Transparency in Coverage (CMS-9882-P)
Proposed Rule Summary

I. Executive Summary

On December 23, 2025, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) published in the *Federal Register* (90 FR 60432) a proposed rule that updates the Transparency in Coverage (TiC) regulations under the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code regarding price transparency reporting requirements for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage.[1] Specifically, the proposed rule is intended to improve the standardization, accuracy, and accessibility of public pricing disclosures in line with the goals of Executive Order 14221.

The deadline for public comment is February 23, 2026.

A. Purpose and Legal Authorities

Previously, the Departments issued proposed TiC requirements in 2019 (2019 proposed rule) and finalized the rule in 2020 (the 2020 final rule). The rules aimed to: provide consumers with price and benefit information that would enable them to better evaluate health care options and make cost-conscious decisions; reduce surprises in consumers' out-of-pocket costs for health care services; create competition and fostering innovation in health care markets; and, over time, potentially lower overall health care costs. The new requirements led to the release of an

[1] Note: A health plan is considered "grandfathered" if it was in existence on March 23, 2010, the date the ACA was signed into law.

enormous amount of pricing data that consumers sometimes found hard to access and use due to file size and the contracting methods employed by plans and issuers.

Among other things, Executive Order 14221[2] directs the Departments to take all necessary and appropriate action, including issuing proposed regulatory action to promote more transparency in health care pricing information. As a result, the Departments are proposing several amendments to the TiC requirements that are intended to improve the standardization, accuracy, and accessibility of pricing information. Specifically, the Departments have identified and are seeking to address three main barriers to fully achieving the goals of the 2020 final rule, including:

- Inaccessibility due to the size of the machine-readable files (MRFs),
- Ambiguity regarding some of the data disclosures due to a lack of contextual information alongside the raw data, and
- Misalignment with the 2019 Hospital Price Transparency final rule[3] that makes comparing data across disclosures challenging.

The Departments propose these rules pursuant to the authority under Section 2715A of the Public Health Service (PHS) Act, incorporated into section 715 of the Employee Retirement Income Security Act (ERISA) and section 9815 of the Internal Revenue Code (the Code), which provide that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must comply with section 1311(e)(3) of the Patient Protection and Affordable Care Act (Affordable Care Act). This section of the Affordable Care Act addresses transparency in health coverage and imposes certain reporting and disclosure requirements on health plans seeking certification as qualified health plans (QHPs) that may be offered on an Exchange (as defined by section 1311(b)(1) of the Affordable Care Act).

The Departments also propose these rules pursuant to the authority under the No Surprises Act, which amended chapter 100 of the Code, Part 7 of ERISA, and title XXVII of the PHS Act. Among other protections, the No Surprises Act provides federal protections against surprise billing by limiting out-of-network cost sharing and prohibiting balance billing in many of the circumstances in which surprise bills most frequently arise. Section 114 of the No Surprises Act added Code section 9819, ERISA section 719, and PHS Act section 2799A-4, which require plans and issuers to offer price comparison guidance by telephone and make a "price comparison tool" available on the plan's or issuer's website.

B. Summary of Major Provisions

[2] On February 25, 2025, President Trump issued Executive Order 14221, "Making America Healthy Again by Empowering Patients With Clear, Accurate, and Actionable Healthcare Pricing Information" (Executive Order 14221). This same Executive Order was used as a basis for many of the Hospital Price Transparency regulatory updates that become effective January 1, 2026.

[3] The Departments refer specifically to the 2019 Hospital Price Transparency Final Rule which HPA notes established regulations at 45 CFR 180 which have been updated several times since the 2019 final rule was issued.

The Departments' proposals amend the regulations under the Public Health Service Act (45 CFR Part 147), the Employee Retirement Income Security Act of 1974 (29 CRF Part 2590), and the Internal Revenue Code (26 CFR Part 54) regarding price transparency reporting requirements for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage. The intent of the proposed rule is to improve the standardization, accuracy, and accessibility of public pricing disclosures in line with the goals of EO 14221.

The proposed rule would, with respect to the in-network rate and out-of-network allowed amount MRFs, add new contextual files and additional data elements like product type, network name, and enrollment counts; change the reporting level for aggregation of data; remove in-network rates for unlikely provider-to-service mappings; increase the reporting period and lower the claims threshold for out-of-network historical data; and reduce the reporting cadence. The proposed rule would also improve the findability of all of the publicly disclosed MRFs required under the TiC rules, including the prescription drug file, by requiring a text file and footer with website URLs and contact information for the files. Finally, the proposed rule would also require pricing information that is made available through an online consumer tool and paper (upon request), to also be made available by phone, and establish that the satisfaction of such requirement also satisfies the requirements of section 114 of the No Surprises Act (including for grandfathered group health plans and health insurance issuers offering grandfathered group and individual health insurance coverage that are not otherwise subject to the proposed rules).

1. Transparency in Coverage – Definitions

The Departments propose to define the term "health insurance market" in these sections for purposes of amendments to 26 CFR 54.9815-2715A3(b)(1)(ii), 29 CFR 2590.715-2715A3(b)(1)(ii), and 45 CFR 147.212(b)(1)(ii) that would require group health plans and health insurance issuers offering group or individual health insurance coverage to make an out-of-network allowed amount MRF available for each health insurance market in which the plan or issuer offers a plan or coverage.

2. Transparency in Coverage – Required Disclosures to Participants, Beneficiaries, or Enrollees

The Departments propose to update the current balance billing disclaimer to state that the displayed cost-sharing information does not account for potential additional amounts in certain situations. Additionally, the Departments propose that the disclaimer would not be required for items and services furnished in states that prohibit balance billing.

In addition, the Departments propose to require plans and issuers to make required cost-sharing estimates via telephone, and that this telephone number be included on any identification card issued to a participant, beneficiary, or enrollee.

The Departments propose to add a new paragraph stating that plans and issuers satisfy the No Surprises Act requirements regarding the price comparison tool by providing the information to participants, beneficiaries, and enrollees in accordance with the method and format requirements set forth in the TiC regulation.

3. Transparency in Coverage – Requirements for Public Disclosure

The TiC regulations at 26 CFR 54.9815-2715A3; 29 CFR 2590.7152715A3; and 45 CFR 147.212 require non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage to disclose on a public website, in the format of MRFs, information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs. The Departments propose a number of amendments that would apply to the disclosure of this information, including:

- Describing the proposed contextual information disclosure requirements for the In-network Rate File.
- Helping users more easily locate the public disclosures made by requiring plans and issuers to post a plain text file in a .txt format (Text File) in the root folder of the plan or issuer's website and a specific internet domain as a link in the footer on the home page of the plan's or issuer's website. The Departments are also considering a standardized file format for all MRFs.
- Removing the requirement to report a specific number of digits of the Health Insurance Oversight System (HIOS) identifier (ID) that are required for each coverage option and to add a requirement to disclose the product type associated with the plan or policy in the In-network Rate Files and the Allowed Amount Files.
- Permitting self-insured group health plans under certain circumstances to allow another party, such as a service provider, with which they have an agreement, to make available in a single In-network Rate File the required information for more than one plan, insurance policy, or contract (including those offered by different plan sponsors with which the other party has an agreement) and across different health insurance markets.
- Permitting self-insured group health plans under certain circumstances to allow another party with which they have an agreement to aggregate the Allowed Amount Files for more than one self-insured group health plan, including those offered by different plan sponsors.
- Technical amendments to prevent unnecessary duplication in regulatory language, conforming edits, and redesignations as needed.

The Departments also propose to amend or specify the timing requirements for each MRF required, including: 1) Amending the required reporting frequency for the In-network Rate and Allowed Amount Files from monthly to quarterly, and 2) Requiring the proposed Text File to be posted beginning on the first day of the calendar-year quarter following the applicability date and updated and posted as soon as practicable but no later than seven calendar days following a change in any of the information required.

The amendments contained in the proposed rule generally modify requirements related to the In-network Rate Files and the Allowed Amount Files. However, several proposed amendments

would amend requirements related to the prescription drug MRFs, specifically: the requirement that plans and issuers must include a Text File in the root folder of a plan's or issuer's website, and the requirements related to the method and format for disclosing information to the public. The Departments note in each applicable section when a proposal would modify requirements related to the prescription drug MRFs.

4. Public Disclosure of In-network Rates

To reduce duplicate in-network rate data, the Departments propose to require plans and issuers to make an In-network Rate File available for each provider network maintained or contracted by the plan or issuer. The Departments propose that:

- Each In-network Rate File would include the common provider network name for which negotiated rate information is included in that file.
- In-network rates would be reflected as a dollar amount except for contractual arrangements under which plans and issuers agree to pay an in-network provider a percentage of billed charges and are not able to assign a dollar amount to an item or service prior to a bill being generated.
- Each In-network Rate File would include current enrollment totals, as of the date the file is posted, for each plan or coverage option offered by a plan or issuer that uses that file's provider network.
- Plans and issuers would exclude any provider and their negotiated rate for an item or service, if the provider is unlikely to be reimbursed for the item or service given that provider's area of specialty.

The Departments also propose to require plans and issuers to prepare and post several new contextual MRFs that would help file users better understand the public disclosures required in the In-network Rate Files. The new files would include:

- A "Change-log File" which would identify any changes made to the required information in the In-network Rate File since the last posted In-network Rate File. This file would be required to be posted beginning on the first day of the calendar-year quarter following the date on which the first In-network Rate File is required to be posted and updated and posted quarterly whether or not there are changes to that file since it was last posted.
- A "Utilization File" which would document, for the 12-month period that ends 6 months prior to its publication date, all items and services covered under the plans or policies represented in the In-network Rate File for which a claim has been submitted and reimbursed. The Utilization File would also include each in-network provider identified by the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code who was reimbursed for a claim for each covered item or service included in the file. This file would be required to be posted beginning on the first day of the calendar-year quarter following the applicability date and updated annually after the initial posting.
- A "Taxonomy File" which would include the plan or issuer's internal provider taxonomy that matches items and services with provider specialties to determine if the plan or issuer should deny reimbursement for an item or service because it was not furnished by a

provider in an appropriate specialty. This file would be required to be posted beginning on the first day of the calendar-year quarter following the applicability date and updated and posted quarterly if changes to the internal provider taxonomy impact the information in the MRF.

The Departments propose certain technical revisions and amendments, such as redesignations, to accommodate the proposals.

5. Public Disclosure of Out-of-Network Allowed Amounts

The Departments propose to make several amendments to increase the amount of historical claims data available in the Allowed Amount Files. These amendments would require plans and issuers to report out-of-network allowed amounts and billed charges at the health insurance market level, rather than the plan or policy level, lower the threshold for including claims in the Allowed Amount File from 20 to 11 different claims per item or service, and increase the reporting period from 90 days to six months and the lookback period from 180 days to nine months.

6. Severability and Technical Amendments

The 2020 final rule included severability clauses to emphasize the Departments' intent that, to the extent a reviewing court holds that any provision of the final rule is unlawful, the remaining rules should take effect and be given the maximum effect permitted by law. The Departments are not modifying the 2020 final rule language. Instead, the Departments clarify that these clauses continue to apply and would extend to the amendments proposed in this rule, if finalized.

The Departments propose a series of technical amendments that are designed to improve consistency in the way group health plans and health insurance issuers offering group or individual health insurance coverage are referenced in the TiC regulations. The proposed changes are technical in nature and would not affect the rights or obligations of any plan, issuer, or other entity.

C. Summary of Costs and Benefits

The proposed rule preamble contains detailed discussions and summary tables of estimated annual costs (totaling $68,201,302), one-time costs (totaling $913,710,577) and annual benefits (totaling $257,046,000). Tables 1a, 1b, and 1c from the proposed rule are reproduced below in section VI. Regulatory Impact Statement.

II. Background

According to the Departments, the lack of health care pricing information is widely understood to be one of the root problems causing dysfunction within America's health care system. President Trump issued two Executive Orders (EO 13877 and EO 14221) directing the Departments to take action that would combat this issue by making meaningful price and quality

information more broadly available to more Americans, thereby increasing competition, innovation, and value in the health care system.

To fulfill their responsibility under Executive Order (EO 13877, issued on June 24, 2019), the Departments proposed and subsequently finalized the TiC rules in the 2020, implementing section 2715A of the PHS Act, which requires group health plans and health insurance issuers offering group or individual health insurance coverage to comply with section 1311(e)(3) of the Affordable Care Act. These provisions address transparency in health coverage and require plans and issuers to make certain information available to the public.

Executive Order (EO 14221, issued February 25, 2025) directs the Secretaries of the Departments to rapidly implement and enforce the health care price transparency regulations issued pursuant to Executive Order 13877, including action to: "(a) require the disclosure of the actual prices of items and services, not estimates; (b) issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans; and (c) issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data." In line with these directives, the Departments have now published the current proposed rule with amendments to the regulations issued under the 2020 final rule.

In this section of the proposed rule, the Departments provide a detailed summary of the statutory background and enactment of the Affordable Care Act (Pub. L. 111-148). In short, section 2715A of the PHS Act, incorporated into section 715 of ERISA and section 9815 of the Code, provides that plans and issuers must comply with certain reporting and disclosure requirements for health plans that are seeking certification as QHPs that may be offered on an Exchange. A plan or coverage that is not offered through an Exchange is required to submit the information required to the relevant Secretary and the relevant state's insurance commissioner, and to make that information available to the public.

The No Surprises Act added new sections 9816(a)-(b) and 9817(a) of the Code, sections 716(a)-(b) and 717(a) of ERISA, and sections 2799A–1, 2799A–2, 2799B–1, 2799B–2, 2799B–3, and 2799B–5 of the PHS Act, which protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage from balance bills by prohibiting nonparticipating providers, facilities, and providers of air ambulance services from billing or holding liable individuals for an amount that exceeds in-network cost sharing determined in accordance with the No Surprises Act's cost-sharing limitations in circumstances where the cost-sharing limitations apply. The No Surprises Act also added new section 9816(e) of the Code, section 716(e) of ERISA, and sections 2799A–1(e) of the PHS Act, which contain requirements for applicable group health plans or issuers to include certain information (relating to deductibles, out-of-pocket limitations, and contacting consumer assistance), in clear writing, on any plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage. Further, section 114 of the No Surprises Act added section 2799A-4 of the PHS Act, section 9819 of the Code, and section 719 of ERISA, which require plans and issuers to: offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled

under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

The enforcement responsibilities of HHS and the states with respect to oversight of health insurance issuer compliance with the federal insurance market reforms are set forth in the PHS Act, with states having primary enforcement authority. Under this framework, HHS has enforcement authority over issuers in a state if the Secretary of HHS makes a determination that the state is failing to substantially enforce a provision (or provisions) of Part A or D of title XXVII of the PHS Act. The Departments of Labor and the Treasury generally have primary enforcement authority over private sector employment-based group health plans. The Internal Revenue Service (IRS) has jurisdiction over certain church plans. HHS also has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers. The Departments will generally use existing processes to ensure compliance with the Code, ERISA, and PHS Act requirements that apply to group health plans and health insurance issuers.[4]

Since publication of the 2019 proposed rule, the Departments have been in regular consultation with interested parties. The Departments state they considered all public input received as they developed the policies in the proposed rule, with the exception of prescription drug request for information (RFI) comments (issued June, 2025). However, the Departments indicate receipt of the prescription drug RFI comments and are separately taking them into consideration to evaluate how to implement the TiC prescription drug disclosure requirements in technical implementation guidance or future rulemaking.

III. Provisions of the Proposed Regulations

A. Definitions

The Departments propose to define the term health insurance market for purposes of proposed amendments to the Allowed Amount File provision at 26 CFR 54.9815-2715A3(b)(1)(ii), 29 CFR 2590.715-2715A3(b)(1)(ii), and 45 CFR 147.212(b)(1)(ii) (discussed in more detail below) which would require group health plans and health insurance issuers offering group or individual health insurance coverage to make an out-of-network allowed amount MRF available for each health insurance market in which plans and issuers offer a plan or coverage. Establishing a standardized definition of the term health insurance market for this purpose would promote consistent data organization across plans and issuers in these market-level Allowed Amount Files.

[4] HHS's enforcement procedures related to the PHS Act federal insurance market reforms are set forth in section 2723 of the PHS Act and 45 CFR 150.101 *et seq*., including bases for initiating investigations, performing market conduct examinations, and imposing civil money penalties. Section 504 of ERISA provides DOL with investigatory authority to determine whether any person has violated or is about to violate any provision of ERISA or any regulation or order thereunder.

Under this proposal, health insurance market would mean, irrespective of the State, one of the following:

- The individual market, as defined in 45 CFR 144.103 (other than short-term, limited-duration insurance or individual health insurance coverage that consists solely of excepted benefits),
- The large group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits),
- The small group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits), or
- For purposes of self-insured group health plans (other than account-based plans, as defined in 26 CFR 54.9815-2711(d)(6)(i), 29 CFR 2590.715-2711(d)(6)(i), and 45 CFR 147.126(d)(6)(i), and plans that consist solely of excepted benefits), all self-insured group health plans maintained by the plan sponsor. The Departments note they are including self-insured group health plans in this definition for purposes of the Allowed Amount Files, even though the term health insurance market is not generally used to refer to such plans.

The Departments note that to the extent self-insured group health plans use an entity to administer the plan, the aggregation rules described in proposed 26 CFR 54.9815-2715A3(b)(5)(iv), 29 CFR 2590.715-2715A3(b)(5)(iv), and 45 CFR 147.212(b)(5)(iv) would allow the entity to aggregate out-of-network allowed amounts for more than one plan offered by a self-insured group health plan sponsor the entity administers, including those offered by self-insured group health plan sponsors. For clarity, the Departments also propose to include cross-references to the market-wide definitions in 45 CFR 144.103 where applicable.

B. Requirements for Disclosing Cost-Sharing Information to Participants, Beneficiaries, and Enrollees

1. Disclaimer on Balance Billing

Currently, under 26 CFR 54.9815-2715A2(b)(1)(vii)(A), 29 CFR 2590.715-715A2(b)(1)(vii)(A), and 45 CFR 147.211(b)(1)(vii)(A), plans and issuers must disclose certain cost-sharing information to participants, beneficiaries, and enrollees, including an estimate of the participant's, beneficiary's, or enrollee's cost-sharing liability for a requested covered item or service from a particular provider or providers. If the request is for cost-sharing information for an out-of-network provider, the plan or issuer must disclose an out-of-network allowed amount or any other rate that the group health plan or health insurance issuer will pay for the requested covered item or service. As discussed in the 2020 final rule, because cost estimates cannot account for potential balance billing by an out-of-network provider, current rules require plans and issuers to include a notice with a number of statements, including that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between a provider's billed charges and the sum of the amount collected from the plan or issuer and the amount collected from the participant, beneficiary, or enrollee in the form of a copayment or coinsurance amount (the difference often referred to as balance billing) and that these estimates do not account for those potential additional amounts. Because there were existing state laws

prohibiting balance billing to some extent, as discussed in the 2020 final rule, the current rules only require this statement if balance billing is permitted under state law.

Following passage of the No Surprises Act, all participants, beneficiaries, and enrollees of group health plans and group and individual health insurance coverage are now protected from certain balance billing under federal law. The Departments therefore propose to amend the balance billing protection notice provision under paragraph (b)(1)(vii)(A). Specifically, the Departments propose to require a statement that the cost-sharing information provided in the self-service tool (pursuant to paragraph (b)(1)(i)) does not account for potential additional amounts in situations where applicable state and federal law allow out-of-network providers to bill participants, beneficiaries, or enrollees, for the difference between a provider's billed charges and the sum of the amount collected from the plan or issuer and from the participant, beneficiary, or enrollee . Because there are circumstances under which participants, beneficiaries, and enrollees can be balance billed under current federal law and state balance billing laws, the Departments propose to clarify that this disclaimer is not required only if the state in which the item or service is to be furnished prohibits all out-of-network providers from balance billing for all items and services payable by the group health plan or health insurance issuer.

2. New Required Method and Format for Disclosing Information to Participants, Beneficiaries, or Enrollees

Currently, the 2020 final rule regulations at paragraph (b)(2) allow plans and issuers to satisfy the disclosure requirements of paragraph (b)(1) through a self-service tool, via paper, or through an alternative means such as phone or email, provided the participant, beneficiary, or enrollee agrees that disclosure through such means is sufficient to satisfy the request and the request is fulfilled at least as rapidly as required for the paper method. However, disclosure by such alternative means is not required. The Departments note that they have determined that No Surprises Act's price comparison tool and self-service tool requirements are largely duplicative. However, Code section 9819, ERISA section 719, and PHS Act section 2799A-4 expands on the requirements for disclosure of cost-sharing information by requiring plans and issuers to "offer price comparison guidance by telephone."

As a result the Departments propose, at new 26 CFR 54.9815-2715A2(b)(2)(iii), 29 CFR 2590.715-2715A2(b)(2)(iii), and 45 CFR 147.211(b)(2)(iii) to require plans and issuers to make available to participants, beneficiaries, and enrollees the cost-sharing estimates and other disclosures described in paragraph (b)(1) via phone. Under this proposal, the information required via a phone number would be required to be accurate at the time of the request and provided in accordance with the method and format requirements in paragraphs (b)(2)(i)(A) through (C). Additionally, plans and issuers would be required to use the same telephone number that Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e) require be indicated on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, and enrollees for obtaining customer assistance. If this new requirement is finalized as proposed, plans and issuers would be required to make available cost-sharing estimates via the internet-based self-service tool, a phone number, and paper upon request. The Departments believe that requiring plans and issuers to provide cost-sharing information in this way would further promote the price transparency goals of providing

accurate, real-time pricing to consumers, and making that information accessible to more consumers.

The Departments note that a 20-provider limit currently applies with respect to paper requests at 26 CFR 54.9815-2715A2(b)(2)(ii), 29 CFR 2590.715-2715A2(b)(2)(ii), and 45 CFR 147.211(b)(2)(ii). That is, in responding to a paper request, the group health plan or health insurance issuer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. The Departments propose to extend this limit to telephonic requests. Specifically, at paragraph (b)(2)(iii), the Departments propose to allow plans and issuers to limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per day and, to require plans and issuers to disclose the applicable provider-per-day limit to the participant, beneficiary, or enrollee when the request for information is made. Similar to its rationale expressed in the 2020 final rule, the Departments believe this approach balances burden on plans and issuers with the benefits of providing consumers with enough information to be able to compare cost and provider options.

The Departments note that nothing in the proposed rule would preclude a participant, beneficiary, or enrollee from obtaining cost-sharing information from more than one method, consistent with the requirements for each method.

The Departments request comment on whether this proposal should include phone service standard to ensure that consumers have access to timely and reliable information, and if so, what such standards should include and what parameters should be applied to each criterion. The Departments also request comment on whether there are other relevant federal, state, or local standards for phone service quality or any industry practices that the Departments should consider.

3. Compliance with PHS Act Section 2799A-4, ERISA Section 719, and Code Section 9819

The Departments explain that the 2020 final rule added 26 CFR 54.9815-2715A2(b)(1) and (b)(2), 29 CFR 2590.715-2715A2(b)(1) and (b)(2), and 45 CFR 147.211(b)(1) and (b)(2), which created a comprehensive set of requirements for plan and issuer disclosure of cost-sharing information through an internet-based self-service tool, and in paper form, upon request. Paragraph (b)(1) of the 2020 final rule regulations requires the disclosure of cost-sharing information, which is accurate at the time the request is made, with respect to a participant's, beneficiary's, or enrollee's cost-sharing liability for covered items and services, and which must reflect any cost-sharing reductions the enrollee would receive. Under paragraph (b)(2), disclosures must be made available through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request, in plain language, without a fee, or in paper form, at the user's request. This paragraph requires certain functionality to make searching using the self-service tool easier, including searching by billing code or descriptive term, and refining and reordering search results based on geographic proximity of in-network providers, and the amount of the participant's, beneficiary's, or enrollee's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

The Departments describe the actions they took in response to passage of the No Surprises Act under which plans and issuers are required to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that allows individuals enrolled under such plan or coverage offered by the plan or issuer to compare the amount of cost sharing that the individual would be responsible for paying for an item or service furnished by an in-network provider. The Departments note their previous announcement that the price comparison methods required by the No Surprises Act price comparison tool are largely duplicative of the self-service tool component of the 2020 final rule regulations. At the time of the announcement, the Departments indicated their intent to undergo future rulemaking and seek public comment regarding whether compliance with the self-service tool requirements of the 2020 final rule regulations should satisfy the analogous requirements set forth Code section 9819, ERISA section 719, and PHS Act section 2799A-4.[5]

Therefore, the Departments propose to add new 26 CFR 54.9815-2715A2(c)(7), 29 CFR 2590.715-2715A2(c)(7), and 45 CFR 147.211(c)(7) stating that a plan or issuer satisfies the requirements of section 9819, ERISA section 719, and the PHS Act section 2799A-4 by providing the information required under paragraph (b)(1) of this section to participants, beneficiaries, and enrollees in accordance with the method and format requirements specified in paragraph (b)(2) of this section.

The Departments acknowledge that, while PHS Act section 2715A does not apply to grandfathered health plans and health insurance issuers offering grandfathered individual and group health insurance coverage, Code section 9819, ERISA section 719, and PHS Act section 2799A-4 do apply to those entities. Therefore, if this rule is finalized, grandfathered health plans and issuers offering grandfathered health insurance coverage may comply with the requirements of PHS Act 2715A, as codified in 26 CFR 54.9815-2715A2, 29 CFR 2590.716-2715A2 and 45 CFR 147.211, to satisfy the requirements of Code section 9819, ERISA section 719, and PHS Act section 2799A-4. The Departments request comments on whether any additional provisions are necessary to assist grandfathered health plans and health insurance issuers in complying with the requirements of 26 CFR 54.9815-2715A2, 29 CFR 2590.716-2715A2 and 45 CFR 147.211.

4. Applicability

The Departments propose to revise 26 CFR 54.9815-2715A2(c)(1), 29 CFR 2590.715-2715A2(c)(1), and 45 CFR 147.211(c)(1) to state that the proposed amendments to (b)(1)(vii)(A), and new paragraphs (b)(2)(iii), (b)(2)(iv), and (c)(7) of this section would apply for plan years (in the individual market, policy years) beginning on or after January 1, 2027. Until such time, the current provisions of paragraph (b) would continue to apply. Because plans and issuers can leverage existing operations, and the proposed applicability date would create alignment between phone and comparison tool data disclosure, the Departments have determined that the proposed applicability date is reasonable.

[5] As added by section 114 of the No Surprises Act.

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

The current In-network Rate File provision at 26 CFR 54.9815-2715A3(b)(1)(i), 29 CFR 2590.715-2715A3(b)(1)(i), and 45 CFR 147.212(b)(1)(i) requires plans and issuers to make available on a public website a MRF that discloses in-network provider rates for covered items and services, with the exception of prescription drugs that are subject to a fee-for-service reimbursement arrangement. The Departments propose to amend the introductory language of paragraph (b)(1)(i) to require plans and issuers to make available an In-network Rate File for each provider network maintained or contracted by the group health plan or health insurance issuer. This proposed change is intended to reduce the size and total number of In-network Rate Files, allow file users to more efficiently aggregate and analyze the data, and align reporting more closely to how data is typically reported by hospitals pursuant to the Hospital Price Transparency rules under 45 CFR part 180.[6]

a. Proposal to Reduce File Size

The most common concern expressed by stakeholders to the Departments is related to the size of the In-network Rate Files. These files are often very large, making them challenging for users to download, analyze, and store. Additionally, the large number of such files can make aggregation and analysis highly resource intensive. In agreement with feedback received by stakeholders, the Departments agree that where multiple plans share the same negotiated rates under an umbrella provider network, organizing the In-network Rate Files by provider network would decrease the size of the files, often significantly while still maintaining data integrity. Therefore, to standardize this method of organizing files across all plans and issuers, the Departments propose to amend the introductory language of paragraph (b)(1)(i) to require plans and issuers to make an In-network Rate File available for each provider network maintained or contracted by the plan or issuer. This approach would also reduce the total number of In-network Rate Files because there are far more plans and policies available than there are distinct, separately managed provider networks.

To make it easier for file users to determine in advance of downloading a provider network-level In-network Rate File whether it contains data of interest to them, the Departments propose to require each In-network Rate File to include the common provider network name for which negotiated rate information is included.[7] The Departments seek comment on whether there is another term or code, in addition to or instead of the common provider network name, that would help producers or file users identify specific provider networks. The Departments expect plans and issuers to define what constitutes a separate provider network according to their current business practices. The Departments solicit comments on whether additional limitations on what constitutes a separate provider network should be required.

[6] The Departments refer to the 2019 and 2023 hospital price transparency final rules, specifically.
[7] This would involve redesignating paragraphs (b)(1)(i)(A) through (C) as paragraphs (b)(1)(i)(B) through (D), respectively, and adding a new paragraph (b)(1)(i)(A).

Further, the Departments propose to require plans and issuers to identify, for each provider network for which the plan or issuer must publish an In-network Rate File, each of the plan's or issuer's coverage options that use that network.[8] This would allow file users to cross reference the rates for a particular plan or policy of interest to its in-network rates. Finally, the Departments propose to make conforming amendments to redesignated paragraphs (b)(1)(i)(C) and (D).

b. Other Improvements for File Users and Alignment with Hospital Price Transparency Reporting

In this section, the Departments describe and provide examples related to their determination that, overall, provider network-level files would simplify data aggregation and analysis for researchers and other groups interested in analyzing specific provider networks, which is important to facilitate consumers' plan selection decisions. Use by other stakeholders, such as by states, is also described.

Additionally, the Departments state that organizing in-network rates by provider network would also promote standardization and streamlined comparison of pricing information across hospitals and health plans, consistent with Executive Order 14221. The Departments explain that currently, a single set of rates negotiated between a plan and hospital system could appear multiple times, under several different plan names, in an issuer's In-network Rate File. Standardizing price disclosures for providers, plans, issuers, and procedures at the same level as the hospital price transparency MRFs would allow for more accurate comparisons between the two sets of data.

2. HIOS Identifier and Product Type

The Departments propose to amend the identifying coverage information that plans and issuers must disclose in the In-network Rate Files at redesignated 26 CFR 54.9815-2715A3(b)(1)(i)(B), 29 CFR 2590.715-2715A3(b)(1)(i)(B), and 45 CFR 147.212(b)(1)(i)(B), and in the Allowed Amount Files at 26 CFR 54.9815-2715A3(b)(1)(ii)(A), 29 CFR 2590.715-2715A3(b)(1)(ii)(A), and 45 CFR 147.212 (b)(1)(ii)(A).

Reporting the HIOS Identifier. The 2020 final rule regulations require plans and issuers to include their 14-digit HIOS ID in the In-network Rate File and Allowed Amount File unless the plan or issuer does not have a 14-digit HIOS ID available, in which case the plan or issuer must include the HIOS ID at the 5-digit issuer level. In response to stakeholders and in order to keep pace with and respond to technological developments, the Departments propose to require plans and issuers to report the HIOS identifier associated with each coverage option for which the data is being reported in a form and manner specified in guidance issued by the Department. If a plan or issuer does not have a HIOS ID, it must use its Employer Identification Number (EIN).

Reporting the Product Type. Based on feedback and the Departments' agreement that requiring disclosure of health plan product types (for example, HMO, PPO) would promote more meaningful transparency of the pricing information disclosed in the In-network Rate and

[8] The Departments propose to amend redesignated paragraph (b)(1)(i)(B) for this purpose.

Allowed Amount Files, the Departments are proposing to amend redesignated paragraph (b)(1)(i)(B) and amend paragraph (b)(1)(ii)(A) to newly require plans and issuers to report the product type for each applicable coverage option offered by a plan or issuer in the In-network Rate File and Allowed Amount File, respectively. The Departments have determined that adding a product type to the Allowed Amount Files would allow file users to compare how historical provider reimbursements differ based on product type, enable more accurate and actionable Comparisons, and allow users to better understand the actual tradeoffs in plan design.

The Departments also acknowledge that the definitions of these product types may differ from State to State and seek comment on whether that would present difficulties for plans and issuers in determining which product type to indicate and whether possible inconsistency between State definitions of certain product types would cause confusion among file users. Additionally, the Departments seek comment on whether self-insured plans generally identify benefit package options by product type, whether there is any existing nomenclature that self-insured plans could use to accurately identify the type of benefit arrangement being offered, and whether it is practical to extend this requirement to self-insured plans.

3. Percentage-of-Billed-Charges Arrangements

Currently, the In-network Rate File provision requires plans and issuers to publish all applicable rates, which may include one or more of the following: negotiated rates, underlying fee schedule rates, or derived amounts for all covered items and services in the In-network Rate File. The Departments specified in the preamble to the 2020 final rule that the In-network Rate File requirement applies to plans and issuers regardless of the type of payment model or models under which they provide reimbursement. Currently, the In-network Rate File provision requires that rates must be reflected in the In-network Rate File as dollar amounts, and if the rate is subject to change based upon participant, beneficiary, or enrollee-specific characteristics, that these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant, beneficiary, or enrollee-specific characteristics. While there are alternative reimbursement arrangements that do not have a dollar amount associated with particular items and services before the item or service is furnished, a dollar amount can still be determined in some instances under these arrangements. In the 2020 final rule preamble, the Departments provided general reporting expectations, including for bundled payment arrangements and capitation arrangements (including sole capitation arrangements and partial capitation arrangements), reference-based pricing without a defined network, reference-based pricing with a defined network, and value-based purchasing.

The Departments received inquiries from interested parties related to reporting dollar amounts for negotiated rates that result from certain "percentage-of-billed-charges" contract arrangements, under which a dollar amount can be determined only retrospectively because the agreement between the plan or issuer and the in-network provider states that the plan or issuer will pay a fixed percentage of the billed charges. The Departments subsequently issued guidance advised that for "percentage-of-billed-charges" arrangements, plans and issuers may report a percentage number in lieu of a dollar amount. Additionally, the Departments provided an enforcement safe harbor for certain types of contract arrangements under which a dollar amount cannot be disclosed according to the file formatting requirements.

In light of continued feedback and inquiries related to this matter, the Departments propose to amend redesignated 26 CFR 54.9815-2715A3(b)(1)(i)(D)(1), 29 CFR 2590.715-2715A3(b)(1)(i)(D)(1), and 45 CFR 147.212(b)(1)(i)(D)(1) to state that applicable rates must be reflected as dollar amounts, with respect to each covered item or service that is furnished by an in-network provider, except for contractual arrangements under which a group health plan or health insurance issuer agrees to pay an in-network provider a percentage of billed charges and is not able to assign a dollar amount to an item or service prior to a bill being generated. In these instances, plans and issuers must report a percentage number, in lieu of a dollar amount, in a form and manner as specified in guidance issued by the Departments.

The Departments reiterate and emphasize that plans and issuers must disclose rates as a dollar amount whenever a dollar amount can be calculated in advance, including when a negotiated base rate can be calculated prior to adjustments. Further, the Departments emphasize that this proposed change, if finalized, would permit plans and issuers to disclose an applicable rate in a non-dollar amount only in instances where the applicable rate is a percentage of billed charges and expect that plans and issuers report all other applicable rates as dollar amounts consistent with the form and manner specified in guidance issued by the Departments.

4. Enrollment Totals

Affordable Care Act sections 1311(e)(3)(A)(iii) and (iv) require health plans seeking certification as a QHP to submit to the Exchange, the Secretary, the state insurance commissioner, and make available to the public, accurate and timely disclosure of data on enrollment and disenrollment. PHS Act section 2715A, incorporated into ERISA section 715 and Code section 9815, gives the Departments the statutory authority to require a plan or coverage that is not offered through an Exchange to submit the information required under Affordable Care Act section 1311(e)(3) to the Secretary and the relevant state's insurance commissioner, and to make that information available to the public.

Currently, the 2020 final rule regulations do not require the disclosure of enrollment data. However, based on stakeholder feedback, the Departments have determined that requiring disclosure of this additional data in the In-network Rate File would provide important context to the health care pricing information. Therefore, the Departments propose to add new 26 CFR 54.9815-2715A3(b)(1)(i)(E), 29 CFR 2590.715-2715A3(b)(1)(i)(E), and 45 CFR 147.212(b)(1)(i)(E) requiring plans and issuers to include in each In-network Rate File, current numerical enrollment totals, as of the date the file is posted, for each coverage option offered by a plan or issuer represented in the In-network Rate File. Such numerical enrollment totals must include the number of participants, beneficiaries, and enrollees (including all dependents) in the coverage option offered by a plan or issuer.

The Departments seek comment on the feasibility of including the enrollment total as of the date the file is posted and whether an enrollment total on a different specified date would be more feasible for file producers and more useful to the data users. The Departments also solicit comment on this proposal in general.

5. Excluded Provider Information

Currently, the 2020 final rule regulations at 26 CFR 54.9815-2715A3(b)(1)(i)(C)(1), 29 CFR 2590.715-2715A3(b)(1)(i)(C)(1), and 45 CFR 147.212(b)(1)(i)(C)(1) require plans and issuers to disclose all applicable rates for in-network providers, including negotiated rates, underlying fee schedule rates, or derived amounts, to the extent they may be used for purposes of determining provider reimbursement or cost-sharing for in-network providers. The 2020 final rule regulations do not specify any exclusions to this requirement. As a result, the Departments have observed and have received feedback that In-network Rate Files often include negotiated rates for providers for items and services that those providers would not likely be reimbursed for because the items and services are outside their specialty (for example, a mental health provider billing for knee replacement). Additionally, there are many provider-rate combinations that are not meaningful for transparency purposes and impose unnecessary burden on both producers and users of the In-network Rate File. The overinclusion also leads to significant file sizes that can create network bandwidth, cost, and data storage problems for file producers and users alike, as well as unnecessary barriers for accurately analyzing the data.

The Departments have determined that excluding provider-rate combinations for services that providers are unlikely to perform or be reimbursed for—because they fall outside their specialty—would significantly reduce the size of the In-network Rate Files and thus relieve current barriers to data access. Therefore, the Departments propose to revise[9] the content requirements for the In-network Rate File to require plans and issuers to exclude provider-rate combinations for an item or service if the provider would be unlikely to be reimbursed for the item or service given the provider's area of specialty, according to the plan's or issuer's internal provider taxonomy that is typically used during the claims adjudication process. In order for users of the In-network Rate Files to understand how plans and issuers constructed the files according to this new proposed requirement, the Departments also propose to require[10] plans and issuers to publish a taxonomy MRF based on a standardized code set established by the National Uniform Claim Committee (NUCC)(discussed in section III.C.7 below).

The Departments are particularly interested in feedback from interested parties related to the following:

- Whether there are plans or issuers that do not map provider specialties to billing codes within their claims adjudication process or use different code sets, and whether there could be a way to standardize the provider specialty mapping to billing code process.
- Whether there are alternative approaches to excluding any provider that has a rate for an item or service that interested parties consider to not be a meaningful rate.
- The relative burdens and benefits of alternative approaches to both producers and file users.

[9] The proposed revision would add new 26 CFR 54.9815-2715A3(b)(1)(i)(F), 29 CFR 2590.715-2715A3(b)(1)(i)(F), and 45 CFR 147.212(b)(1)(i)(F).
[10] The proposed revision would add new 26 CFR 54.9815-2715A3(b)(2)(iii), 29 CFR 2590.715-2715A3(b)(2)(iii), and 45 CFR 147.212(b)(2)(iii),

- Any concerns that parties may have with a proposal to require plans and issuers to make such exclusions at all, including concerns about plans and issuers intentionally or inadvertently over-excluding provider-rate combinations from the In-network Rate File.
- Whether there are alternative approaches that will help meet the Departments' goals of limiting unnecessary information that inflates file size, without limiting the accessibility of the data, and promoting meaningful transparency of in-network rate pricing information.

6. Out-of-Network Allowed Amount Machine-Readable File

The 2020 final rule regulations at paragraph (b)(1)(ii)(C) require plans and issuers to disclose on a public website a MRF that includes, among other things, each unique out-of-network allowed amount with respect to covered items or services furnished by a particular out-of-network provider during the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount File. In addition, plans and issuers must omit such data in relation to a particular item or service and provider when including it would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 20 different claims for payments for an item or service under a single plan or coverage. Current rules at paragraph (b)(4)(iii) also permit, but do not require, plans and issuers to satisfy the public disclosure requirements of paragraph (b)(1)(ii) by making available out-of-network allowed amount data that has been aggregated to include information from more than one plan or policy, under certain circumstances.

The Departments propose to make several amendments to the Allowed Amount File provision at 26 CFR 54.9815-2715A3(b)(1)(ii), 29 CFR 2590.715-2715A3(b)(1)(ii), and 45 CFR 147.212(b)(1)(ii) to increase the amount of historical out-of-network claims data disclosed in the files, including a proposal to lower the threshold for including claims from 20 to 11 different claims per item or service, a proposal to increase the reporting period from 90 days to six months, a proposal to increase the lookback period from 180 days to nine months, and a proposal to require reporting at the health insurance market level, rather than the plan or policy level.

a. Reducing the Claims Threshold

Initially, in the 2020 final rule, the Departments established the 20-claims threshold to limit the possibility that individual participants, beneficiaries, and enrollees may be identified through the public disclosure of historical allowed amount data. The Departments clarified in technical implementation guidance that an Allowed Amount File must still be produced pursuant to paragraph (b)(1)(ii)(C), even if the claims threshold limit results in minimal or no information. The Departments note that, as a result of these policies, many plans and issuers product Allowed Amount Files with limited to no out-of-network claims data, making it difficult for file users to perform meaningful analyses.

Therefore, to increase the volume of allowed amount data available, the Departments propose to amend paragraph (b)(1)(ii)(C) to lower the minimum claims threshold for a particular item or

service under a single plan or coverage to 11 different claims for a particular item or service in a single health insurance market. The proposed 11-claims threshold would align with the CMS cell suppression policy, which sets minimum thresholds for the display of CMS data by researchers or other custodians of CMS data sets, such as Limited Data Set (LDS) files. Additionally, the Departments note that, as specified in current paragraph (b)(1)(ii)(C), disclosure of such information would not be required if doing so would violate applicable health information privacy laws. This is consistent with paragraph (c)(3), which specifies that, among other things, nothing in 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, or 45 CFR 147.212 alters or otherwise affects a plan's or issuer's duty to comply with requirements under other applicable state or federal laws, including those governing the privacy or security of information required to be disclosed under this section. The Departments have determined that lowering the claims threshold in this way would strike a better balance between protecting sensitive health information and allowing for a more comprehensive and useful dataset to support the end goals of price transparency.

Lastly, the Departments propose a technical revision to delete "and provider" from the parenthetical language in (b)(1)(ii)(C) to more clearly specify that the claims threshold pertains to the number of claims for an item or service overall for the file, not the number of claims for an item or service from a particular provider.

b. Increasing the Reporting Period

The Departments also propose to amend paragraph (b)(1)(ii)(C) to specify that plans and issuers would be required to include in the Allowed Amount File allowed amounts and billed charges with respect to covered items or services furnished by out-of-network providers during the 6-month time period that begins nine months prior to the publication date of the file. This amendment would increase the reporting period from 90 days to six months and increase the lookback period from 180 days to nine months. By approximately doubling the reporting period from 90 days to six months and shifting the lookback period from 180 days to nine months, the Departments expect that more out-of-network claims for items and services would meet the required threshold for reporting requirements, meaning there would be more data to populate the Allowed Amount Files.

The Departments are particularly interested in feedback on the impact of the proposed amendment to the required reporting cadence (proposed to be quarterly as discussed in section III.C.10. of the preamble) on the proposed changes to the lookback period and in relation to the proposed reduction in in the number of claims. The Departments also seek comment on whether a potential duplication of out-of-network allowed amounts across multiple files would present any difficulties for the analysis of the data, such as calculating averages or annual amounts.

c. Aggregating Data by Requiring Reporting by Market Type

After consideration of comments, the Departments propose to amend the introductory language in paragraph (b)(1)(ii) to require plans and issuers to aggregate their allowed amount reporting at the health insurance market level. Specifically, under paragraph (b)(1)(ii), plans and issuers would be required to make available an Allowed Amount File for each health insurance market

in which a plan or coverage is offered. The Departments also propose to make conforming amendments in paragraphs (b)(1)(ii)(A) through (C) to indicate that each Allowed Amount File for a given health insurance market must include information aggregated across the coverage options offered by the plan or issuer in that market, rather than all coverage options offered by the plan or issuer. The Departments note that they are proposing special aggregation rules for self-insured group plans which are described in more detail in section III.C.11 of the preamble.

If this proposed amendment is finalized, the Departments anticipate a significant reduction in the overall number of Allowed Amount Files, and that this approach would further protect patient privacy because data aggregated across two or more plans or policies would not be directly associated with a single plan or policy. However, the Departments recognize that this approach may limit the ability of users to match a specific out-of-network allowed amount to a particular plan or policy. Despite this, the Departments have determined that the advantages of having more populated Allowed Amount Files at the market level would outweigh the drawbacks of missing plan-level data. The Departments seek comment on what additional information might be limited or lost by aggregating allowed amount and billed charges data by health insurance market type, and the potential importance of that information to price transparency. The Departments also invite comments more broadly on the proposal to require reporting of out-of-network allowed amount data by health insurance market type.

7. Contextual Files: Change-log, Utilization, Taxonomy, and Text

The 2020 final rule regulations at 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b) require plans and issuers to make available on a public internet website the disclosure of health care pricing information in MRFs, in accordance with specific manner and format requirements. In particular, the Departments require plans and issuers to disclose in-network provider rates, out-of-network allowed amounts and the associated billed charges and negotiated rates and historic net prices for prescription drugs. These requirements have contributed to a broader understanding of the data that drives plan and issuer payments for health care items and services, however, the Departments believe that additional context is necessary to promote a fuller understanding of health care industry pricing dynamics.

As a result, in this section of the proposed rule, the Departments propose to require plans and issuers to publicly disclose, through MRFs, additional contextual information that would help file users better understand the public disclosures required under paragraph (b)(1)(i). These files, which include a Change-log File, Utilization File, and Taxonomy File would contain information about the data within the In-network Rate and Allowed Amount Files. The Departments also propose to require a Text File to help users find the In-Network Rate, Allowed Amount, and prescription drug MRFs required under paragraph (b)(1) and new paragraph (b)(2) of this section. Specifically, the Departments propose to add new paragraphs (b)(2)(i) through (iv) requiring: a Change-log File at paragraph (b)(2)(i), a Utilization File at paragraph (b)(2)(ii), a Taxonomy File at paragraph (b)(2)(iii), and a Text File at paragraph (b)(2)(iv).

Under this proposal, plans and issuers would be required to prepare a Change-log File, a Utilization File, and a Taxonomy File for each In-network Rate File, and a single Text File to facilitate locating the other MRFs required under these proposed rules. To ensure this data can be

imported and read by a computer system directly, without reliance on proprietary software, and to promote standardization, these contextual files would also need to be machine-readable, in the form and manner as specified in guidance pursuant to proposed re-designated paragraph (b)(3)(i).

a. Change-log File

In order to better enable all file users in identifying changes to the required information in the In-network Rate File from one reporting period to the next, the Departments propose to require, in new 26 CFR 54.9815-2715A3(b)(2)(i), 29 CFR 2590.715-2715A3(b)(2)(i), and 45 CFR 147.212(b)(2)(i), that plans and issuers must make available, in a machine-readable format, a Change-log File for each In-network Rate File, that identifies any changes made to the required information in the In-network Rate File since the immediately preceding published In-network Rate File. The proposed Change-log File would be required to be posted on the first day of the calendar-year quarter following the date on which the first In-network Rate File would be required to be posted under proposed paragraph (b)(4)(i). Pursuant to the proposed requirement to publish the In-network Rate File described at (b)(1)(i) quarterly, the updated Change-log File would also be required to be published quarterly, indicating whether or not there were changes.

The Departments seek comment on:

- How the Change-log File can be most effective, including the MRF format in which it should be published.
- Whether any specific information should be required to be included, and if so, what information should be included in the Change-log File. For example, the Departments are interested in feedback from interested parties on *whether* the Change-log File should only identify the information in the file that has changed between one reporting to the next or if it should also identify *how* the specific information has changed since the last reporting.
- Whether there are particular data elements that, when changed, should not be captured in the Change-log File so as to maximize the usefulness of the reporting.
- The minimal level of change information necessary to create the desired efficiencies in light of the burden this requirement would pose on plans and issuers.

b. Utilization File

For reasons discussed in more detail in the proposed rule preamble, the Departments have determined that the Utilization File would provide important insights, both as a stand-alone dataset, as well as in combination with the In-network Rate File. Therefore, the Departments propose to require at new paragraphs 26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii), that plans and issuers must make available in a machine-readable format an annual Utilization File for each In-network Rate File specified under paragraph (b)(1)(i), that includes, for the 12-month period that ends six months prior to the publication of each Utilization File: items and services covered under the plans or policies included in the files prepared as specified in proposed amended paragraph (b)(1)(i) for which a claim has been submitted and reimbursed, in whole or in part, and each in-network provider

identified by the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code who was reimbursed, in whole or in part, for a claim for each covered item or service included as specified in paragraph (b)(2)(ii)(A) of this section.

The Departments explain that under this proposed requirement, plans and issuers would not be required to disclose the number of times that any given provider submitted a claim for any particular item or service, but rather only that a given provider submitted and was reimbursed, partially or in whole, for at least one claim for a covered item or service during the reporting period. Because this would limit the ability of the Utilization File to address some research questions that might be of interest to some stakeholders, the Departments request comment on:

- Whether the inclusion of the volume of items and services performed by an in-network provider would be a valuable addition to the Utilization File.
- Whether additional data elements, such as metrics analyzing a plan or overall percentage of providers with zero utilization for the lookback period should be included in order to make it easier for file users to examine provider network adequacy.
- The burden to plans and issuers to produce a Utilization File with claims volume and any additional metrics included in the files, as well as comments on how to mitigate these concerns.

The Departments are also proposing at 26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii), to require the Utilization File to include data for the 12-month period that ends six months prior to the publication date of each Utilization File, to allow for enough time for plans and issuers to complete the claims processing lifecycle including pre-claim submission, pre-claim payment, and payment determination and collection.

The Utilization File would be required to be updated and posted annually beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1). Plans and issuers would be required to update and post the Utilization File in accordance with the timing requirements proposed at redesignated paragraph (b)(4)(iv) and discussed in section III.C.10. of this preamble.

c. Taxonomy File

Based on comments received, the Departments have determined that it is necessary to give plans and issuers specific guidance for how to exclude provider-rate combinations for items and services for which the provider would not likely be reimbursed given their practice area of specialty, rather than leaving it to each plan and issuer to determine how to exclude such information. Accordingly, the Departments have determined that plans and issuers should be required to post their internal provider taxonomy mappings in the Taxonomy File.

The Departments propose at new 26 CFR 54.9815-2715A3(b)(2)(iii), 29 CFR 2590.715-2715A3(b)(2)(iii), and 45 CFR 147.212(b)(2)(iii), to require plans and issuers to make available, in a machine-readable format, a Taxonomy File that includes the plan or issuer's internal provider taxonomy, which maps items and services (represented by a billing code) to provider specialties (represented by specialty code as established by the NUCC) to determine if the plan

or issuer should deny reimbursement for an item or service because it was not furnished by a provider in an appropriate specialty. The Taxonomy File would be required to include the plan or issuer's internal provider taxonomy mappings and would be required to be published in the form and manner specified in proposed redesignated paragraph (b)(3) and discussed in section III.C.9. of the preamble. Additionally, and as discussed in section III.C.10. of the preamble, the Departments would require plans and issuers to post an updated Taxonomy File quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1). If there are no changes to the taxonomy that affect the information required in the MRF required under (b)(1)(i) in a subsequent quarter, the posted Taxonomy File would not be required to be updated for that quarter.

The Departments solicit comment on the Taxonomy File proposal, including whether there are provider taxonomy code sets commonly used by plans and issuers other than the ones established by the NUCC, or if there are other commonly used processes for plans and issuers to determine which providers should be reimbursed for which types of items and services, based on specialty, and which providers should not. The Departments also seek comment on how frequently plans and issuers update their internal taxonomy used during the claims adjudication process.

d. Text File

The Departments have observed and received feedback from interested parties that locating the files on a plan's or issuer's website can be difficult. In considering how to improve both automated and non-automated access to the MRFs, the Departments have determined it is appropriate to require a standardized Text File at a consistent location which would provide a direct link to the MRFs as opposed to the current approach of having to locate the correct web page within the website. If a plan or issuer does not have a website, they can satisfy this requirement by entering into a written agreement under which another party (such as a third-party administrator (TPA)) posts the Text File in the root folder on its public website on behalf of the plan or issuer pursuant to proposed paragraph (b)(3)(iv). Further, the Departments also received feedback regarding the difficulty of contacting plans and issuers to alert them to problems with their MRFs or to ask for additional information or clarifying context. Contact information for someone at the plan or issuer who is familiar with the details of the MRFs would allow the public to reach out for assistance with accessing or utilizing the MRFs.

The Departments therefore propose to add paragraphs 26 CFR 54.9815-2715A3(b)(2)(iv), 29 CFR 2590.715-2715A3(b)(2)(iv), and 45 CFR 147.212(b)(2)(iv), requiring plans and issuers to post a plain text file in .txt format (Text File) in the root folder (the top-level directory on an electronic file system) of a plan's or issuer's website that includes: 1) the source page URL for the internet website that hosts MRFs required under paragraphs (b)(1) and (2); 2) a direct link to the URL for the MRFs required under paragraphs (b)(1) and (2); and 3) point-of-contact information including an up-to-date name, title, and email address for an individual who can address inquiries and issues related to the MRFs required under paragraphs (b)(1) and (2). This contact information must be prominently displayed on the same website where the MRFs are made available and be kept updated per the requirements in paragraph (b)(4)(vi) of this section. As discussed in section III.C.10. of this preamble, the Departments propose to add paragraph (b)(4)(vi) to require plans and issuers to post a Text File beginning on the first day of the

calendar-year quarter following the applicability date under paragraph (c)(1) and subsequently update the Text File as soon as practicable but not later than seven calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section.

The Departments are proposing these new requirements in accordance with Executive Order 14221 and in alignment with the Hospital Price Transparency regulations.

The Departments request comment, in particular, on whether the Departments should issue guidance regarding whether any standards are required to ensure that the identified point-of-contact for plans and issuers is responsive to inquiries submitted by file users (such as a timeline to respond to inquiries or designated hours of availability for phone contact, and, if so, the recommended timeline and designated hours) or whether additional forms of contact (such as a physical address) are necessary.

8. File Format

The 2020 final rules at 26 CFR 54.9815-2715A3(b)(2), 29 CFR 2590.715-2715A3(b)(2), and 45 CFR 147.212(b)(2) (which the Departments are proposing to redesignate as paragraph (b)(3) per section III.C.9. of this preamble) state that the MRFs described in paragraph (b) must be available in the form and manner as specified in guidance issued by the Departments and must be publicly available and accessible free of charge and without conditions. The Departments are not proposing any changes to the required format for disclosing information under paragraph (b).

After more than three years since the publication of the 2020 final rule's MRF requirements, the Departments have had time to analyze the landscape of plan and issuer file format use in published MRFs and discusses the viability, benefits, and drawbacks of various file formats in the proposed rule preamble. The Departments note that, based on internal analysis, over 90 percent of plans and issuers have chosen to use JSON format, although some interested parties prefer to work with CSV format. To advance the goals in section 3(b) of Executive Order 13877 to ensure pricing information is standardized and easily comparable across health plans, the Departments are now considering indicating in either rulemaking or technical implementation guidance that the MRFs required under paragraph (b)(1) must be published in a standard non-proprietary open format, as well as specifying the particular file format through technical implementation guidance. The Departments seek comment on this issue.

Additionally, in recognition of the developments of electronic data transfer systems since the publication of the 2020 final rule and in anticipation of future developments of new technologies, the Departments seek comment on whether the required information in paragraphs (b)(1) and (2) should be required to be disclosed through an electronic data transfer technology, such as a publicly accessible API, as well as what standards should apply. The Departments also seek comment on whether the use of a standards-based API would benefit consumers, developers of consumer-facing applications, and other entities seeking to access this data.

9. Required Method and Format for Disclosing Information to the Public

The 2020 final rule regulations at 26 CFR 54.9815-2715A3(b)(2), 29 CFR 2590.715-2715A3(b)(2), and 45 CFR 147.212(b)(2) require plans and issuers to make the MRFs described in paragraph (b) of that section available and accessible to any person on a public website in a form and manner as specified in guidance issued by the Departments. Plans and issuers have flexibility to publish the files in the locations of their choosing based upon their knowledge of their website traffic and the places on their website where the MRFs would be readily accessible by the intended users. As discussed in section III.C.7. of the preamble, the Departments have observed and received feedback from interested parties that locating the files on a plan's or issuer's website can be difficult and that there are occasional obstacles to automated and human access.

Therefore, the Departments propose to add paragraph (iii) to redesignated paragraph (b)(3)[11] to require that the source page URL for the internet website that hosts the MRFs required by paragraph (b)(1) and new paragraph (b)(2) must be included as a link in the footer on the home page of the group health plan's or health insurance issuer's website, as well as any page of the website that features a footer, that is labeled "Price Transparency" or "Transparency in Coverage" and links directly to the publicly available web page that hosts the link to the MRFs. Additionally, the Departments propose to amend redesignated paragraph (b)(3)(ii) to ensure that the MRFs remain publicly accessible to automated scripts and web crawlers as well as human users and that blocking server configurations or firewalls cannot be used to impede access.

The Departments also propose to add paragraph (iv) at redesignated 26 CFR 54.9815-2715A3(b)(3), 29 CFR 2590.715-2715A3(b)(3), and 45 CFR 147.212(b)(3), allowing a group health plan or health insurance issuer to satisfy the disclosure requirements of paragraph (b)(3)(iii) by entering into a written agreement under which another party posts the MRFs on its public website on behalf of the plan or issuer. If the files are hosted on a service provider's website, and the plan or issuer does maintain a public website and chooses not to also post the files separately on its own public website, it must provide a link on its own public website to the location where the files are made publicly available. This requirement applies to a public website maintained by the plan or issuer and does not apply to a public website maintained by an employer or plan sponsor.

The Departments also propose to require that the proposed method and format requirements for disclosing information to the public would apply to both the MRFs under paragraph (b)(1) and the proposed contextual MRFs under new paragraph (b)(2).

Table 2, reproduced from the preamble of the proposed rule, summarizes the technical guidance documents that the Departments expect to publish pursuant to the finalization of these proposed rules. The Departments encourage interested parties to submit all questions and issues related to technical guidance on GitHub, as it enables a centralized response and helps to efficiently identify and address common concerns across interested parties.

TABLE 2: Potential Guidance Documents Following Finalization of Proposed Rules

[11] As discussed in section III.C.7. of the preamble, the Departments propose to redesignate paragraphs (b)(2) through (3) of 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212 as paragraphs (b)(3) and (4), respectively.

Guidance Document	Potential Issuance Date	Purpose
Schema 3.0 FAQ	Approximately three months post-finalization	Announcing the timeline for developing and finalizing technical implementation requirements for Schema 3.0 following the finalization of the new Transparency in Coverage final rules.
Draft schema examples	Approximately three months post-finalization	Draft parameters for the data attributes and the reporting structure to meet the new Schema 3.0 requirements.

10. Timing

The Departments have received feedback from both producers and users of the MRFs recommending reducing the reporting frequency to quarterly, to help lower data storage and hosting costs, decrease bandwidth needs, and reduce ongoing maintenance expenses. A reduced reporting cadence may also provide more time to analyze the data. After consideration, with respect to the In-network Rate Files and Allowed Amount Files under paragraph (b)(1)(i) and (ii), the Departments propose to amend the publication frequency under new paragraph (b)(4)(i), from a requirement to post monthly to quarterly. The Departments are not proposing to change the monthly reporting cadence for the prescription drug MRF under paragraph (b)(1)(iii) in proposed paragraph (b)(4)(ii). The Departments request comment on the benefits, drawbacks, and potential impact of the proposed change in reporting cadence for the In-network Rate Files. The Departments have also determined there would be no loss in data value by changing the reporting cadence from monthly to quarterly for the Allowed Amount File under paragraph (b)(1)(ii) since the data represents a historical snapshot that would continue to be captured in its entirety. The Departments seek comment on the potential impact of the proposed change in reporting cadence for the Allowed Amount File.

The Departments also propose to add disclosure timing requirements for the new contextual MRFs under new paragraph (b)(2) as follows:

Change-log File. Under this proposal, plans and issuers would be required to update the Change-log File on the same day as each In-network Rate File is required to be updated, except for the first In-network Rate File for which there would be no changes to report. The Departments propose to require that if there are no changes to an In-network Rate File since it was updated last, a Change-log File would still be required to be posted at that time indicating there are no changes for that quarter.

Utilization File. The Departments propose to require that the Utilization File be updated and posted every 12 months after the initial posting. The Utilization File would be required to be initially posted on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) and annually on the same date thereafter. The Departments have determined that an annual cadence for this file is sufficient to illustrate provider reimbursement for corresponding items and services and appropriately balances the benefit of having recent historical data with the burden on plans and issuers to extract data from their claims systems annually.

Taxonomy File. The Departments also propose to require that plans and issuers update the Taxonomy File prepared pursuant to proposed paragraph (b)(2)(iii) and post such file beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1). If there are no changes to the taxonomy that impact the information required to be included in the In-network Rate File from one quarter to the next, the posted Taxonomy File would not be required to be updated.

Text File. The Departments also propose to require that the Text File required under proposed paragraph (b)(2)(iv) of this section be initially posted on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) and updated and posted as soon as practicable but no later than seven calendar days following a change in any of the information required under paragraph (b)(2)(iv). The Departments request comment on whether the proposed seven calendar days provides sufficient time for plans and issuers to make the required update.

The Departments note that the first MRFs prepared based upon these proposed rules would be required to be disclosed 12 months after the publication of the final rules (as proposed, January 1, 2027). These proposed rules also specify the timing for each MRF to be updated thereafter and example dates are shown in Table 3 (reproduced from the proposed rule).

TABLE 3: Example Initial and Subsequent File Disclosure Timing Requirements

	Example Final Rule Publication Date	Example Applicability Date	Example Initial Disclosure Date	Example Subsequent Disclosures Dates
In-network Rate File (quarterly)	October 15, 2026	October 15, 2027	January 1, 2028	April 1, 2028; July 1, 2028; October 1, 2028, *etc.*
Allowed Amount File (quarterly)	October 15, 2026	October 15, 2027	January 1, 2028	April 1, 2028; July 1, 2028; October 1, 2028, *etc.*
Change-log File (quarterly)	October 15, 2026	October 15, 2027	April 1, 2028	July 1, 2028; October 1, 2028; January 1, 2029, *etc.*
Utilization File (annually)	October 15, 2026	October 15, 2027	January 1, 2028	January 1, 2029, January 1, 2030, *etc.*
Taxonomy File	October 15, 2026	October 15, 2027	January 1, 2028	Quarters when there are updates
Text File	October 15, 2026	October 15, 2027	January 1, 2028	Within 7 days of any updates

11. Special Rules to Prevent Unnecessary Duplication

The Departments propose in 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212 to redesignate and amend paragraph (b)(4)(iii), which permits aggregation of out-of-

network allowed amounts in certain circumstances, as paragraph (b)(5)(iv) and to add new paragraph (b)(5)(iii) to include similar permissions with respect to in-network rates.

In new paragraph (b)(5)(iii), the Departments propose, under certain conditions, to allow self-insured group health plans to permit another party (pursuant to a contract) to make available in a single In-network Rate File, the information required under paragraph (b)(1)(i) for multiple plans, insurance policies, and contracts, including those offered by different plan sponsors with which the other party contracts and across markets that share the same provider network.

Similarly, in redesignated paragraph (b)(5)(iv), the Departments propose amendments that would allow, under certain conditions, self-insured group health plans to permit another party (pursuant to a contract) to make available in a single Allowed Amount File the information required under paragraph (b)(1)(ii) for more than one self-insured group health plan, including those offered by different plan sponsors with which the other party contracts. The Departments also propose: (1) to require that the minimum claims threshold apply across multiple self-insured group health plans whose information is included in a single Allowed Amount File, as described in proposed paragraph (b)(5)(iv), rather than for each such individual self-insured group health plan, and (2) to revise the minimum claims threshold to 11-claims in accordance with proposed paragraph (b)(1)(ii)(C). Lastly, the Departments propose amendments to better organize and streamline requirements in redesignated paragraph (b)(5)(iv) which do not affect any substantive rights or obligations.

a. Special Rule for Self-insured Group Health Plans with Respect to the Disclosure of In-network Rate Files

As discussed in section III.C.1 of this preamble, the Departments propose to amend paragraph (b)(1)(i) to require plans and issuers to make an In-network Rate File available for each provider network maintained or contracted by the plan or issuer. Under this proposal, each self-insured group health plan would be required to make available an In-network Rate File for each provider network it maintains. For self-insured group health plans that are administered by the same service provider and use the same provider network, this approach would require duplicate In-network Rate Files that include the same negotiated rates under the same provider network for each self-insured group health plan using that network. Therefore, to further the goals of reducing duplicative rates and simplifying analysis for file users, the Departments propose in paragraph (b)(5)(iii) to permit and encourage self-insured group health plans to allow another party with which they contract, such as a service provider, to make available an In-network Rate File for each provider network used by more than one self-insured plan.

Further, the Departments propose that these In-network Rate Files may include information about plans, insurance policies, and contracts across health insurance markets. Such a service provider, when acting as a health insurance issuer, would already be required under the Departments' proposed amendments to paragraph (b)(1)(i) to disclose an In-network Rate File for that provider network that includes negotiated rate information for the fully-insured group health plans it offers across the small group and large group markets, as well as any individual policies it offers in the individual market, to the extent those plans or policies use that same provider network. Under new paragraph (b)(5)(iii), a self-insured group health plan could permit

its service provider to include plans and coverage offered in different health insurance markets in the same In-network Rate File, to the extent they use the same provider network. If this In-network Rate File includes the required rates for individual and group health insurance coverage offered by the issuer, the issuer would also be considered to comply with the Departments' proposed amendments to paragraph (b)(1)(i).

The Departments also propose to include two conditions on the applicability of the special rule for self-insured group health plans with respect to the disclosure of the In-network Rate File. First, in new paragraph (b)(5)(iii)(A), the Departments propose that a self-insured group health plan may only avail itself of the special rule described in (b)(5)(iii) if each In-network Rate File made available for a provider network includes information for all covered items and services under each plan, insurance policy, or contract that uses the same provider network for which the In-network Rate File is made available, consistent with the requirements for disclosing rate information under proposed (b)(1)(i). Second, in new paragraph (b)(5)(iii)(B), the Departments propose that a self-insured group health plan may only use the special rule described in (b)(5)(iii) if each proposed Change-log, Utilization, and Taxonomy File include data from the same plans, insurance policies, or contracts (including those offered by different plan sponsors and across different health insurance markets, if applicable) that are represented in the corresponding In-network Rate File. Under this proposal, a self-insured group health plan that contracts with another party that takes advantage of the special rule would not be permitted to publish (either itself or by contracting with another party) the corresponding Change-log, Utilization, and Taxonomy Files only with respect to its own plans.

b. Special Rule for Self-insured Group Health Plans with Respect to the Disclosure of Out-of-network Allowed Amount Files

For reasons described in more detail in the preamble of the proposed rule, the Departments have determined that allowing aggregation of allowed amount data only across self-insured group health plans offered by different plan sponsors maintains the market division grouping necessary to make the data more actionable for research and analysis as discussed in section III.C.6 of this preamble. As such, proposed paragraph (b)(5)(iv) states that a self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) may permit such other party to make available the information required under paragraph (b)(1)(ii) in a single out-of-network Allowed Amount File for more than one self-insured group health plan, including those offered by different plan sponsors with which the other party contracts. This would mean that a self-insured group health plan may permit their service provider or other party with which they contract to include their required allowed amount and billed charges information in a single Allowed Amount File along with allowed amount and billed charges information from more than one self-insured group health plan, including those offered by different plan sponsors (that is, in different health insurance markets). Therefore, the Departments propose to limit the application of redesignated paragraph (b)(5)(iv) to self-insured group health plans; allowed amounts and billed charges from fully-insured group health plans or individual market coverage must not be included.

As discussed in section III.C.6. of this preamble, the Departments now propose in paragraph (b)(1)(ii)(C) to lower the claims threshold from 20 to 11 and apply it at the health insurance

market level, rather than the individual plan or policy level. For consistency in the application of the claims threshold, the Departments propose in new paragraph (b)(5)(iv) that in order for a self-insured group health plan to take advantage of the special rule under paragraph (b)(5)(iv), the proposed 11-claim threshold must be applied to the aggregated data set. Applying the threshold to aggregated data, especially when aggregated across multiple self-insured group health plans offered by different plan sponsors, would likely increase the amount of allowed amount data available because more services would likely exceed the 11-claim threshold.

Finally, the Departments propose to revise the paragraph heading for redesignated paragraph (b)(5)(iv) to better describe the proposed requirements in this paragraph.

c. Better Organizing Existing Requirements

Currently, nothing prevents the Allowed Amount File from being hosted on a third-party website or prevents a plan administrator or issuer from contracting with a service provider to post the file, but that if a plan or issuer chooses not to also host the file separately on its own website, it must provide a link on its own public website to the location where the file is made publicly available. The Departments propose a technical revision to move this language to new paragraph (b)(3)(iv) which it believes is a more appropriate place for requirements concerning the method and format for disclosing information to the public.

12. Applicability

The Departments propose to require under paragraph (c)(1) that the proposed amendments to the provisions of paragraph (b) of 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212 apply 12 months following the date of publication of the final regulations in the *Federal Register*. The Departments are proposing this applicability date to ensure that all plans and issuers begin following the updated set of technical requirements at the same time. Until such time, the current provisions of paragraph (b) continue to apply.

The Departments seek comment on this proposed applicability date, including whether 12 months following publication of final regulations provides enough time for plans and issuers to comply with the amended provisions of paragraph (b) and whether there are particular challenges in complying with such applicability date compared to an applicability date based on plan or policy year.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), the Departments are required to provide notice in the *Federal Register* and solicit comment before a collection of information request (ICR) is submitted to OMB for review and approval. These proposed rules contain ICRs that are subject to review by OMB. In this section, in accordance with requirements of section 3506(c)(2)(A) of the PRA, the Departments solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of an agency, including whether the information shall have practical utility.

- The accuracy of the Departments' estimate of the information collection burden, including the validity of the methodology and assumptions used.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Based on their respective jurisdiction over issuers and TPAs, HHS is estimated to account for 50 percent of the total burden, while the Departments of Labor and the Treasury would each account for 25 percent.

In the proposed rule preamble, the Departments address the estimated collection of information burden hours and costs associated with each of the proposed requirements. Table 35 in the proposed rule preamble summarizes the estimated annual burden hours and costs associated with the proposed requirements for all issuers and TPAs (which totals 1,407,440 annual burden hours and $68,201,320) while Table 36 summarizes the estimated one-time burden hours and costs associated with the proposed requirements for all issuers and TPAs (which totals 6,699,463 annual burden hours and $913,710,577).

V. Responses to Comments

The Departments will consider all comments received by the date and time specified in the "DATES" section of the preamble, and, when the Departments proceed with a subsequent document, the Departments will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

The Departments examined the impacts of the proposed rules as required by statute and Executive Orders noted in the proposed rule preamble. The Departments have concluded that the rule is likely to be a "significant regulatory action" based on likely economic impacts of $100 million or more in at least one year.

The Departments summarize the number of plans, issuers, and participant, beneficiaries and enrollees that would be affected by the proposed rules. The required accounting table – Table 37 – depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with the proposed regulatory actions.

Table 37: Accounting Table

Benefits				
Category	**Estimate**	**Year Dollar**	**Discounted Rate**	**Period Covered**
Annualized Monetized ($year)	$257,046,000	2025	3 percent	2027–2031
Annualized Monetized ($/year)	$257,046,000	2025	7 percent	2027-2031
Quantified Benefits				

- Approximately $11.2 million per year in reduced data cleaning and integration, and quarterly reporting reduction costs for third-party developers and other file users.
- Approximately $73 million per year in storage reductions and quarterly reporting for plans, issuers, third-party developers, and other file users.
- Approximately $171.1 million per year in egress and quarterly reporting reduction costs for plans and issuers.
- Approximately $1.4 million per year in reduced time for third-party developers and other file users locating files by requiring a Text file and footer links to help file users more easily find the data.

Non-Quantified Benefits

- Increases transparency of financial obligations, including coinsurance, copayments, deductibles, out-of-pocket limits, and potential balance billing.
- Helps participants, beneficiaries, and enrollees make more informed financial and health care decisions with clearer cost estimates, particularly those individuals with low computer literacy who may not be able to access the online tool.
- Promotes cost-conscious decision-making by giving participants, beneficiaries, and enrollees information to compare provider prices, so they can weigh cost alongside other important factors such as location, reputation, or quality when selecting care.
- Facilitates timely medical bill payments by giving participants, beneficiaries, and enrollees a clearer understanding of expected costs in advance.
- Fosters provider competition and potential cost savings as participants, beneficiaries, and enrollees use pricing information to shop for health care.
- Improves regulatory oversight by providing better data for assessing premium rates and tracking price trends.
- Improves data usability through standardized file requirements, enabling more effective analysis for file users and developers, as well as for academic researchers and policymakers to study health care costs.
- Helps plans and issuers negotiate more competitive rates by giving them clearer, more detailed pricing information.

Costs

Category	Low Estimate	High Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/year)	$232,091,961	$261,903,1 47	2025	3 percent	2027-2031
Annualized Monetized ($/year)	$246,565,891	$276,468,1 49	2025	7 percent	2027-2031

Quantified Costs

- Ongoing annual costs to plans and issuers for making pricing information available vis phone are estimated at $23,400,000 on the low end and $52,000,000 on the high end.
- One-time costs to update cost-sharing disclosure reflecting federal balance billing protections are estimated at $37,657.
- One-time costs to plans and issuers to train customer service representatives and supervisors to provide cost-sharing information via phone are estimated at $13,727,040.
- One-time costs to plans and issuers to organize In-network Rate Files by provider network are estimated at $43,810,240.
- One-time costs to plans and issuers to include product type in both the In-network Rate and Allowed Amount Files are estimated at $7,141,600.

• One-time costs to plans and issuers to report dollar amounts except for only "percent-of-billed charges" payments are estimated at $1,428,320 on the low end and $7,141,600 on the high end.
• One-time costs to plans and issuers to disclose enrollment data are estimated at $7,141,600.
• One-time costs to plans and issuers to exclude certain providers from In-network Rate Files are estimated at $42,849,600.
• One-time costs to plans and issuers to aggregate Out-of-Network Allowed Amount files by market type and allow service providers and other parties to aggregate by market type across multiple self-insured group health plans are estimated at $14,283,200.
• One-time costs to plans and issuers to add a Change-log File related to the In-network Rate File disclosures are estimated at $133,361,480.
• One-time costs to plans and issuers to develop processes to implement the Utilization File are estimated at $638,958,320.
• Ongoing annual costs to implement the disclosures required for the Utilization File are estimated at $9,186,120.
• One-time costs to plans and issuers to add a Text File to improve discoverability and accessibility of MRFs is estimated at $5,258,240.
• Ongoing annual costs to plans and issuers to respond to MRF inquiries estimated at $7,015,200.
Non-Quantified Costs
• Potential increase in health care costs due to price convergence, as greater transparency may lead lower-cost providers to raise prices.
• Potential decrease in providers' willingness to offer discounted rates, especially in narrow networks, due to public disclosure of negotiated prices.
• Increase in difficulty for smaller issuers to sustain competitive provider networks, potentially impacting compliance with network adequacy standards.
• Potential increase in risk of PHI and PII breaches, requiring investment in enhanced privacy and cybersecurity measures.
• Potential increase in state regulators' costs for monitoring and enforcing compliance with new federal requirements.
Transfers
Non-Quantified Transfers
• Potential transfer from higher-cost to lower-cost providers through market share shifts as participants, beneficiaries, and enrollees switch to providers offering more competitive pricing.
• Potential transfer from providers to participants, beneficiaries, and enrollees as a result of increased price transparency through lower out-of-pocket costs if consumers select lower-cost providers.
• Potential transfer from plans and issuers to consumers, participants, beneficiaries, and enrollees if increased price transparency leads to systemic shifts toward lower-cost providers and overall reductions in health care spending, which could eventually translate to decreased premiums.
• Potential transfer from PTC-eligible consumers to the federal government if there is a reduction in premiums, as a result of increased price transparency, and a subsequent reduction in PTC spending.

• Potential transfer from consumers, participants, beneficiaries, and enrollees to providers if price transparency results in price convergence, leading lower-cost providers to raise their prices to align with higher-cost competitors and thereby increasing out-of-pocket costs.
• Potential transfer from consumers, participants, beneficiaries, and enrollees to plans and issuers if providers raise their prices, as a result of price convergence, leading to increased premiums.
• Potential transfer from the federal government to PTC-eligible consumers if there is an increase in premiums, as a result of the provision in these rules or price convergence effects, and a subsequent increase in PTC spending.

Summary tables, reproduced from the proposed rule include:

Table 1a: Summary of Annual Costs

Provision Description	Annual Cost ($)
Information Collection Requests (ICRs) Regarding Requirements for Disclosures to Participants, Beneficiaries, or Enrollees Under 26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211*	$52,000,000
ICRs Regarding Requirements to Implement the Disclosures Required for the Utilization File (26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii))	$9,186,120
ICRs Regarding Requirements to Respond to MRF Inquiries (26 CFR 54.9815-2715A3(b)(2)(iv), 29 CFR 2590.715-2715A3(b)(2)(iv), and 45 CFR 147.212(b)(2)(iv))	$7,015,200
Total	**$68,201,320**

* High-end 3-year estimated values are represented in the table and used to determine the overall estimated 3year average.

Table 1b: Summary of One-time Costs

Provision Description	Total Cost ($)
ICRs Regarding Requirements to Update Cost-Sharing Disclosure Reflecting Federal Balance Billing Protections (26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211)	$37,657
To Train Customer Service Representatives and Supervisors to Provide Cost-Sharing Information for ICRs Regarding Requirements for Disclosures to Participants, Beneficiaries, or Enrollees to Provide Pricing Information via Phone (26 CFR 54.9815-2715A2, 29 CFR 2590.715-2715A2, and 45 CFR 147.211*)	$13,727,040
ICRs Regarding Requirements to Organize Files by Provider Network, Allow Service Providers or Other Parties to Organize by Provider Network across Multiple Self-insured Group Health Plans (26 CFR 54.9815-2715A3(b)(1)(i) and (b)(5)(iii), 29 CFR 2590.7152715A3(b)(1)(i) and (b)(5)(iii), and 45 CFR 147.212(b)(1)(i) and (b)(5)(iii))	$43,810,240
ICRs Regarding Requirements to Include Product Type in Both In-network Rate and Allowed Amount Files (26 CFR 54.9815-2715A3(b)(1)(i)(B) and (b)(1)(ii)(A), 29 CFR 2590.715-2715A3(b)(1)(i)(B), and (b)(1)(ii)(A), and 45 CFR 147.212(b)(1)(i)(B) and (b)(1)(ii)(A))	$7,141,600

ICRs Regarding Requirements to Report Dollar Amounts Except for Only "Percentage-of-Billed Charges" Payments (26 CFR 54.9815-2715A3(b)(1)(i)(D)(*1*), 29 CFR 2590.7152715A3(b)(1)(i)(D)(1), and 45 CFR 147.212(b)(1)(i)(D)(1)) *	$7,141,600
ICRs Regarding Requirements to Report Required Enrollment Data (26 CFR 54.9815-2715A3(b)(1)(i)(E), 29 CFR 2590.715-2715A3(b)(1)(i)(E), and 45 CFR 147.212(b)(1)(i)(E))	$7,141,600
ICRs Regarding Requirements to Exclude Certain Providers from In-network Rate Files (26 CFR 54.9815-2715A3(b)(1)(i)(F), 29 CFR 2590.715-2715A3(b)(1)(i)(F) and 45 CFR 147.212(b)(1)(i)(F))	$42,849,600
ICRs Regarding Requirements to Aggregate Allowed Amount Files by Market Type and Allow Service Providers or Other Parties to Aggregate by Market Type across Multiple Self-insured Group Health Plans (26 CFR 54.9815-2715A3(b)(1)(ii), 29 CFR 2590.715-2715A3(b)(1)(ii), and 45 CFR 147.212(b)(1)(ii) and Permit Such Aggregation at the Third-Party Administrator (TPA) Level (26 CFR 54.9815-2715A3(b)(5)(iv), 29 CFR 2590.7152715A3(b)(5)(iv), and 45 CFR 147.212(b)(5)(iv))	$14,283,200
ICRs Regarding Requirements to Add a Change-log File Related to the In-network Rate File Disclosures (26 CFR 54.9815-2715A3(b)(2)(i), 29 CFR 2590.715-2715A3(b)(2)(i), and 45 CFR 147.212(b)(2)(i))	$133,361,480
ICRs Regarding Requirements to Implement the Utilization File (26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii))	$638,958,320
ICRs Regarding Requirements to Add a Text File and Identify Point-of-Contact for Inquiries to Improve Discoverability and Accessibility of MRFs (26 CFR 54.9815-2715A3(b)(2)(iv), 29 CFR 2590.715-2715A3(b)(2)(iv), and 45 CFR 147.212(b)(2)(iv))	$5,258,240
Total	**$913,710,577**

* High-end 3-year estimated values are represented in the table and used to determine the overall estimated 3-year average.

Table 1c: Summary of Annual Benefits

Provision Description	**Annual Benefits ($)**
For third-party developers and other file users: ICRs Regarding (1) Requirements to Reduce Data Cleaning Computational Costs (26 CFR 54.9815-2715A3(b)(1)(i)(F), 29 CFR 2590.715-2715A3(b)(1)(i)(F) and 45 CFR 147.212(b)(1)(i)(F)), and (2) Changing Timing Requirements MRFs Reporting from Monthly to Quarterly (26 CFR 54.9815-2715A3(b)(4), 29 CFR 2590.715-2715A3(b)(4), and 45 CFR 147.212(b)(4))	$11,162,400
For plans, issuers, third-party developers, and other file users: ICRs Regarding (1) Requirements to Reduce Storage Costs (26 CFR 54.9815-2715A3(b)(1)(i)(F), 29 CFR 2590.715-2715A3(b)(1)(i)(F) and 45 CFR 147.212(b)(1)(i)(F)), and (2) Changing Timing Requirements for MRFs Reporting from Monthly to Quarterly (26 CFR 54.9815-2715A3(b)(4), 29 CFR 2590.715-2715A3(b)(4), and 45 CFR 147.212(b)(4))	$73,317,600

For plans and issuers: ICRs Regarding (1) Requirements to Reduce Network Egress Costs (26 CFR 54.9815-2715A3(b)(1)(i)(F), 29 CFR 2590.715-2715A3(b)(1)(i)(F) and 45 CFR 147.212(b)(1)(i)(F)), and (2) Changing Timing Requirements for MRFs Reporting from Monthly to Quarterly (26 CFR 54.9815-2715A3(b)(4), 29 CFR 2590.715-2715A3(b)(4), and 45 CFR 147.212(b)(4))	$171,126,000
For third-party developers and other file users: ICRs Regarding Requirements to Reduce Time Locating Files by Requiring a Text File and Footer Links to Quickly Find MRFs (26 CFR 54.98152715A2(b)(2)(iv) and (b)(3)(iii), 29 CFR 2590.715-2715A2(b)(2)(iv) and (b)(3)(iii), and 45 CFR 147.212(b)(2)(iv) and (b)(3)(iii))	$1,440,000
Total	**$257,046,000**