing, Medicare like rates, or direct provider contracts may require additional solutions.

It appears the rule requires plan sponsor engagement to meet posting requirements and complete all necessary data fields. Plans should consider providing a link on their website to the location where the files are publicly available. Auxiant's website, https://transparency.auxiant.com/, will be publicly accessible and updated monthly, to the extent those updated files are made available to us. Manipulation of the MRFs will be required to include plan specific data. At least one network has notified us they will create plans specific files for a monthly fee. Plans should contact their networks to understand options.

Please note, plans with a non-calendar plan year beginning after July 1, 2022 are subject to the rule as of the first day of the 2022 plan year, consistent with the original effective date.

Mental Health Parity Reminders

Auxiant previously issued summaries of the non-quantitative treatment limitation (NQTL) comparative analysis requirement and the current legal landscape impacting autism treatment limitations. We wish to offer a reminder of the NQTL requirement, as the DOL continues to signal its intention to increase enforcement and we have seen further activity on the state level as well. If you haven't completed this, you're not alone but it will have consequences should the DOL key in on your plan. The 2022 Report to Congress revealed none of the NQTL comparative analyses the DOL reviewed contained sufficient information upon initial receipt and many NQTLs ultimately lacked parity. For groups considering a strategy of gathering information and creating an analysis only upon request by the DOL, please note the DOL response demand can be a short as 10 days and a recent client's NQTL comparative analysis took over 10 months to complete.

Please direct any questions regarding the information contained in this Compliance Update to legal@auxiant.com.