DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG–107111–25]

RIN 1545–BQ55

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AC30

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 147

[CMS–9882–P]

RIN 0938–AV64

Transparency in Coverage

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: These proposed rules set forth proposed requirements that would amend the 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. Specifically, these proposed rules would improve the standardization, accuracy, and accessibility of public pricing disclosures in line with the goals of the Executive Order 14221. With respect to the in-network rate and out-of-network allowed amount machine-readable files, these proposed rules would achieve these goals by adding new contextual files and additional data elements like product type, network name, and enrollment counts; changing the reporting level for aggregation of data; removing in-network rates for unlikely provider-to-service mappings; increasing the reporting period and lowering the claims threshold for out-of-network historical data; and reducing the reporting cadence. These proposed rules would also improve the findability of all of the publicly disclosed machine-readable files required under the Transparency in Coverage rules, including the prescription drug file, by requiring a text file and footer with website URLs and contact information for the files. These proposed rules 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 these proposed rules).

DATES: To be assured consideration, comments must be received at one of the addresses provided below by February 23, 2026.

ADDRESSES: Written comments may be submitted to the addresses specified below. Any comment that is submitted will be shared among the Department of the Treasury, the Department of Labor, the Department of Health and Human Services (the Departments), and the Office of Personnel Management. Please do not submit duplicates.

Comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. Comments are posted on the internet exactly as received and can be retrieved by most internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

In commenting, please refer to file code CMS–9882–P. Because of staff and resource limitations, the Departments cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9882–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9882–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Kendra May or Jeremy Rotner, Centers for Medicare and Medicaid Services, (301) 492–4293.

Elizabeth Schumacher or Sharon Aguirre, Employee Benefits Security Administration, (202) 693–8335.

Alexander Krupnick, Internal Revenue Service, Department of the Treasury, (202) 317–5500.

Individuals interested in obtaining information from the Department of Labor (DOL) concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the DOL's website (*www.dol.gov/agencies/ebsa*). In addition, information from the Department of Health and Human Services (HHS) on private health insurance coverage and coverage provided by non-Federal governmental group health plans can be found on the Centers for Medicare & Medicaid Services (CMS) website (*http://www.cms.gov/marketplace*), information on health care reform can be found at *http://www.healthcare.gov,* and information on surprise medical bills can be found at *http://www.cms.gov/nosurprises.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. The Departments post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. The Departments will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. The Departments continue to encourage individuals not to submit duplicative comments. The

Departments will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments. The Departments encourage commenters to include supporting facts, research, and evidence in their comments. When doing so, commenters are encouraged to provide citations to the materials referenced, including active hyperlinks. Likewise, commenters who reference materials that have not been published are encouraged to upload relevant data collection instruments, data sets, and detailed findings as a part of their comment. Providing such citations and documentation will assist the Departments in analyzing the comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/*.

I. Executive Summary

A. Purpose

The Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued proposed requirements in the 2019 Transparency in Coverage proposed rules (2019 proposed rules) [1] and finalized the rules in 2020 (the 2020 final rules).[2] 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 a competitive dynamic that would begin to narrow price differences for the same services in the same health care markets; foster innovation by providing industry the information necessary to support informed, price-conscious consumers in the health care market; and, over time, potentially lower overall health care costs.[3]

The public disclosures made pursuant to the 2020 final rules led to the release of an enormous amount of previously hidden pricing data. However, post-implementation, the Departments continue to receive feedback from users of the machine-readable files emphasizing the need to address certain gaps in reporting and shrink file size by reducing duplication and removing unnecessary data. Since the finalization of the 2020 final rules, the Departments have also received feedback from many interested parties about the myriad ways in which plans and issuers contract with providers for items and services that impact the usability of the data disclosed under the rules.

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).[4] Among other things, Executive Order 14221 directs the Departments to take all necessary and appropriate action, including issuing proposed regulatory action to promote more transparency in health care pricing information. In line with the goals of Executive Order 14221, the Departments propose several amendments to the 2020 final rules to improve the standardization, accuracy, and accessibility of pricing information.

Based on internal assessment and external feedback from interested parties, the Departments have identified three main barriers to fully achieving the goals of the 2020 final rules: inaccessibility due to the size of the machine-readable files, ambiguity regarding some of the data disclosures due to a lack of contextual information alongside the raw data, and misalignment with the ''2019 Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public'' rule [5] (2019 Hospital Price Transparency rule) that makes comparing data across disclosures challenging.

The Departments understand that the large size of many of the required machine-readable files, particularly the in-network rate machine-readable file (In-network Rate File), is the most prominent challenge with working with the machine-readable files. Academics and researchers,[6] data engineers,[7] health plans and health insurance issuers,[8] and members of Congress [9] have stated that these large file sizes create several problems for file users seeking to open and analyze the files, as well as for health plans and health insurance issuers reporting that amount of data. For file users, the amount of data to sift through monthly requires significant resources and time. Smaller datasets are easier to analyze and cheaper to maintain. For plans and issuers, large files have large data storage, maintenance, and bandwidth costs. The amount of data being generated monthly can also lead to increased errors in the files, making it difficult for plans and issuers to ensure they are compliant with the disclosure requirements and for file users to be confident in the integrity of the data being reported. Reducing the collective burden from large file sizes and making it easier for all users to work with the data in the machine-readable files are among the driving goals of these proposed rules.

With the 2020 final rules, the Departments expected the public disclosure of pricing information related to health care items and services to help both uninsured and insured individuals in their health care and health coverage purchasing decisions. As stated in the preamble to the 2020 final rules, research indicates that having access to pricing information can increase consumers' overall satisfaction and provide opportunities for education and engagement on health care pricing.[10]

Price transparency enables consumers to evaluate health care options and make cost-conscious decisions, allowing for the possibility of a competitive dynamic that may narrow price dispersion for the same items and services in the same health care markets and put downward pressure on prices and potentially lower overall health care costs.[11] Since the publication of the 2020 final rules, researchers have continued to analyze price transparency in health care with the benefit of access to the data provided largely by the machine-readable files.

[1] 84 FR 65464 (November 27, 2019).

[2] 85 FR 72158 (November 12, 2020).

[3] 85 FR 72158, 72160 (November 12, 2020).

[4] Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

[5] 84 FR 65524 (November 27, 2019).

[6] Christopher Whaley, Neeraj Radhakrishnan, Michael Richards, Kosali Simon, et al., *Understanding Health Care Price Variation: Evidence from Transparency-in-Coverage Data,* 3 Health Affairs Scholar 2 (2025), *https://doi.org/10.1093/haschl/qxaf011;*

Michael E. Chernew, Sabrina Corlette, Kelly Davenport, François de Brantes, et al., *Transparency in Coverage: Recommendations for Improving Access to and Usability of Health Plan Price Data* (2022), Georgetown University, *https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.*

[7] Adam Geitgey, *A Petabyte of Health Insurance Prices per Month,* Turquoise Health (July 11, 2023), https://blog.turquoise.health/a-petabyte-of-health-insurance-rates-a-month/.

[8] United Health Care, Transparency in coverage, *https://transparency-in-coverage.uhc.com/* (last visited Dec. 8, 2025). (''Files are in a JSON format and may contain millions of lines of data and be up to 1 terabyte (TB) in size. Please consider your system's capacity and memory when downloading these files.'')

[9] Maggie Hassan & Michael Braun, *Letter to CMS Administrator Chiquita Brooks-LaSure* (Mar. 6, 2023), *https://www.hassan.senate.gov/imo/media/doc/tic.pdf.*

[10] 85 FR 72158 (November 21, 2020).

[11] 85 FR 72158, 72159 (November 12, 2020).

Some researchers have identified significant potential cost-savings across the health insurance landscape through greater use of the machine-readable file data.[12] Recent discussions extol the potential benefits of price transparency, echoing the reasons the Departments emphasized in the 2020 final rules. These include effects on the demand for health care by ''guiding patients to lower-priced providers'' and to the supply side by ''promot[ing] price competition among providers,'' [13] as well as benefits to employers to ''redesign health benefits and inform purchasing decisions.'' [14] One analysis emphasized a range of benefits, from ''optimizing current contracts'' to ''increasing the accuracy of performance assumptions, market analysis, and strategic value.'' [15] Early analyses of the potential financial and economic impacts of the 2020 final rules show promise for fulfilling the goals the Departments articulated in the 2020 final rules of ''facilitating a market-driven heath care system by giving consumers of health care services data that will enable consumers to make fully informed, cost-conscious decisions when choosing health care.'' [16]

While the machine-readable file requirements of the 2020 final rules and the 2019 Hospital Price Transparency rule do not require the exact same disclosures, they have similar goals and some overlapping data. Therefore, it can be useful to review studies of hospital machine-readable files for lessons learned and outcomes that may translate to the plan and issuer machine-readable file disclosures. One study using hospital data found that ''choosing plans from the largest insurer in the local market is more likely to result in lower negotiated rates than from other plans,'' which can lead to reduced costs for the ''growing number of self-insured employers engaged in direct contracts with hospitals.'' [17] One county government used hospital data in this manner to reduce its health costs by over 40 percent.[18] Tools allowing comparison of the hospital data recently began populating the internet. The Departments are also aware of app developers conducting similar analyses of the data from plan and issuer disclosures and offering them to consumers (both individuals and employers). The Departments expect that continued analyses and development of consumer-facing tools and services will result in similar savings opportunities achieved from studying the hospital machine-readable files.

However, the success of these analyses and the effectiveness of consumer-facing tools depend on the usability of the machine-readable files. Large file sizes, lack of clarity, and data of limited use hamper efforts to build tools that can be brought to market. These proposed changes, if finalized, would contribute to making the files easier to digest and analyze, reduce challenges for existing tool developers, and open the market to additional tool and app developers.

The Departments seek to address the limitations of the machine-readable files through these proposed rules as well as through updates to the machine-readable file form and manner requirements as detailed in technical implementation guidance. As a first step towards addressing these limitations, on May 22, 2025, the Departments announced in FAQs Part 70 the intention to release schema version 2.0 (Schema 2.0), which will implement revised technical requirements for the In-network Rate File and out-of-network allowed amounts and billed charges machine-readable file (Allowed Amount File).[19] However, the Departments also recognize that more substantive requirements are needed to clarify the data being published and to give users more confidence in the data. Feedback from interested parties demonstrates that, while the raw data from the machine-readable files presents valuable information and opportunities for analysis, additional contextual information is needed to supplement the in-network rates and out-of-network allowed amounts and billed charges disclosed in the machine-readable files. Additional contextual information would allow users to understand changes in pricing over time, promote more accurate reporting, and make pricing information more meaningful and accessible overall. Therefore, the Departments are issuing these proposed rules as a next step to addressing these concerns.

The disclosure requirements under the Transparency in Coverage rules represent just one prong in a multipronged approach to promote greater transparency and understanding of costs and pricing in the health care and the health insurance market. The 2020 final rules must be viewed within the context of other regulatory and statutory changes, such as the Hospital Price Transparency initiative, as well as Title I of Division BB of the Consolidated Appropriations Act, 2021 (CAA), also known as the No Surprises Act, and its consumer protections against surprise billing, its requirements for a good faith estimate, advanced explanation of benefits, and more accurate provider directories. With respect to the Hospital Price Transparency and the Transparency in Coverage initiatives in particular, section 3(b) of Executive Order 14221 instructed the Departments to ''issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans.'' [20] The Departments received encouraging feedback that ''commercial prices disclosed in the TiC [Transparency in Coverage] data are mostly comparable to those disclosed by hospitals in compliance with the hospital price transparency rule and to Marketscan [sic] claims data.'' [21]

[12] Stephen T. Parente, *Estimating the Impact of New Health Price Transparency Policies,* 60 The Journal of Health Care Organization, Provision, and Financing (Feb. 17, 2023);

David N. Bernstein & John R. Crowe, *Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward,* 61 Inquiry (2024).

[13] Juan Carvajal, Christopher Ody, & Christopher Whaley, *The Relationship Between Pricing Transparency and Price Competition in the US Health Care Industry* (Nov. 5, 2024), *https://www.analysisgroup.com/globalassets/insights/publishing/2024_aba_article_relationship_between_pricing_transparency.pdf.*

[14] Christopher Whaley & Austin Frakt, *If Patients Don't Use Available Health Service Pricing Information, Is Transparency Still Important?,* 24 AMA Journal of Ethics 995 (Nov. 2022.

[15] Sarun Charumilind, Shubham Singhal, Oleg Bestsennyy, Erica Coe, et al., *How Price Transparency Could Affect US Healthcare Markets*), McKinsey (Apr. 2, 2024), *https://www.mckinsey.com/industries/healthcare/our-insights/how-price-transparency-could-affect-us-healthcare-markets.*

[16] 85 FR 72158, 72171 (November 12, 2020).

[17] Yang Wang, Michael E. Chernew, Leemore S. Dafny, Maximilian J. Pany, et al., *Do Insurers with Greater Market Power Negotiate Consistently Lower Prices for Hospital Care? Evidence From Hospital Price Transparency Data,* 29 Medical Care Research & Review (Aug. 18, 2023).

[18] Sara Hansard, *One County Combed Hospital Data to Slash Health Plan Costs 43 Percent* (Feb. 6, 2023), Bloomberg, *https://news.bloomberglaw.com/health-law-and-business/employer-health-plan-eyes-43-savings-from-payment-data-audits.*

[19] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *Frequently Asked Questions About Affordable Care Act Implementation Part 70* (May 22, 2025), *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-70.*

[20] Exec. Order No. 14221, 90 FR 11005, 11006 (February 28, 2025).

[21] Yang Wang, Michael Meiselbach, Gerard Anderson & Ge Bai, *Hospital Pricing Information Consistent Between Transparency-In-Coverage Data and Other Commercial Data Sources,* 42 Health Affairs (2023), *https://www.healthaffairs.org/content/forefront/hospital-pricing-information-consistent-between-transparency-coverage-data-and-other.* Information on MarketScan data can be found at *https://www.merative.com/documents/merative-marketscan-research-databases.*

However, other interested parties have noted that, despite the consistency of the raw data across hospital and plan and issuer machine-readable files, there are other challenges in comparing the information between the two sets of machine-readable files.[22] Therefore, the Departments intend in these proposed rules, along with Schema 2.0, to help align the Hospital Price Transparency reporting requirements and the 2020 final rules, as well as to fulfill the directive under Executive Order 14221.

Additionally, to better inform a response to Executive Order 14221, on June 2, 2025, the Departments published a Request for Information (RFI) seeking the public's input on ways to effectively implement or amend the prescription drug machine-readable file requirement in the 2020 final rules.[23]

Building off of the 2020 final rules, 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 (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 that are 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 the Major Provisions

1. Transparency in Coverage—Definitions

The 2020 final rules include definitions at 26 CFR 54.9815–2715A1(a)(2); 29 CFR 2590.715–2715A1(a)(2); and 45 CFR 147.210(a)(2). These proposed rules, if finalized, would add a definition of the term health insurance market 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 machine-readable file available for each health insurance market in which the plan or issuer offers a plan or coverage. Under 26 CFR 54.9815–2715A1 and 45 CFR 147.210, the Departments propose to redesignate paragraphs (a)(2)(xi) through (xxii) as paragraphs (a)(2)(xii) through (xxiii), respectively, and add a new paragraph (a)(2)(xi) with the new definition. Under 29 CFR 2590.715–2715A1, the Departments propose to redesignate paragraphs (a)(2)(x) through (xxi) as paragraphs (a)(2)(xi) through (xxii) and add a new paragraph (a)(2)(x) with the new definition.

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

The 2020 final rules at 26 CFR 54.9815–2715A2; 29 CFR 2590.715–2715A2; and 45 CFR 147.211 require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to make cost-sharing information available to participants, beneficiaries, and enrollees through an internet-based self-service tool (self-service tool), and in paper form, upon request.

The Departments propose to amend paragraph (b)(1)(vii)(A) of this section to require the disclaimer, described in that paragraph, to state that the cost-sharing information does not account for potential additional amounts in situations where applicable State and Federal law allow out-of-network providers to balance bill participants, beneficiaries, and enrollees. This proposed amendment reflects the existence of the Federal balance billing protections set forth in the No Surprises Act, which was not in effect when (b)(1)(vii)(A) was finalized in the 2020 final rules. The Departments also propose to clarify that the disclaimer is not required if the State in which the item or service was furnished prohibits all out-of-network providers from balance billing for all items and services payable by the plan or issuer.

In addition, the Departments propose to add a new paragraph at (b)(2)(iii) under this section to require plans and issuers to make available to participants, beneficiaries, and enrollees the cost-sharing estimates and other disclosures required under paragraph (b)(1) via a telephone number to implement requirements under section 9819 of the Code, section 719 of ERISA, and PHS Act Section 2799A–4, as added by section 114 of the No Surprises Act.[24] The Departments propose to require a telephone number through which a consumer may seek customer assistance which would be required to be the same number that Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e), as added by section 107 of the No Surprises Act requires be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee. The Departments also propose to redesignate paragraph (b)(2)(ii)(D) as new paragraph (b)(2)(iv) and amend redesignated paragraph (b)(2)(iv) to remove phone as an alternative means by which a participant, beneficiary, or enrollee can request the disclosures required under paragraph (b)(1).

The Departments also propose to add a new paragraph (c)(7) stating that plans and issuers satisfy the requirements set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4 regarding the price comparison tool by providing the information to participants, beneficiaries, and enrollees set forth in paragraph (b)(1) as amended in accordance with the method and format requirements set forth in paragraph (b)(2), as amended.[25]

[22] Nikki Tong, *Price Transparency Proposal Leaves Room for Improvement, Experts Say,* Fierce Healthcare (Aug. 1, 2023), *https://www.fiercehealthcare.com/providers/price-transparency-proposal-leaves-room-improvement;* Jing Jiang, Mengqi Jiang & Ge Bai, *Enforcing Hospital Price Transparency: Lessons from CMS Actions,* Health Affairs Forefront (Dec. 3, 2024), *https://www.healthaffairs.org/content/forefront/enforcing-hospital-price-transparency-lessons-cms-actions.*

[23] 90 FR 23303 (June 2, 2025).

[24] 42 U.S.C. 300gg–111(e)(3); 29 U.S.C. 1185e(e)(3); 26 U.S.C. 9819. U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (August 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.*

[25] While PHS Act section 2715A does not apply to grandfathered health plans and health insurance issuers offering grandfathered individual and group health insurance coverage, section 9819 of the Code, section 719 of ERISA, and section 2799A–4

Continued

3. Transparency in Coverage—Requirements for Public Disclosure

The Transparency in Coverage final rules at 26 CFR 54.9815–2715A3; 29 CFR 2590.715–2715A3; 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 machine-readable files, 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 information required under paragraphs (b)(1) and (b)(2). First, the Departments propose to amend the introductory paragraph of (b) to reference new requirements for the public disclosure of contextual information and to redesignate paragraphs (b)(2) through (b)(3) as paragraphs (b)(3) through (b)(4), respectively, and add a new paragraph (b)(2) describing the proposed contextual information disclosure requirements for the In-network Rate File. The Departments also propose to add two new paragraphs, (b)(2)(iv) and (b)(3)(iii), to help users more easily locate the public disclosures made pursuant to these proposed rules 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 machine-readable files. The Departments also propose to amend the required information at redesignated paragraph (b)(1)(i)(B) and paragraph (b)(1)(ii)(A) to remove 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. The Departments also propose to amend the special rules to prevent unnecessary duplication in current paragraph (b)(4) by redesignating paragraph (b)(4)(i) as paragraph (b)(5)(i), redesignating paragraph (b)(4)(ii) as paragraph (b)(5)(ii), redesignating paragraph (b)(4)(iii) as paragraph (b)(5)(iv), and adding paragraph (b)(5)(iii). In new paragraph (b)(5)(iii), the Departments propose to permit self-insured group health plans under certain circumstances to allow another party, such as a service provider, with which they have an agreement as described in paragraph (b)(5)(ii), to make available in a single In-network Rate File as required under paragraph (b)(1)(i), the information required under paragraph (b)(1)(i) 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. The Departments also propose to amend newly redesignated paragraph (b)(5)(iv) to permit self-insured group health plans under certain circumstances to allow another party with which they have an agreement to aggregate the Allowed Amount Files required under paragraph (b)(1)(ii) for more than one self-insured group health plan, including those offered by different plan sponsors.

Finally, the Departments propose to amend newly redesignated paragraph (b)(4) by adding new paragraphs to specify the timing requirements for each machine-readable file required as proposed under these rules. As related to the public disclosures generally, proposed paragraph (b)(4)(i) would amend the required reporting frequency for the In-network Rate and Allowed Amount Files under paragraphs (b)(1)(i) and (b)(1)(ii) from monthly to quarterly but would not propose any changes to the monthly reporting frequency for the prescription drug file required under paragraph (b)(1)(iii). Newly redesignated paragraph (b)(4)(vi) proposes to require the Text File proposed under new paragraph (b)(2)(iv) to be posted beginning 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 7 calendar days following a change in any of the information required under redesignated paragraph b)(2)(iv).

The amendments contained in these proposed rules 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 machine-readable files, specifically: the requirement that plans and issuers must include a Text File in the root folder of a plan's or issuer's website as described in proposed paragraphs (b)(2)(iv) (section III.C.7.d. of this preamble) and the requirements related to the method and format for disclosing information to the public as described in proposed redesignated paragraph (b)(3) (section III.C.9. of this preamble). The Departments note in each applicable section when a proposal would modify requirements related to the prescription drug machine-readable files.

4. Public Disclosure of In-Network Rates

With respect to the disclosure of in-network rates specifically, to reduce duplicate in-network rate data, the Departments propose to amend 26 CFR 54.9815–2715A3(b)(1)(i), 29 CFR 2590.715–2715A3(b)(1)(i), and 45 CFR 147.212(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. As part of this proposal, the Departments propose to redesignate paragraphs (b)(1)(i)(A) through (C) as paragraphs (b)(1)(i)(B) through (D), respectively, and add a new paragraph (b)(1)(i)(A) requiring each In-network Rate File to include the common provider network name for which negotiated rate information is included in that file.

The Departments also propose to amend redesignated paragraph (b)(1)(i)(D)(*1*) to require in-network rates to 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. The Departments also propose to add new paragraph (b)(1)(i)(E), requiring each In-network Rate File to 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.

The Departments also propose in new paragraph (b)(1)(i)(F) to require plans and issuers to exclude any provider and their negotiated rate (provider-rate combination) 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, according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process. The Departments also propose to amend newly redesignated paragraph (b)(1)(i)(D)(*2*) to account for this proposed required exclusion.

The Departments also propose to require plans and issuers to post several contextual machine-readable files under new paragraph (b)(2) that would help file users better understand the public

of the PHS Act do apply to grandfathered health plans and issuers offering grandfathered health insurance coverage.

disclosures required in the In-network Rate Files under paragraph (b)(1)(i). This proposal would mean plans and issuers would be required to prepare new contextual files for each In-network Rate File prepared pursuant to these proposed rules. In particular, the Departments propose to require a change-log file (''Change-log File'') at new paragraph (b)(2)(i), which would identify any changes made to the required information described in paragraph (b)(1)(i) in the In-network Rate File since the last posted In-network Rate File.

The Departments also propose to require a utilization file (''Utilization File'') at new paragraph (b)(2)(ii), which would document, for the 12-month period that ends 6 months prior to the publication date of each Utilization File, all items and services covered under the plans or policies represented in the In-network Rate File prepared pursuant to proposed amended paragraph (b)(1)(i) 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, in whole or in part, for a claim for each covered item or service included in such file.

The Departments also propose to require plans and issuers to publish a taxonomy file (''Taxonomy File'') at new paragraph (b)(2)(iii) which would include their internal provider taxonomy that matches items and services (represented by a billing code) with provider specialties (represented by specialty codes that are derived from the Health Care Provider Taxonomy [26] code set established by the National Uniform Claim Committee (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.

Finally, the Departments propose to add timing requirements for the proposed new contextual files under redesignated paragraph (b)(4). With respect to the contextual files that related to the In-network Rate Files under paragraph (b)(1)(i), under proposed paragraph (b)(4)(iii), the Change-log File proposed at paragraph (b)(2)(i) 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 under paragraph (b)(4)(i), and updated and posted quarterly whether or not there are changes to that file since it was last posted. Under proposed paragraph (b)(4)(iv), the Utilization File proposed at paragraph (b)(2)(ii) would be required to be posted beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) and updated annually after the initial posting. Lastly, under proposed paragraph (b)(4)(v), the Taxonomy File proposed at paragraph (b)(2)(iii) would be required to be posted beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) and updated and posted quarterly if changes to the internal provider taxonomy impact the information required in the machine-readable file required under paragraph (b)(1)(i).

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

The Departments propose to make several 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) 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 6 months and the lookback period from 180 days to 9 months.

6. Severability

The 2020 final rules included severability clauses to emphasize the Departments' intent that, to the extent a reviewing court holds that any provision of the final rules is unlawful, the remaining rules should take effect and be given the maximum effect permitted by law. The 2020 final rules provide that any provision held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, shall be severable from the relevant section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances. The Departments are not modifying this language in the 2020 final rules and clarify that these clauses continue to apply and would extend to the amendments proposed in these rules, if finalized.

7. Technical Amendments

The Departments propose a series of technical amendments to the way group health plans and health insurance issuers offering group or individual health insurance coverage are referenced in 26 CFR 54.9815–2715A2 and 54.9815–2715A3, 29 CFR 2590.715–2715A2 and 2590.715–2715A3, and 45 CFR 147.211 and 147.212. In the 2020 final rules, the Departments generally adopted the convention of referring to those entities using the terms ''group health plan'' and ''health insurance issuer'' throughout the regulations, except that where the Departments refer to those entities more than once in the same paragraph, the terms ''plan'' and ''issuer'' are used after the initial instance. However, that convention was not applied evenly.

Therefore, in the internet-based self-service tool disclosure requirements in 26 CFR 54.9815–2715A2, 29 CFR 2590.715–2715A2, and 45 CFR 147.211, the Departments propose technical amendments to paragraphs (b)(1)(i)(A), (b)(1)(i)(B), (b)(2)(ii), (b)(3)(i), and (b)(3)(ii) that would bring the terms used to describe those entities in line with that convention. In the machine-readable file disclosure requirements in 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212, the Departments propose amendments to redesignated paragraph (b)(1)(i)(D), (b)(5)(i), and (b)(5)(ii) that would bring the terms used to describe those entities in line with that convention. These paragraphs are otherwise unchanged. These 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

[26] National Uniform Claim Committee, *Health Care Provider Taxonomy, https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40* (last visited Dec. 8, 2025).

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 Machine-Readable File 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 3-year 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 2590.715-2715A3(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 2590.715-2715A3(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 2590.715-2715A3(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 Machine-Readable Files (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 for Machine-Readable Files 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 Machine-Readable Files 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 Machine-Readable Files 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 Machine-Readable Files (26 CFR 54.9815-2715A2(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**

II. Background

A. Executive Orders

On June 24, 2019, President Trump issued Executive Order 13877, ''Improving Price and Quality Transparency in American Healthcare to Put Patients First.'' [27] Executive Order 13877 sought to improve transparency in health care and empower patients to make fully informed decisions about their health care. As Executive Order 13877 noted, ''patients often lack both access to useful price and quality information and the incentives to find low-cost, high-quality care.'' The lack of this information is widely understood to be one of the root problems causing dysfunction within America's health care system, ''generally leav[ing] patients and taxpayers worse off than would a more transparent system.''

Executive Order 13877 directed 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. Specifically, section 3(b) of Executive Order 13877 directed the Secretaries of the Departments to issue an advance notice of proposed rulemaking, consistent with applicable law, soliciting comment on a proposal to require health care providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

To fulfill their responsibility under Executive Order 13877, the Departments proposed [28] and subsequently finalized the Transparency in Coverage rules in the 2020 final rules.[29] The 2020 final rules published by the Departments on November 12, 2020, implemented 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. As described more fully elsewhere in this preamble, these provisions address transparency in health coverage and require plans and issuers to make certain information available to the public.

On February 25, 2025, President Trump issued Executive Order 14221,[30] ''Making America Healthy Again by Empowering Patients With Clear, Accurate, and Actionable Healthcare Pricing Information.'' Executive Order 14221 stated that ''[m]aking America healthy again will require empowering individuals with the best information possible to inform their life and healthcare choices'' with the goal to ''make more meaningful price information available to patients to support a more competitive, innovative, affordable, and higher quality healthcare system.'' To that end, the Executive Order directs the Departments to ''promote universal access to clear and accurate healthcare prices[;] . . . to improve existing price transparency requirements; increase enforcement of price transparency requirements; and identify opportunities to further empower patients with meaningful price information, potentially including through the expansion of existing price transparency requirements.'' [31]

Section 3 of Executive Order 14221 directs the Secretaries of the Departments to rapidly implement and enforce the health care price transparency regulations issued pursuant to Executive Order 13877,[32]

[27] Exec. Order No. 13877, 84 FR 30849 (June 27, 2019).

[28] 84 FR 65464 (November 27, 2019).

[29] 85 FR 72158 (November 12, 2020).

[30] Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

[31] *Id.*

[32] Exec. Order No. 13877, 84 FR 30849 (June 27, 2019).

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.'' [33] In line with these directives, the Departments are publishing these proposed rules with amendments to the regulations issued under the 2020 final rules.[34]

B. Statutory Background and Enactment of the Affordable Care Act and the No Surprises Act

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010 (collectively the Affordable Care Act). As relevant here, the Affordable Care Act reorganized, amended, and added to the provisions of part A of title XXVII of the PHS Act relating to health coverage requirements for group health plans and health insurance issuers. The term group health plan includes both insured and self-insured group health plans.

The Affordable Care Act also added section 715 to ERISA and section 9815 to the Code to incorporate the provisions of part A of title XXVII of the PHS Act, PHS Act sections 2701 through 2728, into ERISA and the Code, making them applicable to group health plans and health insurance issuers providing coverage in connection with group health plans.

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 section 1311(e)(3) of the Affordable Care Act, which addresses transparency in health coverage and imposes 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 (as defined by section 1311(b)(1) of the Affordable Care Act) 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 2020 final rules require non-grandfathered health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to disclose cost-sharing information for all covered items and services to participants, beneficiaries, and enrollees through an internet-based self-service tool or, if requested by the individual, on paper. These provisions of the 2020 final rules implement paragraph (C) of section 1311(e)(3) of the Affordable Care Act.

The 2020 final rules also require non-grandfathered plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to disclose on a public website three separate machine-readable files containing certain information regarding health care pricing under the plan or coverage. The machine-readable file disclosure requirements are intended to make health care pricing information accessible and useful to consumers and other interested parties (including employers, and other purchasers of health care),[35] support efforts to lower health care costs by driving competition,[36] and to supplement State transparency efforts.[37] These provisions of the 2020 final rules requiring plans and issuers to disclose in-network negotiated rates, out-of-network allowed amounts and the associated billed charges, and negotiated rates and historical net prices for prescription drugs implement paragraph (A) of section 1311(e)(3) of the Affordable Care Act. In particular, the provisions requiring the disclosure of out-of-network allowed amounts specifically implement the requirement in section 1311(e)(3)(A)(vii) of the Affordable Care Act to provide information on ''payments with respect to any out-of-network coverage.'' In addition, the Secretary of HHS determined that requiring disclosure of payment information on in-network rates and prescription drugs is appropriate under section 1311(e)(3)(A)(ix) of the Affordable Care Act.

The No Surprises Act added new provisions applicable to plans and issuers in Subchapter B of chapter 100 of the Code, Part 7 of ERISA, and Parts D and E of title XXVII of the PHS Act. As relevant here, 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, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage. This information includes any deductible applicable to such plan or coverage, any out-of-pocket maximum limitation applicable to such plan or coverage, and a telephone number and internet website address through which such individual may seek consumer assistance information.

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.

C. Statutory Background for Enforcement With Regards to the Affordable Care Act and the CAA of 2021

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. Pursuant to section 2723(a)(1) of the PHS Act, as amended by the No Surprises Act, states have primary enforcement authority over health insurance issuers regarding the provisions of Parts A and D of title XXVII of the PHS Act. Under this framework, HHS has enforcement

[33] Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

[34] 85 FR 72158 (November 12, 2020).

[35] 85 FR 72158, 72160–61 (November 12, 2020).

[36] 85 FR 72158, 72161–62 (November 12, 2020).

[37] 85 FR 72158, 72162–63 (November 12, 2020).

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.[38]

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.[39]

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. 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.

D. Consultation With and Input From Interested Parties

The Departments have been in regular consultation with interested parties since publishing the 2019 proposed rules. In addition to the thousands of comments received on the 2019 proposed rules, following the publication of the 2020 final rules, the Departments continued to engage in consultation with interested parties and collaboration about implementation of the 2020 final rules through technical implementation discussions on GitHub (an online hosting platform for development and source code management that permits version control), webinars, emails, and an inquiry management system, as well as other informal compliance assistance efforts and meetings with interested parties. This period of collaboration with interested parties led to the finalization of an initial technical format for disclosures (Schema 1.0) that was finalized on March 1, 2022, and became applicable on July 1, 2022. The Departments also regularly review news articles and research publications discussing the 2020 final rules and have received written and verbal recommendations from plans and issuers, data engineers, and researchers and academics.[40]

On May 22, 2025, the Departments released FAQs Part 70 on Schema 2.0, which states the Departments' intention to issue revised technical reporting requirements for the In-network Rate File and Allowed Amount File for group health plans and health insurance issuers, and the applicability date for implementation.[41] FAQs Part 70 requested interested parties to provide feedback through GitHub on how best to address the revised technical reporting requirements. These improvements respond to feedback from interested parties and are designed to reduce unnecessary or duplicative data fields and make cost information easier for consumers to understand and use.

Additionally, on June 2, 2025, the Departments issued an RFI[42] regarding the prescription drug machine-readable file requirement seeking comment and recommendations on the prescription drug price disclosure requirements. More specifically, the RFI requested comments and recommendations to help inform implementation of the prescription drug file disclosure requirements, including information on existing prescription drug file data elements, the ability of health plans to access necessary data for reporting, as well as state approaches and innovation.[43]

The Departments considered all public input received as they developed the policies in these proposed rules, with the exception of prescription drug RFI comments. However, the Departments received these prescription drug RFI comments and are separately taking them into consideration to evaluate how to implement the Transparency in Coverage 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 in section III.C.6. of this preamble), 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 machine-readable file 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.

The Departments propose to redesignate paragraphs (a)(2)(xi) through (xxii) as paragraphs (a)(2)(xii) through (xxiii) under 26 CFR 54.9815–2715A1 and 45 CFR 147.210, respectively, and add a new paragraph (a)(2)(xi) with the new definition. The Departments also propose to redesignate paragraphs (a)(2)(x) through (xxi) as paragraphs (a)(2)(xi) through (xxii) under 29 CFR 2590.715–2715A1, and to add a new paragraph (a)(2)(x) with the new definition. 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).
- 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.

For consistency, this definition would largely align with the definition of the term ''insurance market'' for the purposes of the methodology for calculating the qualifying payment amount (QPA) at 26 CFR 54.9816–6(a)(8), 29 CFR 2590.716–6(a)(8), and 45 CFR 149.140(a)(8). As background, Code section 9816(a)(3)(E), ERISA section 716(a)(3)(E), and PHS Act 2799A–1(a)(3)(E), as added by section 103 of the

[38] *See* section 2723(a)(2) and (b)(1)(A) of the PHS Act; 45 CFR 150.203.

[39] Section 2723(b)(1)(B) of the PHS Act.

[40] *Supra* note 8, 9, 10, and 11.

[41] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs About Affordable Care Act Implementation Part 70* (May 22, 2025), *https://www.cms.gov/files/document/aca-faqs-part-70.pdf* and *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-70.*

[42] *See* 90 FR 23303 (June 2, 2025).

[43] *Id.*

No Surprises Act, generally defines the QPA as ''the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), (III), or (IV) of clause (iv)) as the plan or coverage) . . . under such plans or coverage, respectively, on January 31, 2019,'' subject to other criteria and increased for inflation. Paragraph (a)(3)(E)(iv)(III) of the Code and ERISA and paragraph (a)(3)(E)(iv)(IV) of the PHS Act, provide that in the case of a self-insured group health plan, a health insurance market is ''other self-insured group health plans.''

When interpreting the definition of QPA for purposes of establishing a methodology for calculating the QPA, the Departments defined ''insurance market'' with respect to self-insured group health plans to include, ''at the option of the plan sponsor, all self-insured group health plans administered by the same entity (including a third party administrator (TPA) contracted by the plan), to the extent otherwise permitted by law, that is responsible for calculating the qualifying payment amount on behalf of the plan.'' [44] In other words, the interim final rules permitted plan sponsors to use either rates from only their own plans or rates from all plans administered by their TPA to calculate QPAs. However, this language has been vacated by the United States District Court for the Eastern District of Texas on the basis that the No Surprises Act specifies that QPAs must be calculated using the rates of ''all such plans of such sponsor.'' [45] Therefore, the United States District Court for the Eastern District of Texas interpreted the No Surprises Act to restrict aggregation in that manner for the purpose of calculating the QPA.

In contrast, the language of PHS Act section 2715A neither requires nor prohibits disclosure of information described in the Affordable Care Act section 1311(e)(3) to be aggregated by any specific market. Therefore, in order to avoid confusion between the insurance market applicable to the Allowed Amount File and the insurance market applicable to the definition of QPA, which is subject to the holding of *TMA III,* the Departments propose to use the term ''health insurance market,'' rather than ''insurance market,'' for purposes of organizing the Allowed Amount File. 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.

The Departments understand that the term health insurance market is not generally used to refer to self-insured group health plans. However, for purposes of uniformity in the definition, to facilitate a more streamlined and uniformed disclosure of Allowed Amount File, and for ease of reference, the Departments propose that 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) of this subchapter, and plans that consist solely of excepted benefits), health insurance market would mean all self-insured group health plans maintained by the plan sponsor.

The Departments seek comment on this proposed definition.

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

1. Disclaimer on Balance Billing

The Departments propose to amend the balance billing protection notice that plans and issuers are currently required to include along with the required cost-sharing information to participants, beneficiaries, and enrollees under 26 CFR 54.9815–2715A2(b)(1)(vii)(A), 29 CFR 2590.715–2715A2(b)(1)(vii)(A), and 45 CFR 147.211(b)(1)(vii)(A). These proposed amendments would require a statement that the cost-sharing information in the self-service tool 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 the amount collected from the participant, beneficiary, or enrollee in the form of a copayment, coinsurance, or deductible amount (the difference referred to as balance billing). These changes are being proposed to reflect the existence of the Federal balance billing protections set forth in the No Surprises Act, which were not yet enacted when the current disclaimer language was finalized in the 2020 final rules. This statement would not be required if the State in which the item or service was 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.

Currently, under paragraph (b)(1) of this section, plans and issuers must disclose certain cost-sharing information to participants, beneficiaries, and enrollees, including, under paragraph (b)(1)(i), 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. Paragraph (b)(1)(iv) requires, in part, that 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 rules,[46] because cost estimates cannot account for potential balance billing by an out-of-network provider, current rules under paragraph (b)(1)(vii) require plans and issuers to include a notice with a number of statements, including, under paragraph (b)(1)(vii)(A), 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

[44] 86 FR 36954 (July 13, 2021).

[45] Texas Medical Association, a trade association representing more than 56,000 Texas physicians and medical students; Dr. Adam Corley, a Tyler, Texas physician; Tyler Regional Hospital, LLC, a hospital in Tyler, Texas; LifeNet, Inc.; East Texas Air One, LLC; Rocky Mountain Holdings, LLC; and *Air Methods Corporation* v. *United States Department of Health & Human Services, U.S. Department of Labor, U.S. Department of the Treasury, and the Office of Personnel Management,* No. 6:22–cv–450–JDK (E.D. Tex. August 24, 2023) (*TMA III*) (vacating portions of 26 CFR 54.9816–6T(a)(8)(iv), 29 CFR 2590.716–6(a)(8)(iv), and 45 CFR 149.140(a)(8)(iv). The Department of Justice did not appeal the vacatur of this specific provision and it remains in place. *See also FAQs About Affordable Care Act and Consolidated Act, 2021 Implementation Part 71* (July 30, 2025). *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-71* (until the Fifth Circuit issues its en banc decision, extending enforcement relief for plans and issuers that use a QPA calculated using a good faith, reasonable interpretation of the methodology in place before the district court decision, for items and services furnished before February 1, 2026).

[46] 85 FR 72158, 72201 (November 12, 2020).

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 rules,[47] the current rules only require this statement if balance billing is permitted under State law.

Shortly after the 2020 final rules were published, the CAA, 2021, which included the No Surprises Act, was signed into law on December 27, 2020. The No Surprises Act added provisions that apply to group health plans and health insurance issuers offering group or individual health insurance coverage, including certain limitations on cost sharing for emergency services and for non-emergency services provided by nonparticipating providers with respect to visits to certain participating health care facilities.[48] The No Surprises Act also added certain limitations on cost sharing for air ambulance services provided by out-of-network air ambulance providers.[49] Additionally, the No Surprises Act added that cost-sharing payments for emergency services, non-emergency services furnished by a nonparticipating provider in a participating health care facility, and air ambulance services furnished by a nonparticipating provider must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage (including the annual limitation on cost sharing under section 2707(b) of the PHS Act) (as applicable), respectively (and these in-network deductibles and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to services furnished by a participating provider or facility.[50]

In addition to the new provisions applicable to plans and issuers, the No Surprises Act added a new Part E to title XXVII of the PHS Act establishing requirements applicable to health care providers, facilities, and providers of air ambulance services. Specifically, the No Surprises Act added new PHS Act sections 2799B–1, 2799B–2, 2799B–3, and 2799B–5, which protect participants, beneficiaries, and enrollees in group health plans and group and individual health insurance coverage offered by health insurance issuers from balance bills by generally 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.

Given that after the 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 propose to amend the balance billing protection notice provision under paragraph (b)(1)(vii)(A) to require a statement that the cost-sharing information provided 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 in the form of a copayment, coinsurance, or deductible amount (the difference referred to as balance billing). 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.

The Departments understand that no States currently categorically prohibit balance billing under all circumstances. Therefore, requiring plans and issuers in States without such categorical prohibitions to include this disclaimer would provide an additional layer of transparency for consumers. It would also maintain flexibility for plans and issuers to not include the notice if the State in which the plan or issuer is disclosing cost-sharing information to a participant, beneficiary, or enrollee does, subsequent to the finalization of these proposed rules, pass a law to which all providers are subject that prohibits balance billing for all items and services payable by the plan or issuer.

The Departments seek comment on this proposal.

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

The Departments propose to add 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, at their request, the cost-sharing estimates and other disclosures required under 26 CFR 54.9815–2715A2(b)(1), 29 CFR 2590.715–2715A2(b)(1), and 45 CFR 147.211(b)(1) via a phone number. Under this proposal, the information required via a phone number would be required to be accurate at the time of the request and provided at the time of the request. 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), as added by section 107 of the No Surprises Act,[51] require be indicated on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, and enrollees for obtaining customer assistance. The Departments also propose to redesignate paragraph (b)(2)(ii)(D) as new paragraph (b)(2)(iv) and amend paragraph (b)(2)(iv) to remove phone as an example of an alternative means for providing the disclosures by which a participant, beneficiary, or enrollee may request the disclosures required described in paragraph (b)(1) because providing the disclosures by a phone number would be required, as specified previously. 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 2020 final rules 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.

[47] 85 FR 72158, 72201 (November 12, 2020).

[48] Codified in Code section 9816, ERISA section 716, and PHS Act section 2799A–1.

[49] Codified in Code section 9817, ERISA section 717, and PHS Act section 2799A–2.

[50] Codified in Code sections 9816 and 9817, ERISA sections 716 and 717, and PHS Act sections 2799A–1 and 2799A–2.

[51] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (August 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.*

While the Departments have determined that the No Surprises Act's price comparison tool (codified at Code section 9819, ERISA section 719, and the PHS Act section 2799A–4) and self-service tool required under the 2020 final rules are largely duplicative, as discussed in more detail in section III.B.3. of this preamble, the requirements of Code section 9819, ERISA section 719, and the PHS Act section 2799A–4 expand the requirements for the disclosure of cost-sharing information in the 2020 final rules in one prominent way. Specifically, Code section 9819, ERISA section 719, and the PHS Act section 2799A–4 require group health plans and health insurance issuers offering group or individual health insurance coverage to ''offer price comparison guidance by telephone.''

The Departments intend for these proposed rules to satisfy the requirements of the No Surprises Act to require price comparison guidance via a telephone number, as set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4. Further, implementing this requirement would respond to feedback the Departments have received from participants, beneficiaries, and enrollees since the publication of the 2020 final rules, indicating a limited ability to receive cost-sharing information over the phone when requested from plans and issuers. 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.

To achieve these goals, these proposed rules add paragraph (b)(2)(iii), proposing to require plans and issuers to make available to participants, beneficiaries, and enrollees the cost-sharing estimates and other disclosures required under paragraph (b)(1), via phone, at the time requested and accurate at the time of their request.

In addition, 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. A similar 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). In the 2020 final rules, the Departments determined based on comments that ''limiting paper request to 20 providers per request is a reasonable approach to balancing the burdens on plans and issuers with the benefits of providing consumers with enough information to be able to compare cost and provider options.'' [52] The Departments have determined that the process by which plans and issuers would generate information responsive to requests for receiving cost-sharing information over the phone should be similar to the process for generating such information to deliver via paper, given the practicalities of generating a response on paper and over the phone. Therefore, the Departments propose to adopt the limitations for paper disclosure 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) for phone disclosure such that plans and issuers 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 day and, plans and issuers would be required to disclose the applicable provider-per-day limit to the participant, beneficiary, or enrollee when the request for information is made. This proposal is intended to balance the added burden to plans and issuers of this additional method of delivery with ensuring that participants, beneficiaries, and enrollees that opt to receive cost-sharing information over the phone have access to the same information as those that request such information via the paper method. The Departments note that nothing in these proposed rules precludes a participant, beneficiary, or enrollee from obtaining cost-sharing information from more than one method, consistent with the requirements for each method. Similarly, for consistency with the requirements for the paper method of delivery under the 2020 final rules, the Departments also propose to require plans and issuers to satisfy requests for cost-sharing information over the phone at the time of the phone call in order to ensure that participants, beneficiaries, and enrollees receive information as quickly as possible.

Accordingly, the Departments propose 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 at the time of the request and accurate at the time of the request, and in accordance with the method and format requirements in paragraphs (b)(2)(i)(A) through (C).

The Departments are also proposing to require health plans and health insurance issuers to make cost-sharing estimates and other disclosures available over the phone at a number designated on the ID card for individuals to seek assistance. Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e) (insurance ID card requirements), as added by section 107 of the No Surprises Act, separately require plans and issuers to include in clear writing, on any physical or electronic plan or insurance identification card issued to participants, beneficiaries, or enrollees, certain information including a phone number and website address for individuals to seek consumer assistance. Therefore, plans and issuers are already required to have a phone number designated on any physical or electronic plan or insurance identification card and, under this proposal, plans and issuers should make available cost-sharing estimates and other disclosures at the request of the participant or beneficiary via such phone number, if finalized. These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.[53] The Departments expect that requiring plans and issuers to use an existing phone number would allow them to leverage existing workflows and would make it easier for participants, beneficiaries, and enrollees to obtain the cost information they are seeking.

The Departments request comment on whether this proposal should include phone service standards to ensure that consumers have access to timely and reliable information. In particular, the Departments request comment on 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

[52] 85 FR 72158, 72207 (November 12, 2020).

[53] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (Aug. 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf*. FAQ Part 49 provided that, pending any implementing rulemaking, the Departments would not deem a plan or issuer to be out of compliance with ID card requirements where a plan or issuer includes on any ID card, among other things, a telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and maximum out-of-pocket limits.

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 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 Code section 9819, ERISA section 719, and the PHS Act section 2799A–4, as added by section 114 of the No Surprises Act 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 2020 final rules 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.[54] Paragraph (b)(1) of the 2020 final rules 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) of the 2020 final rules, 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.[55]

Code section 9819, ERISA section 719, and PHS Act section 2799A–4, as added by section 114 of the No Surprises Act, require plans and issuers 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 (hereinafter ''No Surprises Act price comparison tool''). This requirement was applicable with respect to plan years (and in the individual market, policy years) beginning on or after January 1, 2022.

The Departments announced on August 20, 2021, in FAQs Part 49 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 rules except that the information under the No Surprises Act price comparison tool must also be provided over the telephone upon request.[56] Therefore, the Departments indicated they intended to propose rulemaking requiring that the same pricing information that is available through the self-service tool or in paper form, as described in the 2020 final rules, must also be provided over the phone upon request. The Departments also announced that, as an exercise of enforcement discretion, they would defer enforcement of the requirement that plans and issuers make available a price comparison tool by internet website, in paper form, or telephone pursuant to the No Surprises Act until plan years (or in the individual market, policy years) beginning on or after January 1, 2023, to align the enforcement date of the No Surprises Act price comparison disclosure requirements with the enforcement date of the self-service tool described in the 2020 final rules.

Further, the Departments announced their intention to propose rulemaking and seek public comment regarding whether compliance with the self-service tool requirements of the 2020 final rules should satisfy the analogous requirements set forth Code section 9819, ERISA section 719, and PHS Act section 2799A–4. Plans and issuers have built and developed tools to comply with the requirements of the 2020 final rules and have anticipated, since the release of FAQs Part 49, that the Departments would propose in a future rulemaking that plans and issuers satisfy the No Surprises Act price comparison tool requirement by providing the required disclosures to participants, beneficiaries, and enrollees through the self-service tool as required in paragraphs (b)(1) and (2) of the 2020 final rules. Given this, the Departments have determined that requiring plans and issuers to build a second self-service tool would impose significant unnecessary burden and cause considerable confusion for consumers on the purposes of the two tools. Thus, it is appropriate that compliance with the self-service tool described in the 2020 final rules and as amended in these proposed rules should satisfy compliance with the No Surprises Act price comparison tool requirements.

Therefore, as discussed in section II.B.2. of this preamble, to align with the No Surprises Act price comparison tool requirements the Departments propose to require in new paragraph (b)(2)(iii) that plans and issuers make available to participants, beneficiaries, and enrollees the cost-sharing information and other disclosures required under paragraph (b)(1) via the same telephone number that Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e), as added by section 107 of the No Surprises Act, requires be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee for obtaining customer assistance. The Departments also propose at new paragraph (c)(7) that a group plan or health insurance issuer satisfies the requirements of Code section 9819, ERISA section 719, and PHS Act section 2799A–4 by providing the information required in paragraph (b)(1) to participants, beneficiaries, and enrollees in accordance with the method and format requirements specified in paragraph (b)(2).

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. The Departments have also stated that the requirements of PHS Act section 2715A are largely duplicative to those of Code section 9819, ERISA section 719, and PHS Act section 2799A–4, except that the former does not require information to be disclosed by phone. Therefore, if this rule is finalized, grandfathered health plans and issuers offering grandfathered

[54] 26 CFR 54.9815–2715A2(b)(1) and (2), 29 CFR 2590.2715A2(b)(1) and (2), and 45 CFR 147.211(b)(1) and (2).

[55] 26 CFR 54.9815–2715A2(b)(2)(i), 29 CFR 2590.2715A2(b)(2)(i), and 45 CFR 147.211(b)(2)(i).

[56] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (Aug. 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.*

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. The Departments seek comment on all aspects of this proposal.

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) of this section continue to apply.

With respect to proposed provisions at new paragraph (b)(2)(iii), the Departments understand that most plans and issuers already have in place a consumer assistance telephone number for participants, beneficiaries, and enrollees to receive benefit information pursuant to Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e), as added by section 107 of the No Surprises Act, and as clarified in previously issued guidance.[57] Because plans and issuers can leverage the operations of an existing consumer assistance phone number, the Departments have determined that the proposed applicability date appropriately balances the need for improved access to cost-sharing estimates for consumers who wish to access this information over the phone with the time necessary for plans and issuers to make the administrative and operational changes to implement this proposal. Similarly, because most plans are already required to disclose the balance billing disclosures under the 2020 final rules, the Departments have determined that the proposed applicability date for new paragraph (b)(1)(vii)(A) that would amend the balance billing disclosure is appropriate and reasonable.

The Departments propose to make new paragraph (c)(7) applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2027. The Departments selected this date because once plans and issuers are required to provide cost-sharing information by phone on the same date pursuant to proposed new paragraph (b)(2)(iii), it would be reasonable for the Departments to consider a plan or issuer's compliance with paragraphs (b)(1) and (2) to constitute compliance with the No Surprises Act price comparison tool as required by Code section 9819, ERISA section 719, and PHS Act section 2799A–4.

The Departments seek comment on this proposed applicability date for these proposed provisions.

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 machine-readable file 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 2019 and 2023 Price Transparency rules[58] under 45 CFR part 180.

a. Reducing File Size

As discussed in section I.A. of this preamble, file size is the most common concern that the Departments have heard from interested parties regarding the current In-network Rate Files. These files are often very large, making them challenging for users to download, analyze, and store.[59] In-network Rate File sizes often represent many terabytes of data a month for a single issuer,[60] and many exceed most local storage and processing capabilities.[61] Additionally, each issuer may have hundreds of separate files for each plan or coverage it offers, making aggregation and analysis highly resource intensive.[62]

The Departments have determined that the size of the In-network Rate File can be highly dependent on how it is organized. It is very common for multiple plans offered by the same issuer or administered by the same service provider to leverage the same provider networks with the same negotiated rates.[63] This means that when plans and issuers organize In-network Rate Files by plan ID, they often repeat the same negotiated rates across multiple plan files, which leads to significant duplicative data throughout the In-network Rate Files. The Departments have received consistent feedback about the challenges related to file size, and some of that feedback has suggested that the disclosure requirements be amended to organize In-network Rate Files by provider network, whereby each file would contain all rates negotiated by the reporting entity for that provider network, rather than having a file for each plan ID.[64]

[57] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49* (Aug. 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/affordable-care-act-faqs-49-2021.pdf.*

[58] 84 FR 65524 (November 17, 2019) and 88 FR 81540 (November 22, 2023).

[59] *See* Fred Diamond, *Payers' Price Transparency Data Still Not User-Friendly, Say Researchers* (Feb. 7, 2023), *https://www.fiercehealthcare.com/payers/health-insurance-plans-price-transparency-data-still-not-user-friendly-say-researchers; See also*David Muhlestein, *Improving Price Transparency Data: Recommendations From Practice,* Health Affairs. (Mar. 19, 2025), *https://www.healthaffairs.org/content/forefront/improving-price-transparency-data-recommendations-practice.*

[60] *See* David Muhlestein, *Improving Price Transparency Data: Recommendations from Practice,* Health Affairs (Mar. 19, 2025), *https://www.healthaffairs.org/content/forefront/improving-price-transparency-data-recommendations-practice.*

[61] *See* Aileen Y. Choi, Karen Manthe-Cohen, & Robert J. Rosso, *Technical Challenges with Private Health Insurance Price Transparency Data,* Congressional Research Service (June 13, 2025), *https://www.congress.gov/crs-product/R48570.*

[62] *See* Aileen Y. Choi, Karen Manthe-Cohen, & Robert J. Rosso, *Technical Challenges with Private Health Insurance Price Transparency Data,* Congressional Research Service (June 13, 2025), *https://www.congress.gov/crs-product/R48570.*

[63] *See* Lester Adler, Michael Fiedler, & Benjamin Ippolito, *Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce* (May 25, 2023), *https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce.*

[64] *See* Mark Robben, *Learnings from MRF Land,* Serif Health (Mar. 31, 2023), *https://www.serifhealth.com/blog/learnings-from-mrf-land;* Georgetown University, *Transparency in Coverage:*

Continued

Currently, the technical implementation guidance for the In-network Rate File allows plans and issuers flexibility to leverage a Table of Contents File to combine common negotiated rates across multiple In-network Rate Files, rather than publishing negotiated rates individually for each plan ID. This allows issuers to avoid duplicating prices within and across plans by linking the files for each plan that uses a given provider network to an underlying file of in-network prices.[65] Interested parties report that this reduces the total amount of data that must be analyzed to estimate market-level prices.[66] Many plans and issuers currently leverage this optimization. The Departments conducted an internal analysis in 2024 that sampled In-network Rate Files market wide and found that 83 percent of issuers sampled were leveraging a Table of Contents to organize their files.

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.[67]

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 redesignate paragraphs (b)(1)(i)(A) through (C) as paragraphs (b)(1)(i)(B) through (D), respectively, and add a new paragraph (b)(1)(i)(A) requiring each In-network Rate File to include the common provider network name for which negotiated rate information is included. 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.

In order to maintain the connection of rates to plans under this proposal, as further discussed in section III.C.2. of this preamble, the Departments also propose to amend redesignated paragraph (b)(1)(i)(B) 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. This would allow file users to cross reference the rates for a particular plan or policy of interest to its in-network rates.

The Departments also propose conforming amendments to redesignated paragraphs (b)(1)(i)(C) and (D). Specifically, the Departments propose to amend redesignated paragraph (b)(1)(i)(C) to specify that each In-network Rate File must include a billing code and a plain language description for each covered item or service included in the file, rather than under each coverage option offered by plans and issuers.[68] The Departments propose to amend redesignated paragraph (b)(1)(i)(D) to specify that all applicable rates must be included for each covered item or service included in the file, rather than for all items or services the plan or issuer covers, since not all applicable rates for items or services the plan or issuer covers are negotiated under a given provider network. Since plans and issuers would be required to make an In-network Rate File available for each provider network they maintain or contract with, they would ultimately still be required to disclose all applicable rates for items or services they cover, but those rates may not all be reported in every In-network Rate File organized by provider network.

The Departments are also proposing special aggregation rules for self-insured group health plans, which is described in more detail in section III.C.11. of this preamble.

b. Other Improvements for File Users

The Departments have determined 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 consumer's plan selection decisions. For example, the Departments understand that organizing In-network Rate Files by network would make it easier for employers and plan sponsors to analyze the negotiated rates of different networks to make informed decisions about which plans to offer their employees, potentially favoring networks with more competitive pricing, in addition to opening the door for employers to bring health care purchasing decisions in house through direct contracting with provider groups.[69] This proposal may be of particular benefit to smaller employers, who have historically had less leverage to negotiate directly with providers due to lower patient volume, by empowering them with access to network-level pricing data for negotiations.

Similarly, organizing in-network rate information by provider network would help service providers advise clients on network selection and cost management strategies. Likewise, researchers, academics, and policymakers would be better positioned to analyze pricing variations across different providers, specialties, and geographic areas within the same provider network and between

Recommendations for Improving Access to and Usability of Health Plan Price Data (Jan. 9, 2023), *https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.*

[65] *See* Lester Adler, Michael Fiedler, & Benjamin Ippolito, *Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce* (May 25, 2023), *https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce.*

[66] *Id.*

[67] *See* Jianhui Zhu, Yuting Zhang, & Daniel Polsky, *Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care,* 36 Health Affairs 9 (Sept. 2017). (Researchers found that, using 2016 *HealthCare.gov* data, 531unique provider networks were used by 281 different issuers, covering 5,022 qualified health plans in the Federally-facilitated Marketplaces).

[68] ''Plain language'' means ''written and presented in a manner calculated to be understood by the average participant, beneficiary, or enrollee'' under current 26 CFR 54.9815–2715A1(a)(2)(xx), 29 CFR 2590.715–2715A1(a)(2)(xix), and 45 CFR 147.210(a)(2)(xx) (redesignated as 26 CFR 54.9815–2715A1(a)(2)(xxi), 29 CFR 2590.715–2715A1(a)(2)(xx), and 45 CFR 147.210(a)(2)(xxi) under these proposed rules).

[69] *See* Samuel Haitoff, Jay Puthumana, Abhishek Dama, Yang Wang, et al., *Employer-Provider Direct Contracting: Practice and Policy,* Health Affairs Forefront (Apr. 1, 2025), *https://www.healthaffairs.org/content/forefront/employer-provider-direct-contracting-practice-and-policy; See also* Cynthia A. Fisher & Arthur B. Laffer, *Healthcare Price Transparency and Competition: How Real Price Transparency Can Reduce American Healthcare Costs More Than $1 Trillion Annually and Extend Life Expectancy* (Oct. 2023), *https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/652f0429f8ca6d62668bb43d/1697580073561/PRA_Fisher-Laffer+Healthcare+Price+Transparency+Paper_FINAL.pdf; See also* Christopher Whaley, Geetika Sachdev, Michael Bartlett, & Ge Bai, *It's Time for Employers to Bring Health Care Decisions In-House,* Health Affairs Forefront (Sept. 22, 2022), *https://www.healthaffairs.org/content/forefront/s-time-employers-bring-health-care-decisions-in-house.*

different networks that may inform policy interventions aimed at cost containment and market regulations.

The Departments understand that State insurance regulators may also be able to use network-level data to inform and improve rate review processes, optimize public option plans, and potentially guide antitrust enforcement.[70] Currently, State regulators may review unit cost and utilization trends submitted by issuers as part of their rate review process. Access to more consumable provider rates by network and product type in the In-network Rate Files may make it easier for regulators to validate unit cost trends, and to use those trends to assess the reasonableness of premium increases. Also, the reduction of duplicative data in the In-network Rate Files may make it easier for States to monitor rates to identify collusive behaviors, as well as help establish benchmarks for negotiations with providers as part of State oversight activities related to coverage programs.

c. Better Alignment With Hospital Price Transparency Reporting

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.[71] As discussed in section I.A. of this preamble, many interested parties have called for better alignment among Federal price transparency requirements to avoid consumer confusion and duplication of effort.[72]

Currently, the Hospital Price Transparency machine-readable files required under 45 CFR part 180 generally disclose rates at the provider network level.[73] By contrast, rates disclosed pursuant to the 2020 final rules are currently disclosed at the more granular plan or policy level, which presents complications for data matching. For example, a single set of Hospital Price Transparency rates negotiated between a plan and a hospital system could appear multiple times, under several different plan names, in an issuer's current In-network Rate Files, without any reference to the provider network name in the Hospital Price Transparency file. Standardization of price disclosures for providers, plans, issuers, and procedures at the same level would allow for more accurate comparisons between the different types of transparency files.

The Departments seek comment on all aspects of these proposals.

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). Specifically, the Departments propose to remove the requirement for plans and issuers to report the 14-digit Health Insurance Oversight System (HIOS) identifier (ID) or, if the 14-digit HIOS ID is not available, the 5-digit HIOS ID, and instead require them to report the HIOS identifier associated with each coverage option for which data is being reported in a form and manner as specified in guidance issued by the Departments. The Departments also propose to add a requirement for plans and issuers to report the product type (for example, Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)) associated with the coverage option for which data is being reported.

The 2020 final rules 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.[74] If a plan or issuer does not have a HIOS ID, it must use its Employer Identification Number (EIN). The Departments received significant comments on GitHub about requiring the 14-digit HIOS ID,[75] stating that this requirement would result in an enormous amount of redundant data because provider rates are not established based on distinct plan designs, but rather they are applied across multiple plan offerings. The Departments have determined that the number of HIOS digits that plans and issuers must report is a technical implementation detail that should be removed from regulation and set forth in technical implementation guidance to better maintain the Departments' flexibility to determine appropriate technical reporting requirements and to make refinements in response to changes in technology or health care industry business practice. This is in line with the Departments' general approach as described in the preamble to the 2020 final rules, to provide specific technical direction in separate technical implementation guidance, rather than in rulemaking, in order to keep pace with and respond to technological developments.[76] The Departments propose to amend the reporting requirements to specify that for each applicable coverage option offered by a group health plan or health insurance issuer, the plan or issuer must report the name and the HIOS identifier, or, if no HIOS identifier is available, the EIN.

In addition to the HIOS digit amendment, the Departments propose 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 received feedback that requiring plans and issuers to disclose health plan product types (for example, HMO, PPO) would promote more meaningful transparency around the health care pricing information disclosed in the In-

[70] Colorado's State law mandates insurers provide in-network allowed amounts data tailored for State-specific analyses. *See* Colorado Rev. Statutes § 10–16–168(4); Medical Group Management Association, *Unlocking the Potential of Healthcare Price Transparency Data* (Dec. 5, 2024), *https://www.mgma.com/articles/unlocking-the-potential-of-healthcare-price-transparency-data* (noting that Colorado uses price transparency data ''to inform rate reviews, optimize [its] public option plans, and potentially guide antitrust enforcement,'' according to Colorado Insurance Commissioner Michael Conway); *See also* Sabrina Corlette, *The Health Plan Price Transparency Files Are a Mess: States Can Help Make Them Better,* Health Affairs Forefront (May 5, 2023), *https://chirblog.org/the-health-plan-price-transparency-data-files-are-a-mess-states-can-help-make-them-better.*

[71] Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

[72] *See* American Hospital Association, *Fact Sheet: Hospital Price Transparency* (Feb. 24, 2023), *https://www.aha.org/fact-sheets/2023-02-24-fact-sheet-hospital-price-transparency.*

[73] 45 CFR 180.50.

[74] The 14-digit HIOS ID is comprised of the following: (1) issuer's ID number (first 5 digits, for example, 12345), (2) issuer's State abbreviation (next 2 digits, for example, WA); (3) issuer's three-digit Product ID (next 3 digits, for example, 001); and (4) a four-digit sequence number that is the ''Component ID'' (last 4 digits, for example, 0001). Thus, HIOS ID at the 14-digit level would be 12345WA0010001, 10 digits would be 12345WA001, 7 digits would be 12345WA, and 5 digits would be 12345.

[75] *See* GitHub Users, *GitHub Discussion: Updating to allow for reporting at the 10-digit HIOS level vs the 14-digit level #447,* GitHub, *https://github.com/CMSgov/price-transparency-guide/pull/447#issuecomment-1102946004* (last updated Apr. 19, 2022); *See also* GitHub Users, *GitHub Discussion: In-Network-Rates File: Schema and Definition of Plan Name and HIOS/EIN #44,* GitHub, *https://github.com/CMSgov/price-transparency-guide/discussions/44#discussioncomment-645647* (last updated Mar. 28, 2022).

[76] 85 FR 72158, 72221 (November 12, 2020).

network Rate and Allowed Amount Files. The Departments agree with this feedback, as product types dictate the fundamental relationship between the payer and the provider regarding patient access and volume, which are key leverage points in contract negotiations over rates. For example, in instances where HMOs may have narrow networks, providers contracting with such HMOs are likely to see increased patient volume, which may encourage such providers to contract at a lower rate with the HMO than they might with a PPO that is less likely to result in higher patient volume. Product types also dictate the fundamental relationship between payer and patient, with differences, for example, related to patient choice, cost-sharing responsibilities, and accessibility.

Additionally, the Departments have heard from interested parties that although negotiated rates under a provider network are typically consistent across plans and policies with respect to a specific item or service and a specific provider, these rates may differ based on product type. As such, interested parties have stated that requiring plans and issuers to include the product type for each applicable coverage option offered by the plan or issuer in the In-network Rate File would allow users to account for those differences.

In addition to providing context on how prospective rates differ, 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. Disclosing product type data in the Allowed Amount Files would enable more accurate and actionable comparisons for employers, researchers, and regulators so they can understand true market pricing for specific product types. In addition, not only could users of these data make comparisons of allowed amounts across different product types for a specific service for a single payer, they could also make comparisons for the same service based on product type across different payers. For example, an employer or plan sponsor offering a PPO plan could benchmark their out-of-network costs specifically against other PPO plans in the market, rather than a generalized average that includes potentially lower-cost HMOs, and they could use this information to make future plan coverage determinations. Furthermore, with allowed amounts tied to product type, employers and plan sponsors would better understand the actual tradeoffs in plan design—that is, not just premiums and network access, but also how much the plan will pay when employees go out-of-network. One study on out-of-network behavioral health care in employer-sponsored coverage observed that balance billing was higher for HMO enrollees versus non-HMO enrollees.[77] With the inclusion of data on plan type, employers could use historical allowed amounts segmented by plan type to evaluate the level of financial protection offered for out-of-network services.

The Departments acknowledge that product type is often used in the fully insured market, typically to comply with laws that apply to insured products. 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. The Departments also seek comment on whether possible inconsistency between State definitions of certain product types would cause confusion among file users. Under ERISA, self-insured plans are not currently required to be identified by product type and these traditional classifications may not necessarily apply or otherwise accurately describe a self-insured benefit arrangement. As such, 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

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*) (redesignated from paragraph (b)(1)(i)(C)(*1*) as discussed in section III.C.1. of this preamble) of the In-network Rate Files provision to require that in-network rates must be reflected as a dollar amount except for contractual arrangements under which a plan or 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 such circumstances, plans and issuers must report a percentage number, in lieu of a dollar amount, in the form and manner as specified in guidance issued by the Departments.

Paragraph (b)(1)(i)(C) of the current 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 rules 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.[78]

Under the 2020 final rules, paragraph (b)(1)(i)(C)(*1*) of 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. Accordingly, in the preamble to the 2020 final rules, the Departments provided a list of alternative reimbursement arrangements and summarized general reporting expectations for these arrangements, while acknowledging that the list was not exhaustive, as there may be other alternative reimbursement or contracting arrangements in use.[79] Specifically, the Departments summarized the 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. For example, the preamble to the 2020 final rules clarified that for payment arrangements under which adjustments are made after care is provided, the plan or issuer should disclose the base negotiated rate before adjustments are applied.[80]

[77] *See* Sarah A. Friedman, Hao Xu, Fernando Azocar & Susan L. Ettner, *Quantifying Balance Billing for Out-of-Network Behavioral Health Care in Employer-Sponsored Insurance,* 73 Psychiatric Services 1019 (2022).

[78] 85 FR 72158, 72226 (November 12, 2020).

[79] *Id.*

[80] 85 FR 72158, 72228 (November 12, 2020).

After the 2020 final rules were issued, interested parties used GitHub [81] and other forums to raise to the Departments' attention alternative payment arrangements under which reporting a current and accurate dollar amount for items and services in the In-network Rate File before the item or service is furnished may not be possible and requested guidance from the Departments on how to meet the disclosure requirements for such arrangements. Specifically, interested parties questioned the Departments on how to report 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. It is the Departments' understanding that these types of arrangements are not uncommon for certain types of items or services (such as low-volume procedures or high-cost, outlier inpatient care).

On April 19, 2022, the Departments issued FAQs Part 53 [82] to provide an enforcement safe harbor for satisfying the reporting requirements for plans and issuers that use an alternative payment arrangement that does not permit them to derive with accuracy specific dollar amounts contracted for covered items and services in advance of the provision of that item or service, or that otherwise cannot disclose specific dollar amounts according to the file formatting requirements as provided in the Departments' technical implementation guidance through GitHub. This guidance further advised that for contractual arrangements under which a plan or 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, plans and issuers may report a percentage number, in lieu of a dollar amount.

On September 27, 2023, the Departments clarified in FAQs Part 61 [83] that whether a plan or issuer is able to comply with the requirement to disclose certain rates as dollar amounts is a fact-specific determination and that the Departments would exercise enforcement discretion with respect to this requirement on a case-by-case basis, without any categorical ''safe harbor.'' The Departments instructed plans and issuers that are unable to determine dollar amounts for the applicable rate element to continue to follow the existing technical implementation guidance on GitHub.

Since issuing the guidance in 2023, the Departments have continued to receive feedback from interested parties that arrangements where a dollar amount is unable to be determined in advance are not uncommon and should be reflected in the data. Therefore, 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.

While the Departments recognize the importance of allowing plans and issuers to disclose non-dollar amount rates when a dollar amount is unknown in advance, the Departments reiterate 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.

The Departments seek comment on this proposal.

4. Enrollment Totals

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.

Affordable Care Act sections 1311(e)(3)(A)(iii) and (iv) require health plans seeking certification as a qualified health plan 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. However, the 2020 final rules do not require the disclosure of enrollment data.

Since the publication of the 2020 final rules, the Departments have received feedback from interested parties on the importance of additional data elements that would allow users to weigh different plans and coverage options to understand their relative influence on the overall landscape of pricing in health insurance, such as plan enrollment numbers, in line with the goals stated in the 2020 final rules.[84] The Departments understand that requiring the reporting of plan enrollment counts would enable file users to develop analytical models that prioritize negotiated rates for health care

[81] GitHub Users, *GitHub Discussion: If negotiated rate is based on percentage of charge—then how would this be reported in the in-network file? #23,* GitHub, *https://github.com/CMSgov/price-transparency-guide/discussions/23* (last updated Apr. 15, 2022); GitHub Users, *GitHub Discussion: Percentage of Billed Charges #315,* GitHub,*https://github.com/CMSgov/price-transparency-guide/discussions/315* (last visited Dec. 8, 2025); GitHub Users, *GitHub Discussion: Using Claims History for In-Network File when unable to extract rates (that is percent of billed charges) #197,* GitHub, *https://github.com/CMSgov/price-transparency-guide/discussions/197* (last updated Sep. 30, 2022).

[82] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act Implementation Part 53* (April 19, 2022), *https://www.cms.gov/files/document/faqs-part-53.pdf* and *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-53.*

[83] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act Implementation Part 61* (September 27, 2023), *https://www.cms.gov/files/document/faqs-about-affordable-care-act-implementation-part-61.pdf* and *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-61.*

[84] 85 FR 72158, 72161 (November 12, 2020); *See* Gary Claxton, Lynne Cotter, & Shameek Rakshit, *Challenges with Effective Price Transparency Analyses,* Peterson-KFF Health System Tracker (Feb. 25, 2025), *https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/.*

items and services based on the number of individuals covered by the corresponding plan or coverage, thereby focusing analysis on prices with the broadest impact on the insured population. Plans with higher enrollments may have a larger impact on negotiated rates, due to relative market power, approximate size of the overall market, and other factors. Additionally, this contextual information would expand opportunities to conduct analysis and compare rates across ''like'' plans. The Departments understand, based on feedback from interested parties, that enrollment data would be particularly useful in analyzing the small group and individual markets, where small differences may have pronounced impacts on trends and patterns. The Departments are specifying that the numerical enrollment totals must include the number of participants, beneficiaries, and enrollees (including all dependents) to distinguish from other reporting requirements plans and issuers are required to comply with.

Therefore, 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 and propose to require in new paragraph (b)(1)(i)(E) that plans and issuers are required to disclose enrollment totals for each coverage option they offer represented in the In-network Rate File. These proposed rules would require that plans and issuers include enrollment totals as of the date the In-network Rate File is posted. 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

The Departments propose to 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) to the In-network Rate Files provision that would require plans and issuers to exclude from each In-network Rate File a provider and their negotiated rate (provider-rate combination) for an item or service, if the plan or issuer determines it is unlikely that such provider would be reimbursed for the item or service based on the scope of the provider's license or area of specialty. The Departments further propose that plans and issuers must make such a determination using their internal provider taxonomy that is typically used during the claims adjudication process. The Departments have determined that excluding provider-rate combinations that are not likely to result in a reimbursement is necessary to limit unnecessary information that inflates file size and limits the accessibility of the data in the In-network Rate File.

These proposed rules at paragraph (b)(1)(i)(F) would require plans and issuers to use their internal provider taxonomy that is typically used during the claims adjudication process to determine which provider-rate combinations to exclude from the In-network Rate File. The internal provider taxonomy is part of the claims adjudication workflow, in which the plan or issuer assesses whether the billed item or service (represented by a billing code) aligns with the specialty of the rendering provider (represented by a provider taxonomy code). If the specialty does not meet the plan or issuer's requirements for that item or service, the claim may be denied. For example, the Departments expect that a plan or issuer's internal provider taxonomy would be unlikely to reimburse a claim submitted for a heart surgery submitted from a podiatrist because the billing code associated with a heart surgery would not match with a taxonomy code for a podiatrist.

The Departments understand that it is standard business practice for the internal provider taxonomy maintained by a plan or issuer to identify provider specialties using a standardized code set established by the National Uniform Claim Committee (NUCC).[85] The NUCC maintains standard provider taxonomy codes, which are used to define a provider's area of specialty.[86] Provider taxonomy codes are ten characters in length structured into three distinct ''levels'' including provider grouping, classification, and area of specialization.[87] The Departments understand that when a provider submits a claim for reimbursement to a plan or issuer, the provider must include their NUCC code and the billing code for the item or service along with certain other information. The Departments understand that plans and issuers then compare the NUCC provider taxonomy code and billing code included from the claim against their internal provider taxonomy mappings to determine if the claim can proceed through the next step of the payment adjudication process.

The Departments have observed that several third-party data aggregation vendors successfully demonstrated various methods to efficiently filter existing machine-readable file content by utilizing NUCC provider taxonomy codes, demonstrating these codes can help determine whether a provider is likely going to be eligible for reimbursement for a specific service or procedure.[88] Therefore, the Departments have determined this may be a viable approach to excluding certain provider-rate combinations.

The 2020 final rules 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 rules 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).[89] The Departments understand that plans and issuers frequently negotiate applicable rates at the provider organization level (such as large multi-specialty physician groups or integrated health systems) for every provider who is a member of that organization, regardless of whether that

[85] The NUCC establishes and maintains standard provider taxonomy codes, which are used to define a provider's area of specialty. Provider taxonomy codes are ten characters in length structured into three distinct ''levels'' including provider grouping, classification, and area of specialization. *See* National Uniform Claim Committee, *Health Care Provider Taxonomy, https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40* (last visited Dec. 8, 2025).

[86] *See* National Uniform Claim Committee, Health Care Provider Taxonomy, *https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40* (last visited Dec. 8, 2025).

[87] *See* National Uniform Claim Committee, Health Care Provider Taxonomy, *https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40* (last visited Dec. 8, 2025).

[88] *See* Sameer Mukhi, *Zombie Hunting: Filtering Approaches for Price Transparency Data,* Serif Health Blog (Sept. 20, 2024), *https://www.serifhealth.com/blog/zombie-hunting-filtering-approaches-for-price-transparency-data/;* Matt Najarian, *Clinically Implausible Rates Are Getting the Boot,* Turquoise Health Blog (Aug. 30, 2023), https://blog.turquoise.health/clinically-implausible-rates-are-getting-the-boot/.

[89] *See* Sameer Mukhi, *Zombie Hunting: Filtering Approaches for Price Transparency Data,* Serf Health Blog (Sept. 20, 2024), *https://www.serifhealth.com/blog/zombie-hunting-filtering-approaches-for-price-transparency-data/.*

provider would be likely to be reimbursed for that item or service.

Under the 2020 final rules, these rates are required to be disclosed. As a result, the Departments and interested parties have observed that 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. This overinclusion leads to significant file sizes, where In-network Rate Files are consistently enlarged by the inclusion of these unlikely provider-rate combinations. One early examination found that plans and issuers were posting approximately a petabyte (PB) [90] of information each month, in part due to the inclusion of what it refers to as ''clinically implausible rates.'' [91] In September 2024, the Departments analyzed a subset of In-network Rate Files and discovered that 73 percent of hematologists' negotiated rates were for 500 billing codes for services for which they would be unlikely to be reimbursed for. Another researcher reported that 96.5 percent of rates reported in the In-network Rate Files were for services with respect to providers who would be unlikely to be reimbursed for those services based on their specialty.[92] The Departments understand from feedback from interested parties that excessive file size creates network bandwidth and data storage problems for file producers and users alike, including significant costs associated with hosting, downloading, or analyzing significant amounts of data.

In addition, the Departments understand that excess data of limited use poses an unnecessary barrier to analyzing these files for users seeking to understand health care price variation, and to carrying out research on pricing data.[93] For example, one researcher identified a negotiated rate for a Caesarean section (C-section) for a neurological institute that was almost ten times the median rate for a C-section in that geographic region.[94] The researcher identified that the neurological institute must share the same rate for a C-section with all the providers in their parent organization per their contract even though neurologists would be unlikely to be reimbursed for a C-section.[95] These rates may distort patterns, averages, and medians when conducting market-wide analyses, leading to an inaccurate understanding of health care prices.[96]

The Departments recognize that the 2020 final rules specifying that plans and issuers disclose all negotiated rates for all covered items and services for all in-network providers have led to the disclosure of rates beyond what was intended by the Departments. 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. This significant decrease in file size would also reduce the storage space and computer processing resources needed to generate, store, and analyze In-network Rate Files, reducing burden for file producers and users alike.

Therefore, the Departments propose to revise 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 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), to require plans and issuers to publish a taxonomy machine-readable file. As discussed in more detail in section III.C.7. of this preamble, this new machine-readable file would disclose the mapping of billing codes to internal provider taxonomy codes, providing transparency into how plans and issuers determined which provider-rate combinations for covered items and services have been excluded from the In-network Rate Files based on the plan's or issuer's taxonomy rules.

The Departments seek comment on all aspects of this proposal. The Departments are particularly interested in feedback from interested parties on 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. The Departments are also interested in 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. While the Departments have included a discussion of some potential alternatives in section VI.D.2. of this preamble, the Departments are interested in feedback from interested parties on the relative burdens and benefits of alternative approaches to both producers and file users. The Departments are also interested in any concerns that parties may have with a proposal to require plans and issuers to make such exclusions at all. For instance, do file users have concerns about plans and issuers intentionally or inadvertently over-excluding provider-rate combinations from the In-network Rate File? Additionally, do file users recommend alternative approaches to best achieve the goals of transparency as set out in the 2020 final rules? For example, are there 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 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

[90] One petabyte (PB) is a unit of digital information equal to 1,000 terabytes (TB) in the decimal system (or 1,000,000 gigabytes (GB)). In binary terms, which is sometimes used in computing, 1 PB equals 1,024 terabytes.

[91] Adam Geitgey, *A Petabyte of Health Insurance Prices Per Month,* Turquoise Health Blog (July 11, 2023), https://blog.turquoise.health/a-petabyte-of-health-insurance-rates-a-month/.

[92] *See* David Muhlestein, *Improving Price Transparency Data: Recommendations From Practice,* Health Affairs Forefront (Mar. 19, 2025), *https://www.healthaffairs.org/content/forefront/improving-price-transparency-data-recommendations-practice.*

[93] *See* Gary Claxton, Lynne Cotter, & Shameek Rakshit, *Challenges with Effective Price Transparency Analyses,* Peterson-KFF Health System Tracker (Feb. 25, 2025), *https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/; See also* David Muhlestein, *Improving Price Transparency Data: Recommendations From Practice,* Health Affairs Forefront (Mar. 19, 2025), *https://www.healthaffairs.org/content/forefront/improving-price-transparency-data-recommendations-practice.*

[94] *See* Adam Stein, *Beyond the Trillion Prices: Pricing C-Sections in America,* D01thUb Blog (Oct. 13, 2022), *https://www.dolthub.com/blog/2022-10-03-c-sections/.*

[95] *Id.*

[96] *See* James Hines, *Zombie Rates: A Data-Driven Approach to Healthcare Price Transparency,* Gigasheet Blog (Jan. 27, 2025), *https://www.gigasheet.com/post/price-transparency-zombie-rates.*

claims per item or service, a proposal to increase the reporting period from 90 days to 6 months, a proposal to increase the lookback period from 180 days to 9 months, and a proposal to require reporting at the health insurance market level, rather than the plan or policy level. Lastly, the Departments propose to remove the phrase ''and provider'' from paragraph (b)(1)(ii)(C) to clarify 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.

The 2020 final rules at paragraph (b)(1)(ii)(C) require plans and issuers to disclose on a public website a machine-readable file 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.[97] 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.

a. Reducing the Claims Threshold

Initially, 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. In the 2019 proposed rules, the Departments proposed to require plans and issuers to omit out-of-network allowed amounts from the Allowed Amount File in relation to a particular item or service and provider when including this data would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 10 different claims for payments.[98] The Departments requested comment on whether a higher minimum claims threshold, such as a threshold of 20 claims, would better mitigate privacy concerns and minimize complexity in complying with Federal or State privacy laws without compromising the integrity of the compiled information.[99] As discussed in the 2020 final rules, some commenters expressed concerns about maintaining Health Insurance Portability and Accountability Act (HIPAA) protections on the Allowed Amount File due to the small number of claims associated with specific items and services for out-of-network providers.[100] Several commenters stated that the threshold of 10 different claims to require public disclosure of unique historical allowed amounts would be too low to protect consumers' protected health information. Based on commenters' concerns, the Departments determined that increasing the claims threshold from 10 to 20 claims in the 2020 final rules would better balance the policy goal of transparency with the need to protect participants, beneficiaries, and enrollees from the possibility of being re-identified through the data included in the Allowed Amount File.[101]

The Departments clarified in technical implementation guidance that while a plan or issuer with fewer than 20 claims for a particular item or service must omit information on payment of out-of-network allowed amounts for that item or service, the Allowed Amount File must still be produced pursuant to paragraph (b)(1)(ii)(C); however, information in the file would be minimal due to the lack of information to report.[102] The Departments reasoned that the file must be created so that file users know that the plan or issuer does not have any claims that meet the 20-claims threshold, and that maintenance of such files would be minimal.[103]

Since the publication of the 2020 final rules, however, the Departments have received feedback and observed that many plans and issuers produce Allowed Amount Files with limited to no out-of-network claims data, which the Departments have determined is due in part to the 20-claims threshold. Given the limited data available, file users are unable to perform meaningful analyses using out-of-network data.[104] This is because there are too many ''gaps'' in out-of-network data in the file, which occur whenever there are fewer than 20 claims for a specific out-of-network item or service for a given plan.

Out-of-network price transparency data is vital for employers, researchers, and regulators to analyze health care spending, benchmark costs, and inform future policy decisions. This data offers new insight into actual health care expenditures, including a window into the price of an item or service in the context of an arms-length transaction between a provider and a plan or issuer who have not negotiated the rate, and where there is therefore no discount associated with the advantage to a provider of being ''in network.'' [105] Employers and plan sponsors can use this data to benchmark costs, refine benefit designs, and negotiate more effectively with administrators. Health care providers and service providers can use it to estimate what they might be reimbursed and what their patients or their participants, beneficiaries, or enrollees, respectively, might be charged for out-of-network care.[106]

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.[107] The policy stipulates that

[97] 26 CFR 54.9815–2715A3(b)(1)(ii)(C), 29 CFR 2590.715–2715A3(b)(1)(ii)(C), and 45 CFR 147.212(b)(1)(ii)(C).

[98] 84 FR 65464, 65481 (November 27, 2019).

[99] *Id.*

[100] 85 FR 72158, 72233 (November 12, 2020).

[101] *Id.*

[102] Centers for Medicare & Medicaid Services. *Technical Clarifications Question 23: After we compile all our allowed amounts and billed charges for the Allowed Amount file, how do we adjust the file to make sure we have taken into account the 20-claim threshold?, https://www.cms.gov/priorities/healthplan-price-transparency/overview/resources/technical-clarification* (last visited Dec. 8, 2025).

[103] Centers for Medicare & Medicaid Services. *Technical Clarifications Question 15: If a plan does not meet the 20-claim threshold for any of its allowed amounts, must a file be produced?, https://www.cms.gov/priorities/healthplan-price-transparency/overview/resources/technical-clarification* (last visited Dec. 8, 2025).

[104] Matthew Robben, *Learnings from MRF Land,* Serif Health Blog (Mar. 31, 2023), *https://www.serifhealth.com/blog/learnings-from-mrf-land.*

[105] Zack Cooper, Hao Nguyen, Nathan Shekita & Fiona Scott Morton, *Out-of-Network Billing and Negotiated Payments for Hospital-Based Physicians,* 39 Health Affairs 24 (2020) (published Dec. 16, 2019), *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00507.*

[106] Rebecca Hodes, *Demystifying* ''*Allowed Amounts*'' *in Out-of-Network Billing,* Mentaya Blog (Apr. 1, 2025), *https://www.mentaya.com/blog/demystifying-allowed-amounts-in-out-of-network-billing.*

[107] Centers for Medicare & Medicaid Services, *Limited Data Set (LDS) Files, https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/limited-data-set-lds* (last modified July 7, 2025); Research Data Assistance Center (ResDAC), *CMS Cell Size Suppression Policy*

no cell (such as admittances, discharges, patients, services, etc.) containing a value of 1 to 10 can be reported directly.[108] This policy is a safeguard designed to prevent the identification of individual Medicare or Medicaid beneficiaries when CMS data is shared publicly [109] and helps ensure compliance with Federal privacy laws, such as HIPAA, by reducing the risk of re-identification of individuals from aggregated data.

The Departments have determined that the proposed 11-claims threshold, combined with the proposal to require reporting by health insurance market type discussed later in this section of the preamble, would provide sufficient protection against the disclosure of sensitive patient information. Under the proposal to require reporting by health insurance market type, data disclosed in the Allowed Amount Files would not be directly associated with a single plan or policy when two or more plans or policies are aggregated into one file (as discussed in more detail later in this section of the preamble). Instead, the data would be aggregated to a broader health insurance market type (such as ''individual market'' or ''large group market''). For example, a unique allowed amount and billed charge for a given item or service furnished by a given provider might be associated with ''Large Group Market offered by Insurer A,'' rather than ''Insurer A's Employer X Gold PPO Plan.'' This high-level aggregation would provide a strong shield for patient privacy.

Additionally, the Departments also 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.

As such, 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 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. This change would reflect the Departments' current policy (other than the proposed changes to this paragraph discussed elsewhere in this section of the preamble), and is proposed as a technical clarification.[110] The parenthetical in paragraph (b)(1)(ii)(C) would be revised to specify that a plan or issuer must omit out-of-network allowed amount and billed charge data in relation to a particular item or service if including it would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of that item or service in a single health insurance market. The Departments seek comment on this proposal.

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 9 months prior to the publication date of the file. This amendment would increase the reporting period from 90 days to 6 months and increase the lookback period from 180 days to 9 months. In the preamble to the 2020 final rules, the Departments noted that they would monitor the implementation of the lookback period for the Allowed Amount Files and may revisit it if the 90-day reporting period and 180-day lookback period failed to yield sufficient out-of-network data on allowed amounts.[111] By approximately doubling the reporting period from 90 days to 6 months and shifting the lookback period from 180 days to 9 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 welcome comment on all aspects of this proposal. The Departments are also 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 this preamble) on the proposed changes to the lookback period. For example, since the proposed quarterly reporting period would require reporting 6 months' worth of data every 3 months, the Departments 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

Lastly, 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 (as defined in proposed new 26 CFR 54.9815–2715A1(a)(2)(xi), 29 CFR 2590.715–2715A1(a)(2)(x), and 45 CFR 147.210(a)(2)(xi) and discussed in section III.A. of this preamble). 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 have received feedback from interested parties indicating that aggregating health insurance out-of-network claims by health insurance market type—specifically (1) individual market, (2) large group market, (3) small group market, and (4) self-insured group health plans maintained by the same plan sponsor—provides a structured approach to organizing and analyzing claims data. Interested parties suggested that this categorization would be useful because pricing dynamics and reimbursement rates tend to vary by

(Jan. 26, 2024), *https://resdac.org/articles/cms-cell-size-suppression-policy.*

[108] *Id.*

[109] *Id.*

[110] Centers for Medicare & Medicaid Services. *Technical Clarifications Question 23: After we compile all our allowed amounts and billed charges for the Allowed Amount file, how do we adjust the file to make sure we have taken into account the 20-claim threshold?, https://www.cms.gov/priorities/healthplan-price-transparency/overview/resources/technical-clarification* (last visited Dec. 8, 2025).

[111] 85 FR 72158, 72230 (November 12, 2020).

market segments.[112] Therefore, the Departments expect that organizing out-of-network allowed amounts in this way would facilitate a more comprehensive assessment of the volume and characteristics of out-of-network claims and enhance the data's utility for users by aligning it with the distinct pricing structures and regulatory environments of each market type. It would also make comparing allowed amounts for plans and policies within the same market easier for file users.

If this proposed amendment is finalized, the Departments also anticipate a significant reduction in the overall number of Allowed Amount Files (since these would be reported at the market level, rather than at the plan level), even as those data files become more populated. Additionally, this approach would further protect patient privacy, as discussed earlier in this section of the preamble, because data aggregated across two or more plans or policies would not be directly associated with a single plan or policy.

On the other hand, the Departments acknowledge that requiring market-level aggregation may limit or eliminate the ability of file users to map specific allowed amounts and billed charges to an individual plan or policy. However, plans and issuers would still be required under paragraph (b)(1)(ii)(A) to disclose information about the plans or policies whose allowed amounts are included in each file. Therefore, file users would be able to determine which plans or policies have allowed amounts included in the Allowed Amount File, even if they would be unable to match a specific out-of-network allowed amount to a particular plan or policy. 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.

Lastly, the Departments are also proposing special aggregation rules for self-insured group health plans, which are described in more detail in section III.C.11. of this preamble. The Departments request comment on all aspects of these proposals. For a discussion of the Departments' proposal to amend paragraph (b)(1)(ii)(A) related to disclosing HIOS IDs and product types in Allowed Amount Files, see section III.C.2. of this preamble.

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

The Departments propose to require plans and issuers to publicly disclose, through machine-readable files, 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 contextual machine-readable file to help users find the In-Network Rate, Allowed Amount, and prescription drug machine-readable files required under paragraph (b)(1) and new paragraph (b)(2) of this section, which the Departments are proposing to identify as a Text File.[113] In particular, the Departments propose to amend 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212 to redesignate paragraphs (b)(2) through (4) as paragraphs (b)(3) through (5), respectively, and to add new paragraph (b)(2) to require contextual files. 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).

The 2020 final rules 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 machine-readable files, 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. In the 2020 final rules, the Departments recognized the necessity of public disclosure of health care pricing information due to the variation in health care prices across the health care industry and the complexity of health insurance and health plan coverage.[114]

While price disclosures required in the 2020 final rules contributed to a broader understanding of the data that drives plan and issuer payments for health care items and services, the intervening years demonstrated that additional context is necessary to promote a fuller understanding of health care industry pricing dynamics. These proposed additional files would help make the data disclosures of the machine-readable files required under paragraph (b)(1) more meaningful and accessible, which would promote greater transparency in health care pricing information. 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 prepared pursuant to these proposed rules, and a single Text File to facilitate locating the other machine-readable files required under these proposed rules. Each Change-log File would reflect changes in data from one In-network Rate File (under these proposed rules, prepared for a specific provider network) to the publishing of the next In-network Rate File; each Utilization File would reflect utilized covered items and services under the plans and policies represented in one In-network Rate File; and each Taxonomy File would represent the mapping of billing codes to internal provider taxonomy codes used as part of the claims adjudication

[112] There is evidence of consistent alignment *within* market types and significant divergence *between* market types when comparing allowed amounts relative to a common benchmark (Medicare). This pattern holds even for in-network prices. Out-of-network allowed amounts often derive from similar underlying cost structures. Caroline Hanson, Ian McCarthy, Eamon Molloy & Karen Stockley, *Providers Paid Substantially Less by Marketplace Nongroup Insurers Than by Employer Small-Group Plans, 2021,* 43 Health Affairs 1672 (Dec. 20, 2024), *https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00913.*

[113] As previously mentioned, several proposed amendments would amend requirements related to the prescription drug machine-readable files, specifically: the requirement that plans and issuers must include a plain text file in a .txt format in the root folder of a plan's or issuer's website as describe in proposed paragraphs (b)(2)(iv) of 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212 (section III.C.7.d of this preamble) and the requirements related to the method and format for disclosing information to the public as described in proposed paragraph (b)(3) of 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212 (section III.C.9 of this preamble).

[114] The 2020 final rules stated that ''many consumers do not fully comprehend the basics of health coverage, much less the more complex facets of the health care system that can affect an individual's out-of-pocket cost for items and services, including: Its specialized billing codes and payment processes; the various specialized terms used in plan and coverage contracts and related documents (such as copayment and coinsurance); and the various billing and payment structures plans and issuers use to compensate providers and assign cost-sharing liability to individuals (for example, bundled payment arrangements).'' 85 FR 72158, 72210 (November 12, 2020).

process for the plans and policies represented in the In-network Rate File. Each Text File would direct users to the location of the machine-readable files required under paragraphs (b)(1) and (2) and provide contact information for an individual who can address inquiries and issues related to the required machine-readable files. 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

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 publicly posted in the form as specified in guidance issued by the Departments, consistent with redesignated and amended paragraph (b)(3) and discussed in section III.C.9. of this preamble. It would be required to be posted in accordance with the timing requirements proposed at redesignated paragraph (b)(4)(iii) and discussed in section III.C.10. of this preamble. Specifically, it 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).[115] The purpose of the proposed Change-log File would be to assist all file users in identifying changes to the required information in the In-network Rate File from one reporting period to the next. 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 total amount of information contained in every plan's and issuer's set of machine-readable files is extremely large,[116] creating challenges for file users of all backgrounds in ingesting and analyzing the information. Therefore, rather than downloading and analyzing each set of newly posted files to determine if there have been any changes to the required information in a plan's or issuer's In-network Rate File, file users would only need to look at the Change-log File to determine which new files they need to examine. These proposed rules would create efficiencies for file users by reducing the amount of required data storage for file users and save time by eliminating the need to review data that has not changed. This would also allow researchers and other interested parties to more easily track changes over time.

The Departments seek comment on how the Change-log File can be most effective, including what machine-readable file format it should be required to be published. The Departments also seek comment on if any specific information should be required to be included, and if so, what information should be required to be included in the Change-log File. 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. The Departments also seek comment on 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 Departments expect that plans and issuers would likely incur a burden from having to create this new file and develop a system for identifying changes, therefore the Departments are interested in the minimal level of change information necessary to create the desired efficiencies. For instance, the Departments assume that identifying changes to rate information from one In-network Rate File to the next is critical to the usefulness of the Change-log File but are less certain of the relative benefits and drawbacks of requiring plans and issuers to identify less material changes, such as minor changes to the plain language description for each billing code. The Departments also seek comment on the specific burdens to plans and issuers for the different possibilities for a Change-log File.

b. Utilization File

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 6 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 Utilization File 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 this preamble and in accordance with the timing requirements proposed at redesignated paragraph (b)(4)(iv) and discussed in section III.C.10. of this preamble. Specifically, it 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.

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. On its own, the Utilization File would reveal which providers are actively serving enrollees and delivering covered items and services within a plan's or issuer's network. If a provider appears in a plan's or issuer's In-network Rate File but does not appear in the plan's or issuer's Utilization File, then users may reasonably conclude that that provider, despite having a negotiated rate, has had no recent interactions with that plan's or issuer's participants, beneficiaries, or enrollees. This type of analytical approach to the Utilization File would provide empirical evidence regarding which providers are actively providing

[115] See Table 2 for an example.

[116] Gary Claxton, Lynne Cotter, & Shameek Rakshit, *Challenges with Effective Price Transparency Analyses,* Peterson-KFF Health System Tracker (Feb. 25, 2025), *https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/.*

covered items and services to participants, beneficiaries, or enrollees and billing for items or services within a plan's network, as opposed to relying on static provider directories, which can be over-inclusive when describing providers' availability. In turn, the Utilization File could aid consumers in understanding whether certain providers are actually available (whether they are actively seeking new patients or have the capacity to accept new patients) to provide covered items and services to participants, beneficiaries, and enrollees under certain plans.

Extending this type of analysis to all providers for a plan or issuer's network could provide important insights into network adequacy. For example, a plan's In-network Rate File might include many providers who, in theory, deliver a wide range of services in a particular geographic area. However, if the Utilization File reveals that those providers are not actually delivering those services, then this could indicate whether health plans are offering a sufficient and accessible network of providers for the services their members use.

The Utilization File could also provide insights into the types of services performed by specific providers, by indicating whether those providers perform more routine procedures within their field of expertise or instead concentrate on rarer or more complex procedures. This type of analysis performed with the Utilization File could reveal whether networks in specific geographic areas have larger pools of providers performing certain procedures, thereby offering valuable insights into regional provider availability and specialization. Such insights into provider specialization would not be evident from the In-network Rate File alone, since that file lists negotiated rates for all services, regardless of whether a specific provider actually performs them.

The Departments have determined that taken together, these examples of analyses that could be performed with the Utilization File suggest that this file would become a valuable transparency resource for researchers, regulators, consumer-facing decision-tool makers, and other interested parties, who could help consumers benefit from a more accurate picture of provider service patterns, along with the information published in the In-network Rate Files. Some organizations that currently use the In-network Rate Files already combine the data in those files with utilization data from other sources to conduct these types of analyses.[117] But by requiring plans and issuers to generate and publish Utilization Files, this pairing of in-network rates to actual utilization would become more widely and consistently available to users of the Transparency in Coverage pricing data. Finally, the Utilization Files would act as an important qualifier to the data disclosed in the In-network Rate Files, by providing a strong indication of the degree to which negotiated rates are used by providers to deliver actual services to health plan enrollees.

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. The Departments have determined this appropriately balances the need for additional transparency around which in-network providers are actively providing a covered item or service with the burden on plans and issuers associated with extracting data from a claims data repository. The Departments recognize that because plans and issuers would not be required to disclose the number of items and services performed by specific providers, the Utilization File would be limited in its ability to address some research questions that might be of interest to some interested parties. As such, 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. The Departments also request comment on 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 Departments also request comment on 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 6 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.[118] This figure is obtained from research suggesting that claims that take the longest to resolve can take up to 75 days to reach payment determination.[119] While 75 days is considerably shorter than 6 months, due to the lack of available metrics on the time it takes payers to complete payment to providers, the Departments propose a longer lookback period to ensure the Utilization File captures all applicable payments.

The Departments request comment on this lookback period.

c. 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. Under these proposed rules and as discussed in section III.C.5. of this preamble, plans and issuers would be required to use their internal provider taxonomy to determine whether to exclude certain provider-rate combinations from the In-Network Rate file because they are unlikely to result in reimbursement, and therefore do not provide useful information to users of the In-network Rate File. 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 this preamble. Additionally, and as discussed in section III.C.10. of this preamble, the Departments propose to

[117] Sameer Mukhi, *Zombie Hunting: Filtering Approaches for Price Transparency Data,* Serf Health Blog (Sept. 20, 2024), *https://www.serifhealth.com/blog/zombie-hunting-filtering-approaches-for-price-transparency-data/.*

[118] FinThrive, *Understanding the Claims Lifecycle: A Step-by-Step Guide* (Nov. 26, 2024), *https://finthrive.com/blog/understanding-the-claims-lifecycle-a-step-by-step-guide.*

[119] Rajiv Chandawarkar, Prakash Nadkarni, Elizabeth Barmash, Stephany Thomas, et al., *Revenue Cycle Management: The Art and the Science,* 12 Plastic and Reconstructive Surgery Global Open 7 (July 2, 2024).

add paragraph (b)(4)(v) to 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 machine-readable file required under (b)(1)(i) in a subsequent quarter, the posted Taxonomy File would not be required to be updated for that quarter.

The Taxonomy File would provide transparency into how plans and issuers determine whether to exclude certain provider-rate combinations from an In-network Rate File. As explained in section III.C.5. of this preamble, the Departments are proposing to require plans and issuers to exclude from each In-network Rate File a provider-rate combination for an item or service, if the provider would be unlikely to be reimbursed for the item or service given that provider's area of specialty, according to the plan's or issuer's internal provider taxonomy. This is because rates for such items and services generally do not provide useful information to users of the In-network Rate File, and excluding them would improve the reliability of the data reported and significantly reduce the file size.

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.

Requiring plans and issuers to create a separate provider Taxonomy File that discloses their internal provider taxonomy would provide valuable data for file users about the data included in the In-network Rate File. The Taxonomy File would disclose the mapping rules already used by plans and issuers for their claims adjudication process, ensuring that the mapping rules could be available to file users to understand how plans and issuers determined which provider-rate combinations to include in the In-network Rate Files and which to exclude.

In addition to providing critical contextual information to understand the data in the In-network Rate File, the proposed requirement for plans and issuers to provide a Taxonomy File would also offer researchers and other file users potentially valuable insights into the degree of standardization in mapping used by plans and issuers, and how this varies across different market types. Furthermore, the Taxonomy File would offer new information to potentially guide future rate negotiations between plans and issuers and providers, particularly concerning the scope of reimbursable services by provider type to include in contract discussions.

The Departments solicit comment on the Taxonomy File proposal, including whether there are other 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 also 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 machine-readable files required under paragraphs (b)(1) and (2); (2) a direct link to the URL for the machine-readable files 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 machine-readable files required under paragraphs (b)(1) and (2).[120] This contact information must be prominently displayed on the same website where the machine-readable files are made available and be kept updated per the requirements in paragraph (b)(4)(vi) of this section. This information would allow users to more easily locate the plan's or issuer's machine-readable files, increasing both automated and non-automated access to the machine-readable files. Additionally, and 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 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section.

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. To assist the public, CMS provided guidance on how to locate machine-readable files on the Transparency in Coverage website.[121] However, in considering how to improve both automated and non-automated access to the machine-readable files, the Departments have determined it is appropriate to require a standardized Text File at a consistent location (specifically, the root folder of the plan's or issuer's website), which would provide a direct link to the machine-readable files 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 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 machine-readable files 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 machine-readable files would allow the public to reach out for assistance with accessing or utilizing the machine-readable files.

Therefore, the Departments propose to require the Text File to include plan or issuer point-of-contact information, who could help in verifying the contents of the machine-readable files and respond to requests for assistance related to accessing and utilizing the machine-

[120] As previously mentioned, proposed paragraph (b)(2)(iv) (relating to the proposed requirement to include a plain text file in a .txt format in the root folder of a plan's or issuer's website) and (b)(3) (relating to the method and format for disclosing information to the public) of 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212 applies to the prescription drug machine-readable files.

[121] Centers for Medicare & Medicaid Services, *Use of Pricing Information Published Under the Transparency in Coverage Final Rule, https://www.cms.gov/priorities/healthplan-price-transparency/overview/use-pricing-information-published-under-transparency-coverage-final-rule* (last modified Aug. 14, 2025).

readable files. The Departments also propose to require that the point-of-contact information be posted prominently on the same web page where the machine-readable files are located to further reduce the difficulty file users have faced in reaching out to plans and issuers for assistance. Under this proposal, and consistent with the flexibility described in redesignated 26 CFR 54.9815–2715A3(b)(3)(iv), 29 CFR 2590.715–2715A3(b)(3)(iv), and 45 CFR 147.212(b)(3)(iv), nothing would prevent a group health plan or health insurance issuer who contracts with a service provider to provide the machine-readable files on their behalf from listing the service provider as a point-of-contact.

The Departments considered whether frequent changes to the host website could negate the benefit to automated access as well as impose burden in creating and maintaining this Text File. The Departments have determined that the benefits outweigh the drawbacks for having a plan or issuer ensure that the public website on which it chooses to host the machine-readable file includes a Text File in the root folder that includes a direct link to the machine-readable files to establish and maintain automated access.

The Departments also propose these new requirements in accordance with Executive Order 14221 Section 3(b), which directs the Departments to ''issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans.'' [122] CMS added new requirements to the 2019 Hospital Price Transparency rule [123] in the 2023 Hospital Price Transparency rule.[124] The 2023 Hospital Price Transparency rule,[125] which went into effect on January 1, 2024, requires certain hospitals to include a Text File in the root folder of the hospital's public website that includes a direct link to the hospital's machine-readable file containing standard charge information and a link in the footer on its website that links directly to the publicly available web page that hosts the link to the machine-readable file. In proposing to adopt a similar requirement, the Departments would align this requirement with the 2023 Hospital Price Transparency rule [126] requirement to improve machine-readable file accessibility for the public. Based on feedback on this similar provision for the 2023 Hospital Price Transparency rule,[127] the Departments have determined this would be a relatively simple, low burden change, and that the increased benefits to the public outweigh the costs.

The Departments request comment on all aspects of this proposal, and 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 machine-readable files 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.

In the 2020 final rules, the Departments clarified that this meant all machine-readable files must conform to a non-proprietary, open-standards format that is platform-independent and made available to the public without restrictions that would impede the re-use of the information.[128]

The Departments are not including in these proposed rules any changes to the required format for disclosing information under paragraph (b). The Departments are, however, considering whether to indicate in either rulemaking or technical implementation guidance that the machine-readable files required under paragraph (b) must be published in a single, non-proprietary, open-standards format, and, if so, naming either JavaScript Object Notation (JSON) or Comma Separate Value(s) (CSV) as that single format in technical implementation guidance. As such, the Departments seek input from interested parties on such potential future rulemaking or technical implementation guidance.

In the 2019 proposed rules, the Departments requested comment on whether the final rules should require a single, specific non-proprietary format for the machine-readable files, specifically JSON files.[129] The Departments noted that this format generally is easily downloadable, and it could simplify the ability of file users to access the data. The Departments received a comment in support of requiring JSON as the standardized file format for the required machine-readable files. However, in the 2020 final rules, the Departments acknowledged that their internal technical experts agreed that the speed of technology developments weighs heavily in favor of maintaining flexibility to adopt a suitable file format as a non-substantive, operational requirement that will be identified in the relevant implementation guidance for the required machine-readable files.[130] In addition to maintaining the Departments' flexibility, the Departments indicated in the 2020 final rules that being overly prescriptive regarding the file type would impose an unnecessary cost on issuers and service providers despite the advantages of JSON.[131] Therefore, the Departments did not require in the 2020 final rules one, specific non-proprietary open format. The Departments did, however, indicate that they would provide additional guidance regarding the file format in future technical implementation guidance.[132]

When first developing machine-readable file guidance, the Departments considered various file formats that could satisfy the goals of the final rules, including hierarchical, tabular, and columnar formats. The technical implementation guidance hosted on GitHub includes a repository set of schemas describing the data formats (encoded as JSON, Extensible Markup Language (XML), and CSV). The technical implementation guidance was also published as part of the Paperwork Reduction Act (PRA) package developed for the Information Collection Requests (ICRs) included in the 2020 final rules.[133] To help plans and issuers understand the machine-readable file requirements, the Departments built a

[122] Centers for Medicare & Medicaid Services, *Use of Pricing Information Published Under the Transparency in Coverage Final Rule, https://www.cms.gov/priorities/healthplan-price-transparency/overview/use-pricing-information-published-under-transparency-coverage-final-rule* (last modified Aug. 14, 2025).

[123] 84 FR 65524 (November 17, 2019).

[124] 88 FR 81540 (November 22, 2023).

[125] *Id.*

[126] 88 FR 81540, 82112 (November 22, 2023).

[127] 88 FR 81540 (November 22, 2023).

[128] 85 FR 72158, 72242 (November 12, 2020).

[129] 84 FR 65464, 65481 (November 27, 2019).

[130] 85 FR 72158, 72242 (November 12, 2020).

[131] 85 FR 72158, 72272 (November 12, 2020).

[132] *Id.*

[133] Transparency in Pricing Information (CMS–10715), OMB control number 0938–1429 (October 14, 2021), *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202410-0938-006.*

JSON schema on the Transparency in Coverage GitHub site and provided samples in JSON and XML formats.

After more than 3 years since the publication of the 2020 final rules' machine-readable file requirements, the Departments have had time to analyze the landscape of plan and issuer file format use in published machine-readable files and have considered feedback from interested parties on the viability, benefits, and drawbacks of various file formats. Given that, based on internal analysis, over 90 percent of plans and issuers have chosen one format (that is, JSON), that initial flexibility regarding file type may no longer be needed, and to advance the goals in section 3(b) of Executive Order 13877 [134] 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 machine-readable files 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 have received feedback in support of specifying either JSON or CSV formats. Both JSON and CSV formats have benefits and drawbacks, and each serves different audiences. JSON is a widely adopted industry standard that allows the machine-readable file data to be accessible to various users and adaptable to various use-cases. In the 2020 final rules, the Departments noted that the machine-readable files' primary benefit to health care consumers will be the availability of web-based tools and mobile applications developed for consumer use by third-party developers, aggregation, and analysis conducted by researchers, and oversight efforts by regulators. The required machine-readable files will be optimal for ingestion, data aggregation, and data analysis, all of which are functions performed by third-party internet-based developers, researchers, and regulators who use large data sets in a manner that will lead to benefits for consumers.'' [135] In the 3 years since the publication of the machine-readable file requirements, the Departments have observed the creation of a number of web-based tools developed for consumer use by third-party developers. These developers provided feedback on the benefits and drawbacks of various file formats but largely indicated a preference for using JSON due to its flexibility and adaptability.

It is the Departments' understanding that JSON's suitability for the broad, high-volume disclosures required pursuant to the Transparency in Coverage rules stems in part from its ability to effectively handle different stages of the process by which raw data is transformed into more user-friendly outputs. This data process, known as Extract, Transform, and Load (ETL), begins with raw data gathered (''extracted'') from a range of sources; then cleaned and standardized (''transformed'') into a selected format; and then loaded into a repository or database for subsequent uses (and ultimately, for downstream analysis). Different file formats are best suited for different stages of the ETL process. An optimal file format for the machine-readable files would accurately represent the data's underlying relationships through the file format's organizational structure, ensure efficient storage and processing of the data, and make the data accessible to a variety of users with diverse use cases. As applied to the machine-readable files, JSON's strength is its capacity to handle all stages of the ETL process. It is also lightweight and effective for the extraction step from raw data, and it is highly flexible for both the initial transformation step and subsequent transformation of machine-readable file data by downstream users. The widespread use of JSON for the machine-readable files is expected given the advantages of JSON in the data extraction stage, and in efficiently representing the underlying complex relationships in machine-readable file data. Additionally, JSON is widely adopted by industry and government as a common means of data exchanges, and enjoys native support for most programming languages, meaning that these languages and tools already ''speak'' JSON, limiting the time and effort required to work with JSON-formatted files.

The Departments have also received feedback that many file users, especially researchers, prefer to work with the machine-readable file data in CSV format due to its relative simplicity and accessibility, and that they migrate the data from JSON to CSV in order to conduct analyses. For example, CSV files can include a header row specifying the titles of each subsequent column in the file for visual simplicity. CSV files are highly portable and can be loaded into commonly used tools that do not require engineering capability such as Microsoft Excel and may be a more familiar format to a wider audience than JSON.

The Departments recognize that both of these file formats have limitations. A JSON format requires users to have some data engineering sophistication to interact with the machine-readable files directly—capabilities and resources that many individuals and organizations may not have. Additionally, working with JSON may require more computing resources than some other formats to process. Other file formats may have attributes that suit the needs of certain users of the machine-readable files better than JSON does. However, the drawback with using CSV or any row-based tabular flat file structure for machine-readable file publishing and consumption of the amount of data that is being generated pursuant to the Transparency in Coverage requirements is that it makes it challenging for a file user with a standard personal computer to load and work with it effectively. For example, those opening large CSV machine-readable files in Microsoft Excel will encounter the software's limitations in how many rows of data can be opened and will often crash the program.[136] Most significantly, the flat structure of CSV files would force publishers to create numerous columns where the same data values would be repeated up to millions of times per file, which is both inefficient and impractical given current file size concerns by interested parties.

As explained, the Departments are now strongly considering specifying a single, non-proprietary open format in technical implementation guidance. Specifying the file format in technical implementation guidance would reduce flexibility for plans and issuers in selecting alternate file formats but would further standardize reporting of critical health care pricing information. The Departments are of the view that specifying a single format presents an important part of fully realizing the goals of price transparency and Executive Orders 13877 and 14221.[137] The Departments seek comment on specifying a single, non-proprietary open-source format for the machine-readable files and on the relevant benefits and burdens associated with the CSV and JSON formats. The Departments also seek comment on the

[134] *See* Exec. Order No. 13877, 84 FR 30849 (June 27, 2019).

[135] 85 FR 72158, 72240 (November 12, 2020).

[136] The average file size from the files sampled during the Departments' two environmental scans was 5 GB. Excel's limit is 1,048,576 rows by 16,384 columns. *See https://support.microsoft.com/en-us/office/excel-specifications-and-limits-1672b34d-7043-467e-8e27-269d656771c3.*

[137] *See* Exec. Order No. 13877, 84 FR 30849 (June 27, 2019); *See also* Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

Departments' position that specifying a single format in technical implementation guidance, as opposed to regulation, is advisable to maintain maximum flexibility to change formats more quickly to keep pace with technological changes.

Additionally, in recognition of the developments of electronic data transfer systems since the publication of the 2020 final rules and in anticipation of future developments of new technologies, the Departments are revisiting the request for comment made in the 2019 proposed rules regarding a requirement that plans and issuers provide rate information through a publicly accessible API that would comply with standards defined by the Departments.[138] In light of the publication of the CMS Interoperability and Prior Authorization Final Rule,[139] 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

As discussed in section III.C.7. of this 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. The Departments propose to add paragraph (iii) to redesignated paragraph (b)(3) to require that the source page URL for the internet website that hosts the machine-readable files 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 machine-readable files.[140] Additionally, in redesignating paragraph (b)(2) as paragraph (b)(3), the Departments propose to make three changes: first, the Departments propose to divide the existing language in paragraph (b)(2) into two paragraphs at redesignated paragraphs (b)(3)(i) and (ii); second, the Departments propose to indicate that the machine-readable files in paragraphs (b)(1) and (2) (instead of paragraph (b) generally as currently written) must be available in a form and manner as specified in guidance issued by the Departments; and third, the Departments propose to amend redesignated paragraph (b)(3)(ii) to ensure that the machine-readable files 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 machine-readable files on its public website on behalf of the plan or issuer. However, if the files are posted on a service provider's website and the plan or issuer maintains a public website but chooses not to host 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 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) require plans and issuers to make the machine-readable files 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. In the 2020 final rules, the Departments finalized the proposal to allow plans and issuers 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 machine-readable files would be readily accessible by the intended users.[141] As discussed in section III.C.7. of this 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 have determined that they should require the addition of standardized hyperlinks in the footer of a plan's or issuer's website home page, as well as any other page on their website that features a footer, in order to aid file users in the automated and non-automated retrieval of machine-readable files by creating a predictable navigation path to internal web pages that host the machine-readable files posted pursuant to the Transparency in Coverage requirements. Additionally, the Departments propose to amend the existing requirement that the machine-readable files described in paragraphs (b)(1) and (2) must be publicly available and accessible to any person free of charge and without conditions, to specify that they must be publicly available and accessible to any person, automated scripts, or web crawlers free of charge and without conditions such as establishment of a user account, password, submission of personally identifiable information or other credentials, or blocking server configurations or firewalls to access the file. Requiring the machine-readable files to be available to both human and automated users more directly aligns with the purpose of the files being machine-readable. Examples of conditions include a ''captcha,'' [142] a 403 error,[143] or limits on the number of downloads allowed by a user or at a time.

Once a human user or automated web crawler arrives at the website of the plan or issuer, they would be able to identify the specific location of the files. The Departments have determined that making this information more easily accessible to automated searches and data aggregation would help third parties to develop tools that further assist the public in understanding this information and capturing it in a meaningful way for making informed health care decisions. Moreover, the Departments have determined that this requirement would be simple for plans and issuers to implement, because plans

[138] *See* 84 FR 65464, 65483 (November 27, 2019).

[139] *See* 89 FR 8758 (February 24, 2024).

[140] As previously mentioned, proposed paragraph (b)(3) (relating to the method and format for disclosing information to the public) of 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212 applies to the prescription drug machine-readable files.

[141] 85 FR 72158, 72242 (November 12, 2020).

[142] *See* IBM, *What is a CAPTCHA?, https://www.ibm.com/think/topics/captcha* (last visited Dec. 8, 2025). (''CAPTCHA stands for 'completely automated public Turing test to tell computers and humans apart.' It refers to various authentication methods that validate users as humans, not bots, by presenting a challenge that is simple for humans but difficult for machines.'')

[143] *See* Mozilla, *403 Error, https://developer.mozilla.org/en-US/docs/Web/HTTP/Reference/Status/403* (last updated July 4, 2025). (''The HTTP 403 Forbidden client error response status code indicates that the server understood the request but refused to process it.'')

and issuers commonly link to other information in their website footer. In addition, using a standardized label for the link in the footer would make the location of the machine-readable files easier to identify by individual consumers manually searching for such files.

Both this proposed requirement and the proposed contextual machine-readable Text File as discussed in section III.C.7.d. of this preamble, are intended to improve both automated and manual location of the machine-readable files on a plan's or issuer's website. While the Text File will enhance automated searching more so than manual searching, the footer links would assist manual searching more so than automated searching as individuals are likely to first examine a footer for web page navigation. Thus, these proposed requirements would complement each other and improve overall accessibility.

Additionally, for a plan or issuer that does not have a public website, the Departments have determined that it would be overly burdensome to require such plan or issuer to create and maintain a website to satisfy this requirement. Therefore, 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), in line with guidance issued on April 19, 2022 in FAQs Part 55,[144] but extended to apply to issuers, such that any plan or issuer may satisfy the disclosure requirements of paragraph (b)(3)(iii) by entering into a written agreement under which another party posts the machine-readable files on its public website on behalf of the plan or issuer. Additionally, 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. This proposed new paragraph also moves part of current 26 CFR 54.9815–2715A3(b)(4)(iii), 29 CFR 2590.715–2715A3(b)(4)(iii), and 45 CFR 147.212(b)(4)(iii) addressing plans or issuers who do not have a website to new paragraph (b)(3)(iv) for clarity and alignment with other proposed changes.

The Departments recognize that many employer-sponsored ERISA plans do not currently maintain a separate dedicated internet page for their group health plans or have an internet website at all. This proposed new paragraph would codify FAQs Part 55 [145] and extend it to apply to issuers, and recognize the hardship for impacted group health plans, especially for smaller employers. The Departments are proposing this extension to issuers because they were not covered under the guidance in FAQs Part 55 and this would make the requirements consistent across all entities subject to the requirements of paragraph (b)(3)(iii).

The Departments also propose to amend paragraph (b)(3)(i) at redesignated 26 CFR 54.9815–2715A3(b)(3), 29 CFR 2590.715–2715A3(b)(3), and 45 CFR 147.212(b)(3) to require that the proposed method and format requirements for disclosing information to the public would apply to both the machine-readable files under paragraph (b)(1) and the contextual machine-readable files under new paragraph (b)(2).

Finally, as with the public disclosure requirements in the 2020 final rules, the Departments intend to continue to issue form and manner requirements for the machine-readable files specified in technical guidance in the form of sample file schemas and data attributes on GitHub.[146] The technical guidance for the machine-readable files, in the form of schemas,[147] will be updated when appropriate as the Departments receive feedback from the community and interested parties. Additionally, guidance on applicability timelines for new schema requirements and implementation of policy requirements will continue to be posted in the form of Frequently Asked Questions.[148] Table 2 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 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

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.

[144] *See* U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug. 19, 2022), *https://www.cms.gov/files/document/faqs-part-55.pdf* and *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-55.*

[145] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55* (Aug 19, 2022), *https://www.cms.gov/files/document/faqs-part-55.pdf* and *https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-55.*

[146] Centers for Medicare & Medicaid Services, *Price Transparency Guide, https://github.com/CMSgov/price-transparency-guide* (last updated Oct. 1, 2025).

[147] Centers for Medicare & Medicaid Services, *Schema Examples, https://github.com/CMSgov/price-transparency-guide/tree/master/examples* (last updated Oct. 1, 2025).

[148] Centers for Medicare & Medicaid Services, *Affordable Care Act Frequently Asked Questions, https://www.cms.gov/marketplace/resources/fact-sheets-faqs#Affordable_Care_Act* (last updated July 30, 2025); U.S. Department of Labor, *Affordable Care Act Implementation Frequently Asked Questions, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs* (last updated July 30, 2025).

The Departments seek comment on these proposals.

10. Timing

Under 26 CFR 54.9815–2715A3(b)(4), 29 CFR 2590.715–2715A3(b)(4), and 45 CFR 147.212(b)(4) (proposed to be redesignated from paragraph (b)(3), as discussed in section III.C.7. of this preamble), the Departments propose to add new paragraphs to specify timing requirements for each machine-readable file that would be required under these proposed rules. 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 also propose to add disclosure timing requirements for the new contextual machine-readable files that would be required under proposed new paragraph (b)(2) at new paragraphs (b)(4)(iii) through (vi) under redesignated paragraph (b)(4). The Departments note that the first machine-readable files prepared based upon these proposed rules would be required to be disclosed according to the applicability date as proposed at paragraph (c)(1) and discussed in section III.C.12. of this preamble, which is 12 months after the publication of the final rules. These proposed rules also specify the timing for each machine-readable file to be updated thereafter and example dates are shown in Table 3.

In particular, the Departments propose to amend redesignated paragraph (b)(4)(i) to require plans and issuers to update and post the In-network Rate and Allowed Amount Files required under paragraphs (b)(1)(i) and (ii), respectively, quarterly rather than monthly and beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1). The Departments have received feedback from both producers and users of the machine-readable files recommending reducing the reporting frequency to quarterly, to help lower data storage and hosting costs, decrease bandwidth needs, and reduce ongoing maintenance expenses. The Departments have received feedback that a reduced reporting cadence may also provide more time to analyze the data,[149] as some file users have informed the Departments that they have difficulty keeping up with the pace of downloading and ingesting the file data monthly.

With respect to In-network Rate File data, interested parties have indicated that negotiated rates between issuers and health care organizations (for example, hospital systems)—in contrast to individual providers—tend to change slowly over time because contracts generally last a year or more, with some multi-year contracts lasting 2 to 5 years. As such, the Departments have determined negotiated rates between health care organizations and issuers should not significantly change from month to month, so the proposed quarterly reporting cadence would not meaningfully affect the accuracy of reported rates in the In-network Rate File for these entities.

The Departments acknowledge that the accuracy of rates at the individual provider level are more likely to be affected by the proposed quarterly reporting cadence, though not significantly. The Departments understand that individual providers can regularly move in and out of relationships with the institutions that employ them (for example, hospital systems, group medical practices); [150] thus, reported rates at the individual provider level may be less accurate with a change from monthly to quarterly reporting. More specifically, the turnover of individual providers within the roster of a large provider organization (like specialist physicians associated with a hospital system) means that the reporting of negotiated rates that ''flow down'' to the individual providers might become increasingly out of date, given a longer cadence for the reporting requirement. One recent study that quantified physician turnover rates due to retirements and shifts in practice affiliations suggested an annual turnover rate of 7.6 percent in 2018.[151] Given that this relatively low annual percentage would translate to an even smaller quarterly turnover rate, the Departments have determined that under the proposed change in reporting cadence, negotiated rates for individual providers would likely become only somewhat less accurate because there would be more providers who terminate employment with their parent organizations during the extended reporting interval.

Notwithstanding the potential for some of the data in the files to be less accurate, particularly with respect to individual providers, the Departments expect the benefits of quarterly reporting to outweigh these potential limitations, given that for the majority of use cases for the In-network Rate Files, the proposed change in reporting cadence would have only minimal impact on the ability to use the data for reasonable analytic purposes and would significantly reduce burdens both on producers and file users. For example, for a file user that analyzes aggregated rates between plans or issuers and health care organizations and compares reimbursement for orthopedic services in the same geographic market between two issuers, the impact of individual providers (who all share the same rates) moving in and out of health care systems would be immaterial.

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 are not proposing to change the monthly reporting cadence for the prescription drug machine-readable file under paragraph (b)(1)(iii) in proposed paragraph (b)(4)(ii).

With respect to the proposals to require new contextual files under new paragraph (b)(2), the Departments intend for them to be updated at a frequency at which they will be maximally useful and provide the most context to the In-network Rate File and Allowed Amount File. The Departments have determined that since the Change-log File serves as a reference to an In-network Rate File, it should be posted at the same time as the In-network Rate File to show what has changed from an In-network Rate File since it was last updated. Therefore, the Departments propose to require at proposed paragraph (b)(4)(iii) that plans and issuers update the Change-log File under proposed paragraph (b)(2)(i) on

[149] *See* Michael Chernew, Sabrina Corlette, Kevin Davenport, François de Brantes, et al., *Transparency in Coverage: Recommendations for Improving Access to and Usability of Health Plan Price Data* (2022), Georgetown University, *https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.*

[150] *Cf.* Code section 9820(a)(2), ERISA section 720(a)(2), and PHS Act section 2799A–5(a)(2) (requiring plans and issuers to verify and update their provider directory database not less frequently than once every 90 days, and to remove providers and facilities which have the plan or issuer has been unable to verify).

[151] Amelia M. Bond, Lawrence P. Casalino, Ming Tai-Seale, Matthew A. Unruh, et al., *Physician Turnover in the United States,* 175 Annals of Internal Medicine 896, 903 (2023).

the same day as each In-network Rate File described in (b)(1)(i) is required to be updated, except for the first In-network Rate File for which there would be no changes to report. This would mean the plan or issuer would be required to post their first Change-log File beginning 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 paragraph (b)(4)(i).[152] 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.

The Departments also propose to require at proposed paragraph (b)(4)(iv) that the Utilization File described in proposed new paragraph (b)(2)(ii) 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.

The Departments also propose to require at proposed paragraph (b)(4)(v) 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). This would help to ensure file users have all necessary information to assess the data disclosed through the In-network Rate Files as described under paragraph (b)(1)(i) and to provide clarity around what data was excluded from the In-network Rate Files pursuant to the new proposed requirement to exclude certain information under new paragraph (b)(1)(i)(F). 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.

The Departments also propose in new paragraph (b)(4)(vi) 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 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv). The Departments request comment on all aspects of these proposed timing requirements. In particular, the Departments request comment on whether the proposed requirement that plans and issuers update the Text File as soon as practicable but not later than 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section provides sufficient time for plans and issuers to make the required update.

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

The Departments seek comment on these proposed timing requirements.

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 paragraph (b)(4)(i) as paragraph (b)(5)(i) and redesignate paragraph (b)(4)(ii) as paragraph

[152] See Table 3 for an example.

(b)(5)(ii)—each without any substantive changes to the existing policy in the 2020 final rules. The Departments also propose 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.[153] 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 two amendments to redesignated paragraph (b)(5)(iv) to account for proposed amendments to the Allowed Amount File requirements in paragraph (b)(1)(ii): (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

In new paragraph (b)(5)(iii), the Departments propose to permit In-network Rate Files, which for self-insured group health plans under the proposed amendments to paragraph (b)(1)(i) would have been required to be made available at the plan sponsor level, to instead be made available at the service provider level for each provider network used by the self-insured group health plan. This In-network Rate File could include such information for more than one self-insured group health plan with which the other party has an agreement, as well as other policies and contracts offered by the other party acting as a health insurance issuer, that uses the same provider network. This In-network Rate File may also include the relevant information from plans or coverage in different health insurance markets, as described below.

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. This organization by provider network would reduce file size and the overall number of files and make more meaningful information available to file users. 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, since a service provider may use the same provider network for multiple self-insured group health plans it administers and also for multiple fully-insured group health plans or individual health insurance coverage it offers as a health insurance issuer. 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 add new paragraphs (b)(5)(iii)(A) and (B) 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. 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).

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 (all of which must be made available for each In-network Rate File, as discussed in section III.C.7. of this preamble, under proposed new paragraphs (b)(2)(i), (ii) and (iii), respectively), 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. This is because, as discussed in section III.C.7. of this preamble, for the Change-log, Utilization, and Taxonomy Files to be meaningful, they must directly correspond to the disclosures in the In-network Rate Files for which they are made available. Under this proposal, a self-insured group health plan that contracts with another party that takes

[153] For the purposes of this section III.C.11, the term ''health insurance market'' refers to the definition in proposed 25 CFR 54.9815–2715A1, 29 CFR 2590.715.2715A1, and 45 CFR 147.210 as described in section III.A of these proposed rules.

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

As described above, the Departments propose in 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212 to redesignate paragraph (b)(4)(iii) as paragraph (b)(5)(iv), and to amend redesignated paragraph (b)(5)(iv) to state that a self-insured group health plan may permit another party with which it contracts, such as a service provider, to include the required allowed amount and billed charge information in a single 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, provided certain conditions are met.

For improved readability, the Departments propose to move the condition currently described in paragraph (b)(4)(iii) (related to application of the claims threshold to the Allowed Amount File) into new paragraph (b)(5)(iv) and to amend it to align with the Departments' proposed revisions to the claims threshold in paragraph (b)(1)(ii).

Under paragraph (b)(4)(iii) of the 2020 final rules, group health plans and health insurance issuers are currently permitted to satisfy the Allowed Amount File disclosure requirements in paragraph (b)(1)(ii) by contracting with an issuer, service provider, or other party to make available out-of-network allowed amount data that has been aggregated to include information from more than one plan, policy, or contract (provided that the claims threshold described in paragraph (b)(1)(ii)(C) is met independently for each item or service and for each plan or coverage included in an aggregated Allowed Amount File). These plans, policies, or contracts may be across multiple health insurance markets.

As discussed in section III.C.6 of this preamble, the Departments now propose to amend paragraph (b)(1)(ii) to require all plans and issuers to aggregate out-of-network allowed amount data across the plans or coverage they offer in each health insurance market. For example, an issuer offering six plans in the small group market and four in the individual market would be required to make available two Allowed Amount Files: one that aggregates allowed amounts across the issuer's six small group market plans and another that aggregates allowed amounts across its four individual market plans.

Therefore, if proposed (b)(1)(ii) were finalized and current paragraph (b)(4)(iii) were retained, plans and issuers would be required to aggregate out-of-network allowed amount data across the plans or coverage they offer in each health insurance market, and, if a plan or issuer contracts with an issuer, service provider or other party to satisfy the disclosure requirement of (b)(1)(ii), such party would additionally be permitted to aggregate allowed amount data across the plans or coverage in different health insurance markets. Permitting plans and issuers to aggregate data within a health insurance market and then again across multiple different health insurance markets would undermine the Departments' goal of improving data useability of the Allowed Amount Files as discussed in section III.C.6 of this preamble.

As discussed in section III.A. of this preamble, the Departments propose to add new paragraphs 26 CFR 54.9815–2715A1(a)(2)(xi), 29 CFR 2590.715–2715A1(a)(2)(x), and 45 CFR 147.210(a)(2)(xi) to define health insurance markets for purposes of the proposed amendments to the Allowed Amount File at proposed paragraph (b)(1)(ii). If finalized as proposed, 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) of this subchapter, and plans that consist solely of excepted benefits), health insurance market would be defined as all self-insured group health plans maintained by the plan sponsor. Therefore, proposed paragraph (b)(1)(ii) would require self-insured group health plans to aggregate out-of-network allowed amount data across the plans offered by the same plan sponsor (that is, in the same health insurance market), but would not permit aggregation across more than one plan sponsor. 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.

In addition, in new paragraph (b)(5)(iv), the Departments propose that a self-insured group health plan may not take advantage of the special rule under paragraph (b)(5)(iv) unless the proposed 11-claim threshold applies across all plans included in the Allowed Amount File. Under current paragraph (b)(1)(ii)(C), plans and issuers must apply the minimum claims threshold by evaluating the number of different claims for payments under a single plan or coverage. Under current paragraph (b)(4)(iii), when allowed amount data is aggregated at the service provider level, rather than reported by plan, policy, or contract, the minimum claims threshold is applied the same way: it must be met independently for each item or service and for each plan, insurance policy, or coverage included in an aggregated Allowed Amount File.[154]

The Departments finalized this requirement in the 2020 final rules because if the threshold were applied to the aggregated claims data at the service provider level, rather than for each plan or coverage as is required under current paragraph (b)(1)(ii)(C), the Departments determined that the goal of the minimum claims threshold could be undermined.[155] The Departments gave the following example in the 2020 rules: ''Plan A has 20 claims for Service X, while Plan B only has six claims for Service X. In aggregate, the plans meet the 20-claim threshold with 26 total claims for Service X. However, individually, only Plan A has met the

[154] 26 CFR 54.9815–2715A1(b)(4)(iii), 29 CFR 2590.715–2715A1(b)(4)(iii), and 45 CFR 147.212(b)(4)(iii).

[155] 85 FR 72158, 72246 (November. 12, 2020).

minimum claim threshold.'' [156] If the claims threshold were applied to the aggregated data set, data for Service X would be required to be included from both Plan A and Plan B. The Departments determined that ''allowing Plan B data to be included in the file for Service X would undermine the minimum claim threshold, increasing risk that individual patients' claims histories could be identified.'' [157]

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. That is, plans and issuers would be required to exclude claims data for an item or service if there are fewer than 11 claims for that item or service in an Allowed Amount File, regardless of how many plans, insurance policies, or contracts are represented in the file.

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. Notwithstanding, and as discussed in more detail in section III.C.6. of this preamble, the Departments expect this approach would result in maintaining appropriate patient privacy protections.

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

Current paragraph (b)(4)(iii), redesignated as paragraph (b)(5)(iv), also provides that nothing in 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212 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 have determined that this provision more logically belongs in redesignated paragraph (b)(3) concerning the method and format for disclosing information to the public. As such, the Departments propose to move it to new paragraph (b)(3)(iv) with proposed amendments that are discussed in section III.C.9. of this preamble.

The Departments seek comment on these proposals.

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.

Based on initial implementation experience, the Departments have determined that the proposed applicability date appropriately balances the need for achieving increased usability of the machine-readable file data in a timely manner with the time necessary for both file developers and other users to collaborate with the Departments on GitHub and for plans and issuers to make the operational and systems changes to implement these proposals.

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. A description of these provisions is given in sections IV.C. and D. of this preamble with an estimate of the annual burden, summarized in Tables 35 and 36.

To evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that 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.

A. Allocation of Total Burden Hours to the Departments of Health and Human Services, Labor, and the Treasury

Based on their respective jurisdiction over issuers and third-party administrators (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. Tables 4 and 5 present each Department's share of the total on-going and one-time estimated burden hours needed to implement the proposed requirements.

[156] *Id.*

[157] *Id.*

TABLE 4: Estimated Annual Burden Hours of HHS, Labor, and the Treasury to Implement Requirements for Disclosures to Participants, Beneficiaries, or Enrollees and Public Disclosure of In-Network Rates and Allowed Amount Data for Covered Items and Services from In- and Out-of-Network Providers

Agency	Burden Share Percentage	Number of Respondents	Number of Responses*	Burden Hours per Response	Total Burden Hours
HHS	50%	790	3,901,580	0.2	703,720
Labor	25%	395	1,950,790	0.2	351,860
Treasury	25%	395	1,950,790	0.2	351,860

* High-end estimated values are represented in the table and used to calculate the overall estimated figures.

TABLE 5: Estimated One-time Burden Hours of HHS, Labor, and the Treasury to Implement Requirements for Disclosures to Participants, Beneficiaries, or Enrollees and Public Disclosure of In-Network Rates and Allowed Amount Data for Covered Items and Services from In- and Out-of-Network Providers

Agency	Year	Burden Share Percentage	Number of Respondents	Number of Responses*	Burden Hours per Response	Total Burden Hours
HHS	2027	50%	790	8,690	385	3,349,732
Labor	2027	25%	395	4,345	385	1,674,866
Treasury	2027	25%	395	4,345	385	1,674,866

* High-end estimated values are represented in the table and used to calculate the overall estimated figures.

B. Wage Estimates

To estimate wages, the Departments used data from the Contract Awarded Labor Category (CALC) database tool [158] to calculate average labor costs associated with the burden and equivalent costs of the information collection requirements (ICRs). The CALC tool was developed to assist acquisition professionals with market research and price analysis of labor categories under multiple U.S. General Services Administration (GSA) and Veterans Administration (VA) contracts. While the Departments recognize that various methods exist for estimating fringe benefits and overhead costs, the CALC database was selected because, unlike Bureau of Labor Statistics (BLS) data, which is valuable for identifying broad labor market trends, the CALC tool is specifically designed to support market research for government procurement. It provides cost estimates for specific labor categories based on actual contract rates. More importantly, CALC data reflects fully burdened hourly rates, including both base pay and benefits, whereas BLS data reflects only base wages. The Departments determined that CALC's occupation-specific data better aligns with the skill sets and job functions necessary for implementing the requirements in these proposed rules and therefore provides a more suitable basis for estimating labor costs. Table 6 presents the fully burdened mean hourly wage and occupations used in the Departments' estimates.

[158] U.S. General Services Administration, *Pricing Intelligence Suite, CALC information and wage rates, https://buy.gsa.gov/pricing/* (last visited Dec. 8, 2025).

TABLE 6: Hourly Wages Used in Burden Estimates

CALC Occupation Title	Mean Hourly Wage ($/hour)
Project Manager/Team Lead	$153.00
Scrum Master	$105.00
Technical Architect	$149.00
Senior Application Developer	$143.00
Business Analyst	$120.00
DevOps Engineer III	$181.00
Customer Service Representative	$40.00
Training Specialist	$104.00
Supervisor	$91.00
Attorney III	$143.00

C. 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

As discussed previously in this preamble, the Departments propose several amendments to the 2020 final rules to improve price transparency and strengthen consumer protections for participants, beneficiaries, and enrollees. First, the Departments propose revising the disclaimer required under paragraph (b)(1)(vii)(A) to clarify that the cost-sharing information does not account for potential additional amounts in situations where applicable State and Federal law allow out-of-network providers to balance bill participants, beneficiaries, and enrollees. These revisions reflect the Federal balance billing protections introduced by the No Surprises Act, which were not in effect when the original provision was finalized. These proposed revisions aim to ensure that participants, beneficiaries, and enrollees understand that cost-sharing estimates disclosed through their plan's or issuer's self-service tool may not account for additional amounts owed to out-of-network providers.

In addition, the Departments propose adding a new paragraph (b)(2)(iii) requiring plans and issuers to make cost-sharing information available by telephone, consistent with requirements under the No Surprises Act. The Departments propose to require a telephone number for consumer assistance that Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e), as added by section 107 of the No Surprises Act, requires be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee. The proposal further states that, to reduce unnecessary administrative burden and prevent consumer confusion, providing the information as specified in paragraph (b)(1) and in the method and format as specified in paragraph (b)(2), as amended by these proposed rules, would satisfy the price comparison tool requirements under section 114 of the No Surprises Act. The requirements in these proposed rules apply to non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets.

As discussed in section VI.C.3. of this preamble, the Departments assume that self-insured group health plans would depend on TPAs, including issuers providing administrative services only and non-issuer TPAs, to implement these proposed updates, including the new phone disclosure requirement. This assumption is based on the Departments' understanding that most self-insured group health plans already rely on TPAs to perform core administrative functions, such as enrollment and claims processing.[159] For those self-insured plans that choose to develop their own internet-based self-service tools (and which are included in the total count of issuers and TPAs used to estimate burden), the Departments assume that they would incur costs and burdens similar to those estimated for issuers and TPAs. Accordingly, the Departments use issuers and TPAs as the unit of analysis for estimating the cost of proposed changes. The Departments also assume that issuers and TPAs have already developed internet-based self-service tools, originally required for plan or policy years beginning on or after January 1, 2023, and would only need to modify these existing systems to comply with the proposed provisions. The Departments acknowledge that some interactive voice response (IVR) programming work may be necessary, but the Departments expect the associated cost would be minimal. The Departments welcome comment on these assumptions.

As also noted in section VI.C.3. of this preamble, the Departments estimate that approximately 1,375 issuers[160] and 205 TPAs[161] (a total of 1,580 entities) would implement the proposed requirements. The Departments acknowledge that actual costs may vary depending on factors such as the volume of providers and items or services for which cost-sharing information must be disclosed, and whether plans (or TPAs on behalf of plans) and issuers already have tools that fully or partially meet the proposed requirements or can be readily adapted. The Departments welcome comment on the assumptions and inputs used to develop these burden and cost estimates.

The Departments also assume that plans (or TPAs on behalf of plans) have

[159] Louise Norris, *What is Self-Insured Health Insurance? Most Very Large Employers Self-Insure,* Verywell Health (November 9, 2024), *https://www.verywellhealth.com/what-is-self-insured-health-insurance-and-how-is-it-regulated-4688567.*

[160] The Departments' estimate of the number of health insurance companies and the number of issuers (issuer/State combinations) is based on medical loss ratio reports submitted by issuers for the 2023 reporting year. Centers for Medicare & Medicaid Services, *Medical Loss Ratio Data and System Resources* (December 23, 2024), *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.*

[161] Non-issuer TPAs based on data derived from the 2016 Benefit Year reinsurance program contributions.

already built self-service tools and would only be required to revise the disclaimer stating that out-of-network providers may engage in balance billing, subject to applicable State and Federal laws. Although these updates build on existing infrastructure, they would require a one-time cost for minor technical modifications including editing disclosure text, testing for quality assurance, and implementing the update. The Departments estimate that, on average, each issuer or TPA would require 10 minutes (approximately 0.17 hours) of a Senior Application Developer's time (at $143 per hour) to update the disclosure. As shown in Table 7, across all 1,580 issuers and TPAs, the total one-time burden is estimated at 263 hours, with an associated cost of approximately $37,657.

TABLE 7: One-Time Estimated Cost and Hour Burden for All Issuers and TPAs to Update Cost-Sharing Disclosure Reflecting Federal Balance Billing Protections

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	0.17	263	$37,657

a. High Impact for Providing Cost-Sharing Information Via Phone

Under a scenario with increased call volume and duration (that is, high impact), the Departments anticipate that requiring cost-sharing information to also be accessible by phone, could increase call volume and call duration to the plan's or issuer's customer support line. This anticipated increase is driven by participants, beneficiaries, and enrollees who may prefer verbal assistance, have limited digital access or literacy, or need help interpreting complex pricing information.

Accordingly, the Departments estimate that for each issuer or TPA, it would require 10 minutes [162] for a customer service representative (at $40 per hour) to speak with each consumer and provide the requested information and complete post-call documentation. Assuming, as a high impact scenario estimate, there would be 7.8 million calls annually,[163] each issuer or TPA would receive approximately 4,937 calls per year, resulting in an estimated annual burden of 823 hours,[164] with an estimated associated cost of $32,911. As shown in Table 8, the Departments estimate that for all 1,580 issuers and TPAs, the estimated total ongoing annual burden would be approximately 1,300,000 hours, with an estimated associated cost of $52 million annually.

TABLE 8: Estimated High Impact Annual Cost and Hour Burden to Provide Cost-Sharing Information via Phone

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	7,800,000	823	1,300,000	$52,000,000

b. Lower Impact Estimate for Providing Cost-Sharing Information Via Phone

[162] According to a 2012 report by the Healthcare Financial Management Association, the average handle time for call centers generally ranges from 7 to 8 minutes. For purposes of this analysis, the Departments assume an additional 2 minutes would be needed for call documentation, resulting in an average handle time of 9 to 10 minutes. Accordingly, the Departments use 9 minutes as the lower bound and 10 minutes as the upper bound to estimate the potential impact of increased call times under the proposed disclosure requirements. Healthcare Financial Management Association, Ask the Expert: Setting Industry Standards for Call Center Activities (Oct. 25, 2012), *https://www.hfma.org/revenue-cycle/kpis/7256/*.

[163] According to data from the Congressional Research Service, the total insured population in private/commercial insurance, including employer-sponsored and individual market coverage, is projected to be approximately 156 million in 2023 (of the estimated 304 million insured individuals in 2023, approximately 148 million are covered by public programs, including Medicare, Medicaid, VA Care, and TRICARE. The remaining 156 million are covered under private/commercial insurance, including both employer-sponsored and individual market plans). The Departments estimate 5 percent of total calls would be shopping-related calls per year under the high-call time scenario. This estimate is informed by a KFF study (*https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/*) in which 57 percent of adults contacted their insurance in 2023, with under 31percent asking about out-of-pocket expenses—a subset of which could reasonably be considered shopping related calls. Considering that consumers contact plans via phone, online, in-person, or in writing, it was estimated that 25 percent of these contacts were by phone. Of these phone contacts, 10–20 percent of the 31 percent asking about out-of-pocket expenses were assumed to be shopping calls, resulting in an estimated range of 2.5 percent to 5 percent of total calls being shopping-related. Using the upper bound of 5 percent for the high-call time scenario, this results in approximately 7.8 million shopping-related calls per year. Congressional Research Service, U.S. Health Care Coverage and Spending (Feb. 19, 2025), *https://www.congress.gov/crs-product/IF10830*.

[164] This calculation distributes the total workload across all 1,580 issuers and TPAs. At the industry level, there are 7,800,000 high-call time calls per year, with an average handle time of 10 minutes per call, resulting in 78,000,000 total minutes (1,300,000 hours). To compute the per-entity workload, the total calls are divided by the number of issuers and TPAs: 7,800,000/1,580 ≈ 4,937 calls per entity per year. Multiplying the per-entity calls by the 10-minute average handle time gives 49,370 minutes annually per entity, which converts to approximately 823 hours (49,370/60).

Under a scenario with less call volume and duration (that is, lower-impact scenario), the Departments assume that a smaller subset of participants, beneficiaries, and enrollees would opt to request pricing information by phone. In this scenario, the Departments estimate that for each issuer or TPA it would take 9 minutes for a customer service representative (at $40 per hour) to speak with consumers and provide the requested information and complete post-call documentation. Assuming 3.9 million calls annually,[165] each issuer or TPA would receive approximately 2,468 calls per year, resulting in an estimated annual burden of 370 hours [166] with an estimated associated cost of $14,810 per issuer or TPA. As shown in Table 9, across all 1,580 issuers and TPAs, the estimated total ongoing burden would be approximately 585,000 hours, with a total annual cost of approximately $23.4 million.

TABLE 9: Estimated Lower Impact Annual Cost and Hour Burden to Provide Cost-Sharing Information via Phone

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hors	Total Cost
1,580	3,900,000	370	585,000	$23,400,000

Plans (or TPAs on behalf of plans) and issuers would also incur a one-time burden and cost to train customer service representatives and their supervisors on the proposed phone requirement. The Departments assume this requirement would not necessitate hiring additional full-time staff. Instead, the Departments expect issuers and TPAs to rely on existing customer service representatives and supervisors for this task. For each issuer or TPA, the Departments estimate that one training specialist would spend 8 hours (at $104 per hour) to train 20 customer service representatives (totaling 160 hours at $40 per hour) and two supervisors (totaling 16 hours at $91 per hour) on how to respond to participants, beneficiaries, and enrollees seeking pricing information by phone. This results in a one-time burden of 184 hours per issuer or TPA, with an estimated associated cost of $8,688. As shown in Table 10, for all 1,580 issuers and TPAs, the total estimated one-time training hour burden would be 290,720 hours, with a corresponding cost of approximately $13,727,040.

TABLE 10: One-Time Estimated Cost and Hour Burden for All Issuers and TPAs to Train Customer Service Representatives and Supervisors to Provide Cost-Sharing Information via Phone

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	184	290,720	$13,727,040

The Departments anticipate that, in the future, ongoing training costs associated with the proposed phone requirements would be incorporated into existing onboarding programs for new employees and included in the regular annual training provided to current staff.

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

D. ICRs Regarding Requirements for Public Disclosure Under 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212

The Departments are proposing updates to the 2020 final rules to improve the accessibility, clarity, and usefulness of the public disclosures through machine-readable files. The proposed changes aim to help users better locate machine-readable files, revise the content and format of disclosures, and modify the publication frequency for certain files. For In-network Rate Files, the proposal would

[165] According to data from the Congressional Research Service, the total insured population in private/commercial insurance, including employer-sponsored and individual market coverage, is projected to be approximately 156 million in 2023 (of the estimated 304 million insured individuals in 2023, approximately 148 million are covered by public programs, including Medicare, Medicaid, VA Care, and TRICARE. The remaining 156 million are covered under private/commercial insurance, including both employer-sponsored and individual market plans). The Departments estimate that 2.5 percent of total calls would be shopping-related calls per year under the low-call time scenario. This estimate is informed by a KFF study (*https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/*) in which 57 percent of adults contacted their insurance in 2023, with under 31 percent asking about out-of-pocket expenses—a subset of which could reasonably be considered shopping related calls. Considering that consumers contact plans via phone, online, in-person, or in writing, it was estimated that 25 percent of these contacts were by phone. Of these phone contacts, 10–20 percent of the 31percent asking about out-of-pocket expenses were assumed to be shopping calls, resulting in an estimated range of 2.5 percent to 5 percent of total calls being shopping-related. Using the lower bound of 2.5 percent for the low-call time scenario, this results in approximately 3.9 million shopping-related calls per year. Congressional Research Service, U.S. Health Care Coverage and Spending (Feb. 19, 2025), *https://www.congress.gov/crs-product/IF10830.*

[166] This calculation distributes the total workload across all 1,580 issuers and TPAs. At the industry level, there are 3,900,000 high-volume calls per year, with an average handle time of 9 minutes per call, resulting in 35,100,000 total minutes (585,000 hours). To compute the per-entity workload, the total calls are divided by the number of issuers and TPAs: 3,900,000/1,580 ≈ 2,468 calls per entity per year. Multiplying the per-entity calls by the 9 minute average handle time gives 22,212 minutes annually per entity, which converts to approximately 370 hours (22,212/60).

require plans and issuers to create a separate file for each provider network, allow rates to be expressed as a percentage of billed charges when appropriate, associate enrollment totals for each plan or coverage option, disclose provider network product types, and exclude providers unlikely to be reimbursed based on their scope of practice. For Allowed Amount Files, the proposals include requiring data reporting at the market level instead of the individual plan level, lowering the claims threshold from 20 to 11, extending the reporting period from 90 days to 6 months, and increasing the lookback period from 180 days to 9 months to enhance the robustness of historical data. In addition, these proposed rules would require plans and issuers to post several contextual machine-readable files: a Change-log File, a Utilization File, a Taxonomy File, and a Text File, each with specific update and posting requirements. These changes are intended to strengthen transparency and improve the usefulness of publicly available pricing information.

As discussed in section VI.C.3. of this preamble, the Departments assume that self-insured group health plans would depend on TPAs, including issuers providing administrative services only and non-issuer TPAs, to implement these proposed updates, noting that some self-insured plans may choose to comply individually, likely incurring a similar hour burden.

The Departments recognize that some proposed requirements may be integrated into existing operational processes, potentially reducing implementation burdens, though the Departments acknowledge that the extent of integration varies significantly across different requirements. Marginal modifications may include adjusting reporting thresholds from 20 to 11 claims, extending lookback and reporting periods, and adding website footer links, while higher-burden implementations likely include network-level file reorganization, new file creation such as Taxonomy, Change-log, and Utilization Files, and provider-rate combination exclusion logic. Although some activities may align with routine system updates and maintenance cycles, the Departments provide detailed burden estimates for requirements involving substantial system modifications or new operational processes. The Departments seek public comment on additional costs or implementation challenges that may not be fully captured in this assessment.

1. 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 2590.715–2715A3(b)(1)(i) and (b)(5)(iii), and 45 CFR 147.212(b)(1)(i) and (b)(5)(iii))

The Departments propose to amend 26 CFR 54.9815–2715A3(b)(1)(i), 29 CFR 2590.715–2715A3(b)(1)(i), and 45 CFR 147.212(b)(1)(i) to require plans and issuers to make an In-network Rate File available for each provider network they maintain or contract with associated with the plan or policy being reported. The Departments also propose to add new 26 CFR 54.9815–2715A3(b)(5)(iii), 29 CFR 2590.715–2715A3(b)(5)(iii), and 45 CFR 147.212(b)(5)(iii) to permit In-network Rate Files to be made available by provider network for multiple plans administered by service providers or other parties, including those offered by different plan sponsors and including across different health insurance markets.

Under the current technical reporting requirements, plans and issuers publish an In-network Rate File for each plan or coverage they offer. As a result, the scope of the existing disclosure is at the individual plan or policy level, rather than at the broader provider network level. Current technical implementation guidance gives plans and issuers flexibility in how they structure their In-network Rate File to associate providers with negotiated rates. As a result, some plans or issuers may already be using network-based aggregation to both optimize the size of their output files as well as allow for greater file reuse across multiple plans. As discussed in section III.C.1. of this preamble, the Departments understand that many plans and issuers already leverage a Table of Contents to organize their files, an approach that would allow them to combine common negotiated rates across multiple In-network Rate Files, rather than publishing negotiated rates individually for each plan ID. However, the Departments assume that few have fully implemented that second step to organize files by provider networks with common negotiated rates across multiple In-network Rate Files, and many have not adopted it at all.

For burden estimation, the Departments make the assumption that no plans or issuers have adapted their In-network Rate File processes to align with this proposed provision. While this may overstate the implementation burden for some, it provides a reasonable upper bound, ensuring the estimates cover the substantial and complex changes that most plans or issuers may need to make to comply with this proposal.

To implement this proposed provision, plans (or TPAs on behalf of plans) and issuers would need to modify their In-network Rate File processes to produce files aggregated at the provider network level rather than the plan level, and to generate a crosswalk table that associates each coverage option to the corresponding provider network the plan or issuer maintains or contracts with. The implementation will involve a meaningful, one-time recoding effort to revise existing In-network Rate File processes. However, because the underlying data used to build the In-network Rate Files will not change, these revisions will be incremental and build on the current process.

The proposed provision would also require, under newly proposed paragraph (b)(1)(i)(A), that each In-network Rate File be associated with its common provider network name. In practice, this means plans (or TPAs on behalf of plans) and issuers would need to add a new data element and identify the source of the common provider network names within their systems of record so these can be incorporated into the automated process for generating the required information for the In-network Rate Files. However, the Departments assume that plans (or TPAs on behalf of plans) and issuers would already have identified and captured these common provider network names as part of the related proposal to organize the In-network Rate Files by provider network. As a result, the Departments expect that any burden associated with disclosing this new data element is accounted for in the burden estimate for organizing these files by provider network, with no additional burden anticipated. The Departments seek comment on this assumption.

The Departments estimate that issuers and TPAs would incur a one-time cost and burden to modify a plan's or issuer's current process for generating In-network Rate Files to disclose discrete provider networks and crosswalk those networks to relevant plans or policies. As shown in Table 11, the Departments estimate that, on average, each issuer or TPA would require 16 hours from a Project Manager or Team Lead (at $153 per hour), 80 hours from a Technical Architect/Sr. Developer (at $149 per hour), 80 hours from a Senior Application Developer (at $143 per hour), and 16 hours from a

Business Analyst (at $120 per hour) to modify the plan's or issuer's current process, resulting in a one-time burden for each issuer or TPA of 192 hours with an estimated associated cost of $27,728. For all 1,580 issuers and TPAs, as shown in Table 12, the Departments estimate a total one-time burden of 303,360 hours with an estimated associated cost of $43,810,240.

TABLE 11: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Organize Files by Provider Network, Allow Service Providers or Other Parties to Organize by Provider Network across Multiple Self-insured Group Health Plans

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	16	$153.00	$2,448
Technical Architect/Sr. Developer	80	$149.00	$11,920
Senior Application Developer	80	$143.00	$11,440
Business Analyst	16	$120.00	$1,920
Total per Respondent	192		$27,728

TABLE 12: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Organize Files by Provider Network, Allow Service Providers or Other Parties to Organize by Provider Network across Multiple Self-insured Group Health Plans

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	192	303,360	$43,810,240

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

2. 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))

The Departments propose to amend redesignated paragraphs 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) to require plans and issuers to report the product type (for example, HMO or PPO) associated with each coverage option in both the In-network Rate File and the Allowed Amount File. Currently, there is no requirement for plans and issuers to include a product type in their machine-readable files. The only identifier currently required is the HIOS ID or the EIN when a HIOS ID is not available.

The Departments have determined that product type data is readily available to most plans and issuers and that this proposed requirement would only involve a one-time system update to include the product type variable in the machine-readable files. The assumptions account for time and effort to access the data sources from which to populate the product type variable within the machine-readable files.

The Departments estimate a one-time cost and burden for plans (or TPAs on behalf of plans) and issuers to implement the required system automation updates. Each issuer or TPA would, on average, require 8 hours from a Project Manager or Team Lead (at $153 per hour), 8 hours from a Senior Application Developer (at $143 per hour), 8 hours from a Technical Architect/Sr. Developer (at $149 per hour), and 8 hours from a Business Analyst (at $120 per hour) to make the system updates and implement the requirements proposed in these rules. As shown in Table 13, this results in a total estimated burden of 32 hours, with an associated estimated cost of $4,520 per issuer or TPA. As shown in Table 14, for all 1,580 issuers TPAs, the Departments estimate a total one-time burden of 50,560 hours with an associated total cost of approximately $7,141,600.

TABLE 13: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Include Product Type in Both In-network Rate and Allowed Amount Files

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	8	$153.00	$1,224
Senior Application Developer	8	$143.00	$1,144
Technical Architect/Sr. Developer	8	$149.00	$1,192
Business Analyst	8	$120.00	$960
Total per Respondent	32		$4,520

TABLE 14: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Include Product Type in Both In-network Rate and Allowed Amount Files

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	32	50,560	$7,141,600

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

3. 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 2590.715–2715A3(b)(1)(i)(D)(1), and 45 CFR 147.212(b)(1)(i)(D)(1))

The Departments propose to amend 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 clarify that plans and issuers are required to report in-network rates as a dollar amount, except when the contractual arrangement specifies payment as a percentage of billed charges and it is not possible to determine a dollar amount before the bill is generated. In those cases, the plan or issuer would instead be required to report the applicable percentage. This requirement is intended to improve data quality by ensuring plans and issuers consistently use a percentage when the contract bases payment on a percentage of billed charges and plans and issuers cannot calculate a dollar amount in advance.

Since this proposal codifies an exception for situations in which the Departments have indicated they are unlikely to pursue enforcement action, the Departments have determined that many systems would already be compliant, as plans and issuers should already be reporting dollar amounts for rates except in certain ''percentage-of-billed charges'' arrangements. The Departments are also of the view that most plans and issuers have already incurred a one-time cost to make this adjustment and would incur no additional implementation costs or burden to update the In-network Rate Files. However, for those plans and issuers that may not have made this alteration to their In-network Rate Files, the Departments estimate a one-time burden and cost to meet the requirements of this proposed provision. For a low-end estimate, the Departments assume that 20 percent of plans (or TPAs on behalf of the plan) and issuers would need to make this one-time modification to their In-network Rate Files, while for a high-end estimate, it's assumed that all plans (or TPAs on behalf of the plan) and issuers would need to make this adjustment to their In-network Rate Files.

The Departments estimate, on average, each affected issuer or TPA would require 8 hours from a Project Manager or Team Lead (at $153 per hour), 8 hours from a Technical Architect/Sr. Developer (at $149 per hour), 8 hours of work from a Senior Application Developer (at $143 per hour), and 8 hours from a Business Analyst (at $120 per hour) to review their In-network Rate File generation code to determine if there are any instances where a non-dollar amount would appear in the file and then make the necessary coding adjustments and validate the changes, resulting in an estimated burden of 32 hours, with an estimated associated cost of $4,520 per issuer or TPA, as shown in Table 15. The Departments estimate that, under the low-end scenario, affected issuers and TPAs would incur a total one-time burden of 10,112 hours with an associated total cost of approximately $1,428,320. Under the high-end scenario, for all issuers and TPAs, the total one-time burden would be 50,560 hours with an associated total cost of approximately $7,141,600, as shown in Table 16.

TABLE 15: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Adjust In-network Rate Files to Report Dollar Amounts Except for "Percentage-of-Billed Charges" Payments

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	8	$153.00	$1,224
Technical Architect/Sr. Developer	8	$149.00	$1,192
Senior Application Developer	8	$143.00	$1,144
Business Analyst	8	$120.00	$960
Total per Respondent	32		$4,520

TABLE 16: One-Time Estimated Cost and Hour Burden for Health Insurance Issuers or TPAs to Adjust In-network Rate Files to Report Dollar Amounts Except for "Percentage-of-Billed-Charges" Payments Under High- and Low-End Scenarios

Estimate	Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
Low-end estimate – 20 percent of issuers and TPAs need to update their In-network Rate Files	316	316	32	10,112	$1,428,320
High-end estimate – 100 percent of issuers and TPAs need to update their In-network Rate Files	1,580	1,580	32	50,560	$7,141,600

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

4. 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))

The Departments propose adding a new provision at 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 the current enrollment totals (number of individuals) for each coverage option associated with the applicable In-network Rate File, as of the date the file is posted.

The Departments recognize that each plan or issuer would report a different number of coverage options, so the estimates reflect a presumed average. These estimates include the preparatory work needed for plans (or TPAs on behalf of plans) and issuers to understand the requirement, identify data sources (enrollment data may be stored across multiple systems), assess current systems, and agree on necessary system changes.

To implement this provision, plans (or TPAs on behalf of plans) and issuers would incur a one-time cost to update their systems to automate the retrieval and reporting of the required enrollment data. Furthermore, the Departments expect this work to be coordinated with efforts to comply with the proposed amendments under section IV.D.1. of this preamble, which requires listing each plan associated with a network.

Accordingly, the Departments estimate a one-time burden and cost for issuers and TPAs to update their systems to include a field for current enrollment totals and to automate ongoing data extraction. On average, each issuer or TPA would require 8 hours from a Project Manager or Team Lead (at $153 per hour), 8 hours from a Technical Architect/Sr. Developer (at $149 per hour), 8 hours from a Senior Application Developer (at $143 per hour), and 8 hours from a Business Analyst (at $120 per hour) to complete this work. As shown in Table 17, this results in a total estimated burden of 32 hours per issuer or TPA, with an associated cost of approximately $4,520. For all 1,580 issuers and TPAs, as shown in Table 18, the Departments estimate a total one-time burden of 50,560 hours and a total cost of approximately $7,141,600.

TABLE 17: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Report Required Enrollment Data

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	8	$153.00	$1,224
Technical Architect/Sr. Developer	8	$149.00	$1,192
Senior Application Developer	8	$143.00	$1,144
Business Analyst	8	$120.00	$960
Total per Respondent	32		$4,520

TABLE 18: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Report Required Enrollment Data

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	32	50,560	$7,141,600

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

5. 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))

The Departments propose to amend the paragraph on required information under 26 CFR 54.9815–2715A3(b)(1)(i), 29 CFR 2590.715–2715A3(b)(1)(i), and 45 CFR 147.212(b)(1)(i) to increase access to and improve the usability of the data reported in the In-network Rate File, by adding new paragraph (b)(1)(i)(F). This new paragraph would require plans and issuers to exclude from their In-network Rate Files a provider's negotiated rate (provider-rate combination) for an item or service if the plan or issuer determines it is unlikely that such provider would be reimbursed for such item or service given that provider's area of specialty according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process.

In addition, the Departments propose at 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 publish an additional machine-readable file, called 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) 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 new file would increase transparency by showing how decisions to exclude certain provider-rate combinations from the In-network Rate File were determined.

This proposed provision would require plans and issuers to perform two specific updates: (1) update their current programmatic code to exclude certain provider-rate combinations from the existing In-network Rate Files, and (2) create and publish a new Taxonomy File.

The Departments have determined that (1) plans (or TPAs on behalf of plans) and issuers already maintain a complete listing of their in-network providers along with the specialties of those providers; (2) plans and issuers possess the taxonomy needed to map provider specialties to the appropriate billing codes; and (3) plans and issuers have implemented similar logic within their claims adjudication systems to pend or deny claims that fall outside a provider's scope of practice, for example, if a claim for brain surgery is submitted by a provider whose specialty does not align with that procedure.

Given this, the additional burden and cost required to automate the exclusion of certain provider-rate combinations would include (1) extracting and adapting the claims adjudication logic built off the internal provider taxonomy that determines whether a provider is authorized to bill for a particular service for use in generating the In-network Rate File; (2) implementing an automated process to extract the in-network provider list along with their specialties from the plan's or issuer's system of record; and (3) modifying the programmatic logic of the In-network Rate File generation software to exclude the provider-rate combinations for those that are not eligible to submit claims for specific services.

Additionally, posting a Taxonomy File would require plans (or TPAs on behalf of plans) and issuers to list each taxonomy code they use and specify the associated service codes (for example, CPT codes). These mappings are typically stored in a reference table used by issuer claims adjudication systems. The Taxonomy File must be produced separately, in addition to each In-network Rate File.

To update the programmatic code to exclude certain provider-rate combinations from the existing In-network Rate File and to create and publish a new Taxonomy File, the Departments estimate a one-time cost and burden for plans (or TPAs on behalf of plans) and issuers. On average, each issuer or TPA would require 48 hours from a Project Manager or Team Lead (at $153 per hour), 48 hours from a Technical Architect/Sr. Developer (at $149 per hour), 48 hours from a Senior Application Developer (at $143 per hour), and 48 hours from a Business Analyst (at $120 per hour). As shown in

Table 19, this results in a total estimated burden of 192 hours per issuer or TPA, with an associated cost of approximately $27,120. For all 1,580 issuers and TPAs, as shown in Table 20, the Departments estimate a total one-time burden of 303,360 hours and a total cost of approximately $42,849,600.

TABLE 19: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Exclude Certain Providers from In-network Rate Files

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	48	$153.00	$7,344
Technical Architect/Sr. Developer	48	$149.00	$7,152
Senior Application Developer	48	$143.00	$6,864
Business Analyst	48	$120.00	$5,760
Total per Respondent	192		$27,120

TABLE 20: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Exclude Certain Providers from In-network Rate Files

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	192	303,360	$42,849,600

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

6. ICRs Regarding Requirements To Lower Claims Reporting Threshold in the Allowed Amount File From 20 to 11 Claims (26 CFR 54.9815–2715A3(b)(1)(ii)(C), 29 CFR 2590.715–2715A3(b)(1)(ii)(C), and 45 CFR 147.212(b)(1)(ii)(C))

The Departments propose to amend 26 CFR 54.9815–2715A3(b)(1)(ii)(C), 29 CFR 2590.715–2715A3(b)(1)(ii)(C), and 45 CFR 147.212(b)(1)(ii)(C) to require plans and issuers to include data in the Allowed Amount File for items and services provided under a single plan or coverage when there are 11 or more unique claims for that item or service, lowering the current threshold from 20 to 11 to expand the data available.

The Departments assume this requirement would not create additional burden for plans and issuers. Existing systems are currently designed to report out-of-network allowed amounts when there are more than 20 claims for a covered item or service within a relevant 90-day period. Lowering the threshold to 11 claims is expected to require only marginal system variable adjustments, with any associated costs absorbed into the routine system maintenance activities that plans (or TPAs on behalf of plans) and issuers already perform in the normal course of business. The change constitutes a standard simple administrative update, rather than a system redesign, and therefore does not necessitate additional infrastructure, a dedicated project budget, or significant developer time. The adjustment can be implemented by existing IT personnel as part of their routine operational duties, with no disruption and minimal costs.

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

7. ICRs Regarding Expansion of Reporting and Lookback Periods for Allowed Amount Files From 90 Days to 6 Months and 180 Days to 9 Months (26 CFR 54.9815–2715A3(b)(1)(ii)(C), 29 CFR 2590.715–2715A3(b)(1)(ii)(C), and 45 CFR 147.212(b)(1)(ii)(C))

The Departments propose to amend 26 CFR 54.9815–2715A3(b)(1)(ii)(C), 29 CFR 2590.715–2715A3(b)(1)(ii)(C), and 45 CFR 147.212(b)(1)(ii)(C) to expand the data included in the Allowed Amount Files by requiring plans and issuers to report on items and services furnished by out-of-network providers over a 6-month reporting period starting 9 months before the file's publication date, replacing the current 90-day reporting period that begins 180 days prior to the file's publication date.

The Departments assume extending the reporting period from 90 days to 6 months would not create additional burden for plans and issuers, who the Departments assume currently have automated systems in production to report out-of-network allowed amounts. This change is expected to require only marginal system variable adjustments, with any associated costs absorbed into the routine system maintenance activities that plans (or TPAs on behalf of plans) and issuers already perform in the normal course of business. The change constitutes a standard simple administrative update, rather than a system redesign, and therefore does not necessitate additional infrastructure, a dedicated project budget, or significant developer time.

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

8. 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 TPA Level (26 CFR 54.9815–2715A3(b)(5)(iv), 29 CFR 2590.715–2715A3(b)(5)(iv), and 45 CFR 147.212(b)(5)(iv))

The Departments propose to amend 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 require plans and issuers to aggregate out-of-network data reporting by health insurance market, specifically by grouping plan-level data into one of four categories: (1) small group market, (2) individual market, (3) large group market, and (4) plans in self-insured group markets. Under current technical reporting requirements, plans and issuers may, but are not required to, aggregate data across multiple plans or policies to meet public disclosure requirements for the Allowed Amount Files. The Departments also propose to amend redesignated 26 CFR 54.9815–2715A3(b)(5)(iv), 29 CFR 2590.715–2715A3(b)(5)(iv), and 45 CFR 147.212(b)(5)(iv) to permit Allowed Amount Files to be aggregated by market type at the service provider level, rather than the plan level, for more than one self-insured group health plan, including those offered by different plan sponsors.

The Departments are of the view that this proposal would not require plans (or TPAs on behalf of plans) and issuers to make substantial changes to how they currently generate Allowed Amount Files. Instead, it would require modifying the output so that, rather than producing a separate Allowed Amount File for each plan or policy, plans and issuers would aggregate data into a single file for each applicable market category. The four market categories, small group, large group, individual, and plans in self-insured group markets, are already well established under existing market-wide regulations, and plans and issuers can use existing data elements in their systems to classify each plan appropriately.[167]

The Departments estimate that plans (or TPAs on behalf of plans) and issuers would incur a one-time cost and burden to modify and update their existing Allowed Amount File processes to produce output files aggregated by market segment. On average, each issuer or TPA would require 16 hours from a Project Manager or Team Lead (at $153 per hour), 16 hours from a Technical Architect/Sr. Developer (at $149 per hour), 16 hours of work from a Senior Application Developer (at $143 per hour), and 16 hours from a Business Analyst (at $120 per hour) to complete this work. As shown in Table 21, this results in a total estimated burden of 64 hours per issuer or TPA, with an associated cost of approximately $9,040. For all 1,580 issuers and TPAs, as shown in Table 22, the Departments estimate a total one-time burden of 101,120 hours and a total cost of approximately $14,283,200.

TABLE 21: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA 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 and Permit Such Aggregation at the TPA Level

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	16	$153.00	$2,448
Technical Architect/Sr. Developer	16	$149.00	$2,384
Senior Application Developer	16	$143.00	$2,288
Business Analyst	16	$120.00	$1,920
Total per Respondent	64		$9,040

TABLE 22: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs 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 and Permit Such Aggregation at the TPA Level

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	64	101,120	$14,283,200

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

[167] 26 CFR 54.9801–2, 29 CFR 2590.701–2, and 45 CFR 144.103, as applicable.

9. 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))

The Departments propose adding a new provision under 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 would require plans and issuers to publish a Change-log File on a quarterly basis, on the same day the In-network Rate File is published, identifying all changes made since the previous version.

Under this proposal, each plan or issuer would be required to publish a Change-log File each quarter, identifying any changes made to the In-network Rate File for each provider network maintained or contracted by that plan or issuer compared to the file in the preceding quarter. If there are no changes made to the machine-readable file since that previous file's posting, a Change-log File must still be posted indicating there are no changes.

This proposed requirement does not currently specify the required level of detail for the Change-log File, such as whether it should include high-level summaries or detailed information about changes to specific data points. As noted in section III.C.7.a. of this preamble, the Departments are seeking comment on which data elements should be included and on the overall design of the Change-log File. Due to the nature of the proposed provision, the Departments have made certain assumptions based on current information available to estimate the burden hours and cost of this proposed provision.

The Departments assume that plans and issuers would develop an automated system to track changes in the required data fields and report specific detailed information, such as the exact dollar amount of an applicable rate change. The Departments estimate that each issuer and TPA would incur a one-time burden and cost to develop and implement the to the proposed provision including to identify data sources for each field, write code to detect changes from the previous file, generate the Change-log File, and conduct testing and quality control before establishing a process to make the file available to the public. Once these systems are in place, creating the Change-log File is expected to be automated.

On average, each plan (or a TPA on behalf of the plan) or issuer would require 50 hours from a Project Manager or Team Lead (at $153 per hour), 220 hours from a Technical Architect/Sr. Developer (at $149 per hour), 220 hours from a Senior Application Developer (at $143 per hour), 50 hours from a Business Analyst (at $120 per hour), and 36 hours from a DevOps Engineer (at $181 per hour) to complete this work. As shown in Table 23, this results in a total estimated burden of 576 hours per issuer or TPA, with an associated cost of approximately $84,406. For all 1,580 issuers and TPAs, as shown in Table 24, the Departments estimate a total one-time burden of 910,080 hours and a total cost of approximately $133,361,480.

TABLE 23: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Add a Change-log File for Disclosures Related to the In-network Rate File

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Project Manager/Team Lead	50	$153.00	$7,650
Technical Architect/Sr. Developer	220	$149.00	$32,780
Senior Application Developer	220	$143.00	$31,460
Business Analyst	50	$120.00	$6,000
DevOps Engineer	36	$181.00	$6,516
Total per Respondent	576		$84,406

TABLE 24: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Add a Change-log File for Disclosures Related to the In-network Rate File

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	576	910,080	$133,361,480

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

10. 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)).

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), the Departments propose requiring a Utilization File, which would require plans and issuers to list all items and services for which a claim has been submitted and reimbursed, in whole or in part from in-network providers and identify each provider who submitted claims for each item or service. The

Departments propose that the Utilization File include information from the 12-month period that ends 6 months prior to the publication of the Utilization File and be updated every 12 months.

The Departments assume that data for the new Utilization File is readily accessible to all plans and issuers through their existing claims databases. Posting a Utilization File would require issuers to programmatically generate a list of each unique combination of provider NPI, TIN, and place of service from their claims database for in-network providers reimbursed for any covered item or service during a specified period. In addition to the one-time burden and cost associated with the initial coding effort to create the Utilization File, plans and issuers would incur annual ongoing operational burden and cost to produce the annual Utilization File, validate the data, store the Utilization File, and post it to the designated public access location.

Because the process for generating the Utilization File is similar to the logic used for creating the Allowed Amount File, and existing programmatic logic could serve as a starting point for the creation of the Utilization File, the Departments assume the burden and cost would be lower than those originally estimated in the 2020 final rules for the development and implementation of the Allowed Amount File.

Given the differences in the two files and past experience with the Allowed Amount File, the Departments estimate a one-time cost and burden for plans (or TPAs on behalf of plans) and issuers to develop, implement, and operate the Utilization File to meet the requirements of these proposed rules. On average, each issuer or TPA would require 364 hours from a Scrum Master (at $105 per hour), 546 hours from a Technical Architect/Sr. Developer (at $149 per hour), 1,456 hours of work from a Senior Application Developer (at $143 per hour), 364 hours from a Business Analyst (at $120 per hour), and 182 hours from a DevOps Engineer (at $181per hour). As shown in Table 25, this results in a total estimated burden of 2,912 hours per issuer or TPA, with an associated cost of approximately $404,404. For all 1,580 issuers and TPAs, as shown in Table 26, the Departments estimate a total one-time burden of 4,600,960 hours and a total cost of approximately $638,958,320.

TABLE 25: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Implement the Required Utilization File Disclosures

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Scrum Master	364	$105.00	$38,220
Technical Architect/Sr. Developer	546	$149.00	$81,354
Senior Application Developer	1,456	$143.00	$208,208
Business Analyst	364	$120.00	$43,680
DevOps Engineer	182	$181.00	$32,942
Total per Respondent	2,912		$404,404

TABLE 26: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Implement the Required Utilization File Disclosures

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden hours	Total Cost
1,580	1,580	2,912	4,600,960	$638,958,320

In addition to the one-time burden and cost estimated in Tables 25 and 26, plans (or TPAs on behalf of plans) and issuers would incur ongoing annual burden and cost to update the Utilization File. The Departments estimate that, on average, each issuer or TPA would annually require 6 hours from a Scrum Master (at $105 per hour), 16 hours of work from a Senior Application Developer (at $143 per hour), and 16 hours from DevOps Engineer (at $181 per hour) to make the required updates. As shown in Table 27, this results in a total estimated annual burden of 38 hours per issuer or TPA, with an associated cost of approximately $5,814. For all 1,580 issuers and TPAs, as shown in Table 28, the Departments estimate a total ongoing annual burden of 60,040 hours and a total cost of approximately $9,186,120. The 3-year average costs and burden for this proposal are presented in Table 29.

TABLE 27: Estimated Annual Cost and Hour Burden per Health Insurance Issuer or TPA to Update the Utilization File

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Scrum Master	6	$105.00	$630
Senior Application Developer	16	$143.00	$2,288
DevOps Engineer	16	$181.00	$2,896
Total per Respondent	38		$5,814

TABLE 28: Estimated Annual Cost and Hour Burden for All Health Insurance Issuers or TPAs to Update the Utilization File

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	38	60,040	$9,186,120

TABLE 29: Estimated 3-Year Average Annual Hour Burden and Costs for All Issuers and TPAs to Develop, Implement, and Annually Update the Utilization File

Year	Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
2027	1,580	1,580	2,950	4,661,000	$648,144,440
2028	1,580	1,580	38	60,040	$9,186,120
2029	1,580	1,580	38	60,040	$9,186,120
3-year average	1,580	1,580	1,009	1,593,693	$222,172,227

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

11. ICRs Regarding Requirements To Add a Text File, Identify Point-of-Contact for Inquiries To Improve Discoverability and Accessibility of Machine-Readable Files, and Respond to Machine-Readable File 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))

The Departments propose to add new 26 CFR 54.9815–2715A3(b)(2)(iv), 29 CFR 2590.715–2715A3(b)(2)(iv), and 45 CFR 147.212(b)(2)(iv), which would establish a new requirement for plans and issuers to improve the accessibility of their machine-readable files. Under this proposal, plans (or TPAs on behalf of plans) and issuers would be required to generate a Text File that includes the URL of the page hosting the machine-readable files, a direct link to the machine-readable files themselves, and contact information for the individual at the plan, issuer, or TPA that is responsible for the machine-readable files. This Text File would be required to be placed in the root folder of the public website domain selected to host the machine-readable files, without regard to the website's page structure. This proposed new requirement would align with similar provisions under the 2023 Hospital Price Transparency rule [168] at 45 CFR 180.50(d)(6) and is intended to enhance the discoverability, usability, and consistency of pricing information for participants, beneficiaries, and enrollees, third-party developers, researchers, and regulators.

The Departments anticipate plans (or a TPA on behalf of plans) and issuers would incur a one-time development burden to update their systems to support the automated generation and publication of the required Text File. In addition to setting up the ability to produce the Text File, plans (or TPAs on behalf of plans) and issuers would identify a point-of-contact for the file that would be available to address inquiries and issues related to the required machine-readable files and include this point-of-contact in the Text Files. The point-of-contact identified would need to set up a mechanism to receive and respond to inquiries and issues, such an email box or online feedback form.

The Departments estimate a one-time burden and cost for plans (or TPAs on

[168] 88 FR 81540 (November 22, 2023).

behalf of plans) and issuers to develop, test, and implement the automation necessary to generate and post the required Text File in the root folder of their public website as well as set up a mechanism to receive and respond to inquiries and issues. On average, each issuer or TPA would require 8 hours of work from a Senior Application Developer (at $143 per hour), 8 hours from a Project Manager or Team Lead (at $153 per hour), and 8 hours from a Business Analyst (at $120 per hour). As shown in Table 30, this results in a total estimated burden of 24 hours per entity, with an associated cost of approximately $3,328. Across all 1,580 issuers and TPAs, the Departments estimate a total one-time burden of 37,920 hours and a combined cost of approximately $5,258,240, as presented in Table 31.

TABLE 30: One-Time Estimated Cost and Hour Burden per Health Insurance Issuer or TPA to Add a Text File and Identify Point-of-Contact for Inquiries to Improve Discoverability and Accessibility of Machine-Readable Files

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Senior Application Developer	8	$143.00	$1,144
Business Analyst	8	$120.00	$960
Project Manager/Team Lead	8	$153.00	$1,224
Total per Respondent	24		$3,328

TABLE 31: One-Time Estimated Cost and Hour Burden for All Health Insurance Issuers or TPAs to Add a Text File and Identify Point-of-Contact for Inquiries to Improve Discoverability and Accessibility of Machine-Readable Files

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	24	37,920	$5,258,240

In addition to the one-time costs estimated in Tables 30 and 31, plans (or TPAs on behalf of plans) and issuers would incur ongoing annual burden and cost to respond to inquiries and issues on the machine-readable files. The Departments assume that each issuer and TPA would establish a team to triage, review, and respond to the inquiries. The Departments estimate that, on average each year, each issuer or TPA would receive approximately 30 inquiries. Addressing each inquiry is estimated to require 10 minutes of work per inquiry from an Attorney III (totaling 300 minutes for 30 inquiries at $143 per hour), 20 minutes per inquiry from a Senior Application Developer (totaling 600 minutes for 30 inquiries at $143 per hour), and 30 minutes per inquiry from a Project Manager/Team Lead (totaling 900 minutes for 30 inquiries at $153 per hour). As shown in Table 32, this results in a total estimated annual burden of 30 hours per issuer or TPA, with an associated cost of approximately $4,440 for each issuer or TPA. As shown in Table 33, the Departments estimate a total ongoing annual burden of 47,400 hours and a total cost of approximately $7,015,200 for all 1,580 issuers and TPAs. The 3-year average burden hours and costs for this proposal are presented in Table 34.

TABLE 32: Estimated Annual Cost and Hour Burden per Health Insurance Issuer or TPA to Respond to Machine-Readable File Inquiries

Occupation	Burden Hours per Respondent	Labor Cost per Hour	Total Cost per Respondent
Attorney III	5	$143.00	$715
Senior Application Developer	10	$143.00	$1,430
Project Manager/Team Lead	15	$153.00	$2,295
Total per Respondent	30		$4,440

TABLE 33: Estimated Annual Cost and Hour Burden for All Health Insurance Issuers or TPAs to Respond to Machine-Readable File Inquiries

Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
1,580	1,580	30	47,400	$7,015,200

TABLE 34: Estimated 3-Year Average Annual Hour Burden and Costs for All Issuers and TPAs to add a Text File and to Respond to Machine-Readable File Inquiries

Year	Number of Respondents	Number of Responses	Burden Hours per Respondent	Total Burden Hours	Total Cost
2027	1,580	1,580	54	85,320	$12,273,440
2028	1,580	1,580	30	47,400	$7,015,200
2029	1,580	1,580	30	47,400	$7,015,200
3-year average	1,580	1,580	38	60,040	$8,767,947

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

12. ICRs Regarding Requirements To Add a Price Transparency Footer Link on Website Directing Users to the Location of the Machine-Readable Files (26 CFR 54.9815–2715A3(b)(3)(iii), 29 CFR 2590.715–2715A3(b)(3)(iii), and 45 CFR 147.212(b)(3)(iii))

The Departments propose to add a new requirement at 26 CFR 54.9815–2715A3(b)(3)(iii), 29 CFR 2590.715–2715A3(b)(3)(iii), and 45 CFR 147.212(b)(3)(iii) to improve user access to machine-readable files published under paragraphs (b)(1) and (2). Specifically, plans and issuers would be required to include a link to the internet domain where the machine-readable files are hosted on the footer of their website. This link must appear on the home page and on any other page that includes a footer and must be labeled as ''Price Transparency'' or ''Transparency in Coverage.''

The Departments anticipate that the burden associated with this proposed requirement would be minimal, as it would involve only basic website modifications.

The Departments request comment on the estimated cost and burden hours presented in this analysis, including any additional costs or challenges that commenters may identify.

E. Submission of PRA Related Comments

The burden associated with the Transparency in Coverage disclosure requirements for HHS is currently approved under OMB control number 0938–1429 (CMS–10715, Transparency in Coverage).[169] HHS plans to revise this information collection request to include the additional burden resulting from the proposed requirements. For the Departments of Labor and the Treasury, the related burden was submitted to OMB as Request for Common Form (RCF) submissions. Once OMB approves the RCF submissions, both DOL and Treasury will update and submit their respective information collection requests to reflect the proposed changes. The Departments have submitted a copy of these proposed rules to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections for control number 0938–1429, please visit CMS's website at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.* To obtain copies of the supporting statement for control number 0938–1429, please go to *https://www.RegInfo.gov* or email the request to *ebsa.opr@dol.gov* and reference control number 0938–1429.

The Departments invite public comment on these potential information collection requirements. Commenters may send their views on the Department's PRA analysis in the same way they send comments in response to these proposed rules (for example, through the *www.regulations.gov* website), including as part of a comment responding to the broader proposed rules.

F. Summary of Ongoing and One-Time Burden Estimates for the Proposed Requirements

As shown in Tables 35 and 36, the Departments estimate that these proposed requirements would result in an ongoing burden of approximately 1.4 million hours annually, at a cost of $68.2 million per year for all plans (or TPAs on behalf of plans) and issuers. In addition, these proposed requirements are expected to impose one-time implementation costs, totaling approximately 6.7 million hours and $913.7 million across all plans (TPAs on behalf of plans) and issuers. Together, this represents a first-year burden of roughly 7.8 million hours and $982 million in associated costs. In subsequent years, the burden is estimated at about 1.4 million hours and $68.2 million per year.

BILLING CODE 4831–GV–P; 4150–29–P; 4120–01–P

[169] Transparency in Pricing Information (CMS–10715), OMB control number 0938–1429 (October 14, 2021), *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202410-0938-006.*

TABLE 35: Estimated Annual Burden Hours and Costs Associated with the Proposed Requirements for All Issuers and TPAs

Information Collection Requirements (ICRs)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (Hours)	Total Annual Burden (Hours)	Total Cost ($)
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)*	0938-1372	1,580	7,800,000	658	1,300,000	$52,000,000
ICRs Regarding Requirements to Implement the Required Utilization File Disclosures (26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii))	0938-1372	1,580	1,580	38	60,040	$9,186,120
ICRs Regarding Requirements to Respond to Machine-Readable File 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))	0938-1372	1,580	1,580	30	47,400	$7,015,200
Total			**7,803,160**		**1,407,440**	**$68,201,320**

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

TABLE 36: Estimated One-time Burden Hours and Costs Associated with the Proposed Requirements for All Issuers and TPAs

Information Collection Requirements (ICRs)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (Hours)	Total Annual Burden (Hours)	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)	0938-1372	1,580	1,580	0.17	263	$37,657
To Train Customer Service Representatives 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)	0938-1372	1,580	1,580	10	290,720	$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, and Disclose the Common Provider Network Names (26 CFR 54.9815-2715A3(b)(1)(i) and (b)(5)(iii), 29 CFR 2590.715-2715A3(b)(1)(i) and (b)(5)(iii), and 45 CFR 147.212(b)(1)(i) and (b)(5)(iii))	0938-1372	1,580	1,580	192	303,360	$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	0938-1372	1,580	1,580	32	50,560	$7,141,600

Information Collection Requirements (ICRs)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (Hours)	Total Annual Burden (Hours)	Total Cost ($)
147.212(b)(1)(i)(B) and (b)(1)(ii)(A))						
ICRs Regarding Requirements to Report Dollar Amounts Except for Only "Percent-of-Billed Charges" Payments (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*))*	0938-1372	1,580	1,580	32	50,560	$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))	0938-1372	1,580	1,580	32	50,560	$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))	0938-1372	1,580	1,580	192	303,360	$42,849,600
ICRs Regarding Requirements to Aggregate Out-of-Network 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 TPA level (26 CFR 54.9815-2715A3(b)(5)(iv), 29 CFR 2590.715-2715A3(b)(5)(iv), and 45 CFR 147.212(b)(5)(iv))	0938-1372	1,580	1,580	64	101,120	$14,283,200
ICRs Regarding Requirements to Add a	0938-1372	1,580	1,580	576	910,080	$133,361,480

Information Collection Requirements (ICRs)	OMB Control Number	Number of Respondents	Number of Responses	Burden per Response (Hours)	Total Annual Burden (Hours)	Total Cost ($)
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))						
ICRs Regarding Requirements to Implement the Required Utilization File Disclosures (26 CFR 54.9815-2715A3(b)(2)(ii), 29 CFR 2590.715-2715A3(b)(2)(ii), and 45 CFR 147.212(b)(2)(ii))	0938-1372	1,580	1,580	2,912	4,600,960	$638,958,320
ICRs Regarding Requirements to add a Text File to Improve Discoverability and Accessibility of Machine-Readable Files (26 CFR 54.9815-2715A3(b)(2)(iv), 29 CFR 2590.715-2715A3(b)(2)(iv), and 45 CFR 147.212(b)(2)(iv))	0938-1372	1,580	1,580	24	37,920	$5,258,240
Total			**17,380**		**6,699,463**	**$913,710,577**

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

BILLING CODE 4831–GV–C; 4150–29–C; 4120–01–C

V. Response to Comments

Because of the large number of public comments the Departments normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. The Departments will consider all comments we receive by the date and time specified in the **DATES** section of this 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

A. Statement of Need

These proposed rules would amend and strengthen the existing regulations under sections 1311(e)(3) and 2715A of the PHS Act and be incorporated into section 715 of ERISA and section 9815 to the Code to enhance price transparency reporting requirements for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage. Consistent with the goals of Executive Order 14221, these proposed rules aim to provide patients with clear, accurate, and actionable pricing information.[170]

More broadly, these proposed rules seek to improve the quality, accuracy, and usability of publicly available pricing disclosures and cost-sharing information for participants, beneficiaries, and enrollees. They also address new Federal protections under the No Surprises Act and reduce duplicative reporting requirements.

By making pricing data more meaningful and accessible, these changes are intended to help participants, beneficiaries, and enrollees better understand their potential costs, support more informed decision-making, and promote greater competition among health care providers and insurers.

B. Overall Impact

The Departments have examined the impacts of these proposed rules as required by Executive Order 12866, ''Regulatory Planning and Review;'' [171] Executive Order 13132, ''Federalism;'' [172] Executive Order 13563, ''Improving Regulation and Regulatory Review''; [173] Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; [174] the Regulatory Flexibility Act (RFA); [175] section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform

[170] Exec. Order No. 14221, 90 FR 11005 (February 28, 2025).

[171] Exec. Order No. 12866, 58 FR 51735 (September 30, 1993).

[172] Exec. Order No. 13132, 64 FR 43255 (August 4, 1999).

[173] Exec. Order No. 13563, 76 FR 3821 (January 18, 2011).

[174] Exec. Order No. 14192, 90 FR 9065 (January 31, 2025).

[175] Regulatory Flexibility Act, Public Law 96–354, 94 Stat. 1164 (September 19, 1980).

Act of 1995 (March 22, 1995, Pub. L. 104–4).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts).

Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities, or the principles set forth in this Executive order.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under Executive Order 12866. A ''significant regulatory action'' is also subject to review by the Office of Management and Budget (OMB). The Departments have concluded that this rule is likely to have economic impacts of $100 million or more in at least 1 year. The Departments have provided an assessment of the potential costs, benefits, and transfers associated with this rule. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB. Additionally, tax regulatory actions issued by the U.S. Department of the Treasury are subject to the requirements of section 6 of Executive Order 12866 pursuant to the Memorandum of Agreement (MOA) (July 4, 2025) between the Treasury Department and OMB regarding review of tax regulations. As such, the Treasury portions of this rule were also reviewed by OMB and are also incorporated into this RIA.

C. Affected Entities

This section of the preamble summarizes the number of plans, issuers, and participant, beneficiaries and enrollees that would be affected by these proposed rules.

1. Group Health Plans

These proposed rules would affect ERISA-covered group health plans and non-Federal governmental group health plans. The Departments estimate there are approximately 2,600,000 ERISA-covered group health plans, of which approximately 119,000 are self-insured and 1,500,000 are fully funded.[176] The Departments also estimate that these proposed rules would affect 90,900 non-Federal governmental group health plans.[177] Of these plans, approximately 35.7 percent [178] (or 32,400) are self-insured,[179] and 64.3 percent (or 58,400) are fully funded.[180]

2. Participants, Beneficiaries, and Enrollees

The Departments estimate that there are 135.5 million participants in ERISA-covered group health plans, of which 78.9 million are in self-insured plans and 56.6 million are in fully funded plans.[181] There are also approximately 44.5 million participants in non-Federal governmental group health plans, of which 22.8 million are in self-insured plans and 21.5 million are in fully funded plans.[182] In addition, roughly 46 million individuals are covered by private direct-purchase health insurance.[183]

3. Issuers and TPAs

Finally, the Departments estimate that these proposed rules would affect 205 TPAs [184] and 1,375 issuers.[185] The Departments assume that fully-insured group health plans would rely on health insurance issuers. In contrast, self-insured group health plans would depend on TPAs, including issuers providing administrative services only and non-issuer TPAs, to implement the proposed updates to cost-sharing disclosures to participants, beneficiaries, and enrollees, as well as to implement the amended public disclosure requirements. This assumption is based on the Departments' understanding that most self-insured group health plans already rely on TPAs to perform core administrative functions, such as enrollment and claims processing.[186] The Departments use the term TPA in this section of the preamble to refer to any other party with which a self-insured group health plan has an agreement to provide services to meet the proposed requirements in these proposed rules.

D. Detailed Economic Analysis

1. Impact Estimates of the Transparency in Coverage Provisions and Accounting Table

Consistent with Executive Order 12866 and OMB Circular A–4,[187] Table 37 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with these proposed

[176] There are 2,627,159 ERISA-covered group health plans, of which 119,485 are self-insured and 1,476,575 are fully funded. (Based on the 2023 Medical Expenditure Panel Survey Insurance Component (MEPS–IC) and the 2021 County Business Patterns from the Census Bureau. Agency for Healthcare Research and Quality, *2023 Medical Expenditure Panel Survey Insurance Component (MEPS–IC), https://meps.ahrq.gov/mepsweb/data_stats/download_data_files.jsp* (last visited Dec. 8, 2025); U.S. Census Bureau, *2021 County Business Patterns, https://www.census.gov/programs-surveys/cbp/data.html* (last visited Dec. 8, 2025).

[177] Based on data from the 2022 Census of Governments, there are 90,887 State and local entities. The Departments assume there is one plan per entity on average. Therefore, the Departments estimate that there are 90,887 non-Federal governmental plans. U.S. Census Bureau, *2022 Census of Governments, Organization Tables, https://www.census.gov/data/tables/2022/econ/gus/2022-governments.html* (last visited Dec. 8, 2025).

[178] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey—Insurance Component, Table III.A.2.a.* (2023), *https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_3/2023/ic23_iiia_g.pdf.*

[179] This estimate is calculated as follows: 90,887 non-Federal group health plans × 35.7 percent = 32,447 self-insured, non-Federal governmental group health plans.

[180] This estimate is calculated as follows: 90,887 non-Federal group health plans × 64.3 percent = 58,440 fully insured, non-Federal governmental group health plans.

[181] Employee Benefits Security Administration, *Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2023 Annual Social and Economic Supplement to the Current Population Survey* (August 30, 2024), *https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2023.pdf.*

[182] *Id.*

[183] Congressional Research Service, *U.S. Health Care Coverage and Spending, https://sgp.fas.org/crs/misc/IF10830.pdf* (last updated Feb. 19, 2025).

[184] An ''issuer/state combination'' refers to a health insurance issuer and the state in which it offers coverage, such that the same issuer operating in multiple states is treated as separate issuer/state combinations. Centers for Medicare & Medicaid Services, *2023 Medical Loss Ratio Data, https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources* (last updated Dec. 23, 2024).

[185] The Departments' estimate of the number of health insurance companies and the number of issuers (issuer/State combinations) is based on medical loss ratio reports submitted by issuers for the 2023 reporting year. Centers for Medicare & Medicaid Services, *Medical Loss Ratio Data and System Resources, https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr* (last updated Dec. 23, 2024).

[186] Louise Norris, *What is Self-Insured Health Insurance? Most Very Large Employers Self-Insure,* Verywell Health (November 9, 2024), *https://www.verywellhealth.com/what-is-self-insured-health-insurance-and-how-is-it-regulated-4688567.*

[187] Office of Management and Budget, *Circular A–4: Regulatory Analysis* (2003), *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf.*

regulatory actions. The Departments are unable to quantify all of the benefits and costs associated with these proposed rules due to data limitations and uncertainty about how plans, issuers, and other interested parties may respond to these proposed requirements.

BILLING CODE 4831–GV–P; 4150–29–P; 4120–01–P

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	$261,903,147	2025	3 percent	2027-2031
Annualized Monetized ($/year)	$246,565,891	$276,468,149	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 machine-readable files is estimated at $5,258,240.
• Ongoing annual costs to plans and issuers to respond to machine-readable file 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.

BILLING CODE 4831–GV–C; 4150–29–C; 4120–01–C

Since the implementation of the 2020 final rules, many plans and issuers have experienced higher-than-anticipated costs associated with generating,

storing, and updating very large and complex machine-readable files. The Departments acknowledge these burdens, as well as the underestimation of such burdens in the 2020 final rules and seek to address them in these proposed rules by requiring more efficient disclosure formats, clarifying data reporting structures and reducing duplicative data. While the Departments are unable to quantify the extent of the underestimation in the 2020 final rules, they seek comment on which particular burden estimates were underestimated and what data sources can be relied upon to demonstrate the impact.

The following sections outline a more detailed accounting of the quantified and non-quantified benefits and costs associated with these proposed rules.

2. Proposed Requirements for Disclosures to Participants, Beneficiaries, or Enrollees Under 45 CFR 147.211

a. Benefits

The following paragraphs describe the benefits of the proposed revisions to the requirement that plans and issuers disclose certain cost-sharing information to participants, beneficiaries, and enrollees through an internet-based self-service tool, including making pricing information available by phone, and amending the disclaimer related to balance-billing consistent with balance billing protections under the No Surprises Act.

(1) Informed Consumer

These proposed amendments would enhance consumer access to critical cost-sharing information by expanding the available delivery methods and clarifying their scope. Requiring group health plans and issuers to provide cost-sharing estimates by phone using a phone number found on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, and enrollees for which a consumer may seek customer assistance would ensure broader accessibility for all participants, beneficiaries, and enrollees, including those who prefer or rely on verbal communication due to visual impairments, limited literacy, or other challenges. By expanding access to this information, more participants, beneficiaries, and enrollees would be empowered to make cost-conscious decisions about their health care. In addition, the proposed amendments to the currently required notice on balance billing would provide individuals with clearer information about the potential for out-of-network providers to charge additional amounts not reflected in the cost-sharing information provided to the individual, including the fact that there are protections against balance bills under Federal law, as well as to ensure that plans and issuers are including this notice unless the plans or policies are offered in States that categorically prohibit balance billing.

(2) Timely Payment of Medical Bills

The proposed amended requirements are designed to make the cost-sharing information disclosed pursuant to these proposed rules more accessible to more participants, beneficiaries, and enrollees, and easier for participants, beneficiaries, and enrollees to understand and anticipate their health care costs. More transparency around potential health care costs by providing a new method for delivery of the information via the phone and clearer information about potential balance billing and out-of-pocket costs is expected to increase participants', beneficiaries', and enrollees' overall awareness of their potential health care costs. The Departments have determined that this increased transparency and awareness would help participants, beneficiaries, and enrollees better anticipate expenses and lead to more consistent and timely payment of medical bills. A TransUnion survey reported that 79 percent of individuals would be more likely to pay their medical bills promptly if they had out-of-pocket costs estimates before obtaining care.[188] Additionally, recent reports from hospital systems show that when patients receive clear, upfront cost estimates, they are more likely to make payments at the time of service. For example, the Surgery Center of Oklahoma achieved a 22-fold increase in point-of-service collections, from about $900,000 in 2007 to $20.5million in 2017, after implementing an automated cost-estimation tool that provided transparent pricing before care.[189] Similarly, a Florida-based hospital system that adopted real-time price estimates experienced a nearly 30 percent increase in point-of-service collections over 2 years.[190] This suggests that making cost-sharing information disclosures more accessible and understandable can support patients' financial planning, promote more timely payment of medical bills, and provide financial benefits for hospitals and other health care providers.

(3) Increased Competition Among Providers

The proposed amendments in these proposed rules aim to empower consumers to make cost-conscious choices among health care providers by improving the accessibility and clarity of cost-sharing information for participants, beneficiaries, and enrollees. By requiring plans and issuers to provide cost-sharing estimates over the phone, in addition to online and in paper form, these proposed rules would ensure broader access to pricing information. In addition, a clearer notice about potential balance billing by out-of-network providers would further enhance transparency and give individuals a more complete picture of the potential financial obligations associated with different providers.

Evidence suggests that price transparency can lead to reduced health care costs and increased market pressure on higher-cost providers. Studies have shown that when consumers receive pricing information, particularly in combination with incentives such as lower cost-sharing, cash rewards, or premium reductions, they are more likely to choose lower-cost options. For example, a price transparency initiative that allowed consumers to compare MRI prices across facilities resulted in nearly a 19 percent average cost reduction per scan (approximately $220 in savings per scan) and decreased use of higher-cost hospital settings.[191] The study also found that price variations between hospital and non-hospital facilities for MRI scans decreased by 30percent. This reduction was mainly driven by consumers switching to lower-cost options and competitive price adjustments by higher-cost facilities. Another study found that disclosure of negotiated prices stimulated provider competition and led to lower prices for shoppable services.[192] These findings

[188] Beth Kutscher, *Consumers demand price transparency, but at what cost?,* Modern Healthcare (June 2015), *https://www.modernhealthcare.com/article/20150623/NEWS/150629957/consumers-demand-price-transparency-but-at-what-cost.*

[189] Christopher Cheney, *Cost estimation drives huge increase in POS collections,* HealthLeaders (Feb. 1, 2018), *https://www.healthleadersmedia.com/finance/cost-estimation-drives-huge-increase-pos-collections.*

[190] Sze-jung Wu, Gosia Sylwestrzak, Christine Shah, & Andrea DeVries, *Price transparency for MRIs increased use of less costly providers and triggered provider competition,* 33 Health Affairs 1391, 1398 (2014), *https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0168.*

[191] Sze-jung Wu, Gosia Sylwestrzak, Christine Shah, & Andrea DeVries, *Price transparency for MRIs increased use of less costly providers and triggered provider competition,* 33 Health Affairs 1391, 1398 (2014), *https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0168.*

[192] Angela Zhang, Khic-Houy Prang, Nancy Devlin, Anthony Scott, et al., *The impact of price*

Continued

support the Departments' view that greater transparency can drive competition, encourage cost-conscious decision-making, reduce price disparities across the health care system, and potentially contribute to lowering overall health care costs.

The Departments acknowledge that, while price transparency may promote competition and reduce costs, some studies indicate it may lead to price convergence, where lower-cost providers raise prices toward the market average.[193] This can occur when providers observe that competitors charge substantially more for the same service and adjust their own prices upward to capture additional revenue, potentially reducing consumer savings.

(4) Reduced Deadweight Loss [194]

Through Improved Access to Cost-Sharing Information by Phone

The Departments anticipate that requiring plans and issuers to provide cost-sharing information by phone would help reduce information asymmetry in health care markets, particularly for individuals who are less likely to use online tools, have limited internet access or feel less comfortable accessing or interpreting information over the internet. For example, according to the Pew Research Center, while 75 percent of those 65 and older use the internet generally, less than 61 percent own a smartphone,[195] and 22 percent of these adults report never going online at all.[196] By improving access to real-time, personalized cost-sharing data for these populations, this proposed requirement could enable more consumers to compare prices and select lower-cost providers. This shift in behavior could reduce overpayment for services and better align spending with consumers' willingness to pay, thereby decreasing the deadweight loss that results from information asymmetry.

Although quantifying these efficiency gains presents methodological challenges, economic literature supports the notion that improved price transparency can lead to behavioral changes and welfare improvements.[197] The Departments recognize the potential for meaningful economic benefits and welcome comment and data that could inform a more robust estimate of the reduction in deadweight loss associated with these proposed provisions.

b. Costs

Section IV.C. of this preamble outlines the quantified costs associated with updating cost-sharing disclosures to reflect Federal balance billing protections, as described in 26 CFR 54.9815–2715A2(b)(1)(vii)(A), 29 CFR 2590.715–2715A2(b)(1)(vii)(A), and 45 CFR 147.211(b)(1)(vii)(A). The Departments assume that plans and issuers have already developed self-service tools and would only need to revise the disclaimer to state that out-of-network providers may engage in balance billing, subject to applicable State and Federal laws. Although these updates build on existing infrastructure, the Departments estimate that all plans (or TPAs on behalf of plans) and issuers would incur a one-time cost for minor technical modifications, with a total burden of 263 hours and an associated cost of approximately $37,657.

Section IV. of this preamble also outlines the quantified costs associated with providing the cost-sharing information, as described in 26 CFR 54.9815–2715A2(b)(1), 29 CFR 2590.715–2715A2(b)(1), and 45 CFR 147.211(b)(1), over the phone, as proposed in new paragraph 26 CFR 54.9815–2715A2(b)(2)(iii), 29 CFR 2590.715–2715A2(b)(2)(iii), and 45 CFR 147.211(b)(2)(iii). As discussed in more detail in section IV.C. of this preamble, the Departments have provided both lower impact and higher impact cost estimates to account for varying call times. The Departments estimate that all plans (or TPAs on behalf plans) and issuers would incur a total, low-range, annual ongoing time burden of 585,000 hours with an associated estimated cost of $23,400,000, and a total, high-range, burden of 1,300,000 hours with and associated estimated cost of $52,000,000, to provide pricing information by phone.

The Departments have determined that plans and issuers would leverage their existing customer service call center infrastructure to provide cost-sharing information over the phone in order to reduce or eliminate any one-time burden and cost. While the Departments have determined many plans (or TPAs on behalf of plans) and issuers already provide some level of real-time phone-based cost-sharing information, they recognize that some plans and issuers may be required to alter existing or develop new infrastructure and could incur one-time burden and cost in order to meet the proposed requirements.

The Departments also anticipate that providing phone-based access would increase call duration and require plans (or TPAs on behalf of plans) and issuers to train customer service representatives and supervisors, resulting in a one-time burden of 290,720 hours and an estimated total cost of approximately $13,727,040.

The Departments assume that most self-insured group health plans would rely on TPAs to fulfill these newly proposed requirements and that TPAs typically serve multiple clients, allowing for economies of scale, which could result in a lower burden and cost. Additionally, the Departments acknowledge that plans and issuers might choose to upgrade their communication systems voluntarily, such as adding mobile call features or real-time texting, which could result in additional burden or cost reductions.

The Departments recognize that expanding access to personalized pricing data, particularly via phone, may increase the risk of potential exposure of personal health information (PHI) and personally identifiable information (PII). As with internet-based disclosures, additional investments in security infrastructure, staff training on data protection, and consumer privacy tools may be necessary to mitigate the risk of unauthorized access or breaches. Between 2009 and 2024, there were 6,759 health care data breaches involving 500 or more records reported to the Department of Health and Human Services Office for Civil Rights, compromising the data of over 846 million individuals (an average of more than 2.6 per member of the U.S population). Notably, in 2024 alone, nearly 277 million individuals were affected, with an average of over

transparency on consumers and providers: A scoping review, 124 Health Policy 819, 825 (2020).

[193] Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, Michael E. Chernew, et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending,* 315 JAMA 1874, 1881 (2016); Noah Tong, *Transparency has led to uniformity in healthcare costs—but not necessarily lower prices: White paper,* Fierce Healthcare (Oct. 23, 2024), *https://www.fiercehealthcare.com/providers/transparency-leading-uniformity-healthcare-costs-not-necessarily-lower-prices-study.*

[194] Deadweight loss refers to the economic inefficiency that arises when the consumption of a service deviates from the socially optimal level due to inaccurate pricing or insufficient information. In healthcare, lack of price transparency can lead patients to make suboptimal choices, either overpaying or postponing care, thereby decreasing overall economic welfare for both consumers and providers.

[195] Michelle Faverio, *Share of Those 65 and Older who are Tech Users has Grown in the Past Decade* (Jan. 13, 2022), Pew Research Center, *https://www.pewresearch.org/short-reads/2022/01/13/share-of-those-65-and-older-who-are-tech-users-has-grown-in-the-past-decade.* The share of those 65 and older who are tech users have improved at a rapid clip over the past decade and will continue to improve as more utilize online tools and resources.

[196] Andrew Perrin & Sara Atske, *7 percent of Americans Don't Use the internet. Who are They?,* Pew Research Center (Apr. 2, 2021), *https://www.pewresearch.org/short-reads/2021/04/02/7-of-americans-dont-use-the-internet-who-are-they.*

[197] Yiquan Gu & Tobias Wenzel, *Transparency, price-dependent demand and product variety,* 110 Economics Letters 216, 219 (2011).

758,000 records breached daily.[198] As a result, complying with these provisions may necessitate additional safeguards to protect PHI and PII during phone-based interactions.

The Departments seek comment on these burden and cost estimates, including assumptions on disclosures to reflect Federal balance billing protections, call duration, customer service staffing, and the extent to which plans (or TPAs on behalf of plans) and issuers are already equipped to provide real-time cost-sharing information by phone.

While not quantified in this analysis, the Departments acknowledge that State regulators may incur administrative costs to review, monitor, or enforce compliance with these additional requirements. The Departments seek comment on any potential State-level impacts and any other burdens and costs that could be incurred by entities that would be affected by the provision of these proposals.

3. Proposed Requirements for Public Disclosure Under 26 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212

The following paragraphs describe the quantified and non-quantified benefits of the proposed requirements to disclose information related to in-network rates and historical out-of-network allowed amounts through machine-readable files.

a. Quantified Benefits

(1) Reduced Data Cleaning and Integration Costs for Third-Party Developers and Other File Users

The Departments have determined that by reducing the complexity and inconsistency of data that currently require extensive data processing and reconciliation, these proposed rules would make machine-readable data both easier to locate and easier to process for third-party developers and other file users, such as academics, researchers, data engineers, and plans and issuers. These proposed rules would do this by requiring plans and issuers to publish contextual files including a Change-log File, Taxonomy File, and a Utilization File; report at the network rather than the plan or policy level; exclude providers that have in-network rates for items or services for which they are unlikely to be reimbursed; add enrollment numbers, common network names, and product types; and standardize file locations with a Text File and footer links. The Departments anticipate that much of the burden currently involved in cleaning and processing the machine-readable files would be eliminated, since the files would contain more accurate data in smaller sizes. This would reduce the time and resources third-party developers and other file users spend removing duplicative and irrelevant data, which in turn would decrease the computational resources required for data cleaning and integration, further reducing overall costs.

In particular, the Departments estimate that the proposed provisions to require network-level reporting, add enrollment numbers, and specify product types would meaningfully reduce data cleaning and integration costs for approximately 300 third-party developers and other file users,[199] including research shops and consultancies. Specifically, network-level reporting is expected to save about 40 hours per quarterly reporting cycle, or 160 hours annually. Providing enrollment data directly in the files would remove the need for third-party sourcing and integration, saving another 40 hours each year, while the inclusion of product types would save an estimated 20 hours per quarterly cycle, or 80 hours annually. Together, these provisions would reduce about 280 hours of analyst time per year for each third-party developer or other file user. Using an average hourly wage of $120 for a Business Analyst,[200] the total estimated annual labor savings across all 300 third-party developers and other file users would be approximately $10.1 million.[201]

In addition, by requiring plans and issuers to exclude provider-rate combinations for items and services for which a provider would be unlikely to be reimbursed, the Departments estimate a substantial reduction in the data volume that would be disclosed, compared to current volumes, leading to lower computational costs when processing the files. Assuming industry-wide disclosures currently total roughly 1,000,000 gigabytes (GB), equivalent to 1 PB [202] in size per month, the proposed exclusion of these provider-rate combinations would reduce file sizes by about 70 percent [203] to a new estimated size of 300,000 GBs. While most actual savings would be associated with algorithms that are processing the data, which would reflect much higher actual computation savings, an absolute baseline can still be established.

Assuming an average compute cost of $0.015 per GB RAM-hour for general purpose usage,[204] the baseline monthly compute cost for 1 PB is estimated at roughly $334 [205] with an annual cost of $4,008. With a 70 percent reduction in file size, monthly compute costs would decrease to approximately $100, yielding a monthly savings of $234, which corresponds to an estimated annual savings of approximately $2,808 per third-party developer or other file user. Across 300 third-party developers and other file users, this equates to total annual savings of approximately $842,400.

These proposed rules would also shift the reporting frequency from monthly to quarterly for In-network Rate and Allowed Amount Files, reducing the total computational needs accordingly. This change reduces total annual downloads from 3,600 (300 third-party developers and users × 12 months) to 1,200 (300 third-party developers and users × 4 months), or an average of 100 downloads per month to be processed. Under quarterly reporting, the estimated annual industry-wide computational costs for the optimized files would be $120,000.[206] Relative to the monthly baseline, this cadence change combined with the file-size reduction yield $1,082,400 in total annual compute savings. Of this amount, approximately

[198] Steve Adler, *Healthcare Data Breach Statistics,* The HIPAA Journal (Sept. 30, 2025), *https://www.hipaajournal.com/healthcare-data-breach-statistics/.*

[199] This estimate is based on discussions with a sample of third-party developers and other file users. From these discussions, the Departments estimated a total of approximately 300 third-party developers and other file users consuming the public disclosures associated with these rules.

[200] U.S. General Services Administration, *Pricing Intelligence Suite, CALC information and wage rates, https://buy.gsa.gov/pricing/* (last visited Dec. 8, 2025).

[201] The total estimated annual labor savings is calculated by multiplying the 280 hours saved per third-party developer or other file user by the 300 affected users and the average hourly wage of $120 (280 × 300 × $120 = $10.1 million).

[202] Christopher Whaley, Neeraj Radhakrishnan, Michael Richards, Kosali Simon, et al., *Understanding Health Care Price Variation: Evidence from Transparency-in-Coverage Data,* 3 Health Affairs Scholar 2 (2025), *https://doi.org/10.1093/haschl/qxaf011.*

[203] This estimate is based on internal analysis of existing data and stakeholder feedback. External sources, such as Serif Health, report rates exceeding 80 percent. Salman Mukhi, *Zombie Hunting: Filtering Approaches for Price Transparency Data* (Sep. 20, 2024), *https://www.serifhealth.com/blog/zombie-hunting-filtering-approaches-for-price-transparency-data.*

[204] Amazon Web Services, *Amazon EC2 On-Demand Pricing, https://aws.amazon.com/ec2/pricing/on-demand* (last accessed Oct. 1, 2025).

[205] This is calculated using AWS t4g.xlarge throughput of 720 GB/hour and 16 GB of RAM. Total hours = Total data/Throughput = 1,000,000GB/720GB per hour ≈ 1,388.89 hours; GB–RAM-hours = RAM × Hours = 16GB × 1,388.89 hours ≈ 22,222 GB–RAM-hours; Total cost = GB–RAM-hours × Price per GB–RAM-hour = 22,222 × $0.015 ≈ $333.33.

[206] Total computational costs for new files (300,000 GB) processed quarterly are calculated as $100 × 1,200 downloads per year = $120,000.

$842,400 of compute savings is attributable to file-size optimization, while an additional $240,000 results from the reduction in reporting frequency.

The Departments have determined that together these proposed provisions would result in total annual savings of roughly $11.2 million ($10.1 million in labor savings plus $1.1 million in industry-wide storage cost savings from the shift to quarterly reporting) for third-party developers and other users of price transparency data, while supporting the intended goal of making price data more usable and actionable.

The Departments seek comment on the estimated potential cost and time savings from streamlining and standardizing the machine-readable files, and on whether these proposed provisions would effectively result in reduced data processing burdens and costs for users.

(2) Reduced Storage Costs for Plans, Issuers, Third-Party Developers, and Other Files Users

The proposed provisions would lead to reduced storage costs for plans, issuers, third-party developers, and other users by significantly decreasing the total volume of data needed to generate, store, and make available for download. These proposals would minimize data duplication and reduce both the number and size of the machine-readable files by changing the reporting cadence for both the In-network Rate File and the Allowed Amount File from monthly to quarterly, requiring reporting of negotiated rates at the network level rather than the plan or policy level, and excluding provider-rate combinations in the In-network Rate File for certain items and services.

The Departments have determined that these changes could lower ongoing storage, backup, and processing costs for the In-network Rate File, making it easier and more cost-effective for third-party users to download and build and manage consumer-facing price comparison tools based on the machine-readable data. Further, the Departments anticipate some users would opt not to download and store all of the new In-network Rate Files, given the Change-log File would identify changes in data from one In-network Rate File to the next, further decreasing data storage and processing costs.

Researchers have estimated that the combined monthly file sizes across industry for the In-network Rate Files are over 1 PB. The Departments estimate that the proposed changes would reduce file sizes by approximately 70 percent, lowering the monthly data volume from about 1,000,000 GB to approximately 300,000 GB.

Using Amazon Web Services (AWS) S3 pricing as a benchmark, $0.023 per GB for the first 50 TB, $0.022 per GB for the next 450 TB, and $0.021 per GB beyond that,[207] storing 1 PB worth of data would result in an estimated baseline monthly storage cost of roughly $22,583 with an annual cost of approximately $270,996. With a 70 percent reduction in file size, monthly storage costs would decrease to approximately $6,651 ($79,812 annually), yielding a monthly savings of $15,932 and an estimated annual savings of approximately $191,184. These cost savings would apply for all plans and issuers.

Assuming 300 third-party developers and other file users download the files each month, total annual storage costs under current file size assumptions would be approximately $81,298,800.[208] With the 70 percent file-size reduction, the annual cost for all 300 third-party developers and other file users would drop to $23,943,600.[209] This results in an annual storage savings of roughly $57,355,200 [210] for the 300 third-party developers and other files users based on file-size optimizations.

However, because these proposed rules also shift the reporting frequency from monthly to quarterly, total storage needs and corresponding savings would be reduced accordingly. Under quarterly reporting, annual industry-wide storage cost for the reduced file size for the In-network Rate Files savings is estimated at $7,981,200.[211] Relative to the monthly baseline, this cadence change combined with the file-size reduction yield about $73,317,600 in total annual savings.[212] Of this amount, approximately $57,355,200 in storage savings can be attributed to file-size optimization, while an additional $15,962,400 can be attributed to the reduction in reporting frequency.

The Departments seek comment on the assumptions made and the estimated storage cost savings for plans and issuers, third-party developers, and other users from reducing data volume.

(3) Reduced Network Egress Costs for Plans and Issuers

In addition to the estimated savings from reduced storage requirements, the Departments anticipate that the proposed provisions would also lead to a reduction of bandwidth network costs for plans and issuers needed with making their machine-readable files available for download.

Using the estimates developed and discussed in the preceding section for the In-network Rate File, and applying AWS egress costs, which are fees for data transferred from AWS to the public internet, as a benchmark—the first 100 GB are free, followed by $0.09 per GB for the first 50 TB, $0.085 per GB for the next 40 TB, $0.07 per GB for the next 100 TB, and $0.05 per GB for any amount exceeding 150 TB.[213] The Departments estimate a monthly tiered egress cost of transferring 1 PB data would be approximately $53,800 with an estimated annual cost of roughly $645,600. With a 70 percent reduction in file size to 300,000 GB, monthly data transfer egress costs would decrease to about $18,795, with estimated annual costs of approximately $225,600. This would yield a monthly savings of $35,005 and annual cost savings of approximately $420,060 for all plans and issuers. These cost estimates assume a single data transfer, or download, each month.

Because files would not be downloaded just once, the Departments would also estimate the number of users that would download the entire data set each month. Assuming 300 third-party developers and other file users download the files each month, total annual egress costs under current file size assumption would be nearly $194 million.[214] With the optimized file size estimates, the costs would be reduced

[207] Amazon Web Services, *Amazon S3 pricing, https://aws.amazon.com/s3/pricing/* (last accessed Oct. 1, 2025).

[208] This is calculated by multiplying the current yearly cost to download multiplied by the number of third-party developers and other file users: $270,996 × 300 = $81,298,800.

[209] This figure is calculated by multiplying the annual cost per user after the file-size reduction ($79,812) by the number of third-party developers and other file users (300): $79,812 × 300 = $23,943,600.

[210] Annual storage savings of $57,355,200 is calculated by subtracting the total annual cost after file-size reduction ($23,943,600) from the total annual cost under current file-size assumptions ($81,298,800): $81,298,800 − $23,943,600 = $57,355,200.

[211] This is calculated by multiplying the reduced monthly storage cost ($6,651) by 4 quarterly reports and 300 third-party developers and other files: $6,651 × 4 × 300 = $7,981,200.

[212] This is calculated by subtracting the total storage costs for the new, quarterly file downloads ($7,981,200) from the total storage costs for the current monthly downloads ($81,298,800): $81,298,800 − $7,981,200 = $73,317,600.

[213] Amazon Web Services, *Amazon EC2 On-Demand Pricing, https://aws.amazon.com/ec2/pricing/on-demand/* (last accessed Oct. 1, 2025).

[214] At current file sizes, data transfer cost estimates are approximately $53,800 per month for 1 PB data. The Departments assume that 300 third-party developers and other file users each download one file per month (12 annually), resulting in 3,600 total downloads per year. Based on a cost of $53,800 per download, the estimated annual cost is approximately $193,680,000 ($53,800 × 3,600).

by about $68 million annually,[215] yielding total industry-wide savings of $126 million annually.[216]

Similar to reduced storage costs for plans and issuers discussed in section VI.D.3.a.(2). of this preamble, these proposed rules would also shift the reporting frequency from monthly to quarterly, which reduces total egress needs and corresponding savings. This change reduces total annual downloads from 3,600 (300 third-party developers and other file users × 12 months) to 1,200 (300 third-party developers and other file users × 4 months), or an average of 100 downloads per month. Under quarterly reporting, annual industry-wide egress costs for the optimized files would be about $22.6 million.[217] Relative to the monthly baseline, this cadence change combined with the file-size reduction would yield about $171 million in total annual savings.[218] Of this amount, approximately $126 million egress savings would be attributable to file-size optimization, while an additional $45 million would result from the reduction in reporting frequency.

The Departments seek comment on the assumptions made and anticipated egress cost savings for plans and issuers from reducing data volume and reporting cadence.

(4) Reduced Time Locating the Files for Third-party Developers and Other File Users

The Departments' proposal to require plans and issuers to include a standardized Text File and place a direct link to the files in the website footer would make it easier for third-party developers and other file users, who currently face challenges navigating plan or issuer websites to find their machine-readable files, to more efficiently locate and access the data needed for their applications and analyses.

The time savings from locating files primarily stem from the proposed requirement that plans and issuers include a standardized Text File that includes, among other things, the source page URL for the internet website that hosts the machine-readable files, and a footer link in certain prominent locations that links directly to the web page that hosts the link to the machine-readable files. Additionally, the proposed change from monthly to quarterly reporting would reduce the number of times a file user would need to locate the In-network Rate and Allowed Amount Files to find updated information. Together, the Departments estimate that these changes would save about 10 hours [219] of labor quarterly (or 40 hours annually) for each third-party developer or file user, reflecting the reduced need to manually track down and verify file locations. Using an average hourly wage of $120 for a Business Analyst,[220] the Departments estimate that total annual labor savings for all third-party developers and other file users would amount to approximately $1.4 million.[221] The Departments seek comment on the assumptions and estimated burden and cost savings from making the machine-readable files easier to locate through standardized links.

The Departments have determined that the provisions of these proposed rules would help reduce administrative complexity and advance the objective of making price transparency data more accessible, efficient, and actionable for participants, beneficiaries, and enrollees.

As shown in Table 38, the proposed provisions are estimated to generate total annual benefits of approximately $257 million for plans, issuers, third-party developers, and other users.

TABLE 38: Summary of Annual Quantified Benefits from the Proposed Provisions

Benefit	Annual Benefits ($)
Reduced Data Cleaning and Integration Costs for Third-Party Developers, and Other File Users, including Changing Timing Requirements for Machine-Readable Files Reporting from Monthly to Quarterly	$11,162,400
Reduced Storage Costs for Plans, Issuers, Third-Party Developers, and Other Files Users, including Changing Timing Requirements for Machine-Readable Files Reporting from Monthly to Quarterly	$73,317,600
Reduced Network Egress Costs for Plans and Issuers, including Changing Timing Requirements for Machine-Readable Files Reporting from Monthly to Quarterly	$171,126,000
Reduced Time Locating the Files for Third-party Developers and Other File Users	$1,440,000
Total	**$257,046,000**

[215] This is calculated as follows: Estimated size data transfer cost estimates for optimized files are $18,795 per month for transferring 300,000 GB. The Departments assume that 300 third-party developers and other file users each download one file per month (3,600 downloads each year). At this rate, the total annual cost is estimated at $67,662,000 ($18,795 × 3,600).

[216] Estimated annual size data transfer cost savings are calculated by subtracting the total annual cost for the optimized 300TB files ($67,662,000) from the total annual cost for the original 1PB files ($193,680,000): $193,680,000 − $67,662,000 = $126,018,000.

[217] Total network costs for transferring new files (300,000 GB) on a quarterly basis are calculated by multiplying the monthly cost per file transfer ($18,795) by the total annual downloads (1,200): $18,795 × 1,200 downloads per year = $22,554,000.

[218] Total network cost savings are calculated by subtracting the total annual network costs for the new files downloaded quarterly ($22,554,000) from the total annual costs for the current monthly downloads ($193,680,000): $193,680,000 − $22,554,000 = $171,126,000.

[219] The estimated 10 hours saved annually per organization is based on the assumption that, for each update, organizations review the prior month's links to locate files, and only a subset of those files requires additional effort to determine their posting location.

[220] U.S. General Services Administration, *Pricing Intelligence Suite, CALC information and wage rates, https://buy.gsa.gov/pricing/* (last visited Dec. 8, 2025).

[221] The total annual labor savings estimate is derived as follows: each of the approximately 300 third-party developers and other file users is estimated to save 10 hours of labor per quarterly reporting cycle as a result of the proposed standardized Text file and footer link, which facilitate easier file location. With four reporting cycles per year, this equates to 40 hours saved annually per third-party developer or other file user. Applying an average hourly wage for a Business Analyst of $120 results in an estimated annual savings of approximately $4,800 per third-party developer or other file user (40 hours × $120). When aggregated across the estimated 300 third-party developers and other file users, the total annual labor savings amount to approximately $1,440,000.

b. Non-Quantified Benefits

(1) Stronger Market Leverage for Plans and Issuers

By requiring more streamlined, meaningful, and clear disclosure of in-network rates and detailed out-of-network data, the provisions in these proposed rules would better enable plans and issuers to compare their in-network rates and out-of-network coverage with those of competitors. The addition of contextual files, including the Taxonomy File, Utilization File, and Change-log File, would enhance the practical value of this data, helping plans and issuers see not just raw prices but also provider specialties, actual in-network utilization, and historical changes in rate information. This would support plans and issuers in identifying gaps, trends, and outliers within their own networks and relative to the market. This enhanced transparency might strengthen their ability to negotiate lower reimbursement rates with providers based on knowing what those providers have negotiated with other payers that are similarly situated within the market for the same items or services with other plans and issuers that are similarly situated within the market. However, as noted in section VI.D.2.a.(3). of this preamble, the Departments also recognize the potential for this information to drive rates up if providers learn they are being paid less than other providers and use that information to seek higher negotiated rates.

By enhancing the transparency of out-of-network allowed amounts and historic billed charges, these provisions might facilitate broader adoption of private health insurance market reference-based pricing strategies. Specifically, the proposed requirements related to the Allowed Amount File would provide the public with clearer information on what out-of-network providers charge. This additional transparency could help plans and issuers, and other consumers, better identify lower-cost providers and benchmark reasonable prices, ultimately supporting strategies where participants, beneficiaries, or enrollees pay the difference when selecting higher-cost providers in circumstances where they have a meaningful choice among providers. Plans and issuers may use such reference-based pricing structures to guide participants, beneficiaries, and enrollees toward lower-cost providers. While the Departments recognize that reference-based pricing may not apply uniformly (for example, some plans offer exemptions based on clinical need or geographic limitations), it has generally led to cost reductions. For instance, combining price transparency with reference pricing has led to significant shifts in consumer choice of facility, resulting in a 27 percent reduction in the average price paid per laboratory test and a 13 percent reduction in the average price paid per imaging test.[222]

(2) Enhanced Regulatory Oversight and Inform Policymaking

The Departments expect that State and Federal regulators could gain efficiencies and increased insights from the data reporting pursuant to the amended disclosure requirements in these proposed rules. The proposals would give regulators access to more streamlined, usable, and actionable in-network rate and out-of-network data, which may support more informed oversight of premium rate filings by enabling more effective monitoring of market trends and price variations. The proposals may also help States monitor rates to identify collusive behaviors, as well as help establish benchmarks for negotiations with providers as part of State oversight activities related to coverage programs, ultimately strengthening regulatory oversight and promoting more competitive markets.

(3) Increased Understanding and Empowered Consumers

These proposals aim to empower participants, beneficiaries, and enrollees by increasing transparency around what plans and issuers reimburse providers for covered items and services. By providing access to clearer, more streamlined, and more specific in-network rates, historical out-of-network allowed amounts, and billed charges, file users and ultimately health care consumers might be better equipped to understand how their choices of coverage and providers affect their costs. This transparency may support more informed consumer decision-making when comparing plans or selecting providers. Adding supporting contextual information to accompany the data is expected to enhance overall usability for third-party developers and other file users. As stated in the preamble to the 2020 final rules, the Departments expected third-party developers and other innovators to use the machine-readable file data to create ''easy-to-use internet-based tools and mobile applications that will present information to laypersons in easy-to-understand, plain language that is sufficiently concise and well-organized,'' [223] which would allow ''consumers to consider price as a factor when making meaningful comparisons between different coverage options and providers.'' [224] The Departments are encouraged by the consumer-facing tools that have been built since implementation of the 2020 final rules and look forward to additional growth in this space following implementation of the enhancements in these proposed rules.

c. Costs

This section of the preamble provides both quantitative and qualitative discussion of the costs associated with the Departments' proposed revisions to the requirements that plans and issuers make information regarding in-network negotiated rates and out-of-network allowed amounts available through machine-readable files on a public website. The Department request comment and data on how to better quantify these costs.

Section IV.D. of this preamble outlines the quantified costs associated with requirements for public disclosure of in-network rates and allowed amount data for covered items and services from in- and out-of-network providers, as described under 26 CFR 54.9815–2715A3, 29 CFR 2590.715–2715A3, and 45 CFR 147.212.

For In-network Rate Files, this proposal would require plans and issuers to create a separate file for each provider network, allow rates to be expressed as a percentage of billed charges when appropriate, include enrollment totals for each plan or coverage option, disclose provider network product types, and exclude providers unlikely to be reimbursed based on their scope of practice. The Departments estimate that all plans (or TPAs on behalf of plans) and issuers would incur a one-time burden of 717,952 hours on the low end and 758,400 hours on the high end, with associated costs of approximately $102,371,360 and $108,084,640, respectively. While these proposals would involve a one-time cost to modify existing processes, the Departments expect that, once these updates are implemented, the ongoing burden related to including product type, excluding certain providers, reporting dollar amounts (except for ''percentage-of-billed-charges'' payments), including enrollment data, organizing files by provider network, and allowing service

[222] Christopher Whaley, Timothy Brown, & James Robinson, *Consumer responses to price transparency alone versus price transparency combined with reference pricing,* 5 American Journal of Health Economics 227, 249 (2019).

[223] 85 FR 72169 (November 12, 2020).

[224] 85 FR 72210 (November 12, 2020).

providers to organize files across multiple self-insured plans would be minimal, beyond current costs for monitoring and maintaining these processes.

For Allowed Amount Files, the proposal includes requiring data reporting at the market level instead of the individual plan level, lowering the claims threshold from 20 to 11, extending the reporting period from 90 days to 6 months, and increasing the lookback period from 180 days to 9 months to enhance the robustness of historical data. The Departments estimate that all plans (or TPAs on behalf of plans) and issuers would incur a one-time burden of 101,120 hours, with associated costs of approximately $14,283,200. While lowering the claims threshold to 11 is expected to require only minor system adjustments, the Departments anticipate minimal ongoing costs for maintaining and monitoring compliance. Similarly, extending the lookback period is not expected to impose a significant additional burden, as automated systems are already in place to report out-of-network allowed amounts for the 90-day reporting period beginning 180 days before publication. Ongoing costs for aggregating out-of-network Allowed Amount Files by market type are also expected to be minimal.

In addition, these proposed rules would require plans and issuers to post several contextual machine-readable files: a Change-log File, a Utilization File, a Taxonomy File, and a Text File, each with specific update and posting requirements. The Departments estimate a one-time burden of 5,548,960 hours for plans (or TPAs on behalf of plans) and issuers, with associated costs of approximately $777,578,040 to add and implement these files, with an ongoing annual burden of 60,040 hours (costing approximately $9,186,120) to update the Utilization File and 47,400 hours (costing approximately $7,015,200) to address point-of-contact inquiries to improve discoverability and accessibility of the machine-readable files. The Change-log File is expected to be fully automated, and the Departments anticipate only minimal system maintenance beyond the initial generation and posting of the file. Similarly, once the initial setup for adding a Text File is complete, ongoing updates are expected to require minimal effort. The Departments also assume that including a link to the internet domain hosting the machine-readable files on the website footer would result in minimal additional burden.

(1) Non-Quantified Costs for Public Disclosure of In-Network Provider Rates

The proposed provisions are expected to introduce meaningful improvements to the quality, clarity, and usability of In-network Rate Files, such as requiring files to be organized by provider network rather than by plan or policy, allowing for percentage-of-billed charges reporting when the dollar amount is not known in advance, adding contextual files like Taxonomy, Utilization, and Change-log files, and excluding certain provider-rate combinations if it is unlikely that a provider would be reimbursed for an item or service given that provider's area of specialty. While these improvements aim to help file users, tool developers, and regulators better navigate and interpret rate data, they may also create non-quantified operational and market-level costs for plans and issuers.

Specifically, plans and issuers could face additional administrative and compliance costs from producing and maintaining stricter standardized machine-readable files. This may involve internal quality reviews, greater coordination across business units, as well as potential redesign of existing automated processes to create network-specific files and incorporate new required data fields.

There is also a risk that improving the transparency of negotiated rates may cause some providers to raise their prices if they discover they are paid less than their peers. This response could contribute to price convergence rather than sustained downward pressure on costs, an effect observed in some transparency studies, where high prices fall slightly but lower prices rise, ultimately reducing overall savings. For instance, one study found that although price transparency has helped narrow price variation in health care, it has not consistently lowered overall prices. According to the study, the highest prices fell by 6.3 percent, while the lowest prices rose by 3.4 percent, and mid-range prices decreased only slightly by 1.1 percent.[225] While the study does not address the effect on average prices, these findings suggest that transparency can pressure high-cost providers to reduce prices but may also lead lower-cost providers to increase prices. A 2020 study also suggests that price transparency could facilitate tactical collusion, resulting in higher prices in markets that are not perfectly competitive, such as health care. In these markets, there are fewer sellers and higher barriers to entry for new competitors.[226]

Another potential cost stemming from increased transparency due to improvements in In-network Rate Files is the impact on a plan's or issuer's ability or incentive to develop and maintain a robust provider network. A provider network consists of health care providers that have entered into agreements with plans or issuers to deliver care at a negotiated rate, which the provider accepts as full payment. Plans and issuers often prefer their participants, beneficiaries, and enrollees to use in-network providers, as these providers meet the health plan's quality standards and agree to lower rates in exchange for the patient volume they will receive by being part of the network.[227] Some plans and issuers use narrow networks, which include a more limited group of providers. While these networks offer fewer in-network options to participants, beneficiaries and enrollees, they often result in lower monthly premiums and reduced out-of-pocket costs.[228] The Departments recognize that publicly disclosing negotiated rates may reduce the incentive for providers to enter into such contractual agreements, particularly in narrow networks, if they know those rates will be made public or they are being offered lower than market rates. This could, in turn, limit network options available to plans and issuers.

Smaller issuers may be disproportionately affected by the improved transparency of negotiated rates, as they may be unable to match the higher rates that larger issuers can offer. In turn, smaller issuers may be forced to contract only with lower-cost providers, potentially leading to narrower networks and affecting participant, beneficiary, and enrollee access to care. Such network constraints may also make it more difficult for these issuers to fully comply with network adequacy standards described at 45 CFR 156.230 or applicable State standards. Ultimately, while the purpose of

[225] Forrest Xiao, *The Healthcare Cost Conundrum: Prices are Stabilizing. Why are Expenses Still Rising?,* Turquoise Health (Oct. 31, 2024), https://blog.turquoise.health/the-healthcare-cost-conundrum/.

[226] Robert F. Graboyes & Jessica McBirney, *Price Transparency in Healthcare: Apply With Caution,* Mercatus Center, George Mason University (2020), *https://www.mercatus.org/system/files/graboyes-price-transparency-mercatus-research-v1.pdf.*

[227] Elizabeth Davis, *Health insurance provider network overview,* Verywell Health (Feb. 9, 2025), *https://www.verywellhealth.com/health-insurance-provider-network-1738750.*

[228] Tracy Anderman, *What to know about narrow network health insurance plans,* Consumer Reports (Nov. 23, 2018), *https://www.consumerreports.org/health-insurance/what-to-know-about-narrow-network-health-insurance-plans.*

improving price transparency is to empower participants, beneficiaries, and enrollees and enhance market efficiency, the Departments acknowledge that these proposed provisions could, in some cases, reduce the ability or incentive of plans and issuers, especially smaller ones, to build and maintain robust networks that satisfy quality and access requirements.

(2) Non-Quantified Costs for Public Disclosure of Out-of-Network Allowed Amounts

The Departments recognize the potential costs arising from the proposed expansion of data in the Allowed Amount Files. These may include the increased complexity and administrative burden of managing and reporting a larger volume of data over extended reporting and lookback periods, as well as at the broader health insurance market level rather than at the plan or policy level. Additionally, to account for the expanded handling of detailed claims data, plans and issuers might face additional expenses for enhanced cybersecurity measures and compliance with data privacy regulations. These potential costs are difficult to quantify given current data limitations, but the Departments acknowledge that they represent important considerations associated with implementing these proposed provisions.

The Departments seek comment and data on the potential magnitude of these non-quantified costs, including legal, operational, and network impacts, and how they may affect plan and issuer implementation and that may assist the Departments' estimate on any related additional burden and cost.

4. Summary of Transfers

The requirements of these proposed rules, as discussed in section III. of this preamble, require plans and issuers to enhance the accuracy and usability of pricing information through improved machine-readable files, expand cost-sharing disclosure methods (including phone access), and streamline reporting requirements. As a result of the proposed requirements, the Departments expect various transfers, discussed in this section of the preamble, to occur between plans and issuers; providers; participants, beneficiaries, and enrollees; and the Federal government. While the precise magnitude of these transfers is difficult to quantify due to varying market conditions and consumer behaviors, the directional effects and distributional impacts can be analyzed conceptually.

a. Transfer From Higher-Cost to Lower-Cost Providers

If participants, beneficiaries, and enrollees gain easier access to pricing information through enhanced machine-readable files and phone-based cost-sharing estimates, some consumers might switch from higher-cost to lower-cost providers for comparable services. This transfer occurs as consumer cost preferences result in shifts from providers who charge what consumers feel are above-market rates, to those offering what the consumer feels to be more competitive pricing. The magnitude of this transfer would depend on several factors: the degree of price variation between providers, consumer price sensitivity, and the consumer's relationships between those providers.

Some evidence shows that in competitive markets, price ranges may narrow as lower-cost providers raise their prices to align with higher-cost competitors, potentially increasing costs.[229] Disclosing negotiated rates can enable providers to match each other's prices, which may further limit cost reductions or even lead to higher overall prices despite the increased transparency.[230] However, in some instances, increased transparency could lead higher-cost providers to face new pressure to lower costs, potentially decreasing costs.[231] The Departments acknowledge that this transfer may be partially offset by potential price convergence effects, where lower-cost providers may increase their prices toward market averages once pricing becomes more transparent. However, the net effect is expected to favor more efficient providers and create competitive pressure for cost reduction across the market.

b. Transfer From Providers to Consumers Through Reduced Out-of-Pocket Spending

If consumers use enhanced pricing information to select lower-cost providers, their out-of-pocket expenses for health care services are expected to decrease, representing a transfer from the provider to the consumer. This transfer is facilitated by the proposed requirement to make cost-sharing information available by phone, which might particularly benefit populations who face barriers to using online tools, including older adults, individuals with disabilities, and those with limited internet access. By expanding access to personalized pricing information, these consumers might make more cost-conscious health care decisions, resulting in lower deductibles, copayments, and coinsurance amounts. The magnitude of this transfer could vary significantly based on individual utilization patterns, plan design, and the availability of lower-cost alternatives within their provider networks. This shift is consistent with empirical findings that greater price transparency can help consumers make more cost-effective choices and encourage market competition.[232]

c. Transfer From Plans and Issuers to Participants, Beneficiaries, and Enrollees Through Potential Premium Reductions

If enhanced price transparency leads to systematic shifts toward lower-cost providers and overall reductions in health care spending, plans and issuers may experience lower claims costs, which could eventually translate to reduced premiums for participants, beneficiaries, and enrollees. That is, as plans and issuers experience lower medical costs due to participant, beneficiary, and enrollee price shopping, competitive pressure may lead to premium reductions to attract and retain enrollees. However, the magnitude of this transfer would depend on several factors, including the degree of competition across different market segments and geographic areas (for example, urban vs. rural markets) and the rate in which consumer utilization patterns change.

d. Transfer From Premium Tax Credit (PTC) Eligible Consumers to Federal Government Through Reduced PTC

If enhanced price transparency leads to lower premiums in the individual insurance market, consumers eligible for PTCs would receive smaller subsidy amounts, resulting in a transfer from consumers to the Federal government. This transfer would occur if, through the use of transparency tools, premiums in the individual market declined

[229] Forrest Xiao, *The Healthcare Cost Conundrum: Prices are Stabilizing. Why are Expenses Still Rising?,* Turquoise Health (Oct. 31, 2024), *https://blog.turquoise.health/the-healthcare-cost-conundrum/.*

[230] David N. Bernstein & Jonathan R. Crowe, *Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward,* 61 INQUIRY: The Journal of Health Care Organization, Provision, and Financing (2024).

[231] Yanzhi Feng, *Price Transparency in Healthcare: Bargaining Incentives and Patient Responses,* 102 Journal of Health Economics (2025).

[232] Zachary Y. Brown, *Equilibrium Effects of Health Care Price Information,* 101 Review of Economics and Statistics 4 (2019); Christopher Whaley, Zachary Brown, & John C. Robinson, *Consumer Responses to Price Transparency Alone Versus Price Transparency Combined with Reference Pricing,* 5 American Journal of Health Economics 227 (2019).

(including the second lowest-cost silver benchmark plan) and thus resulted in a reduction in Federal spending through reduced PTC amounts. The magnitude of this transfer would depend on the extent to which price transparency leads to substantial competitive pressure, overall premium reductions, and the number of PTC-eligible consumers affected. For subsidized consumers, the net effect may be largely neutral, since their required premium contributions are based on income rather than plan cost; however, if they choose a lower-cost plan as premiums decrease, they could experience a net benefit. On the other hand, unsubsidized consumers would generally see a positive impact from any premium reductions.

e. Transfer From Federal Government to Consumers Through Increased PTCs

If the costs associated with enhanced transparency requirements contribute to premium increases, for example, through price convergence, this could result in higher PTC payments to eligible consumers, representing a transfer from the Federal government to consumers. This transfer could also occur if the costs of implementing enhanced machine-readable file requirements, phone-based cost-sharing tools, and other transparency measures result in increased premiums. The magnitude and direction of this transfer is uncertain due to the variation in market responses; however, these proposed rules are designed to reduce administrative burden and streamline reporting requirements and thus reduce premiums and overall costs.

The Departments acknowledge uncertainty in both the magnitude and timing of these potential transfers. Market responses to price transparency efforts might vary widely based on local competitive conditions, consumer behavior patterns, provider networks, and the specific design of transparency tools. This analysis focuses on directional effects and distributional considerations rather than precise quantification, given the limited empirical evidence on the specific transparency enhancements proposed in this rule, and evidence indicates that, while transparency may create competitive pressure and encourage cost reductions, the net effects on prices and transfers remain uncertain.[233] Price transparency can influence consumer decision-making, potentially encouraging shifts toward lower-cost providers; [234] however, in markets that are not perfectly competitive, it can sometimes lead to price alignment or collusion, which may increase prices rather than lower them.[235]

The Departments seek comment on the potential transfers described previously, including any potential transfers from higher-cost providers to participants, beneficiaries, and enrollees and issuers resulting from improved price transparency, as well as any possible impacts resulting from the potential for provider collusions and price convergence.

5. Uncertainty Analysis

The Departments recognize that the assumptions underlying the estimated costs and benefits described in sections VI.D.2.b. and VI.D.3.a. of this preamble involve a degree of uncertainty. Differences in plan and issuer size, internal systems, and workflows may affect the resources required to implement the proposed requirements. The quality, structure, and reporting practices of existing files could also shape the extent of savings realized by third-party developers and other users. In addition, labor costs, technical implementation needs, and the pace of adopting new practices are likely to vary across the industry. External factors, such as market behavior, regulatory changes, or shifts in the number of file users, may further influence the overall impacts. The Departments seek comment on these assumptions and uncertainties, and welcome data or information that could improve the accuracy of the estimates or help identify ways to address potential variability.

6. Regulatory Review Cost Estimation

To comply with these proposed rules, affected entities must first review and understand the regulatory requirements. While plans and issuers are ultimately responsible for meeting these proposed requirements, the Departments expect, as assumed elsewhere, that the burden of compliance would fall primarily on issuers and TPAs, with only the largest self-insured plans likely to assume this responsibility directly. While the Departments do not have specific data on how many large self-insured plans will opt to comply independently, such plans would likely incur similar costs and burdens as issuers and TPAs in developing compliant tools and reviewing these proposed rules. Therefore, for purposes of estimating regulatory review costs, the Departments assume that a total of 1,580 issuers and TPAs would take on these responsibilities.

Additionally, the Departments expect States to review these proposed rules to prepare for oversight and enforcement duties. If these proposed rules impose administrative costs on private entities, such as the time required to review and interpret these proposed rules, the Departments should estimate the costs associated with regulatory review. Given the difficulty in precisely determining how many entities will undertake such a review, the Departments assume that all plans (or TPAs on behalf of plans) and issuers, and States would need to review these proposed rules in order to comply.

The Departments acknowledge that this assumption may overstate or understate actual costs, as not all entities may conduct an in-depth review, and some may rely on external counsel or consultants. Nonetheless, the Departments have determined that using the total number of plans, issuers, and States provides a reasonable basis for estimating the regulatory review burden.

Using data from the Bureau of Labor Statistics' Occupational Employment and Wage Statistics,[236] the Departments assume that issuers and TPAs would rely on a Computer and Information Systems Manager (Code 11–3021) and a Lawyer (Code 23–1011) to review and interpret these proposed rules. For States, a Compliance Officer (Code 13–1041) is assumed to perform this task. Assuming an average reading speed of 200 words per minute and using BLS median wage data (including a 100 percent increase to account for the cost of fringe benefits and other indirect costs), the Departments estimate that each issuer or TPA would require approximately 2.9 hours of review by a Computer and Information Systems Manager (at $164.62/hour) and 5.8 hours by a Lawyer (at $145.34/hour). Based on these assumptions, the combined labor cost for all 1,580 issuers and TPAs is approximately $2,068,200.

[233] Harold A. Pollack, *Necessity for and Limitations of Price Transparency in American Health Care,* 24 AMA Journal of Ethics E1069 (Nov. 2022).

[234] McKinsey & Company, *Consumer Decision Making in Healthcare: The Role of Information Transparency* (July, 2020), *https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Consumer%20decision%20making%20in%20healthcare/Consumer-decision-making-in-healthcare-The-role-of-information-transparency.pdf.*

[235] Robert F. Graboyes & James McBirney, *Price Transparency in Healthcare: Apply with Caution,* Mercatus Center, George Mason University (2020), *https://www.mercatus.org/system/files/graboyes-price-transparency-mercatus-research-v1.pdf.*

[236] U.S. Bureau of Labor Statistics, *National Occupational Employment and Wage Estimates* (May 2024), *https://www.bls.gov/oes/current/oes_stru.htm.*

For States, it is estimated that a Compliance Officer would need approximately 4.6 hours (at $75.40/hour) to review these proposed rules, resulting in a total cost of $22,111 across all 50 States and the District of Columbia. Accordingly, the total combined estimated cost of regulatory review for all plans and issuers, and State DOIs is approximately $2,090,311.

E. Alternatives Considered

1. Disclosure of Claims Volume

The Departments considered adding a new content element under the In-network Rate File requirements at 26 CFR 54.9815–2715A3(b)(1), 29 CFR 2590.715–2715A3(b)(1), and 45 CFR 147.212(b)(1) requiring disclosure of claims volume for each negotiated rate for each provider for each item and service as an additional or alternative method of providing contextual plan and coverage usage information. The Departments also considered requiring the Utilization File 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 disclose the number of times that any given provider submitted a claim for any particular item or service. Claims volume could inform which providers are associated with high-volume services and the respective negotiated rates as well as help indicate the degree to which negotiated rates are used by providers to deliver actual services to health plan enrollees. However, the Departments are concerned that this additional information may impose a significant burden for plans and issuers, who would need to pull claims data for each item and service for each provider that has a negotiated rate for such item and service and update the claims count. Claims data most likely resides in different systems from contract data and would need to be imported and kept up to date in the In-network Rate File according to the cadence in which the In-network Rate File must be updated, potentially making the production of In-network Rate Files, as well as the annual Utilization File, much more burdensome. Further, this level of querying is complex and potentially always changing based on the frequency of provider groups changing (which providers are included in the TIN/NPI combination) and claims activity associated with such providers for such items and services, making the burden not only significant but ongoing. Lastly, current In-network Rate Files contain contract data which is prospective in nature and claims data is retrospective. The mixing of types of data within a file may introduce potential data confusion. Therefore, the Departments are not proposing to require disclosure of claims-related information in the In-network Rate File or the Utilization File. The Departments seek comment on the relative benefits and burdens interested parties might anticipate with requiring claims-related information.

2. Excluded Information

As an alternative to the proposal to require plans and issuers to exclude from each In-network Rate File a provider and their negotiated rate (provider-rate combination) for an item or service, if it is unlikely that such provider would be reimbursed for the item or service given that provider's area of specialty according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process, the Departments considered two alternative approaches. The first approach involved running each combination of provider and service as a mock claim and only including in the In-network Rate File those claims that passed validation edits for appropriateness of that provider to perform the service. This is different from the proposed process described in section III.C.5. of this preamble because it would require plans and issuers to process each potential provider-rate combination through its claims adjudication, rather than relying on its internal mapping of billing codes to exclude providers. This method establishes a clear standard and provides meaningful information, resulting in smaller In-network Rate Files that are far more accessible and manageable. However, there are significant drawbacks to this approach. Plans and issuers would face a high initial and ongoing administrative and financial burden, as they would need to run every provider through the claims adjudication system for every item or service with a negotiated rate, repeating this process quarterly. This method imposes the greatest engineering burden among the options considered, as it may require setting up and maintaining parallel adjudication systems specifically for this task, separate from production adjudication systems. The Departments considered the administrative burden associated with this approach to be a significant deterrent to proposing this approach as a viable option.

Second, the Departments explored the idea of requiring plans and issuers to create In-network Rate Files with negotiated rates based solely on historic claims data, identifying providers who have submitted claims for specific items or services. This approach has several advantages. It would establish a clear standard, provide meaningful information, and ensure that negotiated rates are disclosed only for providers who have actually submitted claims for those items and services over the course of a particular period of time. However, the proposal also presented significant drawbacks. First, this approach would lack a mechanism to monitor over-filtering by plans and issuers, potentially excluding relevant providers. Also, mixing prospective and retrospective data within the In-network Rate File could confuse users about which services are available under current contracts versus historical activity. Finally, the approach might require exceptions for new providers who have not yet submitted claims, making it difficult for users to distinguish between active providers and those who are unlikely to offer specific services. As a result, the Departments determined this approach was overly complex as compared with the proposed approach of utilizing the taxonomy data discussed.

3. Data Retention

The Departments received feedback from interested parties recommending that plans and issuers be required to retain the Transparency in Coverage data required pursuant to 26 CFR 54.9815–2715A3(b), 29 CFR 2590.715–2715A3(b), 45 CFR 147.212(b) on a public website for 7 years. They argue their recommendation on the fact that, because plans and issuers are currently only required to post their machine-readable files monthly, most plans and issuers replace the files on their website each month, making the prior month's files unavailable, and consequently making it difficult for file consumers like researchers and academics to analyze pricing trends over time, verify historical rates, or assess the evolution of provider-plan relationships.

The Departments considered data retention standards of 7 years, as well as shorter durations, but are not proposing any data retention requirements at this time due to the significant cost and burden the Departments have determined it would incur on plans and issuers. Specifically, storing, maintaining, and making 7 years of machine-readable files publicly available would be costly, and the benefits, such as enabling longitudinal analysis of contractual data and historical price benchmarking, are relatively marginal especially if other proposals in these proposed rules are finalized. In particular, the recommendation would necessitate

robust additional data storage capacity—moving beyond transient monthly files to a vast archive capable of accommodating potential petabytes of historical records. Concurrently, significant network bandwidth allocations would be required to handle the consistent monthly influx of new data, as well as the eventual high-volume demands of researchers or other entities accessing and downloading years' worth of historical files. Furthermore, the ongoing maintenance and organization of the datasets would require ensuring data integrity over time, implementing efficient indexing and cataloging of systems for easy discoverability. Without careful engineering planning and dedicated resources, the archived files risk becoming digital landfills, undermining the transparency they are intended to provide.

The Departments' proposed change from a requirement to post updated In-network Rate and Allowed Amount Files every month to quarterly in redesignated 26 CFR 54.9815–2715A3(b)(4)(i), 29 CFR 2590.715–2715A3(b)(4)(i), and 45 CFR 147.212(b)(4)(i) and described in section III.C.10. of this preamble would reduce the number of files required to be retained by users for future reference and thus the associated costs of doing so. Similarly, a quarterly cadence should ease the difficulty some users have when downloading and collecting the file data monthly, thus expanding access to more users without losing any data. The Departments also expect that the proposed requirement for plans and issuers to produce a quarterly Change-log File 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) and described in section III.C.7.a. of this preamble may help users more easily catalog and assess data changes over time, limiting the need to access all the data in prior files.

The Departments, however, seek comment on the relative burdens and benefits of requiring files to be publicly posted for a specific period of time. The Departments are particularly interested in whether interested parties believe that public retention of prior files would continue to be valuable if combined with the other changes in these proposed rules. The Departments are also interested in views from interested parties on what would be a sufficient amount of retention time that would still provide value for file users without imposing an undue burden on plans and issuers.

4. Deemed Compliance With PHS Act Section 2799A–4, ERISA Section 719, and Code Section 9819

The Departments indicated in FAQs Part 49 on August 20, 2021 [237] that, because the price comparison methods required by the No Surprises Act (codified in Code section 9819, ERISA section 719, and PHS Act section 2799A–4) are largely duplicative of the self-service tool described in the 2020 final rules, the Departments intended to propose rulemaking and seek public comment regarding whether compliance with the self-service tool requirements of the 2020 final rules satisfies the analogous requirements set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4. The Departments recognized that plans and issuers had already been working to implement the self-service tool requirement of the 2020 final rules.

The Departments considered requiring plans to develop a separate cost comparison tool to fulfill the requirements of the No Surprises Act, however, such a proposal would likely impose significant costs on plans and issuers for having to build an entirely new technical infrastructure, with little additional benefits for participants, beneficiaries, and enrollees, given that the provisions of the No Surprises Act largely duplicate the requirements of the Transparency in Coverage rules. Additionally, there would be great potential for public confusion, as participants, beneficiaries, and enrollees would be unsure of which tool use, whether they had different purposes, and the potential for search results to be different. The Departments have received feedback from plans and issuers that their participants, beneficiaries, and enrollees expressed similar concerns of confusion as the plan and issuer transitioned from a legacy self-service tool to a tool that satisfied the requirements of the 2020 final rules. For these reasons, the Departments are not proposing to require an additional self-service tool.

F. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) [238] requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of a proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Departments have determined that the costs calculated in these proposed rules do not rise to the level of significance under the RFA. The Departments have prepared the following justification for this determination.

1. Proposed Rules

These proposed amendments aim to improve the accessibility, standardization, and utility of pricing data disclosures by refining certain requirements and aligning regulatory text with the No Surprises Act and Executive Order 14221. Key changes include clarifying the balance billing disclaimer to reflect Federal protections, requiring that cost-sharing information to also be made available by phone, and enhancing the format and usability of machine-readable files by reducing duplication and file size.

2. Affected Entities

The RFA generally defines a ''small entity'' as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of ''small entity.'' The Departments use a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdiction.

a. Group Health Plans

As discussed in section VI.C.1. of this preamble, these proposed rules would affect ERISA-covered group health plans and non-Federal governmental group health plans. The Department estimates that there are approximately 2,500,000 ERISA-covered group health plans with less than 100 employees, of which 1,400,000 are fully funded.[239] For purposes of the RFA, the Department of Labor continues to consider a small entity to be an employee benefit plan

[237] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act Implementation Part 49* (Aug. 20, 2021), *https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-49.pdf* and *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf*.

[238] 5 U.S.C. 601, *et seq*.

[239] There are 2,454,996 ERISA-covered group health plans with less than 100 employees, of which 1,423,897 are fully insured. Agency for Healthcare Research and Quality, *2023 Medical Expenditure Panel Survey Insurance Component (MEPS–IC), https://meps.ahrq.gov/mepsweb/data_stats/download_data_files.jsp* (last visited Dec. 8, 2025); U.S. Census Bureau, *2021 County Business Patterns, https://www.census.gov/programs-surveys/cbp/data.html* (last visited Dec. 8, 2025).

with fewer than 100 participants.[240] Further, while some large employers may have small plans, in general, most small plans are maintained by small employers. Thus, the Departments have determined that assessing the impact of these proposed rules on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards issued by the SBA (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631, *et seq.*). Therefore, the Departments invite comments on the appropriateness of the size standard used in evaluating the impact of these proposed rules on small entities.

The Department also estimates there are approximately 90,900 non-Federal governmental group health plans.[241] Of these plans, approximately 35.7 percent [242] (or 32,400) are self-insured,[243] and 64.3 percent (or 58,400) are fully insured.[244] Furthermore, approximately 93.4 percent of group health plans have less than 100 employees.[245] Therefore, the Department estimates there are approximately 84,900 non-Federal governmental health plans with less than 100 employees, of which 30,300 are self-insured [246] and 54,600 are fully funded.[247]

b. Participants and Enrollees

The Departments estimate that there are 35.6 million participants in ERISA-covered group health plans with also 100 employees, of which 5.6 million are in self-insured plans and 30.1 million are in fully funded plans.[248] There are also approximately 2.2 million participants in non-Federal governmental group health plans with less than 100 employees, of which one million are in self-insured plans and 1.2 million are in fully insured plans.[249]

c. Issuers and TPAs

For purposes of the RFA, the Departments have determined that health insurance companies are generally classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards,[250] entities with average annual receipts of $47 million or less are considered small entities within this classification. Alternatively, some may fall under NAICS code 621491 (HMO Medical Centers), which has a size standard of $44.5 million or less.[251]

Based on data from Medical Loss Ratio (MLR) annual report submissions for the 2023 reporting year, approximately 84 out of 479 (18 percent) issuers of health insurance coverage nationwide had total premium revenues of $47 million or less.[252] The Departments also estimate, based on MLR data, that over 80 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies, are likely to have non-health lines of business that would result in their revenues exceeding $47 million. The Departments have determined that the same assumptions also apply to TPAs that would be affected by these proposed rules.[253] However, it should be noted that at least 76 percent of these small companies belong to larger holding groups that may not be small, and many, if not all, of these companies are likely to have non-health lines of business that would result in their revenues exceeding $47 million.

3. Cost of These Proposed Rules

Using a threshold approach, if the total costs of these proposed rules were spread evenly across all 1,375 issuers and 205 TPAs, the high-end per-entity costs would be approximately $578,298 in one-time first-year costs and $43,165 in ongoing annual costs, which would also be incurred in the first year.[254] Although the Departments are not able to apply the 3 to 5 percent change in revenues standard as a measure of significant economic impact on a substantial number of small entities due to limited data, as discussed in section VI.F.3. of this preamble, it is notable that over 80 percent of issuers and at least 76 percent of TPAs classified as small businesses are affiliated with larger holding groups that may not themselves qualify as small. Based on this information, the Departments anticipate that the costs associated with these proposed rules do not rise to the level of significance under the RFA. Therefore, the Departments conclude that an initial regulatory flexibility analysis is not required for such firms. The Departments seek comment on the assumptions and methodology underlying this analysis, including whether alternative data or approaches could better assess the impact on small plans and issuers, and on potential ways to reduce burden while meeting the objectives of these proposed rules.

Although ERISA-covered plans are often small entities, the Departments have determined that these plans would rely on the larger health insurance issuers and TPAs to comply with these proposed rules. Nevertheless, these plans may still experience increased

[240] The Department of Labor consulted with the Small Business Administration Office of Advocacy in making this determination, as required by 5 U.S.C. 603(c) and 13 CFR 121.903(c) in a memo dated June 4, 2020.

[241] Based on data from the 2022 Census of Governments, there are 90,887 State and local entities. The Departments assume there is one plan per entity on average. Therefore, the Departments estimate that there are 90,887 non-Federal governmental plans. U.S. Census Bureau, *2022 Census of Governments, Organization Tables, https://www.census.gov/data/tables/2022/econ/gus/2022-governments.html* (last visited Dec. 8, 2025).

[242] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey—Insurance Component, Table III.A.2.a.* (2023), *https://datatools.ahrq.gov/meps-ic/?tab=private-sector-national&dash=19* (last visited Dec. 8, 2025).

[243] This estimate is calculated as follows: 90,887 non-Federal group health plans × 35.7 percent = 32,447 self-insured, non-Federal governmental group health plans.

[244] This estimate is calculated as follows: 90,887 non-Federal group health plans × 64.3 percent = 58,440 fully insured, non-Federal governmental group health plans.

[245] Based on the 2023 Medical Expenditure Panel Survey Insurance Component (MEPS–IC) and the 2021 County Business Patterns from the Census Bureau. Agency for Healthcare Research and Quality, *2023 Medical Expenditure Panel Survey Insurance Component (MEPS–IC), https://meps.ahrq.gov/mepsweb/data_stats/download_data_files.jsp* (last visited Dec. 8, 2025); U.S. Census Bureau, *2021 County Business Patterns, https://www.census.gov/programs-surveys/cbp/data.html* (last visited Dec. 8, 2025).

[246] This estimate is calculated as follow: 32,447 self-insured, non-Federal governmental group health plans × 93.4 percent = 30,300 self-insured, non-Federal governmental group health plans with less than 100 employees.

[247] This estimate is calculated as follow: 58,440 fully funded, non-Federal governmental group health plans × 93.4 percent = 54,582 fully funded, non-Federal governmental group health plans with less than 100 employees.

[248] Employee Benefits Security Administration, *Health Insurance Coverage Bulletin: Abstract of Auxiliary Data for the March 2023 Annual Social and Economic Supplement to the Current Population Survey* (Aug. 30, 2024), *https://www.dol.gov/sites/dolgov/files/EBSA/researchers/data/health-and-welfare/health-insurance-coverage-bulletin-2023.pdf.*

[249] *Id.*

[250] U.S. Small Business Administration, *Table of Size Standards* (2023), *https://www.sba.gov/document/support--table-size-standards* (last updated Dec. 26, 2024).

[251] *Id.*

[252] Based on internal calculations. Centers for Medicare & Medicaid Services, *Medical Loss Ratio Data and System Resources* (2023), *https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources* (last modified Dec. 23, 2024).

[253] The Departments have determined that most TPAs are or are affiliated with issuers.

[254] The per-entity costs are estimated at $578,298 for the first year and $43,165 on an ongoing annual basis. These figures are derived by dividing the total estimated first-year cost of $913,710,577 and the total estimated ongoing annual cost of $68,201,320 by the total number of affected entities (1,375 issuers + 205 TPAs = 1,580).

costs due to the requirements, as the costs associated with implementation are likely to be passed on to them. However, the Departments are not of the view that the additional costs rise to the level of a significant economic impact. In addition, although the requirements of this proposal do not directly apply to providers, providers may experience a loss in revenue as a result of the demands of price-sensitive consumers and plans, as well as a potential unwillingness among smaller issuers to continue paying higher rates than those of larger issuers for the same items and services.

The Departments acknowledge that it may be likely that a number of small entities might enter into contracts with other entities in order to meet the requirements in these proposed rules, perhaps allowing for the development of economies of scale. However, due to limited information about how small entities may choose to meet these requirements and the potential costs associated with such contractual arrangements, the Departments seek comment on ways that these proposed rules could impose additional costs and burdens on small entities and how many such entities would likely enter into contracts to meet these proposed requirements.

Finally, section 1102(b) of the Social Security Act (SSA) (42 U.S.C. 1302) requires agencies to prepare a regulatory impact analysis if a rule is expected to have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must align with the provisions of section 603 of the RFA. For purposes of section 1102(b) of the SSA, the Departments define a small rural hospital as a hospital that is located outside of a metropolitan statistical area with fewer than 100 beds. While these proposed rules are not anticipated to directly regulate small rural hospitals, the Departments acknowledge that the transparency requirement may have indirect effects on these facilities through potential changes in negotiated rates and patient cost-sharing, behaviors that could impact hospital revenues, particularly given that rural providers typically operate with thinner profit margins than their urban counterparts. However, the Departments recognize that rural hospitals may also face lower levels of competition and any indirect effects that result from these proposed rules may have a lower impact, in some areas. Therefore, the Departments have determined that while there may be indirect effects, these do not rise to the level of a significant impact on the operations of a substantial number of small rural hospitals.

4. Duplicate, Overlapping, or Relevant Federal Rules

There are no duplicate, overlapping, or relevant Federal rules.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires agencies to assess anticipated costs and benefits before issuing any rule that may result in expenditures of $100 million or more in any one year (in 1995 dollars), adjusted annually for inflation. For 2025, this threshold is approximately $187 million. These proposed rules include disclosure requirements that may impact private sector entities, such as health insurance issuers offering coverage in the individual and group health insurance markets and TPAs administering group health plans. In addition, States, local, or Tribal governments may incur costs related to enforcement of certain provisions. The Departments expect the total burden on States, local, or Tribal governments and the private sector to exceed the UMRA threshold. The regulatory impact analysis proceeding this section of the preamble constitutes the assessment of anticipated costs and benefits required by UMRA.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. Federal agencies issuing regulations that have federalism implications must consult with States and local officials and describe the extent of their consultation and the nature of the concerns of States and local officials in the preamble to the regulation.

In the Departments' view, these proposed rules may have federalism implications, because it would have direct effects on the States, the relationship between the Federal Government and States, or on the distribution of power and responsibilities among various levels of government relating to the disclosure of health insurance coverage information to consumers.

Under these proposed rules, all group health plans and health insurance issuers, including self-insured, non-Federal governmental group health plans as defined in section 2791 of the PHS Act, would be required to enhance the accessibility and transparency of cost-sharing and pricing information for a participant, beneficiary, or enrollee (or an authorized representative on behalf of such individual). Specifically, plans and issuers would need to update disclaimers to reflect Federal balance billing protections, make cost-sharing estimates available by phone, and clarify how to meet the requirements for price comparison tools. These proposed rules would also require improvements to the format and accessibility of machine-readable files, expansion of required data elements, and adjustments to posting frequency and structure to ensure pricing data is more usable and understandable for consumers. Federal standards developed under section 2715A of the PHS Act preempt any related States' standards that require pricing information to be disclosed to the participant, beneficiary, or enrollee, or otherwise publicly disclosed, to the extent the State disclosure requirements would provide less information to the consumer or the public than what is required under these proposed rules.

The Departments have determined that these proposed rules may have federalism implications based on the required disclosure of pricing information, as they are aware of at least 25 States that have passed some form of price transparency legislation, such as all-payer claims databases, consumer-facing price comparison tools, and the right to shop programs, with varying requirements regarding the scope and level of disclosure.[255] While some States provide prices for individual services, others report aggregated costs across providers or over time to reflect the cost of an episode of care. The methods of sharing this information also vary. For instance, California requires uninsured patients to receive price estimates upon request, whereas other States use websites or software applications to enable consumers to compare prices across providers. Only seven States have published pricing information of issuers on consumer-facing public websites.[256] Therefore, these proposed rules may require plans and issuers to disclose more detailed pricing information than some State laws currently mandate.

In general, through section 514, ERISA supersedes State laws to the

[255] National Conference of State Legislatures, *Health Costs, Coverage and Delivery State Legislation Data Base, https://www.ncsl.org/health/health-costs-coverage-and-delivery-state-legislation* (last updated Sep 26, 2025).

[256] Melanie Evans, *One State's Effort to Publicize Hospital Prices Brings Mixed Results,* Wall Street Journal (June 26, 2019), *https://www.wsj.com/articles/one-states-effort-to-publicize-hospital-prices-brings-mixed-results-11561555562.*

extent that they relate to any covered employee benefit plan but preserves State laws that regulate insurance, banking, or securities. Furthermore, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the provisions of Part 7 of ERISA and chapter XXVII of the PHS Act (including the amendments made by the Affordable Care Act) are not to be ''construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a 'requirement' of a Federal standard.'' The conference report accompanying HIPAA indicates that this preemption is intended to be the ''narrowest'' preemption of State laws.[257] States may therefore continue to apply State law requirements to issuers so long as such requirements do not prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132, which requires agencies to examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected States. These efforts have included participation in conference calls and events hosted by the NAIC, as well as direct engagement with State insurance officials. The Departments intend to act in a similar fashion in enforcing the Affordable Care Act, including the provisions of section 2715A of the PHS Act. While drafting these proposed rules, the Departments attempted to balance the States' interests in regulating issuers with the goal of enhancing price transparency nationwide. By doing so, the Departments have determined that they have complied with the requirements of Executive Order 13132.

The Departments request comment on any potential effects these proposed rules may have on States. The Departments also request comment regarding any duplicative burdens that may exist between State and Federal requirements and ways such duplicative burdens can be addressed, if applicable.

In accordance with the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these proposed rules, the Departments certify that the Department of the Treasury, Employee Benefits Security Administration, and the CMS have complied with the requirements of Executive Order 13132 for the attached proposed rules in a meaningful and timely manner.

I. Executive Order 14192, ''Unleashing Prosperity Through Deregulation''

Executive Order 14192, titled ''Unleashing Prosperity Through Deregulation,'' was issued on January 31, 2025. Section 3(a) of Executive Order 14192 requires an agency, unless prohibited by law, to identify at least ten existing regulations to be repealed when the agency issues a new regulation. In furtherance of this requirement, section 3(c) of Executive Order 14192 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with prior regulations. A significant regulatory action (as defined in section 3(f) of Executive Order 12866) that would impose total costs greater than zero is considered an Executive Order 14192 regulatory action. This proposed rule, if finalized as proposed, is, therefore, expected to be an Executive Order 14192 regulatory action. Details on the estimated costs appear in the preceding analysis.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Child support, Employee benefit plans, Health care, Health insurance, Infants and children, Maternal and child health, Penalties, Pensions, Privacy, Reporting and recordkeeping requirements.

45 CFR Part 147

Aged, Citizenship and naturalization, Civil rights, Health care, Health insurance, Individuals with disabilities, Intergovernmental relations, Reporting and recordkeeping requirements, Sex discrimination.

Frank J. Bisignano,

Chief Executive Officer, Internal Revenue Service.

Daniel Aronowitz,

Assistant Secretary, Employee Benefits Security Administration.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

For the reasons set forth in the preamble, the Department of the Treasury proposes to amend 26 CFR part 54 as set forth below:

PART 54—PENSION EXCISE TAXES

■ 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805, unless otherwise noted.

* * * * *

Sections 54.9815–2715A1, 54.9815–2715A2, and 54.9815–2715A3 are also issued under 26 U.S.C. 9833;

* * * * *

■ 2. Section 54.9815–2715A1 is amended by:

■ a. Redesignating paragraphs (a)(2)(xi) through (xxii) as paragraphs (a)(2)(xii) through (xxiii); and

■ b. Adding new paragraph (a)(2)(xi).

The addition reads as follows:

§ 54.9815–2715A1 Transparency in coverage—definitions.

(a) * * *

(2) * * *

(xi) *Health insurance market* means, irrespective of the State, one of the following:

(A) 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).

(B) The large group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(C) The small group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(D) For purposes of self-insured group health plans (other than account-based plans, as defined in § 54.9815–2711(d)(6)(i), and plans that consist solely of excepted benefits), all self-insured group health plans maintained by the plan sponsor.

* * * * *

■ 3. Section 54.9815–2715A2 is amended by—

[257] U.S. Department of Labor, U.S. Department of Health & Human Services & U.S. Department of the Treasury, *FAQs about Affordable Care Act Implementation Part 54* (July 28, 2022), *https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-54.pdf* and *https://www.cms.gov/files/document/faqs-part-54.pdf.*

■ a. Revising paragraphs (b)(1)(i)(A) and (B), (b)(1)(vii)(A), and (b)(2)(ii) introductory text;
■ b. Redesignating paragraph (b)(2)(ii)(D) as paragraph (b)(2)(iv);
■ c. Adding paragraph (b)(2)(iii);
■ d. Revising newly redesignated paragraph (b)(2)(iv);
■ e. Revising paragraphs (b)(3)(i) and (ii);
■ f. Revising paragraph (c)(1); and
■ g. Adding paragraph (c)(7).

The revisions and additions read as follows:

§ 54.9815–2715A2 Transparency in coverage—required disclosures to participants and beneficiaries.

* * * * *

(b) * * *

(1) * * *

(i) * * *

(A) If the request for cost-sharing information relates to items and services that are provided within a bundled payment arrangement, and the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate cost-sharing liabilities. While plans and issuers are not required to provide estimates of cost-sharing liability for a bundled payment arrangement where the cost-sharing is imposed separately for each item and service included in the bundled payment arrangement, nothing prohibits plans or issuers from providing estimates for multiple items and services in situations where such estimates could be relevant to participants or beneficiaries, as long as the plan or issuer also discloses information about the relevant items or services individually, as required in paragraph (b)(1)(v) of this section.

(B) For requested items and services that are recommended preventive services under section 2713 of the Public Health Service Act (PHS Act), if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a plan or issuer may allow a participant or beneficiary to request cost-sharing information for the specific preventive or non-preventive item or service by including terms such as ''preventive,'' ''non-preventive,'' or ''diagnostic'' as a means to request the most accurate cost-sharing information.

* * * * *

(vii) * * *

(A) A statement that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for potential additional amounts in situations where applicable State or Federal law allow out-of-network providers to bill participants or beneficiaries for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer and from the participants or beneficiaries in the form of a copayment, coinsurance, or deductible amount (the difference referred to as balance billing). This statement is not required if the State in which the item or service was furnished prohibits all out-of-network providers from balance billing for all items and services payable by the plan or issuer.

* * * * *

(2) * * *

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary. In responding to such a 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 plan or issuer is required to:

* * * * *

(iii) *Phone method.* Information provided under this paragraph (b) must be made available at the request of the participant or beneficiary via a telephone number through which a consumer may seek customer assistance that Code section 9816(e) requires be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee. Such information must be accurate at the time of the request and must be provided at the time of the request. In responding to such a 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 day. The plan or issuer is required to:

(A) Disclose the applicable provider-per-day limit; and

(B) Provide the cost-sharing information, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section.

(iv) *Alternative method.* In circumstances where participants and beneficiaries request disclosure other than by the internet-based self-service tool, paper, or phone (for example, by email) group health plans and health insurance issuers may provide the disclosure through alternative means and satisfy the requirements of this section, provided the participant or beneficiary agrees that such disclosure through such means is sufficient to satisfy the request and the plan or issuer meets the timing requirements established under paragraph (b)(2)(ii)(C) of this section for paper method disclosure.

(3) * * *

(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information required by this paragraph (b) in compliance with this section pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a pharmacy benefit manager or other third-party) provides the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(c) * * *

(1)(i) The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2023 with respect to the 500 items and services to be posted on a publicly available website, and with respect to all covered items and services, for plan years (in the individual market, for policy years) beginning on or after January 1, 2024.

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraphs

(b)(1)(vii)(A), (b)(2)(iii) and (iv), and (c)(7) of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2027. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

(7) A group health plan or health insurance issuer that provides to the participant or beneficiary the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section, satisfies the requirements set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4.

* * * * *

■ 4. Section § 54.9815–2715A3 is amended by—

■ a. Revising paragraph (b) heading and introductory text;

■ b. Revising paragraphs (b)(1)(i) and (ii);

■ c. Redesignating paragraphs (b)(2) and (3) as paragraphs (b)(3) and (4), respectively;

■ d. Adding new paragraph (b)(2);

■ e. Revising newly redesignated paragraphs (b)(3) and (4);

■ f. Redesignating paragraphs (b)(4)(i) and (ii) as paragraphs (b)(5)(i) and (ii), respectively;

■ g. Revising newly redesignated paragraphs (b)(5)(i) and (ii);

■ h. Redesignating paragraph (b)(4)(iii) as paragraph (b)(5)(iv);

■ i. Adding new paragraph (b)(5)(iii);

■ j. Revising newly redesignated paragraph (b)(5)(iv); and

■ k. Revising paragraph (c)(1).

The revisions and additions read as follows:

§ 54.9815–2715A3 Transparency in coverage—requirements for public disclosure.

* * * * *

(b) *Requirements for public disclosure of in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, negotiated rates and historical net prices for covered prescription drugs, and contextual information.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraphs (b)(1) and (2) of this section in machine-readable files, in accordance with the method and format requirements described in paragraph (b)(3) of this section, and that are updated as required under paragraph (b)(4) of this section.

(1) * * *

(i) An in-network rate machine-readable file for each provider network maintained or contracted by a group health plan or health insurance issuer that includes the required information under this paragraph (b)(1)(i) for all covered items and services under each coverage option offered by the plan or issuer that uses such provider network, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file pursuant to paragraph (b)(1)(iii) of this section. Each in-network rate machine-readable file must include:

(A) The common provider network name;

(B) For each coverage option offered by a group health plan or health insurance issuer that uses such provider network, the name; the Health Insurance Oversight System (HIOS) identifier, or, if no HIOS identifier is available, the Employer Identification Number (EIN); and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(C) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service included in the machine-readable file;

(D) For each covered item or service included in the machine-readable file, all applicable rates, which may include one or more of the following: Negotiated rates, underlying fee schedule rates, or derived amounts. If a group health plan or health insurance issuer does not use negotiated rates for provider reimbursement, then the plan or issuer should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the plan or issuer uses underlying fee schedule rates for calculating cost sharing, then the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rate or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must be:

(*1*) Reflected as dollar amounts, with respect to each covered item or service that is furnished by an in-network provider. If the negotiated rate is subject to change based upon participant or beneficiary-specific characteristics, these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant or beneficiary-specific characteristics. 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, 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 Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(*2*) Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider, except those specified in paragraph (b)(1)(i)(F) of this section;

(*3*) Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

(*4*) Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

(E) Current numerical enrollment totals, as of the date the file is posted, for each coverage option offered by a group health plan or health insurance issuer that uses such provider network. Such numerical enrollment totals must include the number of participants and beneficiaries (including all dependents) in the coverage option offered by a plan or issuer.

(F) A group health plan or health insurance issuer must exclude from each file under paragraph (b)(1)(i) of this section a provider and their negotiated rate (provider-rate combination) for an item or service if the plan or issuer determines it is unlikely that the provider would be reimbursed for the item or service given that provider's area of specialty according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process.

(ii) For each health insurance market, as defined in § 54.9815–2715A1(a)(2)(xi), in which a group health plan or health insurance issuer offers a plan or coverage, an out-of-network allowed amount machine-readable file, including:

(A) For each coverage option offered by a group health plan or health insurance issuer in such health insurance market, the name and the HIOS identifier, or, if no HIOS identifier is available, the EIN; and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for

each billing code for each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market; and

(C) Aggregated unique out-of-network allowed amounts and billed charges with respect to each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market furnished by out-of-network providers during the 6-month time period that begins 9 months prior to the publication date of the machine-readable file (except that a plan or issuer must omit such data in relation to a particular item or service when compliance with this paragraph (b)(1)(ii)(C) would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of that item or service in a single health insurance market). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an out-of-network provider; and

(*2*) Associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

* * * * *

(2) *Required contextual files.* A group health plan or health insurance issuer must make available in a machine-readable format:

(i) A change-log file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that identifies any changes made to the required information described in paragraph (b)(1)(i) of this section since the immediately preceding published in-network rate machine-readable file.

(ii) A utilization file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that includes, for the 12-month period that ends 6 months prior to the publication date of each utilization file:

(A) Items and services covered under the plans or policies included in the files prepared as specified in paragraph (b)(1)(i) of this section for which a claim has been submitted and reimbursed, in whole or in part; and

(B) Each in-network provider identified by the NPI, 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.

(iii) A taxonomy file, for each in-network rate machine-readable file prepared as specified in paragraph (b)(1)(i) of this section, which includes the group health plan's or health insurance issuer's internal provider taxonomy that matches items and services (represented by a billing code) with provider specialties (represented by specialty codes which are derived from the Health Care Provider Taxonomy code set established by the National Uniform Claim Committee (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.. Plans and issuers must use their internal provider taxonomy to determine whether to exclude certain provider-rate combinations from the in-network rate machine-readable file as specified in paragraph (b)(1)(i)(F) of this section.

(iv) A plain text file in a .txt format in the root folder (that is, the top-level directory on an electronic file system) of a group health plan's or health insurance issuer's website that includes:

(A) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section;

(B) A direct link to the URL for the machine-readable files required under paragraphs (b)(1) and (2) of this section; and

(C) 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 machine-readable files required under paragraphs (b)(1) and (2) of this section. This contact information must be prominently displayed on the same website where the machine-readable files are made available and be kept updated per the requirements in paragraph (b)(4)(vi) of this section.

(3) *Required method and format for disclosing information to the public.* (i) The machine-readable files described in paragraphs (b)(1) and (2) of this section must be available in a form and manner as specified in guidance issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(ii) The machine-readable files must be publicly available and accessible to any person, automated scripts, or web crawlers free of charge and without conditions, such as establishment of a user account, password, submission of personally identifiable information or other credentials, or blocking server configurations or firewalls to access the file.

(iii) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section 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 machine-readable files.

(iv) The group health plan or health insurance issuer may satisfy the requirements of paragraph (b)(3)(iii) of this section by entering into a written agreement under which another party (such as a third-party administrator) posts the machine-readable files on its public website on behalf of the plan or issuer, including if the plan or issuer does not have a website. However, if the files are posted on a service provider's website, and the plan or issuer maintains a public website but chooses not to host 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.

(4) *Timing.* A group health plan or health insurance issuer must update the machine-readable files in accordance with the following timeframes and clearly indicate the date that the files were most recently updated:

(i) The in-network rate and out-of-network allowed amount machine-readable files required by paragraphs (b)(1)(i) and (ii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(ii) The prescription drug machine-readable file required by paragraph (b)(1)(iii) of this section must be updated monthly;

(iii) The change-log machine-readable file required by paragraph (b)(2)(i) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the date on which the first in-network rate machine-readable file is required to be posted under paragraph (b)(4)(i) of this section in accordance with the applicability date of the amendments to paragraph (b)(1) of this section as specified in paragraph (c)(1) of this section. If there are no changes to the in-network rate machine-readable file described in paragraph (b)(1)(i) of this section since the last such file was

updated, a change-log machine-readable file must still be updated and posted quarterly indicating there are no changes;

(iv) The utilization machine-readable file required under paragraph (b)(2)(ii) of this section must be updated and posted annually beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(v) The taxonomy machine-readable file required under paragraph (b)(2)(iii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section. If there are no changes to the taxonomy that affect the information required in the machine-readable file required under paragraph (b)(1)(i) of this section in a subsequent quarter, the posted taxonomy file is not required to updated that quarter; and

(vi) The text file required by paragraph (b)(2)(iv) of this section must be posted beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section and subsequently updated and posted as soon as practicable but no later than 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section.

(5) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(iii) *Special rule for self-insured group health plans with respect to the disclosure of in-network rate machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available in a single in-network rate machine readable file as required under paragraph (b)(1)(i) of this section the information required under paragraph (b)(1)(i) for each provider network used by 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, provided that—

(A) Each in-network rate machine-readable file made available for a provider network includes the required information under paragraph (b)(1)(i) of this section 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 machine-readable file is made available; and

(B) Each of the self-insured group health plan's change-log, utilization, and taxonomy machine-readable files include the information required under paragraphs (b)(2)(i), (ii), and (iii) of this section, respectively, for the same plans, insurance policies, or contracts (including those offered by different plan sponsors and across different health insurance markets, if applicable) represented in the corresponding in-network rate machine-readable files specified in paragraph (b)(1)(i) of this section.

(iv) *Special rule for self-insured group health plans with respect to the disclosure of out-of-network allowed amount machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available the information required under paragraph (b)(1)(ii) of this section 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 has an agreement), provided that the out-of-network allowed amount and billed charge data described in paragraph (b)(1)(ii)(C) of this section in relation to a particular item or service is omitted if it would require disclosure of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of such item or service across all of the plans (including those offered by different plan sponsors) included in the out-of-network machine-readable file.

(c) * * *

(1)(i) Beginning on or after January 2, 2022, the requirements of this section apply for plan years (in the individual market, for policy years).

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraph (b)(1) of this section applies on [DATE 12 MONTHS AFTER PUBLICATION OF FINAL REGULATIONS IN THE **FEDERAL REGISTER**]. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

DEPARTMENT OF LABOR

Employee Benefits Security Administration

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2590 as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 5. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a-n, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Pub. L. 116–260, 134 Stat. 1182; Secretary of Labor's Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ 6. Section 2590.715–2715A1 is amended by—

■ a. Redesignating paragraphs (a)(2)(x) through (xxi) as paragraphs (a)(2)(xi) through (xxii); and

■ b. Adding new paragraph (a)(2)(x).

The addition reads as follows:

§ 2590.715–2715A1 Transparency in coverage—definitions.

(a) * * *

(2) * * *

(x) *Health insurance market* means, irrespective of the State, one of the following:

(A) 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).

(B) The large group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(C) The small group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(D) For purposes of self-insured group health plans (other than account-based plans, as defined in § 2590.715–2711(d)(6)(i), and plans that consist solely of excepted benefits), all self-insured group health plans maintained by the plan sponsor.

* * * * *

■ 7. Section 2590.715–2715A2 is amended by—

■ a. Revising paragraphs (b)(1)(i)(A) and (B), (b)(1)(vii)(A), and (b)(2)(ii) introductory text;

■ b. Redesignating paragraph (b)(2)(ii)(D) as paragraph (b)(2)(iv);

■ c. Adding paragraph (b)(2)(iii);

■ d. Revising newly redesignated paragraph (b)(2)(iv);

■ e. Revising paragraphs (b)(3)(i) and (ii);

■ f. Revising paragraph (c)(1); and

■ g. Adding paragraph (c)(7).

The revisions and additions read as follows:

§ 2590.715–2715A2 Transparency in coverage—required disclosures to participants and beneficiaries.

* * * * *

(b) * * *

(1) * * *

(i) * * *

(A) If the request for cost-sharing information relates to items and services that are provided within a bundled payment arrangement, and the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate cost-sharing liabilities. While plans and issuers are not required to provide estimates of cost-sharing liability for a bundled payment arrangement where the cost-sharing is imposed separately for each item and service included in the bundled payment arrangement, nothing prohibits plans or issuers from providing estimates for multiple items and services in situations where such estimates could be relevant to participants or beneficiaries, as long as the plan or issuer also discloses information about the relevant items or services individually, as required in paragraph (b)(1)(v) of this section.

(B) For requested items and services that are recommended preventive services under section 2713 of the Public Health Service Act (PHS Act), if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a plan or issuer may allow a participant or beneficiary to request cost-sharing information for the specific preventive or non-preventive item or service by including terms such as ''preventive,'' ''non-preventive,'' or ''diagnostic'' as a means to request the most accurate cost-sharing information.

* * * * *

(vii) * * *

(A) A statement that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for potential additional amounts in situations where applicable State or Federal law allow out-of-network providers to bill participants or beneficiaries for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer and from the participants or beneficiaries in the form of a copayment, coinsurance, or deductible amount (the difference referred to as balance billing). This statement is not required if the State in which the item or service was furnished prohibits all out-of-network providers from balance billing for all items and services payable by the plan or issuer;

* * * * *

(2) * * *

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary. In responding to such a 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 plan or issuer is required to:

* * * * *

(iii) *Phone method.* Information provided under this paragraph (b) must be made available at the request of the participant or beneficiary via a telephone number through which a consumer may seek customer assistance that ERISA section 716(e) requires be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee. Such information must be accurate at the time of the request and must be provided at the time of the request. In responding to such a 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 day. The plan or issuer is required to:

(A) Disclose the applicable provider-per-day limit; and

(B) Provide the cost-sharing information, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section.

(iv) *Alternative method.* In circumstances where participants and beneficiaries request disclosure other than by the internet-based self-service tool, paper, or phone (for example, by email) group health plans and health insurance issuers may provide the disclosure through alternative means and satisfy the requirements of this section, provided the participant or beneficiary agrees that such disclosure through such means is sufficient to satisfy the request and the plan or issuer meets the timing requirements established under paragraph (b)(2)(ii)(C) of this section for paper method disclosure.

(3) * * *

(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information required by this paragraph (b) in compliance with this section pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a pharmacy benefit manager or other third-party) provides the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in

compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(c) * * *

(1)(i) The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2023 with respect to the 500 items and services to be posted on a publicly available website, and with respect to all covered items and services, for plan years (in the individual market, for policy years) beginning on or after January 1, 2024.

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraphs (b)(1)(vii)(A), (b)(2)(iii) and (iv), and (c)(7) of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2027. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

(7) A group health plan or health insurance issuer that provides to the participant or beneficiary the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section, satisfies the requirements set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4.

* * * * *

■ 8. Section 2590.715–2715A3 is amended by—

■ a. Revising paragraph (b) heading and introductory text;

■ b. Revising paragraphs (b)(1)(i) and (ii);

■ c. Redesignating paragraphs (b)(2) and (3) as paragraphs (b)(3) and (4), respectively;

■ d. Adding new paragraph (b)(2);

■ e. Revising newly redesignated paragraphs (b)(3) and (4);

■ f. Redesignating paragraphs (b)(4)(i) and (ii) as paragraphs (b)(5)(i) and (ii), respectively;

■ g. Revising newly redesignated paragraphs (b)(5)(i) and (ii);

■ h. Redesignating paragraph (b)(4)(iii) as paragraph (b)(5)(iv);

■ i. Adding new paragraph (b)(5)(iii);

■ j. Revising newly redesignated paragraph (b)(5)(iv); and

■ k. Revising paragraph (c)(1).

The revisions and additions read as follows:

§ 2590.715–2715A3 Transparency in coverage—requirements for public disclosure.

* * * * *

(b) *Requirements for public disclosure of in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, negotiated rates and historical net prices for covered prescription drugs, and contextual information.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraphs (b)(1) and (2) of this section in machine-readable files, in accordance with the method and format requirements described in paragraph (b)(3) of this section, and that are updated as required under paragraph (b)(4) of this section.

(1) * * *

(i) An in-network rate machine-readable file for each provider network maintained or contracted by a group health plan or health insurance issuer that includes the required information under this paragraph (b)(1)(i) for all covered items and services under each coverage option offered by the plan or issuer that uses such provider network, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file pursuant to paragraph (b)(1)(iii) of this section. Each in-network rate machine-readable file must include:

(A) The common provider network name;

(B) For each coverage option offered by a group health plan or health insurance issuer that uses such provider network, the name; the Health Insurance Oversight System (HIOS) identifier, or, if no HIOS identifier is available, the Employer Identification Number (EIN); and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(C) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service included in the machine-readable file;

(D) For each covered item or service included in the machine-readable file, all applicable rates, which may include one or more of the following: Negotiated rates, underlying fee schedule rates, or derived amounts. If a group health plan or health insurance issuer does not use negotiated rates for provider reimbursement, then the plan or issuer should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the plan or issuer uses underlying fee schedule rates for calculating cost sharing, then the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rate or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must be:

(*1*) Reflected as dollar amounts, with respect to each covered item or service that is furnished by an in-network provider. If the negotiated rate is subject to change based upon participant or beneficiary-specific characteristics, these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant or beneficiary-specific characteristics. 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, 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 Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(*2*) Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider, except those specified in paragraph (b)(1)(i)(F) of this section;

(*3*) Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

(*4*) Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

(E) Current numerical enrollment totals, as of the date the file is posted, for each coverage option offered by a group health plan or health insurance issuer that uses such provider network. Such numerical enrollment totals must include the number of participants and beneficiaries (including all dependents) in the coverage option offered by a plan or issuer.

(F) A group health plan or health insurance issuer must exclude from each file under paragraph (b)(1)(i) of this section a provider and their negotiated rate (provider-rate combination) for an item or service if the plan or issuer determines it is unlikely that the provider would be reimbursed for the item or service given that provider's area of specialty according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process.

(ii) For each health insurance market, as defined in § 2590.715–2715A1(a)(2)(x), in which a group health plan or health insurance issuer offers a plan or coverage, an out-of-network allowed amount machine-readable file, including:

(A) For each coverage option offered by a group health plan or health insurance issuer in such health insurance market, the name and the HIOS identifier, or, if no HIOS identifier is available, the EIN; and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market; and

(C) Aggregated unique out-of-network allowed amounts and billed charges with respect to each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market furnished by out-of-network providers during the 6-month time period that begins 9 months prior to the publication date of the machine-readable file (except that a plan or issuer must omit such data in relation to a particular item or service when compliance with this paragraph (b)(1)(ii)(C) would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of that item or service in a single health insurance market). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an out-of-network provider; and

(*2*) Associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

* * * * *

(2) *Required contextual files.* A group health plan or health insurance issuer must make available in a machine-readable format:

(i) A change-log file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that identifies any changes made to the required information described in paragraph (b)(1)(i) of this section since the immediately preceding published in-network rate machine-readable file.

(ii) A utilization file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that includes, for the 12-month period that ends 6 months prior to the publication date of each utilization file:

(A) Items and services covered under the plans or policies included in the files prepared as specified in paragraph (b)(1)(i) of this section for which a claim has been submitted and reimbursed, in whole or in part; and

(B) Each in-network provider identified by the NPI, 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.

(iii) A taxonomy file, for each in-network rate machine-readable file prepared as specified in paragraph (b)(1)(i) of this section, which includes the group health plan's or health insurance issuer's internal provider taxonomy that matches items and services (represented by a billing code) with provider specialties (represented by specialty codes which are derived from the Health Care Provider Taxonomy code set established by the National Uniform Claim Committee (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.. Plans and issuers must use their internal provider taxonomy to determine whether to exclude certain provider-rate combinations from the in-network rate machine-readable file as specified in paragraph (b)(1)(i)(F) of this section.

(iv) A plain text file in a .txt format in the root folder (that is, the top-level directory on an electronic file system) of a group health plan's or health insurance issuer's website that includes:

(A) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section;

(B) A direct link to the URL for the machine-readable files required under paragraphs (b)(1) and (2) of this section; and

(C) 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 machine-readable files required under paragraphs (b)(1) and (2) of this section. This contact information must be prominently displayed on the same website where the machine-readable files are made available and be kept updated per the requirements in paragraph (b)(4)(vi) of this section.

(3) *Required method and format for disclosing information to the public.* (i) The machine-readable files described in paragraphs (b)(1) and (2) of this section must be available in a form and manner as specified in guidance issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(ii) The machine-readable files must be publicly available and accessible to any person, automated scripts, or web crawlers free of charge and without conditions, such as establishment of a user account, password, submission of personally identifiable information or other credentials, or blocking server configurations or firewalls to access the file.

(iii) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section 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 machine-readable files.

(iv) The group health plan or health insurance issuer may satisfy the requirements of paragraph (b)(3)(iii) of this section by entering into a written agreement under which another party (such as a third-party administrator) posts the machine-readable files on its public website on behalf of the plan or issuer, including if the plan or issuer does not have a website. However, if the files are posted on a service provider's website, and the plan or issuer maintains a public website but chooses not to host 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.

(4) *Timing.* A group health plan or health insurance issuer must update the machine-readable files in accordance with the following timeframes and clearly indicate the date that the files were most recently updated:

(i) The in-network rate and out-of-network allowed amount machine-readable files required by paragraphs (b)(1)(i) and (ii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(ii) The prescription drug machine-readable file required by paragraph (b)(1)(iii) of this section must be updated monthly;

(iii) The change-log machine-readable file required by paragraph (b)(2)(i) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the date on which the first in-network rate machine-readable file is required to be posted under paragraph (b)(4)(i) of this section in accordance with the applicability date of the amendments to paragraph (b)(1) of this section as specified in paragraph (c)(1) of this section. If there are no changes to the in-network rate machine-readable file described in paragraph (b)(1)(i) of this section since the last such file was updated, a change-log machine-readable file must still be updated and posted quarterly indicating there are no changes;

(iv) The utilization machine-readable file required under paragraph (b)(2)(ii) of this section must be updated and posted annually beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(v) The taxonomy machine-readable file required under paragraph (b)(2)(iii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section. If there are no changes to the taxonomy that affect the information required in the machine-readable file required under paragraph (b)(1)(i) of this section in a subsequent quarter, the posted taxonomy file is not required to updated that quarter; and

(vi) The text file required by paragraph (b)(2)(iv) of this section must be posted beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section and subsequently updated and posted as soon as practicable but no later than 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section.

(5) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(iii) *Special rule for self-insured group health plans with respect to the disclosure of in-network rate machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available in a single in-network rate machine-readable file as required under paragraph (b)(1)(i) of this section the information required under paragraph (b)(1)(i)for each provider network used by 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, provided that—

(A) Each in-network rate machine-readable file made available for a provider network includes the required information under paragraph (b)(1)(i) of this section 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 machine-readable file is made available; and

(B) Each of the self-insured group health plan's change-log, utilization, and taxonomy machine-readable files include the information required under paragraphs (b)(2)(i), (ii), and (iii) of this section, respectively, for the same plans, insurance policies, or contracts (including those offered by different plan sponsors and across different health insurance markets, if applicable) represented in the corresponding in-network rate machine-readable files specified in paragraph (b)(1)(i) of this section.

(iv) *Special rule for self-insured group health plans with respect to the disclosure of out-of-network allowed amount machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available the information required under paragraph (b)(1)(ii) of this section 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 has an agreement), provided that the out-of-network allowed amount and billed charge data described in paragraph (b)(1)(ii)(C) of this section in relation to a particular item or service is omitted if it would require disclosure of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of such item or service across all of the plans (including those offered by different plan sponsors) included in the out-of-network machine-readable file.

(c) * * *

(1)(i) Beginning on or after January 2, 2022, the requirements of this section apply for plan years (in the individual market, for policy years).

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraph (b)(1) of this section applies on [DATE 12 MONTHS AFTER PUBLICATION OF FINAL REGULATIONS IN THE **FEDERAL REGISTER**]. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR part 147 as set forth below:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 9. The authority citation for part 147 is revised to read as follows:

Authority: 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–114, as amended.

■ 10. Section 147.210 is amended by—

■ a. Redesignating paragraphs (a)(2)(xi) through (xxii) as paragraphs (a)(2)(xii) through (xxiii), respectively; and

■ b. Adding new paragraph (a)(2)(xi).

The addition reads as follows:

§ 147.210 Transparency in coverage—definitions.

(a) * * *

(2) * * *

(xi) *Health insurance market* means, irrespective of the State, one of the following:

(A) 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).

(B) The large group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(C) The small group market, as defined in 45 CFR 144.103 (other than coverage that consists solely of excepted benefits).

(D) For purposes of self-insured group health plans (other than account-based plans, as defined in § 147.126(d)(6)(i), and plans that consist solely of excepted benefits), all self-insured group health plans maintained by the plan sponsor.

* * * * *

■ 11. Section 147.211 is amended by—

■ a. Revising paragraphs (b)(1)(i)(A) and (B), (b)(1)(vii)(A), and (b)(2)(ii) introductory text;

■ b. Redesignating paragraph (b)(2)(ii)(D) as paragraph (b)(2)(iv);

■ c. Adding paragraph (b)(2)(iii);

■ d. Revising newly redesignated paragraph (b)(2)(iv);

■ e. Revising paragraphs (b)(3)(i) and (ii);

■ f. Revising paragraph (c)(1); and

■ g. Adding paragraph (c)(7).

The revisions and additions read as follows:

§ 147.211 Transparency in coverage—required disclosures to participants, beneficiaries, or enrollees.

* * * * *

(b) * * *

(1) * * *

(i) * * *

(A) If the request for cost-sharing information relates to items and services that are provided within a bundled payment arrangement, and the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate cost-sharing liabilities. While plans and issuers are not required to provide estimates of cost-sharing liability for a bundled payment arrangement where the cost-sharing is imposed separately for each item and service included in the bundled payment arrangement, nothing prohibits plans or issuers from providing estimates for multiple items and services in situations where such estimates could be relevant to participants or beneficiaries, as long as the plan or issuer also discloses information about the relevant items or services individually, as required in paragraph (b)(1)(v) of this section.

(B) For requested items and services that are recommended preventive services under section 2713 of the Public Health Service Act (PHS Act), if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a plan or issuer may allow a participant, beneficiary, or enrollee to request cost-sharing information for the specific preventive or non-preventive item or service by including terms such as ''preventive,'' ''non-preventive,'' or ''diagnostic'' as a means to request the most accurate cost-sharing information.

* * * * *

(vii) * * *

(A) A statement that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for potential additional amounts in situations where applicable State or 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 group health plan or health insurance issuer and from the participants, beneficiaries, or enrollees in the form of a copayment, coinsurance, or deductible amount (the difference referred to as balance billing). This statement is not required if the State in which the item or service was furnished prohibits all out-of-network providers from balance billing for all items and services payable by the plan or issuer;

* * * * *

(2) * * *

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant, beneficiary, or enrollee. In responding to such a 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 plan or issuer is required to:

* * * * *

(iii) *Phone method.* Information provided under this paragraph (b) must be made available at the request of the participant, beneficiary, or enrollee via a telephone number through which a consumer may seek customer assistance that PHS Act section 2799A–1(e) required be indicated on any physical or electronic plan or insurance identification card issued to a participant, beneficiary, or enrollee. Such information must be accurate at the time of the request and must be provided at the time of the request. In responding to such a 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 day. The plan or issuer is required to:

(A) Disclose the applicable provider-per-day limit; and

(B) Provide the cost-sharing information, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section.

(iv) *Alternative method.* In circumstances where participants, beneficiaries, and enrollees request disclosure other than by the internet-based self-service tool, paper, or phone (for example, by email) group health plans and health insurance issuers may provide the disclosure through alternative means and satisfy the requirements of this section, provided the participant, beneficiary, or enrollee agrees that such disclosure through such means is sufficient to satisfy the request and the plan or issuer meets the timing requirements established under paragraph (b)(2)(ii)(C) of this section for paper method disclosure.

(3) * * *

(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information required by this paragraph (b) in compliance with this section pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a pharmacy benefit manager or other third-party) provides the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(c) * * *

(1)(i) The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2023 with respect to the 500 items and services to be posted on a publicly available website, and with respect to all covered items and services, for plan years (in the individual market, for policy years) beginning on or after January 1, 2024.

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraphs (b)(1)(vii)(A), (b)(2)(iii) and (iv), and (c)(7) of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2027. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

(7) A group health plan or health insurance issuer that provides to the participant, beneficiary or enrollee the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section, satisfies the requirements set forth in Code section 9819, ERISA section 719, and PHS Act section 2799A–4.

* * * * *

■ 12. Section 147.212 is amended by—

■ a. Revising paragraph (b) heading and introductory text;

■ b. Revising paragraphs (b)(1)(i) and (ii);

■ c. Redesignating paragraphs (b)(2) and (3) as paragraphs (b)(3) and (4), respectively;

■ d. Adding new paragraph (b)(2);

■ e. Revising newly redesignated paragraphs (b)(3) and (4);

■ f. Redesignating paragraphs (b)(4)(i) and (ii) as paragraphs (b)(5)(i) and (ii), respectively;

■ g. Revising newly redesignated paragraphs (b)(5)(i) and (ii);

■ h. Redesignating paragraph (b)(4)(iii) as paragraph (b)(5)(iv);

■ i. Adding new paragraph (b)(5)(iii);

■ j. Revising newly redesignated paragraph (b)(5)(iv); and

■ k. Revising paragraph (c)(1).

The revisions and additions read as follows:

147.212 Transparency in coverage—requirements for public disclosure.

* * * * *

(b) *Requirements for public disclosure of in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, negotiated rates and historical net prices for covered prescription drugs, and contextual information.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraphs (b)(1) and (2) of this section in machine-readable files, in accordance with the method and format requirements described in paragraph (b)(3) of this section, and that are updated as required under paragraph (b)(4) of this section.

(1) * * *

(i) An in-network rate machine-readable file for each provider network maintained or contracted by a group health plan or health insurance issuer that includes the required information under this paragraph (b)(1)(i) for all covered items and services under each coverage option offered by the plan or issuer that uses such provider network, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file pursuant to paragraph (b)(1)(iii) of this section. Each in-network rate machine-readable file must include:

(A) The common provider network name;

(B) For each coverage option offered by a group health plan or health insurance issuer that uses such provider network, the name; the Health Insurance Oversight System (HIOS) identifier, or, if no HIOS identifier is available, the Employer Identification Number (EIN); and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(C) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service included in the machine-readable file;

(D) For each covered item or service included in the machine-readable file, all applicable rates, which may include one or more of the following: Negotiated rates, underlying fee schedule rates, or derived amounts. If a group health plan or health insurance issuer does not use negotiated rates for provider reimbursement, then the plan or issuer should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the plan or issuer uses underlying fee schedule rates for calculating cost sharing, then the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rate or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must be:

(*1*) Reflected as dollar amounts, with respect to each covered item or service that is furnished by an in-network provider. If the negotiated rate is subject to change based upon participant, beneficiary, or enrollee-specific characteristics, 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. 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, 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 Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(*2*) Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider, except those specified in paragraph (b)(1)(i)(F) of this section;

(*3*) Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

(*4*) Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

(E) Current numerical enrollment totals, as of the date the file is posted, for each coverage option offered by a group health plan or health insurance issuer that uses such provider network. 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.

(F) A group health plan or health insurance issuer must exclude from each file under paragraph (b)(1)(i) of this section a provider and their negotiated rate (provider-rate combination) for an item or service if the plan or issuer determines it is unlikely that the provider would be reimbursed for the item or service given that provider's area of specialty according to the plan's or issuer's internal provider taxonomy used during the claims adjudication process.

(ii) For each health insurance market, as defined in § 147.210(a)(2)(xi), in which a group health plan or health insurance issuer offers a plan or coverage, an out-of-network allowed amount machine-readable file, including:

(A) For each coverage option offered by a group health plan or health insurance issuer in such health insurance market, the name and the HIOS identifier, or, if no HIOS identifier is available, the EIN; and the product type (for example, Health Maintenance Organization, Preferred Provider Organization);

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market; and

(C) Aggregated unique out-of-network allowed amounts and billed charges with respect to each covered item or service under any coverage option offered by a group health plan or health insurance issuer in such health insurance market furnished by out-of-network providers during the 6-month time period that begins 9 months prior to the publication date of the machine-readable file (except that a plan or issuer must omit such data in relation to a particular item or service when compliance with this paragraph (b)(1)(ii)(C) would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of that item or service in a single health insurance market). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(*1*) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an out-of-network provider; and

(*2*) Associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

* * * * *

(2) *Required contextual files.* A group health plan or health insurance issuer must make available in a machine-readable format:

(i) A change-log file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that identifies any changes made to the required information described in paragraph (b)(1)(i) of this section since the immediately preceding published in-network rate machine-readable file.

(ii) A utilization file, for each in-network rate machine-readable file specified in paragraph (b)(1)(i) of this section, that includes, for the 12-month period that ends 6 months prior to the publication date of each utilization file:

(A) Items and services covered under the plans or policies included in the files prepared as specified in paragraph (b)(1)(i) of this section for which a claim has been submitted and reimbursed, in whole or in part; and

(B) Each in-network provider identified by the NPI, 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.

(iii) A taxonomy file, for each in-network rate machine-readable file prepared as specified in paragraph (b)(1)(i) of this section, which includes the group health plan's or health insurance issuer's internal provider taxonomy that matches items and services (represented by a billing code) with provider specialties (represented by specialty codes which are derived from the Health Care Provider Taxonomy code set established by the National Uniform Claim Committee (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. Plans and issuers must use their internal provider taxonomy to determine whether to exclude certain provider-rate combinations from the in-network rate machine-readable file as specified in paragraph (b)(1)(i)(F) of this section. (iv) A plain text file in a .txt format in the root folder (that is, the top-level directory on an electronic file system) of a group health plan's or health insurance issuer's website that includes:

(A) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section;

(B) A direct link to the URL for the machine-readable files required under paragraphs (b)(1) and (2) of this section; and

(C) 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 machine-readable files required under paragraphs (b)(1) and (2) of this section. This contact information must be prominently displayed on the same website where the machine-readable files are made available and be kept updated per the requirements in paragraph (b)(4)(vi) of this section.

(3) *Required method and format for disclosing information to the public.* (i) The machine-readable files described in paragraphs (b)(1) and (2) of this section must be available in a form and manner as specified in guidance issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services.

(ii) The machine-readable files must be publicly available and accessible to any person, automated scripts, or web crawlers free of charge and without conditions, such as establishment of a user account, password, submission of personally identifiable information or other credentials, or blocking server configurations or firewalls to access the file.

(iii) The source page URL for the internet website that hosts the machine-readable files required under paragraphs (b)(1) and (2) of this section 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 machine-readable files.

(iv) The group health plan or health insurance issuer may satisfy the requirements of paragraph (b)(3)(iii) of this section by entering into a written agreement under which another party (such as a third-party administrator) posts the machine-readable files on its public website on behalf of the plan or issuer, including if the plan or issuer does not have a website. However, if the files are posted on a service provider's website, and the plan or issuer maintains a public website but chooses not to host 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.

(4) *Timing.* A group health plan or health insurance issuer must update the

machine-readable files in accordance with the following timeframes and clearly indicate the date that the files were most recently updated:

(i) The in-network rate and out-of-network allowed amount machine-readable files required by paragraphs (b)(1)(i) and (ii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(ii) The prescription drug machine-readable file required by paragraph (b)(1)(iii) of this section must be updated monthly;

(iii) The change-log machine-readable file required by paragraph (b)(2)(i) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the date on which the first in-network rate machine-readable file is required to be posted under paragraph (b)(4)(i) of this section in accordance with the applicability date of the amendments to paragraph (b)(1) of this section as specified in paragraph (c)(1) of this section. If there are no changes to the in-network rate machine-readable file described in paragraph (b)(1)(i) of this section since the last such file was updated, a change-log machine-readable file must still be updated and posted quarterly indicating there are no changes;

(iv) The utilization machine-readable file required under paragraph (b)(2)(ii) of this section must be updated and posted annually beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section;

(v) The taxonomy machine-readable file required under paragraph (b)(2)(iii) of this section must be updated and posted quarterly beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section. If there are no changes to the taxonomy that affect the information required in the machine-readable file required under paragraph (b)(1)(i) of this section in a subsequent quarter, the posted taxonomy file is not required to updated that quarter; and

(vi) The text file required by paragraph (b)(2)(iv) of this section must be posted beginning on the first day of the calendar-year quarter following the applicability date under paragraph (c)(1) of this section and subsequently updated and posted as soon as practicable but no later than 7 calendar days following a change in any of the information required under paragraph (b)(2)(iv) of this section.

(5) *Special rules to prevent unnecessary duplication*—(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information pursuant to a written agreement. Accordingly, if an issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a third-party administrator or health care claims clearinghouse) will provide the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(iii) *Special rule for self-insured group health plans with respect to the disclosure of in-network rate machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available in a single in-network rate machine-readable file as required under paragraph (b)(1)(i) of this section the information required under paragraph (b)(1)(i) for each provider network used by 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, provided that—

(A) Each in-network rate machine-readable file made available for a provider network includes the required information under paragraph (b)(1)(i) of this section 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 machine-readable file is made available; and

(B) Each of the self-insured group health plan's change-log, utilization, and taxonomy machine-readable files include the information required under paragraphs (b)(2)(i), (ii), and (iii) of this section, respectively, for the same plans, insurance policies, or contracts (including those offered by different plan sponsors and across different health insurance markets, if applicable) represented in the corresponding in-network rate machine-readable files specified in paragraph (b)(1)(i) of this section.

(iv) *Special rule for self-insured group health plans with respect to the disclosure of out-of-network allowed amount machine-readable files.* A self-insured group health plan that enters into an agreement with another party described in paragraph (b)(5)(ii) of this section may permit such other party to make available the information required under paragraph (b)(1)(ii) of this section 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 has an agreement), provided that the out-of-network allowed amount and billed charge data described in paragraph (b)(1)(ii)(C) of this section in relation to a particular item or service is omitted if it would require disclosure of out-of-network allowed amounts in connection with fewer than 11 different claims for payment of such item or service across all of the plans (including those offered by different plan sponsors) included in the out-of-network machine-readable file.

(c) * * *

(1)(i) Beginning on or after January 2, 2022, the requirements of this section apply for plan years (in the individual market, for policy years).

(ii) Notwithstanding paragraph (c)(1)(i) of this section, paragraph (b)(1) of this section applies on [DATE 12 MONTHS AFTER PUBLICATION OF FINAL REGULATIONS IN THE **FEDERAL REGISTER**]. Until such time, the current provisions of paragraph (b) of this section continue to apply.

* * * * *

[FR Doc. 2025–23693 Filed 12–19–25; 4:15 pm]

BILLING CODE 4831–GV–P; 4150–29–P; 4120–01–P]