



COUNCIL FOR AFFORDABLE  
**HEALTH COVERAGE**

February 23, 2026

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

Re: Transparency in Coverage Proposed Rule (CMS-9882-P; Federal Register Vol. 90, No. 244, Dec. 23, 2025)

To Whom It May Concern:

The Council for Affordable Health Coverage (CAHC, [www.cahc.net](http://www.cahc.net)) appreciates the opportunity to comment on the Transparency in Coverage (TiC) Proposed Rule. CAHC supports market-based reforms that improve transparency for consumers and purchasers, strengthen competition, and reduce health care costs and premiums.

CAHC generally supports the proposed rule. We believe:

1. Transparency combined with incentives can lead to significantly lower costs for patients
2. Making TiC information useful and useable by consumers will drive cost sharing behavior
3. The proposed rule will make coverage more affordable

Our comments are outlined below.

## 1. **Background**

Our health care system is seriously off track, and the number one problem is affordability. Put simply, health costs are too high and rising too fast. Because health costs are rising faster than wages, we project the typical American family will spend 40 percent of their income on health insurance premiums alone by 2032.

Health care markets suffer from severe information asymmetry: consumers frequently face high deductibles and coinsurance yet cannot readily compare the prices they will actually pay before or at the point of care across providers. This undermines the consumer-shopping and purchaser discipline that are essential to cost containment in a market-based system.

Consumers could save money if they know the price and their costs before purchasing a service or prescription drugs. McKinsey estimates that approximately \$125 - 175 billion (30 – 40 percent) of outpatient commercial spending is potentially “shoppable,”<sup>1</sup> with within-market price variation frequently

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<sup>1</sup> Services identified including imaging, discretionary ambulatory care, lab tests, specialist visits, and infusions.

exceeding 2 - 5x for identical services. Modeling suggests that if even 20 – 30 percent of volume shifted to lower-quartile providers, category spending could decline 10 – 20 percent, yielding system-wide savings of 1 – 3 percent when applied across high-variation services.<sup>2</sup>

RAND's employer-led transparency studies report that, using 2022 claims data, private payers and employers paid hospitals on average about 254 percent of Medicare rates, with many states exceeding 300 percent.<sup>3</sup>

Because facility setting (hospital outpatient department vs. freestanding ASC or imaging center) is often the dominant cost driver, transparency plus incentive alignment such as benefit design and cost sharing obligations can produce measurable cost savings – especially in outpatient categories with extreme variation. Based on the McKinsey figures, CAHC estimates annual savings of at least \$10 billion for patients if transparency and incentives are aligned.

## **2. General Support**

While we have some concerns with specific aspects of the proposed rule, CAHC generally supports the Departments' diagnosis that TiC implementation has been hindered by (i) inaccessibility due to large file sizes, (ii) ambiguity from missing context, and (iii) misalignment across federal transparency programs. We also support the proposal to improve comparability with Hospital Price Transparency disclosures by moving in-network reporting to the provider-network level and adding standardized metadata such as common network names.

### **A. Network-level reporting and duplicate reduction**

CAHC supports requiring one In-network Rate File per provider network (rather than per plan/policy). The Departments note that the same negotiated rates can appear multiple times across plan-level files, creating duplication that increases file size and complicates matching to hospital transparency disclosures. Network-level reporting is a practical step toward a more coherent national transparency dataset. We encourage the Departments to retain the monthly reporting to encourage reporting automation. Moving to a quarterly report may surrender accuracy consumers need to make informed choices.

### **B. Excluding unlikely provider–service combinations with a transparent methodology**

CAHC supports excluding provider–service rate combinations that are unlikely to occur in practice, because these artifacts can distort analytic results and obscure true market pricing patterns. The preamble documents how contractual structures can yield implausible rates (e.g., a C-section rate for a neurological institute at nearly ten times the regional median), which can bias medians and averages if

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<sup>2</sup> McKinsey & Company, *Understanding Shoppable Health Care Services* (2019); McKinsey & Company, *How Price Transparency Could Affect U.S. Health Care Markets* (2018); see also Health Care Cost Institute, *Shoppable Services: Opportunities and Challenges* (Mar. 2016), finding that 43 percent of outpatient spending could be considered shoppable.

<sup>3</sup> RAND Hospital Price Transparency Study (Round 5/2022 data summaries) and related RAND reporting. <https://www.rand.org/health/projects/hospital-pricing/round5.html>

not addressed. We support the proposal to operationalize exclusions using internal taxonomy mappings, paired with public disclosure of those mappings via a Taxonomy File.

### **C. Improve out-of-network transparency by fixing the ‘empty Allowed Amount File’ problem**

CAHC supports lowering the minimum claims threshold from 20 to 11 and applying it to an aggregated dataset at the market-type level, paired with extended reporting windows. The Departments identify that many allowed amount files contain limited or no usable claims data due in part to the 20-claim threshold, which prevents meaningful analysis. The proposed approach is a reasonable attempt to balance privacy with utility.

### **D. Findability improvements**

CAHC supports the standardized Text File in the root folder of plan/issuer websites and the standardized homepage footer link. These changes improve automation and reduce search costs for third-party developers and the public, making the disclosures more usable in practice.

### **E. Cost-sharing information by phone**

CAHC supports requiring plans/issuers to provide cost-sharing estimates by phone at the time of request to address problems consumers with limited internet access or low digital literacy may face. We are concerned this could lead to higher plan costs that will increase premiums and encourage the Departments to explore a unified data center to handle phone requests.

## **4. Areas Where the Proposed Rule Should Be Strengthened**

While CAHC is generally supportive of the proposed rule, we make the following suggestions to improve the final rule’s impact.

### **A. Standard identifiers and comparability guardrails**

The proposal’s reliance on a ‘common network name’ is directionally helpful, but naming conventions can vary. CAHC recommends adding a stable, machine-readable network identifier to prevent fragmentation and facilitate longitudinal tracking.

### **B. Data integrity and enforceability**

Transparency data has limited value without confidence in accuracy and completeness. Early experience with hospital transparency rules suggests compliance challenges can be persistent as studies have found high noncompliance rates among major hospitals early in implementation. CAHC recommends that the Departments establish a public compliance dashboard for TiC disclosures, require executive attestation, and set a predictable escalation process for non-compliance.

### **C. Consumer impact: estimator functionality and incentive-compatible benefit design**

Machine-readable files are necessary but insufficient for most consumers. The rule should more clearly define minimum functional requirements for consumer-facing cost estimators, including totals that reflect facility and professional components where relevant, and should support episode-level estimates for core shoppable services. In addition, transparency produces measurable savings when paired with benefit designs that create actual price signals (e.g., reference pricing). Evidence from CalPERS shows pre-reference-pricing procedure prices ranged widely (e.g., \$12,000 to \$75,000 for joint replacement) and reference pricing has been associated with lower prices for targeted services in the literature.<sup>4</sup>

## **5. Implementation Burden – Minimize Redundant Costs**

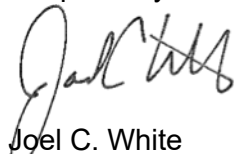
CAHC recognizes that implementation burden is significant. The Departments estimate first-year burden of roughly 7.8 million hours and \$982 million, with subsequent-year burden around 1.4 million hours and \$68.2 million annually. CAHC encourages the Departments to prioritize requirements most likely to improve consumer decision-making and purchaser leverage, while streamlining technical implementation through standardized guidance and coordinated timelines.

For example, the Departments estimate the Change-log File would require a one-time burden of 576 hours per issuer/TPA (about \$84,406), totaling ~\$133.4 million across 1,580 issuers/TPAs. To maximize value, the Departments should ensure the Change-log File is specified in a way that enables automated change detection with minimal ambiguity and maximum interoperability across issuers.

## **6. Conclusion**

CAHC supports the overall direction of the proposed rule: standardization, comparability, and usability of price transparency data. To deliver meaningful consumer and premium benefits, the final rule should strengthen identifiers and validation, improve accountability, and ensure consumer-facing tools and incentive-compatible benefit designs translate transparency into lower out-of-pocket costs and slower premium growth.

Respectfully submitted,



Joel C. White  
President, Council for Affordable Health Coverage

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<sup>4</sup> Health Affairs Forefront (Reference Pricing/CalPERS examples):  
<https://www.healthaffairs.org/content/forefront/appropriate-use-reference-pricing-can-increase-value>