APPENDIX 3:

The Allowed Amount Machine-Readable File
Data Elements

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have proposed requiring group health plans and health insurance issuers (plans and issuers) in the individual and group markets to disclose certain pricing information. Under the proposed rules, a plan or issuer must disclose certain data elements to the public, including allowed amounts for out-of-network providers, through a machine-readable file posted on an internet website. The table below identifies data elements that a plan or issuer would be required to include in each allowed amount machine-readable file.

DATA ELEMENT	DESCRIPTION
General Information	
Name of Reporting Entity[1]	The legal name of the entity publishing the machine-readable file.
Type of Entity	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).
Date of Last File Update	The date on which the machine-readable file was last updated.
Identification of Plan or Coverage	
Plan or Coverage Name	The plan name and name of plan sponsor and/or insurance company (for example, "Maximum Health Plan: Alpha Insurance Group").
Plan Identifier	The Employer Identification Number (EIN) or the Health Insurance Oversight System Identification Number (HIOS ID), as applicable, for each plan option or coverage offered by a group health plan or health insurance issuer.
Type of Plan Identifier	The EIN or HIOS ID, as applicable.

[1]A plan or issuer may contract with a third party (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) to satisfy the disclosure requirements, subject to the requirements in the proposed rules.

DATA ELEMENT	DESCRIPTION
Type of Plan Market	The type of market in which the plan is offered (individual or group market coverage).
Type of Product Network	The particular type of product network (for example, health maintenance organization, preferred provider organization, exclusive provider organization, or point of service) through which a group health plan or health insurance issuer offers a discrete package of health coverage.
Network Name	The name of the network through which a group health plan or health insurance issuer offers a discrete package of health coverage.
Identification of Providers	
Provider Name	The legal name of the person or entity associated with a National Provider Identifier (NPI).
NPI	The unique 10-digit identification number issued to a provider by the Centers for Medicare & Medicaid Services.
Provider Zip Code	The postal ZIP code of the physical location where the servicing provider renders items or services or dispenses prescriptions. May include non-U.S. ZIP codes. For U.S. ZIP codes, the ZIP+4 (also referred to as the "plus-four" or "add-on" code) must be included. A complete record of each of the data elements listed in this table must be separately reported for each separate physical location of a provider.
Historical Out-of-Network Allowed Amounts	

DATA ELEMENT	DESCRIPTION
Unique Out-of-Network Allowed Amount	Each unique allowed amount, reflected as a dollar amount, that a group health plan or health insurance issuer paid for a covered item or service furnished by an out-of-network provider during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file. The allowed amount would be reported as the aggregate of the actual 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. To protect patient privacy, a plan or issuer must not provide out-of-network allowed amount data for a particular provider and a particular item or service when compliance would require the plan or issuer to report out-of-network allowed amounts for a particular provider in connection with fewer than 10 different claims for payment. Issuers, service providers, or other parties with which the plan or issuer has contracted may aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract. If information is aggregated, the 10 minimum claims threshold would apply to the aggregated claims data set, and not at the plan or issuer level.
NPI Associated with Allowed Amount	The NPI associated with each provider-specific allowed amount for each covered item or service included in the machine-readable file.
Identification of Items and Services	
Billing Code	The code used by a group health plan or health insurance 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.
Type of Billing Code	The types of billing codes include the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifier.
Billing Code Type Version	Any version designation associated with the billing code type. For example, Medicare is currently using the International Classification of Diseases (ICD) version 10.
Bundle Indicator	Indication as to whether the billing code applies to a bundle of items and services under a bundled payment arrangement or whether the billing code only applies to a singular item or service.
Covered Items and Services	The name of each item or service for which the costs are payable, in whole or in part, under the terms of the group health plan or health insurance coverage.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The Departments are seeking OMB approval for the model as part of the approval for a new OMB control number 0938-NEW. The time required to complete this information collection is estimated to average 1,290 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.