SUBCHAPTER UU. MACHINE-READABLE FILES
28 TAC §§21.5501 - 21.5503

INTRODUCTION. The Commissioner of Insurance adopts new 28 TAC §§21.5501 - 21.5503, concerning machine-readable files.

The Commissioner adopts §21.5501 without changes and §21.5502 and §21.5503 with changes to the proposed text published in the March 4, 2022, issue of the *Texas Register* (47 TexReg 1059). The adoption implements House Bill 2090, 87th Legislature, 2021.

REASONED JUSTIFICATION. The new sections are necessary to implement legislation. New Insurance Code Chapter 1662 requires health benefit plan issuers or administrators to publish to the internet certain information in three machine-readable files. Specifically, Insurance Code §1662.103 requires issuers or administrators to publish rate information for covered health care services and supplies; unique billed charges and allowed amounts for covered services provided by out-of-network providers; and negotiated rates for prescription drugs. Insurance Code §1662.107 requires the department to prescribe by rule the form and manner in which the machine-readable files must be made available.

Section 21.5501. New §21.5501 identifies the types of health benefit plans that are, and are not, subject to the requirements to produce machine-readable files. The section also specifies when issuers must begin publishing machine-readable files, including providing additional time for smaller issuers. In addition, the new section provides that issuers are not required to publish machine-readable files under this proposal's requirements until the federal Departments of Labor, Health and Human

Services, and Treasury begin enforcing the corresponding federal Transparency in Coverage rules (26 C.F.R. §§54.9815-2715A1 - .9815-2715A3; 29 C.F.R. §§2590.715-2715A1 - .715-2715A3; and 45 C.F.R. §§147.210 - .212), or January 1, 2024, whichever is earlier. As of the date of this publication, federal guidance states that the federal departments will defer enforcement of the requirement that plans and issuers publish machine-readable files related to prescription drug pricing pending further federal rulemaking, while enforcement of the requirements related to in-network rates and out-of-network allowed amounts and billed charges will be deferred until July 1, 2022. *See* FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 (available at dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf).

Section 21.5502. New §21.5502 addresses various details concerning the form and manner in which machine-readable files are to be published, including transport mechanisms, nonproprietary data, and file-naming conventions. The new section also provides a safe harbor for issuers that are compliant with federal machine-readable file requirements.

In response to comments, the department makes changes to the proposed text in subsections (a) and (g) to track statutory language. The department also adds a new subsection (h) to the proposed text to allow an issuer that has multiple plans with the same negotiated rates with the same group of providers for the covered health care services and supplies to group multiple plans together within a single file. This provides flexibility for issuers and will reduce the total number of files that issuers will be required to publish. As adopted, proposed subsections (h) and (i) are redesignated as subsections (i) and (j), respectively. The department also adds new subsection (i)(2) to address the file-

naming convention for the Table of Contents File that applies if an issuer chooses to include multiple plans per file. Paragraphs (2) and (3) in subsection (i), originally proposed as subsection (h)(2) and (3), are redesignated as paragraphs (3) and (4). The department also makes changes to Figure: 28 TAC §21.5502(i)(4) to add an example of the Table of Contents File naming convention, update the dates provided in the examples, clearly state the naming conventions for single-plan files and multiple plans per file, and delete two instances of an extraneous "and," four extraneous semicolons, two extraneous periods, and one extraneous comma. Finally, the department adds a reference to Insurance Code §1662.107 and changes "re-use" to "reuse" in subsection (d), and the department adds an "and" to §21.5502(i)(1)(C).

Section 21.5503. New §21.5503 describes the data schemas that specify the data fields that must be included in each machine-readable file and the technical parameters associated with each data field. The department has published the data schemas on its website.

The department changes the proposed text to adopt Machine-Readable Files: Data Schemas (version 1.1), rather than the proposed version 1.0. The department also makes grammatical changes in subsections (a) - (c) and adds new subsections (d) and (e) to address new schemas provided in the federal machine-readable file requirements.

New subsection (d) addresses the Table of Contents File Schema, which an issuer must use if the issuer chooses to include multiple plans per file, as permitted by §21.5502(h). New subsection (e) addresses the Provider Reference File Schema, which an issuer may use to map the provider network to the item or service that is being documented within the In-Network File.

The following changes have been made to version 1.0 of the data schemas to produce version 1.1:

- A Table of Contents File Schema has been added and corresponding changes are made to existing objects within the In-Network File and Out-Of-Network Allowed Amount File Schemas. The Reporting Plans Object previously contained within the In-Network File and Out-Of-Network Allowed Amount File Schemas has been moved into the Table of Contents Schema. For single-plan files, new fields for "plan_name," "plan_id_type," "plan_id," and "plan_market_type" are added in the In-Network File and Out-Of-Network Allowed Amount File Schemas. These changes support new subsection (h) added to §21.5502, which allows an issuer to include data for multiple plans in a single file.

- Within the In-Network File Schema, a Provider Reference Object has been added. Within the Negotiated Price Object, new "billing_code_modifier" and "additional_information" fields are added. Additional notes are added concerning "billing_code_type."

- Within the Out-of-Network Allowed Amount File Schema, in the Out-of-Network Payment Object, a new "billing_code_modifier" field has been added.

- A Provider Reference File Schema has been added. With respect to the Negotiated Rate Details Object, a note has been added clarifying that issuers must include either a "provider_groups" or "provider_references" attribute to map the provider network to the item or service that is being documented.

Nonsubstantive updates are also made to the formatting and hyperlinks contained in the schema document.

SUMMARY OF COMMENTS. The department received comments from three commenters on the proposed rule.

SUMMARY OF COMMENTS AND AGENCY RESPONSES.

Commenters: Commenters in support of the proposal with changes were Community Health Choice, the Texas Association of Health Plans, and the Texas Medical Association.

Comment on the proposed rule generally

Comment. One commenter requests that enforcement of phase one of the rule be extended to January 2024. The commenter does not provide their reasoning behind the request.

Agency Response. The department declines to make this change. Under proposed §21.5501(d), issuers with fewer than 1,000 total enrollees in all health benefit plans are not required to publish their machine-readable files until January 1, 2024. Therefore, the commenter's request is only applicable to issuers with 1,000 or more total enrollees in all health benefit plans. And under proposed §21.5501(e), those larger issuers are not required to publish their machine-readable files until the relevant federal agencies begin enforcing the corresponding federal Transparency in Coverage rules (provided that the date of federal enforcement occurs after the 180th day following the effective date of this rule), or January 1, 2024, whichever is earlier. The primary purpose of this delayed enforcement mechanism is to streamline the compliance process for issuers that are subject to both these rules and the federal Transparency in Coverage rules.

The department anticipates that enforcement of the federal rules related to publishing in-network rates and out-of-network allowed amounts and billed charges will only be deferred until July 1, 2022. To further delay enforcement of the corresponding department rules for larger issuers, as suggested by the commenter, would frustrate the legislative intent behind HB 2090, which went into effect on September 1, 2021, without truly alleviating the regulatory burden on those issuers since most of those issuers must also comply with the federal government's enforcement timeline for its rules. Furthermore, the department believes the rule, as proposed, provides sufficient time for larger issuers to begin complying with its requirements.

Comment on §21.5501

Comment. A commenter suggests a change to §21.5501(d) to make the proposed publication delay applicable on an issuer's individual plan level rather than the issuer's total covered lives so "that small issuers are not disproportionately impacted by this rule." The commenter suggests replacing "[a] health benefit plan issuer with fewer than one thousand total enrollees in all health benefit plans" with "[a] health benefit plan issuer with fewer than one thousand total enrollees in a health benefit plan . . . must begin publishing machine-readable files for that plan" to achieve this change.

Agency Response. The department believes §21.5501(d) provides an adequate accommodation for smaller issuers and declines to make the change. However, the department appreciates the challenge created by the requirement to publish a separate file for each plan and adds §21.5502(h) to permit issuers to include multiple plans per file if the plans have the same negotiated rates with the same group of providers for the same items and services.

Comments on §21.5502

Comment. A commenter suggests replacing "all items and services" in §21.5502(a)(1) with language from Insurance Code §1662.103(a)(1) for consistency and clarity.

Agency Response. The department agrees and changes the proposed language in §21.5502(a)(1) and §21.5502(g)(1) to "all covered health care services and supplies" to mirror the language contained in the statute.

Comment. A commenter suggests replacing "containing billed and allowed amounts for" in §21.5502(b) with language from Insurance Code §1662.103(a)(2)(C) to be consistent with the term as defined by statute.

Agency Response. The department believes the commenter is referring to the language in §21.5502(a)(2) and §21.5502(g)(2), as the cited language is not found in §21.5502(b). The department agrees and changes the proposed language to "containing billed charges and allowed amounts for covered health care services or supplies provided by" to mirror the language contained in the statute.

Comment. A commenter suggests replacing "without restrictions that would impede the reuse of that information" in §21.5502(d) with language from Insurance Code §1662.107 to mirror the language contained in the statute.

Agency Response. The department agrees that Insurance Code §1662.107 applies with respect to the availability and accessibility of the files and has added a reference to that statute in §21.5502(d). The department believes this change accomplishes the goal of the commenter without unnecessarily restating the statutory language.

SUBCHAPTER UU. MACHINE-READABLE FILES.

28 TAC §§21.5501 - 21.5503.

STATUTORY AUTHORITY. The Commissioner adopts new 28 TAC §§21.5501 - 21.5503 under Insurance Code §§1662.004, 1662.107, and 36.001.

Insurance Code §1662.004 provides that the Commissioner may adopt rules necessary to implement Chapter 1662.

Insurance Code §1662.107 provides that the files described by §1662.103 must be available in a form and manner prescribed by department rule.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

TEXT.

§21.5501. Applicability and Effective Date.

(a) Except as provided in subsections (b) and (c) of this section, this subchapter applies to issuers of health benefit plans as specified in Insurance Code §1662.003, concerning Applicability of Chapter, that provide major medical coverage for which federal reporting requirements under 26 C.F.R. Part 54, concerning Pension Excise Taxes; 29 C.F.R. Part 2590, concerning Rules and Regulations for Group Health Plans; 45 C.F.R. Part 147, concerning Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets; and 45 C.F.R. Part 158, concerning Issuer Use of Premium Revenue: Reporting and Rebate Requirements, do not apply, including:

(1) issuers providing short-term limited-duration insurance, as defined in Insurance Code Chapter 1509, concerning Short-Term Limited-Duration Insurance;

(2) issuers providing grandfathered health plan coverage, as defined in 45 C.F.R. §147.140, concerning Preservation of Right to Maintain Existing Coverage; and

(3) a regional or local health care program operated under Health and Safety Code §75.104, concerning Health Care Services.

(b) This subchapter does not apply to the following types of plans:

(1) a plan that is not considered creditable coverage as specified under Insurance Code §1205.004(b), concerning Creditable Coverage;

(2) the child health plan program operated under Health and Safety Code Chapter 62, concerning Child Health Plan for Certain Low-Income Children;

(3) the health benefits plan for children operated under Health and Safety Code Chapter 63, concerning Health Benefits Plan for Certain Children; and

(4) the state Medicaid program operated under Human Resources Code Chapter 32, concerning Medical Assistance Program, including the Medicaid managed care program operated under Government Code Chapter 533, concerning Medicaid Managed Care Program.

(c) Except as provided by subsections (d) and (e) of this section, with respect to an applicable health benefit plan, an issuer must begin publishing machine-readable files as required under this subchapter in the month in which the plan year or policy year begins.

(d) A health benefit plan issuer with fewer than 1,000 total enrollees in all health benefit plans subject to reporting as of December 31, 2021, must begin publishing machine-readable files as required under this subchapter no later than January 1, 2024.

(e) Except as provided by subsection (d) of this section, an issuer is required to begin publishing machine-readable files no sooner than 180 days after the effective date of this section and no later than the earliest date specified in paragraphs (1) and (2) of this subsection:

(1) the date that the federal Departments of Labor, Health and Human Services, and Treasury begin enforcing the federal Transparency in Coverage rules specific to the publication of machine-readable files for prescription drug pricing, in-network rates, and out-of-network allowed amounts and billed charges, if the date of enforcement occurs after the 180th day following the effective date of this section; or

(2) January 1, 2024.

§21.5502. Form and Method of Publishing Machine-Readable Files.

(a) Required machine-readable files. Issuers must publish the following machine-readable files consistent with Insurance Code Chapter 1662, Subchapter C, concerning Required Public Disclosures, and the rules under this subchapter:

(1) an in-network negotiated rates file, containing in-network provider negotiated rates for all covered health care services and supplies, consistent with Insurance Code §1662.103(a)(1), concerning Required Information, and §1662.104, concerning Network Rate Disclosures;

(2) an out-of-network allowed amounts file, containing billed charges and allowed amounts for covered health care services or supplies provided by out-of-network providers, consistent with Insurance Code §1662.103(a)(2) and §1662.105, concerning Out-of-Network Allowed Amounts; and

(3) an in-network prescription drugs file, containing in-network historical net prices and negotiated rates for prescription drugs, consistent with Insurance Code §1662.103(a)(3) and §1662.106, concerning Historical Net Price.

(b) Transport mechanism. An issuer must make all machine-readable files available via HTTPS.

(c) Content type. An issuer must use a nonproprietary and open format for publishing machine-readable files. Examples of acceptable formats include JSON, XML, and YAML. Examples of proprietary formats that are not acceptable include PDF, XLS, and XLSX.

(d) Public discoverability. An issuer must make machine-readable files available to the public consistent with Insurance Code §1662.107, concerning Required Method and Format for Disclosure, and without restrictions that would impede the reuse of that information. The issuer must provide the location of the URLs for the machine-readable files over HTTPS to ensure the integrity of the data.

(e) Indexing. To allow for search engine discoverability, an issuer may not use a mechanism, such as a robots.txt file or a meta tag on the page where the files are hosted, or other mechanism that gives instructions to web crawlers to not index the page.

(f) Special data types. Dates must be strings in ISO 8601 format (e.g., YYYY-MM-DD).

(g) Different flat files. Issuers must publish three machine-readable files using the following file type names:

(1) "in-network-rates" for the file containing in-network provider negotiated rates for all covered health care services and supplies, consistent with Insurance Code §1662.103(a)(1) and §1662.104;

(2) "allowed-amounts" for the file containing billed charges and allowed amounts for covered health care services or supplies provided by out-of-network providers, consistent with Insurance Code §1662.103(a)(2) and §1662.105; and

(3) "prescription-drugs" for the file containing historical net prices and negotiated rates for prescription drugs, consistent with Insurance Code §1662.103(a)(3) and §1662.106.

(h) Multiple plans per file. An issuer that has multiple plans with the same negotiated rates with the same group of providers for the same covered health care services and supplies may group multiple plans together within a single file. An issuer that groups multiple plans into a single file must create a file with the file type name "table-of-contents" that uses the naming convention and standards required under subsection (i)(2) of this section. The filing convention for single plan files under subsection (i)(1) of this section will not apply to files published as permitted under this subsection.

(i) File-naming convention. An issuer must name each file using the naming convention and standards required under this subsection.

(1) The file naming convention for single plan files includes the elements identified in subparagraphs (A) - (D) of this paragraph, each separated by an underscore, followed by a period and the file extension:

(A) the four-digit year, two-digit month, and two-digit day, each separated by dashes (e.g., "2022-12-01" would be used for a file published December 1, 2022);

(B) the issuer name, with any spaces replaced with dashes (e.g., "issuer-abc" would be used for an issuer called "issuer abc");

(C) the plan name, with any spaces replaced with dashes (e.g., "healthplan-100" would be used for a plan called "healthplan 100"); and

(D) the file type name (e.g., "in-network-rates").

(2) The file naming convention for the table-of-contents file published by an issuer that includes multiple plans per file, as permitted by subsection (h) of this section, includes the elements identified in subparagraphs (A) - (C) of this paragraph, each separated by an underscore, followed by a period and the file extension:

(A) the four-digit year, two-digit month, and two-digit day, each separated by dashes (e.g., "2022-12-01" would be used for a file published December 1, 2022);

(B) the issuer name, with any spaces replaced with dashes (e.g., "issuer-abc" would be used for an issuer called "issuer abc"); and

(C) the word "index."

(3) An issuer may include only alphanumeric characters in the file name. An issuer may not include special characters or punctuation other than the dashes, underscores, and periods specified in the naming convention. An issuer must either remove special characters completely or replace the special characters with a dash ("-").

(4) Examples of the file naming conventions are provided in figure: 28 TAC §21.5502(i)(4).

Figure: 28 TAC §21.5502(i)(4)

Single-Plan Files

The following is the required naming standard for each file:

<YYYY-MM-DD>_<payer or issuer name>_<plan name>_<file type name>.<file extension>

Example 1

If the Centers for Medicare and Medicaid Services (CMS) published a JSON file for the Medicare plan on July 1, 2022, the required file names would be as follows:

a. "2022-07-01_cms_medicare_in-network-rates.json"

b. "2022-07-01_cms_medicare_allowed-amounts.json"

c. "2022-07-01_cms_medicare_prescription-drugs.json"

Example 2

If an issuer named "issuer abc" published a JSON file for a plan named "healthcare 100" on July 1, 2022, the required file names would be as follows:

a. "2022-07-01_issuer-abc_healthcare-100_in-network-rates.json"

b. "2022-07-01_issuer-abc_healthcare-100_allowed-amounts.json"

c. "2022-07-01_issuer-abc_healthcare-100_prescription-drugs.json"

Multiple Plans Per File

The following is the required naming standard for the table-of-contents file: <YYYY-MM-DD>_<payer or issuer name>_index.<file extension>

Example 3

If an issuer named "issuer abc" published data on July 1, 2022, for multiple types of plans in a single JSON file, the required file name for the table-of-contents file would be as follows:

"2022-07-01_issuer-abc_index.json"

(j) Safe harbor. An issuer that publishes machine-readable files in the form and method specified by the federal guidance published on the following website: github.com/CMSgov/price-transparency-guide, and its associated schemas, will be deemed compliant for the purposes of this subchapter.

§21.5503. Data Schemas.

(a) In-network negotiated rate file schema. For the "in-network-rates" file published under this subchapter, an issuer must include data elements consistent with the In-Network File Schema contained in Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

(b) Out-of-network allowed amount file schema. For the "allowed-amounts" file published under this subchapter, an issuer must include data elements consistent with the Out-of-Network Allowed Amount File Schema contained in Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

(c) In-network prescription drugs file schema. For the "prescription-drugs" file published under this subchapter, an issuer must include data elements consistent with the Rx File Schema contained in Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

(d) Table of contents file schema. If an issuer chooses to include multiple plans in a single file, as permitted under §21.5502(h) of this title (relating to Form and Method of Publishing Machine-Readable Files), the issuer must publish a "table-of-contents" file, consistent with the Table of Contents File Schema contained in Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

(e) Provider reference file schema. If an issuer chooses to include an external file of provider references, the issuer must include a "Provider Reference" file, consistent with the Provider Reference File Schema contained in the Machine-Readable Files: Data Schemas (version 1.1), published on the department's website.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on May 12, 2022.

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The Commissioner adopts new 28 TAC §§21.5501 - 21.5503.

DocuSigned by:
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Cassie Brown
Commissioner of Insurance

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