CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

February 23, 2026

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

Submitted electronically via regulations.gov

RE: CMS-9882-P: Transparency in Coverage

Dear Administrator Oz,

On behalf of *Consumers First*, an alliance that brings together the interests of consumers, employers, labor unions, and primary care clinicians working to realign and improve the fundamental economic incentives and design of our health care system, we appreciate the opportunity to provide comment on the Transparency in Coverage rule. *Consumers First* seeks to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone, and transparency in health coverage is foundational to that goal.

For the two-thirds of Americans who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans, and based on which organization has more market power.[1] These health care prices—referred to as negotiated rates—are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[2] This lack of transparency is alarming, particularly given that high and rising health care prices are the primary driver of our nation's health care affordability crisis.[3]

In 2021, CMS released the Transparency in Coverage (TiC) rule, requiring commercial insurers to publicly disclose in-network and out-of-network payment rates. This rule marked a significant step in driving higher value care in the U.S. health care system by beginning to unveil the actual prices of health care services for the first time. Standardized, accurate, and accessible in-network and out-of-network rates are central to the provision of affordable, cost-effective care. Despite the important steps this rule took to drive price transparency into the health care system, additional improvements to the rule are needed to reach meaningful price transparency.

***Consumers First* supports CMS' efforts to improve the quality and accessibility of TiC data and implores the administration to take further steps to ensure TiC and Hospital Price**

Transparency data empowers consumers, researchers, policymakers, and other purchasers with critical information to rein in prices and improve health care quality for our nation's families.

Our comments are focused on the following areas of the proposed rule:

- **III.C.1** Provider Network Level Reporting for the In-Network Rate Files
- **III.C.3**. Percentage-of-Billed-Charges Arrangements
- **III.C.7** Contextual Files: Change-log, Utilization, Taxonomy, and Text

III.C.1 Provider Network Level Reporting for the In-Network Rate Files

Consumers First **strongly supports efforts to streamline and improve TiC data by requiring insurers to post their in-network rates by provider network.** In the Transparency in Coverage proposed rule CMS proposes to require health insurers to publish an in-network file for each provider network maintained or contracted by the insurer. This proposed change is intended to reduce the size and total number of in-network rate files in order to align TiC data reporting with Hospital Price Transparency rules and make the files easier to analyze. Importantly, the proposal would still require insurers to identify each plan that uses a given provider network so file users can identify the rates for a particular plan.

Currently, the TiC rules require insurers to publish a machine-readable file (MRF) that discloses in-network rates for *each* plan or contract, with some flexibility to link common negotiated rates across multiple plans and in-network files using a common table of contents. While this may be reflective of a well-intentioned attempt to get a detailed and comprehensive array of data, because many plans under the same insurer share the same provider network and negotiated rates, these existing reporting guidelines have actually resulted in unnecessarily large TiC data files with excessive duplication of pricing information. This makes the data difficult for policymakers, researchers, and advocates to access or use.[4] For example, in the 2024 TiC files, UnitedHealthcare included detailed pricing for 51,000 plans but maintained only 5,126 networks, indicating significant duplication.[5] In fact, researchers estimate that close to half of all pricing files could be duplicates, contributing to massive and unmanageable file sizes.[6] While the MRFs are technically available to anyone, the volume of the data requires specialized computer processing systems and programs to access and analyze it, rendering the data inaccessible for anyone who does not have sufficient resources, technology and expertise.[7]

By requiring insurers to post their in-network rates by provider network, CMS is taking an important step to make the TiC files more reasonably sized and usable. This change would also make it easier for researchers, academics, and purchasers to isolate price variation across providers, specialists, and geographic areas without needing to account for duplicative pricing information across multiple, separately reported plans.[8]

III.C.3. Percentage-of-Billed-Charges Arrangements

CMS must require insurers to post applicable rates in dollars and cents. In the Transparency in Coverage proposed rule, CMS proposes to codify previous sub-regulatory guidance that allows insurers to post their negotiated rates as a "percentage-of-billed-charges" rather than a dollars and cents format.[9] **Posting negotiated rates as a percentage of billed charges directly undermines the intended purpose of achieving price transparency because it is not the actual price of the service.**

In some contractual agreements between payors and providers, health plans agree to pay providers a set percentage of the gross charges, or the chargemaster price, for each service rendered. [10] These rates are typically not calculated until after the service bill has been generated. This means, if an insurer agreed to pay 80% of a service's gross charge, they were allowed to disclose the percentage value of "80" in the negotiated rate field rather than the actual price.[11] To calculate the actual negotiated rate–or price–of a service from the percentage-of-billed-charges, stakeholders would have to cross reference the TiC data files with the hospital price transparency data files to determine if they included the actual payment rate. Not only does this create significant burden for those trying to analyze TiC data, but it also means the data is meaningless unless hospitals disclose the price for that same service in their hospital pricing files. This problem is compounded by the fact that reports show over 79% of hospitals remain noncompliant with the Hospital Price Transparency rule.[12]

Codifying this sub regulatory guidance directly undermines the purpose of the Transparency in Coverage rule to disclose meaningful and useable health care prices across and within U.S. health care markets, and would ultimately set price transparency efforts back by weakening the TiC rule. It is well documented that health insurers often fail to fully comply with TiC disclosure requirements, often neglecting to provide negotiated rates in dollars and cents or submitting incomplete files.[13] By codifying this loophole into the TiC rule, CMS would create a massive gap in federal rules that would more permanently allow insurers to obscure pricing data and hide behind meaningless and inactionable percentages.

In order for TiC data to be meaningfully used by employers, advocates, researchers, and policymakers, **CMS must require insurers publish negotiated rates in dollars and cents. When not possible due to percentage-of-billed-charges arrangements, CMS should require insurers to post a historical average price in addition to the percentage.**

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

CMS proposes to require plans and issuers to publish additional machine-readable files that include contextual information to help stakeholders better understand the data available

through TiC files. ***Consumers First*** **supports this change and urges CMS to include it in the final rule**.

These contextual files include:

- ***The change-log file***, which would reflect changes in data from one in-network rate file to the next file, posted in accordance with each newly published in-network rate file. Change-log files mean file users can more easily assess changes occurring between reporting periods, no longer necessitating file users to download and analyze each set of newly posted files to determine if there have been any notable changes.[14]
- ***The utilization file***, which would require insurers to annually publish an MRF detailing all items and services for which there has been at least one claim submitted and reimbursed, and each in-network provider who received reimbursement for such services. This data helps provide important insight into provider availability and service patterns.[15] Additionally, the data gives a sense of the degree to which negotiated rates are used by providers to deliver actual services. TiC files frequently include an alarming amount of "ghost-codes," where rates are included for providers who do not or cannot furnish such services.[16] For example, insurers may report a rate for delivery of a cardiology service at a dermatologist office. The prevalence of ghost codes contributes to even greater challenges for file users hoping to draw meaningful analysis from the data.[17] Utilization data can help file users sift through and "eliminate" ghost data.
- ***The taxonomy file,*** which would require plans to publish on a quarterly basis an MRF file detailing the plan's "internal provider taxonomy." The internal provider taxonomy maps items and services (identified via billing code) to select provider specialties (identified via provider code). This data creates greater transparency into how plans prepare their in-network provider rate files.
- ***The text files,*** which would require that plans publish a plain text file in the root folder of their website that directs users to the location of the MRF files along with point of contact information for an individual who can address questions and issues related to the files. This is important as data files have been historically difficult to find, in large part because there was previously no standardized location for file reporting across insurers.[18]

File users face an uphill battle when trying to access and decipher TiC data. These newly proposed contextual files provide file users with important information to help improve access to TiC files, streamline review of updated TiC data, and expand insight into health care utilization and pricing. ***Consumers First*** **urges CMS to finalize the required reporting of additional contextual files and continue to work to improve data quality of TiC MRF files.**

Conclusion

In addition to the recommendations above, ***Consumers First*** **urges CMS to further strengthen Transparency in Coverage by:**

1. **Requiring a senior official (Chief Executive Officer, Chief Financial Officer, or their equivalent) to attest to the accuracy and completeness of the TiC data** to create greater accountability for compliance with the regulation**.**
2. **Implement requirements for a prescription drug MRF under the transparency in coverage rule** to expand transparency of drug prices in the commercial market.
3. **Continue to streamline and standardize data reporting requirements** to reduce file sizes and improve data usability.

On behalf of *Consumers First*, we thank you again for the opportunity to comment on the Transparency in Coverage proposed rule, and for considering the above recommendations. Please contact Alicia Camaliche, Senior Policy Analyst at Families USA at acamaliche@familiesusa.org for further information.

Sincerely,

American Academy of Family Physicians
American Federation of State, County, and Municipal Employees
Families USA
Purchaser Business Group on Health

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