VIA ELECTRONIC SUBMISSION

February 23, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9882-P
P.O. Box 8016
Baltimore, MD 21244-8016

Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

Re: Transparency in Coverage (File Code: CMS-9882-P)

Dear Administrator Oz, Acting Commissioner Bessent, and Assistant Secretary Aronowitz:

The Peterson Center on Healthcare (the Center) appreciates the opportunity to submit comments on select provisions of the Transparency in Coverage (TiC) proposed rule.

The Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. We are working to create a more efficient and effective healthcare system in the United States and believe that system-wide price transparency is important to increase market competition in order to enhance the quality of patient care and reduce healthcare spending.

One of the Center's major focus areas is equipping employers with the data they need to be more effective purchasers and managers of healthcare benefits for their employees. Employers purchase healthcare coverage for half of all Americans, at an average annual cost of nearly $27,000 for family coverage in 2025—about $20,000 of which is paid by employers, with the remainder coming from employees' paychecks.[1] These high costs are largely driven by provider prices: even a 1 percentage point increase in hospital prices leads to lower incomes, job losses, and higher unemployment claims in that market, with disproportionate effects on lower- and middle-income workers.[2] Yet, until TiC data were released, employers lacked a

[1] 2025 Employer Health Benefits Survey. KFF. October 22, 2025. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/
[2] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *The Quarterly Journal of Economics*. 2019;134(1):51-107. https://academic.oup.com/qje/article-abstract/134/1/51/5090426

reliable, neutral “source of truth” to compare prices and therefore know whether the prices they are paying for coverage are fair.

Given our focus, we funded the Purchaser Business Group on Health (PBGH) to run a pilot project that analyzed TiC and Hospital Price Transparency (HPT) data to determine if and how employers can use those data sources to make more informed healthcare purchasing decisions.[3] This pilot generated valuable insights. It also underscored how much potential still exists to improve the files and advance public policy to make price transparency data meaningful and actionable. Work conducted by Simple Healthcare has shed light on “ghost rates,” payment rate data for items and services that a clinician is highly unlikely to perform, which bloat the TiC files, make them more difficult to analyze, and obscure useful information.[4] Simple Healthcare has also documented the wide variation in data completeness that inhibits employers’ usability of the files today.[5]

For example, consider an employer that seeks to negotiate with its existing third-party administrator (TPA) or vendor partners to get better prices. The employer would want to use the files to help identify whether and where they can get a better deal across dimensions of price and quality. Currently, TiC data in many markets are too incomplete to use for this purpose. Even in markets where completeness is better, the files do not include data on the quantity of services and items delivered by providers. This information would enable employers to better understand utilization patterns (useful to identify which providers are needed to form a competitive network), allow employers to calculate weighted average market prices by service (to inform their network and benefit design decisions), and to inform quality assessments (since high-volume providers often have better outcomes), equipping them with new information they need to negotiate more effectively.

TiC data is emerging as an essential tool for employers to understand their market positioning and negotiated rates relative to others, which can enable smarter purchasing and lower healthcare costs for employees. We commend the Departments for taking steps to improve the TiC files to make the data more accessible, interpretable, and meaningful. We appreciate the opportunity to share insights and learnings from our work and the work of our grantees. Our comments include further recommendations to advance three goals:

1. **Enhance TiC data quality and reliability:** File improvements that make TiC data easier to access, clean, and analyze will in turn make it easier for the data to be used by employers to inform their health benefits purchasing decisions. Improvements will also enable regulators to assess the files for compliance and, if necessary, take action to address systematic noncompliance. TiC files should be manageable to ingest and clean;

[3] Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

[4] Muhlestein D. High prevalence of ghost rates in transparency in coverage data. *Health Affairs Scholar*. 2025;3(11): qxaf212. https://academic.oup.com/healthaffairsscholar/article/3/11/qxaf212/8321476

[5] Muhlestein D, Pathak Y. Price Transparency With Gaps: Assessing the Completeness of Payer Transparency in Coverage Data. *American Journal of Managed Care*. 2025;31(Spec. No. 15):SP1121-SP1127. https://www.ajmc.com/view/price-transparency-with-gaps-assessing-the-completeness-of-payer-transparency-in-coverage-data

exclude redundant and irrelevant information; and enable easy identification of plan sponsors, issuers, provider networks, and negotiated prices. We support the Departments' efforts to improve data usability through proposals to promote data simplification, reduce file size, provide plain language instructions, promote better alignment with the HPT reporting requirements, and require reporting of important contextual information alongside rates. While we appreciate the Departments' intent to address the "ghost rate" issue, we offer an alternative, more precise method for your consideration that will not add undue burden to those plan sponsors and issuers subject to these rules.

2. **Expand the utility of the TiC files:** Inclusion of new data elements would enable employers as plan sponsors and their supporting vendors to generate more comprehensive and actionable insights on behalf of their employees and to fulfill their fiduciary responsibilities. We believe many of the Departments' proposals advance this goal, including the proposals to connect rate information with new data on product types (i.e., Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)), provider networks, plan enrollment totals, and to increase the amount of usable data in the Out-of-Network Allowed Amount Files. We offer considerations that may further augment the ability of employers and plan sponsors to use the data to guide their purchasing decisions. Specifically, we recommend the Departments require reporting of quantities data (i.e., claims volumes), which, if reported, would enable the creation of data insights for employers as plan sponsors beyond addressing the "ghost rate" issue.
3. **Strengthen compliance:** Changes to the TiC data and reporting processes should enable policymakers to assess reporting compliance and improve data integrity. Widespread noncompliance with TiC file construction and completeness severely limits the data's utility. A major thrust of this proposed rule is aimed at making the data cleaner, which should reduce the reporting burden on issuers and plan sponsors and will allow users and policymakers to parse data compilation errors from deliberate omissions. Given these important advancements, it is prudent that the Departments go further and propose new enforcement provisions. We point the Departments to new enforcement models under development in states like Colorado[6] and Indiana[7] as promising examples to emulate at the federal level.

Summary of Recommendations

Specifically, we recommend that the Departments:

- Strengthen enforcement to improve TiC data reporting compliance.

[6] Colorado Division of Insurance to Enforce Federal and State Transparency in Coverage Rules. Colorado Division of Insurance. December 18, 2025. https://doi.colorado.gov/news-releases-consumer-advisories/colorado-division-of-insurance-to-enforce-federal-and-state

[7] Sachdev G, Lambert H. Re: Response to Executive Order 25-21 Increasing Freedom and Opportunity for Hoosiers by Improving Price Transparency in Healthcare. Indiana Department of Insurance. January 21, 2026. https://www.in.gov/gov/files/EO-25-21-Memo,-Executive-Summary,-and-Study.pdf

- Require reporting of quantities data. Work with technical experts to develop schema specifications to improve the utility and reliability of quantities reporting, given the complexity of National Provider Identifier (NPI) roles on claims.
- Issue additional guidance to define what a “network” is, to specify network naming conventions, and to require group health plans and issuers to clearly map networks to associated plans/products in their files.
- Require group health plans and issuers to post a Table of Contents file that crosswalks the networks to each plan using a given network and requires standard data elements on the included plans and networks.
- Consider requiring group health plans and issuers to report information on how benefit design may vary by product type in relation to the provider network.
- Issue clear guidance on how group health plans and issuers should report the names of their products and networks (i.e., market name, internal name, or other identifier), to better assist employers as purchasers with accurately identifying plans and the networks that map to them.
- Develop a methodology for standardizing reporting of percentage-of-billed-charges arrangements in dollar amounts (specifically, align TiC requirements with HPT).
- Standardize the reporting of bundles and require group health plans and issuers to provide additional information to help employers, regulators, and analysts understand and compare costs for specific episodes.
- Require reporting of enrollment totals at both the plan and network levels and clarify where enrollment totals should be reported to ensure consistency across group health plans and issuers (e.g., plan enrollment in the Table of Contents file, network enrollment in metadata in the In-network Rate Files).
- Conduct an analysis to better understand the implications of removing provider-rate combinations based on group health plans’ and issuers’ internal taxonomy mapping on data quality and variance.
- Consider replacing the taxonomy-only approach to ghost rate removal with a hybrid approach that leverages combined quantities data and taxonomy mapping to support more precise removal of ghost rates.
- Implement Change-log reporting data elements through technical implementation guidance to maintain flexibility in making updates.
- Require group health plans and issuers to provide data that supports output in a relational structure, meaning there is a unique ID field that allows users to follow data across multiple tables (e.g., CSV files that support relational outputs are superior to JSON due to structure and file efficiency).

- Implement TiC file standardization requirements through technical implementation guidance to maintain maximum flexibility to change formats or structures more quickly to keep pace with technological changes.
- Require group health plans and issuers to provide the agency with the web location of TiC files for publication by CMS in a central repository of links to these web locations.
- Finalize the proposal to reduce reporting frequency from monthly to quarterly, with the addition of the Change-log file to help identify updates between files.
- Shorten the timeline for when this rule becomes applicable (i.e., sooner than 12 months following publication).
- Implement the prescription drug TiC file.

This proposed regulation takes important steps that, if finalized, will increase TiC data access and use. We appreciate the opportunity to comment on this proposed rule and welcome opportunities to support the Departments on any of the topics addressed in this letter. For questions or follow-up, please contact Mairin Mancino, Vice President, Policy at mmancino@petersonhealthcare.org and Natalie Joyce, Vice President of Advocacy at njoyce@petersonsolutions.org.

Sincerely,

Caroline Pearson

Executive Director, Peterson Center on Healthcare

Comment on Updating Enforcement Policies to Ensure Compliance

Stronger compliance with TiC data reporting requirements is critical to advancing the three major goals described in our cover letter, and we believe robust enforcement action by the federal government and states is needed. *90 Fed. Reg. 60441-60442 (Dec. 23, 2025)*

We appreciate the Departments' efforts to propose certain improvements—schema clarifications, standardized data elements, and reduced reporting frequency—that should reduce reporting burdens and improve data consistency, thereby making compliance easier to both attain and verify.

Notably, however, the proposed rule does not identify any new or increased penalties associated with noncompliance, nor any new or amended Departmental audit procedures or systematic monitoring methodologies that would communicate to group health plans and issuers the risks of noncompliance. The proposed rule indicates only that "existing processes" shall continue to be employed, creating no new incentives for group health plans and issuers to improve performance. We are concerned that the Departments' "existing processes," which rely on "discretion," are not sufficient for promoting compliance.

Our work and the work of our grantees[8,9,10] have highlighted systematic failures in both TiC data completeness and employer claims data access. These findings were echoed in a report released in January 2026 by the State of Indiana, which compared TiC data to claims data in the state's All Payer Claims Database (APCD), and revealed that "all payers need to make improvements to the quality and completeness of their in-network TiC files."[11] According to the study, only 21 percent of the allowed dollars (or $964 million) in Indiana's APCD exactly matched the posted TiC rates.[12]

The Indiana assessment also identifies issues within the TiC files themselves. Examples include a high prevalence of unnecessary duplication, multiple rate schedules for the same provider, multiple rates for the same services, missing or incorrect data, and invalid/non-standard codes. The report concluded: "These issues introduce ambiguity and must be addressed before the TiC data is complete and reliable enough to be utilized."[13]

Indiana's report reviewed enforcement policies from other states and cited four examples of states that have adopted some or all of the federal transparency requirements, but the report

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[8] Muhlestein D, Pathak Y. Price Transparency With Gaps: Assessing the Completeness of Payer Transparency in Coverage Data. *American Journal of Managed Care*. 2025;31(Spec. No. 15):SP1121-SP1127. https://www.ajmc.com/view/price-transparency-with-gaps-assessing-the-completeness-of-payer-transparency-in-coverage-data

[9] Muhlestein D. High prevalence of ghost rates in transparency in coverage data. *Health Affairs Scholar*. 2025;3(11): qxaf212. https://academic.oup.com/healthaffairsscholar/article/3/11/qxaf212/8321476

[10] Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

[11] Sachdev G, Lambert H. Re: Response to Executive Order 25-21 Increasing Freedom and Opportunity for Hoosiers by Improving Price Transparency in Healthcare. Indiana Department of Insurance. January 21, 2026. https://www.in.gov/gov/files/EO-25-21-Memo,-Executive-Summary,-and-Study.pdf

[12] Ibid.

[13] Ibid.

found “no history of penalizing payers.”[14] We are not aware of any penalties issued—either by the federal government or states—for violations associated with TiC data reporting, despite having the authority to do so and evidence of pervasive noncompliance. Making compliance easier for group health plans, their vendor partners, and issuers to achieve should be combined with more predictable consequences for noncompliance, especially if noncompliance is willful (e.g., out of concern for sharing potentially commercially sensitive information).

Data limitations and challenges notwithstanding, PBGH’s pilot project demonstrated real value can be derived from analysis of TiC data, especially in combination with claims data and Hospital Price Transparency (HPT) file data.[15] The project validated the Administration’s goals in part by making pricing and other discrepancies transparent and generating novel insights into plan spending and contracting practices. Yet, third-party administrators (TPAs) and issuers have strong financial and competitive incentives to keep such discrepancies and insights hidden, inaccessible, or difficult to use, which is why the continued advancement of these transparency requirements is so crucial to strengthening the purchasing power of employers and plan sponsors.

We strongly encourage the Departments to strengthen enforcement of TiC data reporting requirements. Potential options include:

- **Require submission of Text File location information and points of contact to the Departments**: A central, federal repository of this information would make it easier for employers and other TiC data users to find these files and enhance accountability of entities producing the MRFs. It would also support the Departments in conducting compliance assessments more efficiently and stretch available compliance and enforcement resources. This approach has proven feasible at the state level (e.g., Colorado) and could be adopted at the federal level.[16]
- **Establish metrics and a cadence for auditing/analysis of compliance (e.g., analyzing a percentage of plans per quarter):** The bipartisan Patients Deserve Price Tags Act, for example, if passed, would require the Department of Health and Human Services (HHS) to audit Machine Readable Files (MRFs) from at least 20 group health plans or issuers annually, and the Department of Labor to audit MRFs annually from 200 group health plans or service providers furnishing TPA services.[17] We are not aware of any legal obstacle preventing the Departments from adopting such practices today under current law by rulemaking and we encourage the Departments to move forward with such a requirement.

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[14] Ibid.
[15] Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/
[16] Colorado Division of Insurance to Enforce Federal and State Transparency in Coverage Rules. Colorado Division of Insurance. December 18, 2025. https://doi.colorado.gov/news-releases-consumer-advisories/colorado-division-of-insurance-to-enforce-federal-and-state
[17] S.2355 Patients Deserve Price Tags Act. 119th United States Congress. July 17, 2025. https://www.congress.gov/bill/119th-congress/senate-bill/2355

- **Define what compliance means and issue penalties:** Group health plans and issuers may be more likely to increase compliance if noncompliance is not an all-or-nothing proposition, and if regulators start issuing penalties.
    - We encourage regulators to establish degrees of compliance, which could include posting/discoverability of files, adhering to schema requirements, completeness of data, accuracy of data, and use of data integrity checks. For example, in Indiana, the Braun Administration has articulated two potential enforcement frameworks, including one that calculates and weights TiC data compliance issues and imposes differential penalty amounts depending on the nature of the noncompliance.[18]
    - The Departments may also be able to reduce the need for post-submission assessment of compliance by requiring group health plans and issuers to use and certify compliance via federally-developed or certified third-party validation tools to test MRFs for achievement of certain compliance tiers before posting.
    - As data schemas improve and compliance is better defined, federal and state regulators should move to issue financial penalties. Today, federal TiC file noncompliance penalties may not exceed $100 per day, per violation, per enrollee (with the potential for inflation adjustment).[19] States are considering adopting their own penalties—either through existing authorities or through new legislation.[20] Federally, the Patients Deserve Price Tags Act, by contrast, calls for a corrective process that, if not fixed, would result in a $300 per day, per member penalty, capped at $10 million.[21] As that piece of legislation moves through Congress, we encourage the Departments to move swiftly and assertively to issue penalties to motivate better TiC data submission.
- **Align with HPT to require executive attestation:** We supported the CMS proposal in the 2026 Hospital Outpatient Prospective Payment System (OPPS) rule to require that hospital executives complete an attestation for HPT data MRFs to certify accuracy and completeness.[22,23] We encourage the Departments to apply this same requirement to TiC file submissions, with attestation certification required for executives at TPAs, vendors, and issuers, as they are the responsible parties for the negotiation of rates and contract terms with providers.

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[18] Sachdev et al.
[19] 45 C.F.R. § 150.315 (July 5, 2021). https://www.ecfr.gov/on/2021-07-05/title-45/section-150.315
[20] Sachdev et al.
[21] S.2355 Patients Deserve Price Tags Act. 119th United States Congress. July 17, 2025. https://www.congress.gov/bill/119th-congress/senate-bill/2355
[22] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots. *Federal Register*. 2025;90(226), 53448–54088. https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
[23] Center Responds to CMS Proposed Rule on Hospital Outpatient Prospective Payment System. Peterson Center on Healthcare. October 28, 2025. https://petersonhealthcare.org/news/center-responds-to-cms-proposed-rule-on-hospital-outpatient-prospective-payment-system/

C. Requirements for Public Disclosure of In-Network Rates and Historical Allowed Amount Data for Covered Items and Services from In- and Out-of-Network Providers

1. Provider Network-Level Reporting for the In-Network Rate Files *90 Fed. Reg. 60447-60449 (Dec. 23, 2025)*

The Departments propose to require group health plans and issuers to organize their In-network Rate Files by provider network rather than by individual plan, given that many plans share the same provider networks. Under this proposal, group health plans and issuers would make available a single In-network Rate File for each provider network they maintain or contract with, even when multiple plans share the same negotiated rates under an umbrella network arrangement. Each file would contain all rates negotiated by the reporting entity for that provider network and would include a billing code and plain language description for each covered item or service, rather than repeating this information across each coverage option that shares the same network.

We support this proposal, which will reduce redundancies and significantly streamline the size and total number of files, making them easier to analyze. One of our grantees shared that Cigna organizes their files by provider network, which results in approximately 100 files nationwide, compared to the thousands of files posted by other major payers. In addition to making the files less cumbersome to navigate and use, moving to network-level reporting would enable employers to use the data for a range of purposes, including to:

- More easily compare pricing across a plan's network to support negotiations and plan selection
- Evaluate whether switching plans or vendor partners would impact network breadth and/or cause a disruption in their employees' provider networks
- Identify discrepancies between fully-insured and self-funded negotiated rates
- Explore direct contracting with provider groups and other alternative payment strategies to improve the value of their plan offerings

However, additional guidance may be needed to define what a "network" is, to specify network naming conventions, and to require group health plans and issuers to clearly map networks to associated plans/products in their files. We outline several questions for your consideration below:

1. How are the Departments defining what constitutes a distinct network? (e.g., distinct combination of providers and negotiated rates)
2. Would the network be identified by its market name, its internal name, or by some other network identifier? Would requiring multiple network identifiers aid in ensuring accurate identification of the network?

3. How would group health plans and plan sponsors identify cases where products may use the same network but have different benefit designs (e.g., different out-of-network coverage)? For example, Aetna offers multiple plans with various benefit design elements that all use the same provider network: HSA Aetna Choice POS II, Aetna Choice POS II, Open Access Aetna Select, etc.
4. Will the Departments require group health plans and issuers to link products to network identifiers, in an existing file or a newly proposed file?

We encourage the Departments to require group health plans and issuers to provide a Table of Contents file that crosswalks the networks to each plan using a given network. According to an internal CMS analysis, 83 percent of group health plans and issuers sampled in 2024 were already leveraging a Table of Contents to organize their files. Making the Table of Contents file a requirement would ensure this becomes an industry standard. This file could also be a vehicle for the additional data elements outlined in our questions above. For example, the Table of Contents file could include the following data elements:

- Employer name & ID
- Plan name and unique plan identifier
- Link to information on the plan (e.g., benefit guide)
- Total enrollment at the plan level
- Networks that are included under that plan
- Link to information on the network(s) (e.g., provider directory search)

2. HIOS Identifier and Product Type *90 Fed. Reg. 60449-604650 (Dec. 23, 2025)*

The Departments are proposing to require group health plans and issuers to report for each applicable coverage option, the name and the Health Insurance Oversight System (HIOS) identifier (or the Employer Identification Number (EIN) in the absence of an HIOS identifier), as well as the product type (i.e., Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)) associated with the coverage option for which data is being reported in both the In-network Rate File and the Out-of-Network (OON) Allowed Amount File.

We support the proposal to require reporting product type in the In-network and OON Files, which will enable analysis of how negotiated rates correlate with product type. As the Departments note, plans with HMO narrow networks may have more leverage to negotiate lower prices with in-network providers, since the providers would expect to have increased patient volumes than in a more expansive network. Greater visibility into whether and to what extent these patterns exist would be useful information for employers and plan sponsors as they consider what coverage options to offer their employees. It would also be beneficial for employers and plan sponsors to conduct apples-to-apples comparisons of prices for a given service, including OON costs for employees, among plans of the same product type.

However, as we discuss in the "Provider Network-Level Reporting" section on pg. 9-10, we encourage the Departments to consider requiring additional information on how benefit design may vary by product type in relation to the provider network.

3. Percentage-of-Billed-Charges Arrangements *90 Fed. Reg. 60450-60451 (Dec. 23, 2025)*

The Department's proposed rule would continue to allow and instruct group health plans and issuers to disclose an applicable in-network rate in a non-dollar amount in instances where the applicable rate is a percentage of billed charges. While the Departments reiterate that group health plans and issuers must disclose rates as a dollar amount whenever a dollar amount can be calculated in advance, they acknowledge that contractual arrangements where this is unable to be determined in advance are not uncommon and should be reflected in the data.

We understand that contracts are often written using this percentage formula, and the proposed rule provides some clarity for group health plans and issuers by specifying how to report such information. However, percentages are difficult to interpret on their own and billed charge information is not always available. We are concerned that this policy will not advance the goals of empowering employers to be better stewards of employee health plans and enabling policymakers to seek better insights into compliance and potential policy reforms. **We encourage the Departments to develop a methodology for standardizing reporting of percentage-of-billed-charges arrangements in dollar amounts.**

Currently, rates reported as a percentage of billed charges constitute between 0 to 100 percent of plans' data. Across approximately 200 plans (including all of the national insurers and Blues plans), the average has 11.1 percent of their data reported as a percentage of billed charges. Collectively, 12.3 percent of negotiated rates are reported as a percentage of billed charges.[24] These values cannot be effectively interpreted in isolation and are effectively meaningless without the additional context of the total price for that service. Employers and plan sponsors should not be reasonably expected to have access to a hospital chargemaster to gather this information, and a similar resource does not exist for non-hospital providers. Furthermore, our pilot project with PBGH found that group health plans and issuers often submitted percentage-of-billed-charge rates without accompanying billed charge information specifying to which services the percentages apply.[25] Since analysts cannot easily apply the percentage to a starting price, our grantees tell us that they disregard percentage-of-billed-charges entirely.

We believe this is an area where greater alignment with HPT is possible, which is a stated goal of the Departments for this rule. We encourage the Departments to consider the changes to HPT reporting recently promulgated in the 2026 Hospital Outpatient Prospective Payment

[24] Internal analysis of TiC data conducted by Simple Healthcare on February 12, 2026.
[25] Leveraging Health Care Price Transparency: Making Transparency Data Actionable for Employers and Public Purchasers. Purchaser Business Group on Health. October 6, 2025. https://www.pbgh.org/initiative/pbgh-health-care-data-demonstration-project/

System (OPPS) final rule.[26] Specifically, the Departments sought to address the issue of payment rates reported as a percentage or an algorithm by requiring hospitals to report median, tenth percentile, and ninetieth percentile allowed amounts during a specified lookback period. **The Departments should consider a similar methodology in finalizing this proposed rule so that MRF data are more usable for employers and plan sponsors, policymakers, and other data users.**

Percentage-of-billed-charges arrangements are just one of several reasons why negotiated rates in TiC data may differ from the actual amount paid. Requiring group health plans, the entity producing the TiC MRF, and issuers to report the median paid amount (and potentially the tenth and ninetieth percentile allowed amounts) would also be useful for evaluating the true expected costs in instances where the final amount paid is impacted by outlier payments, bundling, and value-based care adjustments.

We also recommend standardizing the reporting of bundles and requiring group health plans and issuers to provide additional information to help employers, regulators, and analysts understand and compare costs for specific episodes. TiC files currently provide rates which represent a complete bundle of services, a partial bundle, a bundle with passthrough elements, or a singular component of a bundle, without any indication of which interpretation is correct. Reported negotiated rates also vary as to whether they include costs like facility fees and implant costs, for example. Given these inconsistencies and incomplete information, data users are unable to gain an accurate understanding of the total cost of an episode such as a knee replacement and compare costs across plans. **We encourage the Departments to consider requiring a standardized structure for bundles, such as that proposed by Simple Healthcare, to enable consistent, useful comparisons across plans.**[27]

4. Enrollment Totals *90 Fed. Reg. 60451-60452 (Dec. 23, 2025)*

The Departments propose to require that group health plans and issuers report current enrollment totals, as of the file posting date, for each coverage option offered by a group health plan or issuer in the In-network Rate File. The numerical enrollment totals must include the number of participants, beneficiaries, and enrollees, including all dependents.

We strongly support this proposal, which will help improve data usability by supporting accurate identification of coverage options and support meaningful analyses by employers and policymakers. **We encourage the Departments to consider requiring group health plans**

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[26] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots. *Federal Register*. 2025;90(226), 53448–54088. https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

[27] Muhlestein D. Improving Transparency in Coverage Data: Reducing Ghost Rates, Adding Utilization, and Standardizing File Structure. Simple Healthcare. February 20, 2026. https://simplehc.com/resources/improving-transparency-in-coverage-data

and issuers to report total enrollment at both the plan level and the network level, since negotiations are conducted at the network level.

Enrollment totals would enable employers and purchasers to track the correlation between enrollment and negotiated rates and would give them a line of sight into which group health plans and issuers may have the greatest potential for negotiating lower rates because of their larger relative market power. With these data, employers and purchasers could compare plans with similar enrollment sizes to support decision making. Policymakers would be able to use the data to answer important questions, such as where plans may have a larger impact on negotiated rates due to relative market power, approximate size of overall market, and other factors. While enrollment totals would enable useful analyses, the value of these analyses would be further enhanced by additional data on actual utilization (i.e., the quantities of services/items delivered at each reported rate).

We recommend that the Departments clarify where enrollment totals should be reported in the TiC files to ensure consistency across group health plans and issuers. For example, this information could potentially be included in a schema for a Table of Contents file, as we describe in the "Provider Network-Level Reporting" section on pg. 9-10. We would also encourage the Departments to require network enrollment information to be reported in the metadata section of the In-network Rate File. This information would be otherwise extremely challenging, if not impossible, to calculate from the plan enrollment data since many plans use multiple networks and covered lives would be counted multiple times. Network enrollment information would better support employers with health benefit negotiations, which are typically done at the network level. It would also give employers and regulators a better understanding of how enrollment volume correlates with network types and competitive dynamics (e.g., how large a group health plan's or issuer's network is relative to others in market).

5. Excluded Provider Information *90 Fed. Reg. 60452-60453 (Dec. 23, 2025)*

In response to the issue of ghost rates, the Departments are proposing to require group health plans and issuers to exclude a provider and their negotiated rate (the provider-rate combination) for an item or service from the In-network Rate File when the group health plan or issuer determines that it is unlikely that the provider would be reimbursed for the item or service based on the scope of the provider's license or area of specialty. This determination would be made using the internal provider taxonomy used by the TPA or issuer during the claims adjudication process.

We appreciate the Departments' strong focus on addressing ghost rates and the impact of ghost rates on file sizes. Research has found that 91.8 percent of prices in payer dataset files are ghost rates.[28] That means employers and plan sponsors largely have access to files with large amounts of unusable information. Additionally, because ghost rates significantly

[28] Muhlestein D. High prevalence of ghost rates in transparency in coverage data. *Health Affairs Scholar*. 2025;3(11): qxaf212. https://academic.oup.com/healthaffairsscholar/article/3/11/qxaf212/8321476

increase file sizes and make the files harder to analyze, high prevalence of ghost rates also impedes regulators' ability to assess compliance with reporting requirements.

The Departments' proposal would greatly reduce file sizes and remove irrelevant data, improving usability for employers and making the files more manageable for regulators to assess compliance. **However, we have concerns that the proposed taxonomy-only approach would result in less consistent, precise, and accurate removal of ghost rates than the alternative approach we propose, which leverages quantities data.** In our comments in the "Utilization File" section on pg. 17-20, in addition to supporting ghost rate removal, we describe the broad array of use cases for which employers and plan sponsors can use quantities data to more prudently determine value and manage healthcare costs for their employees.

The Departments' current proposal would charge TiC data filers with removing ghost rates based on their own internal taxonomy mapping and providers' specialties. However, group health plans, their TPAs, and issuers do not always utilize taxonomy mapping to adjudicate claims, instead opting to use other strategies like using the location of care to determine whether a claim should be paid. For example, an issuer might deny paying an emergency room claim if they deem that the care was "non-emergent." In another case, an issuer might deny a hospital claim for services such as an MRI which could have been performed at a lower-cost site of care. Those that do use a taxonomy approach may map it differently, which would impact the provider-rate combinations included in a given issuer's TiC data. The proposed approach introduces variability and room for error by deferring to group health plans' and issuers' internal taxonomy mapping and makes it challenging for regulators to ensure or assess accuracy. While we understand that a plan-specific approach is more feasible to implement in the immediate term than a national taxonomy mapping, a standardized mapping would be beneficial for the Departments to move towards in the longer term.

Additionally, we are concerned that reliance on taxonomy mapping can be both over-inclusive and under-inclusive, depending on which provider-rate combinations the group health plan or issuer chooses to include and how they determine the threshold or logic for inclusion. An analysis using claims data illustrates the wide variation in accuracy of "ghost rate" removal using taxonomy-only filtering when different provider taxonomies are included.[29] For example, while knee replacements are performed by orthopedic surgeons, only 32 percent of these surgeons perform them. An overly broad filter would include many provider-rate combinations that are inaccurate. Further, physician assistants (PAs) and nurse practitioners (NPs) can also be part of the care team that participates in the surgery, and these non-physician providers represent a substantive portion of knee replacement claims volume. Thus, a filtering mechanism not including PAs and NPs for this code would represent a material under-inclusion of claims volume.[30] **We recommend conducting an analysis to better understand the**

[29] Muhlestein D. Improving Transparency in Coverage Data: Reducing Ghost Rates, Adding Utilization, and Standardizing File Structure. Simple Healthcare. February 20, 2026. https://simplehc.com/resources/improving-transparency-in-coverage-data
[30] Ibid.

implications of removing provider-rate combinations based on group health plans' and issuers' internal taxonomy mapping on data quality and variance.

The Departments should also consider potential challenges posed by using provider taxonomies to include and exclude data since these fields are often incorrect or incomplete in the National plan and Provider Enumeration System National Provider Identifier (NPPES NPI) Registry.[31,32] Providers in this system may have a primary taxonomy, as well as multiple other taxonomies, which are not frequently updated in a timely manner as providers continue to train and specialize in other areas. This may also compromise the accuracy of the proposed approach to removing ghost rates. We understand that NPIs can be inconsistently applied by providers themselves and can be a source of additional clutter in TiC data files. We acknowledge and support the Administration's broader efforts to address NPI inconsistencies and hope these efforts will make both TiC data and provider directory information more reliable.

The Departments' proposal does not include information as to how or if they would assess the accuracy of taxonomy mapping and the associated excluded provider-rate combinations. We caution the Departments that the lack of standardization across plans, issues with the inclusion/exclusion criteria, and taxonomy inaccuracies will lead to lower quality data, particularly in the absence of a robust audit or assessment process for excluded data.

Alternatively, to more precisely remove ghost rates (and still reduce file sizes), the Departments could consider requiring group health plans and issuers to leverage combined quantities data and taxonomy mapping (see recommendation in the "Utilization File" section on pg.17-20 to require reporting quantities for each negotiated rate). By starting with quantities data, data filers would include negotiated rates for provider groups where any provider (i.e., orthopedic surgeons, PAs, or other providers) performed the procedure in the previous year. In addition, using taxonomy mapping, data submitters could also include specialties that are very likely to perform the procedure (e.g., orthopedic surgeons where nearly a third perform the procedure).[33]

With group-level data, data submitters can also release the quantity of procedures performed. For groups that regularly perform the procedure, this would be a meaningful number. For groups that have not performed the procedure in the past year (either because they do not have providers who perform the procedure, or they simply were not in network with the TPA or issuer), the number could be zero. This will achieve the goal of including real rates, while limiting the amount of data for those that are unlikely to perform the procedure.

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[31] Improvements Are Needed To Ensure Provider Enumeration and Medicare Enrollment Data Are Accurate, Complete, and Consistent. Department of Health and Human Services Office of the Inspector General. May 28, 2013. https://oig.hhs.gov/reports/all/2013/improvements-are-needed-to-ensure-provider-enumeration-and-medicare-enrollment-data-are-accurate-complete-and-consistent/

[32] Oliphant BW, Sangji NF, Dolman HS, Scott JW, Hemmila MR. The National Provider Identifier Taxonomy: Does it Align With a Surgeon's Actual Clinical Practice*? Journal of Surgical Research*. 2023;282:254-261. https://pmc.ncbi.nlm.nih.gov/articles/PMC10204001/

[33] Muhlestein D. Improving Transparency in Coverage Data: Reducing Ghost Rates, Adding Utilization, and Standardizing File Structure. Simple Healthcare. February 20, 2026. https://simplehc.com/resources/improving-transparency-in-coverage-data

To protect privacy, the Departments could follow the CMS data suppression policy that has been used extensively to report on volumes with an 11-count threshold. Included rates[34] could have a value of 0, from 1-10, or with 11 or more reimbursed claims in the previous year, the actual number of claims.

We encourage the Departments to consult technical experts to explore how this alternative approach could be implemented and what additional technical specifications would be needed. For example, the proposed Utilization File (i.e., binary indicator of at least one reimbursed claim) could potentially support this option.

6. Out-of-Network Allowed Amount Machine-Readable File *90 Fed. Reg. 60453-60456 (Dec. 23, 2025)*

The Departments are proposing to increase the amount of historical out-of-network claims data disclosed in the Out-of-Network (OON) Allowed Amount Files by lowering the threshold for including claims from 20 to 11 different claims per item or service, increasing the reporting period from 90 days to six months, increasing the lookback period from 180 days to nine months, and requiring reporting at the health insurance market level, rather than the plan or policy level. The Departments would additionally require issuers and group health plans to report the product type for the coverage option for which payment data is being reported in the OON Allowed Amount File. The Departments note that the current 20-claim threshold at the plan or policy level has created gaps in OON data, sometimes rendering it unusable for analysis.

The Center supports the Departments' efforts to increase the amount of usable data in the OON Allowed Amount Files. We agree with the Departments' conclusion that this information is useful for providing insight into actual healthcare expenditures and believe improving the usability of this data will yield positive results. The lowered threshold would also put this file in alignment with the CMS data suppression policy, improving the usability of the data while still adequately protecting beneficiary privacy.[35]

Additionally, the Center supports the inclusion of data on product type for the OON Allowed Amount Files, which can be used for purchasing decisions by employers and purchasers. As stated in the earlier section on "HIOS Identifier and Product Type" on pg. 10-11, this information would enable employers and purchasers to compare prices for a given service, including OON costs for employees, across plans of the same product type. However, as mentioned previously, the Center encourages the Departments to consider linking this price data to additional network identifiers and plan information, since product types are not always defined consistently across the industry.

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[34] CMS Cell Size Suppression Policy. Research Data Assistance Center. January 26, 2024. https://resdac.org/articles/cms-cell-size-suppression-policy
[35] Ibid.

7. Contextual Files: Change-log, Utilization, Taxonomy, and Text *90 Fed. Reg. 60456-60460 (Dec. 23, 2025)*

The Departments propose to require group health plans and issuers to make available additional MRFs with contextual information, including a Change-log File, a Utilization File, and a Taxonomy File for each In-network Rate File prepared; a single Text File would also be required to facilitate locating the other required MRFs. Our specific comments on each proposed contextual file are outlined below.

a. *Change-log File*

We support the Departments' proposal to require a new quarterly MRF documenting any changes in the In-network Rate Files and OON Allowed Amounts Files during the prior quarter. By providing an easier way to identify whether data in the files have changed from one quarter to the next, the proposed Change-log file can help streamline tracking and analysis of MRFs by group health plans, TPAs, and vendors, and relieve users of the costs and time required for routine, unnecessary downloading and storage of the quarterly MRF data.

The Change-log file will highlight for employers and policymakers what might otherwise be missed, enhancing the reliability and utility of TiC data while making it easier to derive meaningful insights into spending, cost trends, and utilization. **The Change-log file will be especially helpful to TiC data users if the Departments finalize their proposal to reduce the reporting frequency for the In-network Rate and OON Allowed Amounts Files from monthly to quarterly, which we support.** Rates do not typically change on a monthly basis, making monthly reporting an unnecessary burden on group health plans, TPAs, issuers, and other data users. Because changes are more likely to occur within a quarter, the Change-log File would help users clearly identify those updates and mitigate data challenges that less frequent reporting might create.

The Departments seek comment on how the Change-log File can be most effective, including what MRF format should be required to be published. The Departments also seek comment on whether any specific information should be required to be included, and if so, what information should be required to be included in the Change-log File. **We suggest implementing this through technical implementation guidance as opposed to regulation to maintain greater flexibility to add, remove, and revise required elements.**

b. *Utilization File*

The Departments propose to require a new MRF providing information on the covered items or services for which in-network providers submitted and were reimbursed for at least one claim during the year that ended six months prior to the reporting date. This information would be reported for "each in-network provider identified by the NPI, Taxpayer Identification Number (TIN), and Place of Service Code, who was reimbursed, in whole or in part, for a claim." The Departments believe that the Utilization File will:

- Reveal which providers are actively serving enrollees and delivering covered items and services within a group health plan's or issuer's network, as opposed to relying on static provider directories, which can be over-inclusive when describing providers' availability;
- Aid consumers in understanding whether certain providers are actually available for a procedure or service (i.e., whether they are seeing patients);
- Provide important insights into network adequacy by extending this type of analysis to all providers for a group health plan's or issuer's network; and
- Provide insights into the types of services performed by specific providers, by indicating whether those providers perform more routine procedures within their field of expertise or instead concentrate on rarer or more complex procedures.

The Departments seek comments on whether claims volume, or quantities, data should be included in the proposed Utilization File. They also note in the section on alternative proposals considered that they explored adding it to the current In-network Rate File.

The Center has previously advocated for the inclusion of quantities (i.e., claims volume, or the number of claims submitted and reimbursed for a given service or item) in the TiC data to help put negotiated prices in the context of utilization rates for each service or item.[36] While we have already identified addressing the ghost rate issue as one valuable application for quantities data, there are many other meaningful use cases that this information would unlock for employers and purchasers. **We therefore continue to recommend that the Departments require reporting of quantities data (claims volume).**

Quantities data would not only facilitate a more precise approach to identifying and removing ghost rates and outliers that are potentially inaccurate, but can also enable employers and plan sponsors to more accurately assess the value (across dimensions of both price and quality) they are getting out of their network.

On prices, consider an employer seeking to determine a fair price for a specific service in a given region. Currently, employers can only use TiC data to calculate a simple average across each provider's price; however, if a particularly low- or high-cost provider accounts for most of the volume, the straight average would be misleading. With quantities data, employers could calculate the weighted average of the prices for that service by volume and use that as a more meaningful benchmark for price negotiations.

Information on quantities also serves as the best available proxy for quality at scale. There is a robust body of evidence that quantities are correlated with quality, for example, surgeons who

[36] Helping Employers and Consumers Evaluate the Cost and Quality of Healthcare Services. Peterson Center on Healthcare. March 19, 2025. https://petersonhealthcare.org/news/improvements-to-price-transparency-data/

perform certain procedures at higher quantities are seen to make fewer medical errors.[37,38,39,40] Quantities data also helps illuminate network breadth and depth as individual specialists do not perform all procedures that are performed by the broader specialty; using again the knee replacement example, adding quantities would help an employer understand if their in-network orthopedic surgeons perform them, and how their network stacks up to other networks in terms of price and quality. If employer plan sponsors had ready access to this information, they would be better equipped to implement strategies to steer their employees to higher-quality providers and use this data to negotiate better deals to bring down healthcare costs for their businesses and their employees.

With quantities data, policymakers and other interested audiences can analyze trends and assess the relationship between quantities and negotiated rates, for various provider types and services, which would deepen their understanding of market dynamics and opportunities for policy intervention. The proposed rule includes a provision to add enrollment totals to support more sophisticated analyses weighting plans and policies by number of enrollees and analyzing the relative impact of plans and policies on negotiated rates based on enrollment population size and overall market size; these analyses would be further enhanced by more granular information on quantities by service and negotiated rates. For example, the state of Virginia recently worked with researchers to use TiC data to study mental health networks in commercial plans and to use commercial rates to help inform Medicaid rate setting.[41] If the state and its partner researchers had access to quantities data, they could have greater visibility into how those commercial rates trended with quantities, and the extent to which mental health providers in the network were actually delivering services—another powerful example of a policy application where quantities data could lead to more actionable insights.

While the Departments acknowledge that quantities could inform important analyses, they conclude that the burden of requiring group health plans and issuers to provide quantities data outweighs the benefits of these analyses. **We respectfully disagree with the Departments' cost-benefit assessment and urge the Departments to incorporate quantities as a data element in TiC data reporting.**

We believe the barriers enumerated in the proposed rule are not as insurmountable as described. For instance, the Departments cite that claims data likely resides in different systems than contracted rate data, which would be difficult to link. However, group health plans, their

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[37] Gooiker GA, van Gijn W, Wouters MW, et al. Systematic review and meta-analysis of the volume-outcome relationship in pancreatic surgery. *The British Journal of Surgery*. 2011;98(4):485–494. https://academic.oup.com/bjs/article-abstract/98/4/485/6142240

[38] Birkmeyer JD, Stukel TA, Siewers AE, et al. Surgeon Volume and Operative Mortality in the United States. *The New England Journal of Medicine*. 2003;349:2117-2127. https://www.nejm.org/doi/full/10.1056/NEJMsa035205

[39] Post P, Kuijpers M, Ebels T, Zijlstra F. The relation between volume and outcome of coronary interventions: a systematic review and meta-analysis. *European Heart Journal*. 2010;31(16):1985–1992. https://academic.oup.com/eurheartj/article-abstract/31/16/1985/432271

[40] Rafaqat W, Lagazzi E, Jehanzeb H, et al. Which Volume Matters More? Systematic Review and Meta-Analysis of Hospital vs Surgeon Volume in Intra-Abdominal Emergency Surgery. *Journal of the American College of Surgeons*. 2024;238(3):332-346. https://journals.lww.com/journalacs/citation/2024/03000/which_volume_matters_more__systematic_review_and.14.aspx

[41] Examining Negotiated Rates for Behavioral Health and Primary Care Providers. AcademyHealth. https://academyhealth.org/page/examining-negotiated-rates-behavioral-health-and-primary-care-providers

vendor partners, and issuers are already processing and linking historical claims data to produce the Out-of-Network Allowed Amounts File, and the newly proposed Utilization File also requires ingestion of claims data for each in-network provider. The Departments also state that mixing retrospective and prospective data would cause confusion, but this could be mitigated through clearly defining the data element in the TiC schema 3.0 to indicate the time period to which it corresponds. The Departments also discuss the challenge of frequently changing NPIs and the provider groups into which they fall; this could be addressed by requiring quantities reported at the network level, at the TIN level, rather than at the NPI level.

We encourage the Departments to work with technical experts to develop schema specifications to improve the utility and reliability of quantities reporting, given the complexity of NPI roles on claims. Claims include three different fields for the referring NPI, the performing NPI, and the billing NPI, and there are often multiple NPIs on one claim. Given providers populate these fields inconsistently, quantities reporting at the NPI-level is not reliably comparable across payers and providers. For example, a group may all bill under a single NPI, or an individual provider NPI may appear in one field, leading to double-counting. Further guidance is needed to clarify the level at which quantities should be reported (e.g., provider group, TIN, or NPI), reporting period and cadence, and other major claim factors that should be included in reporting.

We recognize the challenges with accurately matching quantities to individual providers, but matching to a provider group is much more straightforward. We thus recommend the following approach:

- Counts be provided with the quarterly in-network data that present how many times the provider group has been reimbursed for the procedure in the past year (likely representing the 12-month period ending six months prior to the quarterly release). This would be based on the billing ID (NPI or TIN).
- The Utilization File would be updated annually and provide a binary determination about whether the individual provider (at the NPI-level) was listed as the performing NPI on one or more claims in the previous year (using 12-month period ending six months prior to the annual release).

Finally, as we describe above in the “Excluded Provider Information” section on pg. 13-16, if the Departments choose to finalize their Utilization File proposal, we suggest considering how this information may be combined with taxonomy mapping to facilitate a more precise approach to ghost rate removal. We offer an alternative approach that begins with examining utilization to pull in provider-rate combinations, and subsequently removes irrelevant provider-rate combinations based on group health plans’ and issuers’ internal taxonomy mappings. Please reference the “Excluded Provider Information” section for more details.

c. Taxonomy File

The Departments propose to require a new Taxonomy File that would serve as an aid to data users in understanding how group health plans’ and issuers’ internal provider taxonomies were

used in matching items and services with provider specialties to eliminate likely or evident ghost rates from the In-network Rate Files.

The proposal to require group health plans and issuers to post a taxonomy file will be helpful for users if the Departments finalize their proposed approach to eliminating or reducing ghost rates. Although the proposed rule specifies the use of certain standard specialty codes, group health plans and issuers are instructed to use their internal taxonomies, which may differ across entities, mapping those specialty codes to billing codes to validate associations between providers and services. It is therefore prudent in that case that the Departments also require the proposed Taxonomy File to allow users to understand differences in taxonomies that may affect comparisons of plan networks or rates in a market or across markets.

The taxonomy file could also be beneficial to help employers understand the providers that are in-network. The file could include additional information on the individual NPIs who are in-network including name, address, and specialty. Separating this from the in-network file would limit the size of the in-network files while still allowing access to the information.

However, as we noted in the "Excluded Provider Information" section on pg. 13-16, we recommend replacing the taxonomy-only approach to ghost rate removal with a hybrid approach that combines quantities data with taxonomy mapping.

d. Text File

The Departments propose to require group health plans and issuers to post a plain text file in .txt (Text File) in the top-level directory (root folder) of their website that includes the following elements:

- The source page URL for host website for required MRFs;
- A direct URL link for required MRFs; and
- Point-of-contact information including an up-to-date name, title, and email address for an individual who can answer questions regarding the required MRFs.

The Center supports this proposal; it would codify changes previously recommended by the Center, directionally align with HPT URL link publishing requirements,[42] and enhance data access and usability for all TiC data users. **We suggest requiring group health plans and issuers to submit the hosting location for their TiC files to CMS, and that CMS should make available a consolidated list of hosting locations to the public**. We continue to believe this would greatly facilitate findability of files and reduce burdens on employers and other data users at a negligible cost to the federal government or burdens on group health plans, TPAs, and issuers. It could also aid in assessing and promoting auditing and compliance by providing the Departments with a centralized list of reporting group health plans and issuers.

[42] 45 C.F.R. § 180.50(d)(6)(i)-(ii) (2024). https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180/subpart-B/section-180.50

8. File Format *90 Fed. Reg. 60460-60462 (Dec. 23, 2025)*

The Departments are considering specifying a single, non-proprietary open format for the MRFs, either Comma-Separated Values (CSV) or JavaScript Object Notation (JSON), through either rulemaking or technical implementation guidance.

We appreciate the Departments' interest in standardizing TiC data and believe that further standardization would improve the ability of data users to access, clean, and analyze this data. However, we would encourage the Departments to prioritize standardizing the structure of the data. Multiple file formats can be effectively used to organize large amounts of data; the structure of that data will determine how easy it is to understand data across and within different files. With this in mind, **we recommend that the Departments utilize technical guidance to require generation of a schema that supports the ability of users to export TiC data to a rectangular, or spreadsheet-style, database structure.** This structure is the standard among data analysts and would make it easier for users of TiC data to understand and analyze these files. Additionally, using technical guidance for this standardization would maintain maximum flexibility to keep pace with technological changes.

In the proposed rule, the Departments explained the tradeoffs between standardized rectangular formats (like CSVs) and more flexible formats like JSON files. The major concern with the CSV (or any other rectangular format) was the significant duplication in data. There is an additional option that combines the flexibility of the JSON files (and enhances it) with the ease of use of CSV files—a relational structure with multiple tables that connect with common identifiers. This approach is already used to share information including the Hospital Cost Reports.[43] Requiring a relational format would also be unlikely to introduce significant additional burden for group health plans and issuers as producing JSON files typically depends on first creating interim CSV tables and then converting to the JSON format.

JSON files have a number of disadvantages, including their structure, complexity, and size. Simple Healthcare's white paper describes and illustrates these challenges.[44] For example, when analysts converted JSON files to CSV, the median CSV file was less than one-fifth the size of the JSON; and the median zipped file was one-third the size of zipped JSON files. **For these reasons, we recommend that the Departments do not move forward with requiring the JSON format in regulation or technical guidance.**

[43] Cost Reports by Fiscal Year. Centers for Medicare and Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year
[44] Muhlestein D. Improving Transparency in Coverage Data: Reducing Ghost Rates, Adding Utilization, and Standardizing File Structure. Simple Healthcare. February 20, 2026. https://simplehc.com/resources/improving-transparency-in-coverage-data

9. Method and Format for Disclosing Information to the Public *90 Fed. Reg. 60462 - 60464 (Dec. 23, 2025)*

The Departments propose to require each group health plan and issuer to include a link in the footer of the home page of their website (and any page of that website that includes a footer) called “Price Transparency” or “Transparency in Coverage” that directs users to the webpage where MRFs are posted. Alternatively, the Departments would allow group health plans and issuers to satisfy this requirement by using another party to post the MRFs as long as a link is posted to this information on their own website. Furthermore, the Departments would require files to be available to automated scripts or web crawlers (as opposed to just humans) without access barriers like user accounts, passwords, CAPTCHAs, 403 errors, or download limits.

The Center supports the Departments’ proposals to standardize the location of TiC data. However, we recommend that the Departments also require group health plans and issuers to provide the agency with the web location of TiC files and that CMS create a central location for links to these web locations. While the Center welcomes further standardization of hosting location as required by the proposed rule, the proposal would still require users to find websites individually, as opposed to being able to access all webpages with TiC data in a centralized location. We encourage the Departments to centralize this information so that data users may more easily find and make use of TiC data. As noted in our comments concerning enforcement and the proposed Text File, we also believe a CMS repository of TiC data locations would streamline assessment of compliance and enforcement of TiC rules.

10. Timing *90 Fed. Reg. 60464-60465 (Dec. 23, 2025)*

The Departments are proposing to amend the current reporting cadence by reducing the requirement to provide the In-network Rate and Allowed Amount Files from monthly to quarterly. The changes included in these proposed rules would become applicable 12 months after the final regulations are published.

We support the Departments proposal to reduce the reporting cadence to quarterly. The Center believes that this change will reduce file sizes, the total number of files, and the amount of data users would need to analyze, making the process of deriving useful information easier, less time-consuming, and less complex. We agree with the Departments that these benefits would outweigh any potential, minimal loss of accuracy as a result of moving to quarterly reporting. Reducing the cadence of reporting may also improve compliance by reducing the burden on group health plans, TPAs and issuers, which may also lead to improvements in data quality.

The Center believes that the Departments should make this rule applicable sooner than the 12-month timeline they propose. Unlike the original TiC regulations and subsequent schema development, these modifications should not take extensive time to implement. We believe that the Departments should consider a shorter timeline for applicability of these rules following publication.

Comment on the Omission of Prescription Drug Data *90 Fed. Reg. 60442 (Dec. 23, 2025)*

The Departments state that they are separately taking into consideration public comments they have received on how to implement the TiC prescription drug disclosure requirements in technical implementation guidance or future rulemaking. Employers and plan sponsors are concerned about the rapid growth in prescription drug spending, driven by high-cost drugs and growing demand and utilization. The opacity of the drug pricing chain and the complex web of payment flows limit the ability of employers and plan sponsors to manage costs and assess alternative plan designs and formulary options.

Congress and the Department of Labor have recently taken steps to bring greater transparency and regulation to pharmacy benefit manager payments and compensation with enactment of the Consolidated Appropriations Act of 2026[45] and the release of the proposed rule on "Improving Transparency into Pharmacy Benefit Manager Fee Disclosure,"[46] respectively. While these actions will improve the data available to employers and plan sponsors related to their own drug spending, a public prescription drug MRF requirement is needed to:

- Facilitate benchmarking and competition in plan design and selection;
- Support development of consumer-facing tools; and
- Provide researchers with the data needed to inform policymaking.

We encourage the Departments to expedite implementation of the TiC MRF requirements for prescription drug pricing. The data should include prices, rebates, indirect remuneration, restocking fees, dispensing fees, and all other important channel financial information that impact costs and pricing.

[45] Consolidated Appropriations Act, 2026, Pub. L. No. 119-75, H.R. 7148, 119th Cong. (2026). https://www.congress.gov/bill/119th-congress/house-bill/7148/text

[46] Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure, Fed. Reg. Vol. 9 No. 20 pg. 4348 (January 30, 2026). https://public-inspection.federalregister.gov/2026-01907.pdf