APPENDIX 3:

The Allowed Amount Machine-Readable File Data Elements

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued the Transparency in Coverage proposed rules, which would require group health plans and health insurance issuers in the individual and group markets (plans and issuers) to disclose certain pricing information. Under the final rules, at 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR147.212(b), a plan or issuer must disclose allowed amounts and billed charges for out-of-network providers through a machine-readable file posted on an internet website. Out-of-network allowed amount and billed charge are defined at 26 CFR 54.9815-2715A1, 29 CFR 2590.715-2715A1, and 45 CFR 147.210. The table below identifies data elements that a plan or issuer is required to include in each machine-readable Allowed Amount File.[1]

DATA ELEMENT	DESCRIPTION
General Information	
Name of Reporting Entity[2]	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 the machine-readable file was last updated.
Version	The version of the schema on which the machine-readable file is based.

[1] For more technical implementation guidance for this machine-readable file, please see the GitHub website space established by the Departments. GitHub is a website and cloud-based service that helps developers store and manage their code, as well as to track and control changes to their code. The GitHub space offers the Departments the opportunity to collaborate with industry, including regulated entities, and third-party developers to ensure the file format is adapted for reporting of the required public disclosure data for various plan and contracting models. The GitHub space is available at: github.com/CMSgov/price-transparency-guide.

[2] 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 final rules.

DATA ELEMENT	DESCRIPTION
Identification of Plan or Coverage	
Plan Name	The plan name.
Plan Sponsor Name	The name of the plan sponsor, if applicable.
Plan Identifier	If the Type of Plan Identifier is "HIOS," the 10-digit Health Insurance Oversight System (HIOS) identifier, or, if the 10-digit HIOS identifier is not available, the 5-digit HIOS identifier. If the Type of Plan Identifier is "EIN," the Employer Identification Number (EIN) of the plan sponsor.
Type of Plan Identifier	The EIN or HIOS, as applicable.
Type of Plan Market	The type of market in which the plan is offered (individual, large group, small group, or self-insured group market coverage).
Type of Plan Product	The categorized product type of the plan. This could include Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), etc.
Issuer Name	The name of the plan's issuer.
Enrollment Total	The current numerical enrollment total of number of participants, beneficiaries, and enrollees (including all dependents) as of the date the file is posted.
Identification of Providers and Place of Service	
Individual Provider Identifier	*The National Provider Identifier (NPI) Type 1* [3] - The unique 10-digit identification number issued to a provider by the Centers for Medicare & Medicaid Services (CMS) to identify individual health care providers.
Provider Group Identifier (*Required if the out-of-network provider is a group organization or pharmacy*)	*The NPI Type 2* [4] - The unique 10-digit identification number issued to a provider by CMS for an organization of health care providers, such as a medical group or pharmacy.

[3] CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf.

[4] *Ibid.*

DATA ELEMENT	DESCRIPTION
Tax Identifier Number (TIN)	The unique identification number issued either by the Social Security Administration or by the Internal Revenue Service (IRS).
Place of Service Code[5]	The CMS-maintained two-digit code that is placed on a professional claim to indicate the setting in which a service was provided.
Historical Out-of-Network Allowed Amounts	
Unique Out-of-Network Allowed Amount	Each unique allowed amount, reflected as a dollar amount, that a plan or issuer paid, aggregated by market type, for a covered item or service furnished by an out-of-network provider during the 6 month time period that begins 9 months prior to the publication date of the machine-readable file. The allowed amount must be reported as 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 item or service when compliance would require the plan or issuer to report out-of-network allowed amounts paid in connection with fewer than 11 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 by market type for more than one plan or insurance policy or contract.
Billed Charge	The total charges for an item or service billed to a plan or issuer by an out-of-network provider.
Identification of Items and Services	
Billing Code	The code used by a plan or issuer or providers to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service.

[5] "Place of Service Code Set." Centers for Medicare & Medicaid Services. Available at: CMS.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

DATA ELEMENT	DESCRIPTION
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 identifiers.
Billing Code Type Version	Any version designation associated with the billing code type.
Covered Items and Services	Items or services for which the costs are payable, in whole or in part, under the terms of the plan or coverage.
Plain Language 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

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 Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1429. This information collection is necessary to implement the Transparency in Coverage requirements and to ensure that plans and issuers publicly disclose out-of-network allowed amounts and billed charges as required by regulation. The information will be used to increase transparency, support oversight and compliance activities, and help consumers, employers, and other stakeholders better understand out-of-network pricing. The time required to complete this information collection is estimated to average 132 hours per response including the time to review instructions, search existing data resources, gather the data needed, and review and complete the information collection. This information collection is mandatory for group health plans or health insurance issuers offering group or individual health insurance coverage, as required under 26 CFR 54.9815-2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212. 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.