Turquoise

Turquoise Health
Public Comment

File Code [CMS-9882-P]
Transparency in Coverage

Introduction

Turquoise Health (Turquoise) thanks the 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 (the Departments) for the opportunity to comment on CMS-9882-P (the Proposed Rule), which seeks comments on health plans' and health insurance issuers' (payers) price transparency requirements.

Turquoise is in full support of the Departments' commitment to creating streamlined, comprehensive, and accurate payer machine-readable files (MRFs). In our detailed responses below, we

- Support clearer standards and definitions, particularly around provider networks, and stronger structural guidance to improve rate uniformity
- Request clarity to create a more structured file ecosystem, including a robust table of contents (TOC) that clearly links plans, networks, and related files
- Point to alignment with hospital price transparency efforts so MRF standards converge
- Align with the Departments' changes that improve data completeness and usability, including enhanced out-of-network allowed amount reporting and additional files providing contextual data
- Affirm the Departments' prioritization of accessibility and automation, backing standardized file discovery, removal of technical access barriers, and a single open format (JSON)
- Recommend practical, proportionate implementation timelines

We also acknowledge the Departments' use of GitHub as a knowledge repository and way of communicating best practices for payer MRF creation, ingestion, and parsing. The Turquoise team engages with the TiC GitHub daily and is committed to continuing to do so as this Proposed Rule gets finalized and the Departments continue to offer more guidance on GitHub.

Turquoise Responses

Excerpt from the Proposed Rule - Health Plans Definitions
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 uniform 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…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.

Turquoise Response
Turquoise reviewed the Departments' four definitions of individual market, large group market, small group market, and self-insured group health plans and agrees with the proposed definitions.

Excerpts from the Proposed Rule - Network Definition & Specificity
To make it easier for file users to determine in advance of downloading a provider network-level In-network Rate (INR) 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 INR 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.

[AND]

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 INR 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.

Turquoise Response
We affirm the Departments' decision to require producers of Transparency in Coverage (TiC) files to publish data at the network level. **We specify that a network in this context should represent a single collection of contracted providers and corresponding negotiated rates within a defined structure, and represent the providers and rates for any member who access services while in-network.** If variations among either participating providers or negotiated rates exist, those variations should constitute a separate network and therefore be reflected in a separate file. In such cases, the network name should clearly denote the variation to avoid ambiguity and preserve analytic integrity.

Furthermore, Turquoise believes network naming conventions should align with the external, consumer-facing marketing name of the network rather than an internal or publicly unknown mnemonic. At the same time, preserving plan-level identification remains essential. The plan represents the most granular level of benefit design and member applicability, and it is often necessary to generate estimates that more closely reflect actual member cost-sharing. Strong identifiers tied to the specific plan, including group identifiers where appropriate, would further enhance usability and analytic precision.

We also recommend the Departments require a clear indication of whether a file represents a base network or a derived network. This could best be accomplished through a discrete data element designed specifically for this purpose. A less technical but still viable alternative would be to utilize a descriptive text field. The clarity provided by this discrete data element would allow downstream users to better understand structural relationships between networks and avoid misinterpretation of derivative rate constructs.

Lastly, we affirm that the TOC file is crucial in the context of network reporting. Requiring a TOC file creates a structured way to associate individual plans and their attributes with the applicable network files. This approach preserves both network-level rate standardization and plan-level specificity. More broadly, **the Departments should consider providing clearer, standardized definitions distinguishing plan, product, and network, as ambiguity among these terms continues to create operational and interpretive challenges across TiC submissions.**

Excerpt from the Proposed Rule - ERISA Product Types
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.

Turquoise Response

With respect to self-funded employer plans, the Departments should encourage alignment with commonly accepted state-level product definitions to the extent feasible. For example, product types such as HMO and PPO are broadly understood across the market and serve as meaningful indicators of benefit design structure. Even in the context of ERISA, where self-insured plans are not formally required to be identified by product type, adopting standardized nomenclature would improve consistency, reduce user confusion, and enhance parity across fully insured and self-funded arrangements. Product type is generally a function or attribute of the plan that dictates benefit design parameters, and understanding that classification is critical to connecting transparency data back to the consumer experience.

In our years of downloading and parsing TiC MRFs, the Turquoise team observes that employers rarely publish files directly and typically rely on carrier or third-party administrator partners to do so on their behalf. Many employers also offer multiple plan options with varying benefit designs, sometimes administered by different carriers. Where an employer offers multiple product types through a single carrier tied to a single network, the TOC file should clearly identify the plan name, the product type associated with each plan, and the specific INR file or files applicable to that plan. Ideally, a user should be able to see the plan name, its product type, and a clear linkage to the corresponding INR files that dictate the relevant providers and negotiated rates.

We note instances where an underlying network is used for both an HMO and PPO offering and the distinction between those product types relates solely to benefit design and thus does not affect the participating providers or negotiated rates. In that scenario, a single INR file is generally sufficient and referenced by both plans in the TOC. However, **if the HMO and PPO distinctions extend beyond benefit design and materially affect the network composition or negotiated rates, then separate network files should be created and referenced accordingly from each respective plan entry.**

We highlight the importance of recognizing that product type labels such as HMO and PPO are often used interchangeably to describe either plan-level benefit design attributes or network-level characteristics. In some cases, terms like HMO or PPO refer strictly to cost-sharing and referral mechanics at the plan level; in others, they reflect a distinct network construct. **The final rule guidance should clarify this distinction and provide a structured approach to ensure that product type is consistently represented as either a plan attribute, a network attribute, or both where appropriate.**

Excerpt from the Proposed Rule - Negotiated Rates as Dollar Amounts

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.

Turquoise Response

Turquoise affirms the Departments' efforts to codify requiring reporting negotiated rates in dollar format whenever possible within TiC MRFs. This aligns with hospital price transparency MRF requirements and, as noted in the proposed rule, standardizing rates into dollar amounts would improve comparability and create greater parity with hospital price transparency files. That standardization helps make the data more usable for downstream analysis and consumer-facing applications.

Turquoise acknowledges not all contract terms are structured as fixed dollar amounts; however, as the industry has observed in the hospital MRFs, many rate types can feasibly be converted into dollar-equivalent values. Algorithm-based payment methodologies can also be expressed as a derived rate, with the underlying formula or methodology disclosed in the additional notes field to preserve context and accuracy. Turquoise maintains documented examples of algorithms and percentage-based rate types for accurate hospital MRF reporting and encourages the Departments to publish lists and examples on GitHub so payers produce files aligned with hospital files. **Providing file publishers with clear scenario-based examples would be particularly helpful to ensure consistency in how these conversions are approached and implemented, and eliminate a wide array of interpretations on how to implement.**

At the same time, CMS should recognize that certain arrangements—such as percentage-of-charge methodologies—present structural asymmetry. In these cases, the payer may not know, and is not expected to know, the provider's underlying charge amount. However, the payer can accurately report the negotiated percentage. Guidance should clarify how these scenarios should be reflected so that reporting remains faithful to contractual reality while maximizing transparency. **Turquoise will be providing examples of how algorithms can be effectively reported on the TiC GitHub site and are hopeful the Departments will continue to use GitHub as a place to provide feedback and clarification on the most appropriate way to display rates in MRFs.**

Finally, Turquoise advocates that contract-level provisions such as stop-loss should be incorporated into TiC MRFs. The standard reimbursement methods often found in MRFs (case rates, fee schedules, per diems, and percent of billed charges) do not typically fully disclose reimbursement for the highest acuity care, and thus, MRFs do not report on over $100 billion in outlier costs[1].

Stop-loss provisions materially affect reimbursement outcomes and are essential to understanding the true economics of a negotiated arrangement. Existing code types (e.g., LOCAL or CSTM-ALL) provide a viable mechanism to represent these contract-level terms in a structured way that allows a more complete and accurate picture of reimbursement to be conveyed. The Departments should provide clear, practical examples demonstrating how payers should reflect these types of provisions within their files to promote uniformity, completeness, and interpretability across submissions. We provide one such example below.

In the **In Network** file, in the **in_network** object:

- **billing_code_type** = “CSTM-ALL”
- **billing_code** = “outlier”
    - In the **negotiated_prices** object:
        - **negotiated_type**: “outlier” [Needs to be added as a valid value via Github]
        - **additional_information**: Text of the outlier clause [additional_information would be made a required field when **negotiated_type** = “outlier”]

There are a number of benefits to this approach:

- Minimal burden for payers
- Does not require an additional MRF or addendum file or new fields
- Maintains fidelity to Payer, Network and Provider which is required in MRF

We recommend that non-standard billing code types such as CSTM-ALL and LOCAL be used only as a last resort within payer MRFs. These code types serve an important function in limited scenarios, but they should not become a substitute for reporting standardized billing codes when those codes exist and are contractually relevant. This philosophy is consistent with the broader principle that negotiated rates should be expressed in dollar terms whenever feasible, as discussed in our response regarding algorithms earlier in this comment. **If a negotiated rate applies to a specific CPT, HCPCS, DRG, or other recognized code set, that code should be explicitly disclosed.** File users should not be required to rely on proprietary crosswalks, internal carrier logic, or external assumptions to determine which standardized billing codes correspond to a negotiated rate object.

Overuse of CSTM-ALL or LOCAL codes introduces ambiguity and reduces interoperability. As a result, downstream users must reverse-engineer rate applicability, which undermines the goal of price transparency. Where non-standard codes are necessary, such as in the case of highly customized payment bundles or contract constructs that do not align cleanly with existing national code sets, clear documentation should accompany their use. However, such scenarios should be the exception rather than the norm.

Excerpt from the Proposed Rule - Reporting Cadence
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.

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.

The Departments seek comment on these proposed timing requirements.

Turquoise Response
Turquoise supports the move from monthly to quarterly MRF refreshes. We observe that most contract renegotiation cycles typically occur at a quarterly, bi-annual, or annual cadence. A quarterly cadence of all file refreshes - INR file, Allowed Amount File, Utilization File, etc. - would be the most efficient and effective use of MRF creation infrastructure. The Departments solicit comment on the claims lookback period, as seen below, and a quarterly refresh of all files translates into a rolling lookback period that, quarter over quarter, will produce a consistent and accurate picture of rate and allowed amount changes over time.

We also observe that a common area of concern on payer MRF generation teams is the resource and time-intensive nature of updating files due to the sheer magnitude of the required MRFs. The file size has been prohibitive as payers perform quality assurance on their own files to review compliance. With the proposed requirements tied to eliminating clinically implausible and duplicative rates, a quarterly refresh and quality assurance process can and should take less time and require less computing power. We believe this will lead to fewer incomplete or broken files and an increase in overall file quality.

Excerpts from the Proposed Rule - Allowed Amounts Reporting
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.

[AND]

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.

[AND]

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.

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.

Turquoise Response

Turquoise agrees with the Departments' view that the Allowed Amount (AA) Files are conceptually valuable and serve an important role in understanding out-of-network (OON) reimbursement patterns. However, we observe that under the current structure and thresholds, the files are often too sparsely populated to be meaningfully usable. Thus, the Turquoise team welcomes modifications that increase the volume of reportable data, even if doing so requires some reduction in plan-level granularity. The utility of AA files lies in their ability to help stakeholders evaluate prevailing OON payment levels for particular services within a market. Today, that objective is undermined by insufficient claim counts and a narrow reporting window.

We support reducing the reporting threshold to 11 claims per item or service at the file level, rather than per provider per service. This clarification aligns with current policy intent and should meaningfully expand the number of services eligible for inclusion. While we recognize the Departments' sensitivity to privacy concerns, lowering the claims threshold to include instances of costly infusion or high-acuity care puts the TiC requirements in alignment with the hospital MRF AA claims threshold reporting requirements.

We also support the proposal to aggregate AA files at the health insurance market level. Plan-level reporting is often too granular to meet reporting thresholds, while the concept of a network-level AA file is not coherent given that the data pertains to out-of-network services. Because OON claims are, by definition, not tied to a specific in-network construct, aggregation at the market level is a reasonable compromise that balances usability and feasibility. While this approach limits the ability to attribute specific allowed amounts to a particular plan, the tradeoff appears justified if it materially increases the volume and completeness of reported data. Requiring clear disclosure of which plans are included in the market-level file helps preserve transparency even if one-to-one mapping is not possible.

We further support the expansion of both the reporting window and the lookback period. Although extending the lookback period means the oldest data in a file may be older than under the current framework, the practical effect will likely be a substantial increase in the number of claims that meet the reporting threshold. This expansion should significantly improve the

robustness of AA files. With respect to quarterly reporting and potential duplication of claims across overlapping reporting windows, any analytic complexity introduced by duplication is likely manageable for file users and is outweighed by the benefit of a larger, more reliable claims universe.

Overall, we support the Departments' efforts to rebalance privacy safeguards with usability. The proposed changes move the AA files closer to fulfilling their intended purpose: providing meaningful visibility into out-of-network reimbursement patterns at a market level.

Excerpt from the Proposed Rule - Enrollment Totals
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 INR File. These proposed rules would require that plans and issuers include enrollment totals as of the date the INR 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.

Turquoise Response
Turquoise supports the inclusion of enrollment totals as part of TiC reporting. This information provides important context for interpreting negotiated rate data and understanding the relative scale of coverage options in the market. Enrollment data enhances the utility of the files by allowing users to better assess the practical impact and reach of specific benefit arrangements.

However, we suggest enrollment totals should be calculated and reported at the plan level rather than at the network level. INR files are, in principle, representations of a defined network as a collection of providers and negotiated rates that may be accessed by multiple plans across a carrier's book of business. Because enrollment is inherently tied to a specific plan and its benefit design, it is more appropriately treated as a plan attribute. Accordingly, enrollment totals should be reflected within the TOC file, alongside other plan-level metadata, rather than embedded within the INR file.

For enrollment data to be meaningful, all plans offered must be reported and clearly enumerated within the TOC. This ensures that enrollment figures can be accurately associated with each specific coverage option and appropriately linked to the applicable INR files. We affirm that enrollment totals should be accurate as of the date the data is published, as this provides the clearest and most administratively feasible reference point for both file producers and data users.

Excerpt from the Proposed Rule - Change-log File

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 INR 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.

Turquoise Response

Based on our experience creating payer MRFs and reviewing rate changes within posted MRFs, the Turquoise team does not believe a standalone Change-log File is necessary to achieve the Departments' stated objectives. We do appreciate the intent to help users identify meaningful changes without ingesting and reprocessing an entire INR File; however, in practice, implementing a robust change-log architecture would likely be operationally complex and would require substantial system development to track, compare, and publish structured deltas across very large datasets. The burden associated with building and maintaining this infrastructure may outweigh the incremental benefit, particularly given the scale and frequency of file updates. This would require significant implementation time and resources that may not be proportional to the value delivered.

As an alternative solution, Turquoise proposes that rather than requiring a separate change-log construct, the Departments can consider more targeted and less intrusive ways to improve user visibility into meaningful changes. Specifically, clearer and more consistent definitions around contract terms within the INR Files would provide greater contextual transparency. For example, if MRF creation teams were required to indicate when a specific negotiated rate became effective and when it is scheduled to expire, users would be better equipped to interpret historical context, detect recent changes, and anticipate upcoming renegotiations.

To make this approach effective, the Departments would need to provide clear guidance directing issuers to use the actual contract term dates applicable to the negotiated rates. Currently, many MRFs reflect rate end dates of 12/31/9999, which functionally represent evergreen contract structures. While contracts may technically auto-renew, negotiated rates are often set for defined terms or may be on common one-, two-, or three-year cycles, at which point

the rates are subject to renegotiation. **Requiring disclosure of the true effective and term dates associated with negotiated rates would provide more meaningful transparency than a separate change-log file and would allow users to identify substantive rate changes over time without imposing the added complexity of a new reporting framework.**

Excerpt from the Proposed Rule - Utilization File

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.

Turquoise Response

Turquoise supports both of the proposed requirements to create both a Utilization and Taxonomy File, which we discuss further in our comment below. When the two files are paired together, utilization data introduces an important additional dimension that helps contextualize negotiated rates. Utilization signals whether a rate is not only theoretically plausible based on specialty mapping, but also empirically present within historical rate activity. Even a basic indicator that a provider has submitted and been reimbursed for at least one claim during the reporting period is helpful. However, disclosure of actual claim counts would be materially more impactful. **True volume data significantly enhances modeling, impact analysis, and interpretability, and can help explain why certain rates are relatively high or low based on observed utilization patterns.** Thus, the service volume present in a Utilization File would greatly increase MRF utility.

Turquoise believes the claims lookback period for the Utilization File should be aligned with the lookback period used for Percentile Allowed Amount reporting within hospital MRFs, which is currently defined as 12-15 months. **Maintaining parity would allow a generally consistent and observable claims universe to be used across reporting requirements, reduce confusion among file users, and simplify operational implementation for MRF creation teams**. Clear data fields should delineate the specific lookback period applied, as well as the number of claims observed within that timeframe, even if the Departments limit disclosure to a boolean indicator.

As with taxonomy-based scrubbing, careful consideration should be given to the structural level at which utilization metrics are applied. We recommend that the utilization indicator, which is most preferably total claim count, exists at the same structural level at which a negotiated rate

object is connected to a provider reference group. In many cases, multiple Type 1 or Type 2 NPIs may roll up under a provider reference group represented at the EIN level. While this does not provide NPI-level granularity, it remains analytically useful and avoids introducing excessive structural complexity into provider reference objects. Greater granularity is beneficial where feasible, but should not come at the cost of disproportionate file fragmentation or system burden.

From a technical implementation perspective, when a single negotiated rate applies to multiple provider references but each provider has distinct empirical support characteristics (such as different historical claim counts or lookback windows), the negotiated rate object should remain the canonical representation of the contractual pricing term. Provider-specific support metadata should instead be modeled as a subordinate structure scoped to that rate. This preserves normalization by avoiding duplication of identical negotiated price attributes while allowing heterogeneous empirical evidence to be expressed per provider.

Practically, this can be implemented as a provider_support collection within the negotiated rate object, keyed or indexed by provider_reference, where each entry contains support metrics such as historical_claim_count, and lookback_period. This design maintains a clear semantic separation between contractual pricing terms and analytical validation attributes, supports scalable provider expansion, and enables deterministic joins between provider identifiers and their corresponding support metadata without fragmenting the negotiated rate definition.

Example:

```
{  "provider_references": [1, 7, 19],
  "provider_support": [
    {  "provider_reference ": 1,
       "historical_claim_count":  842 ,
       "look_back_start": "2025-01-01",
       "look_back_end": "2025-12-31"
    },
    {  "provider_reference ": 7,
       "historical_claim_count":  63 ,
       "look_back_start": "2025-01-01",
       "look_back_end": "2025-12-31"
    },
    {  "provider_reference ": 19,
       "historical_claim_count":  0 ,
       "look_back_start": "2025-01-01",
       "look_back_end": "2025-12-31"
  ],
},"negotiated_prices": [ ... ]
```

Excerpts from the Proposed Rule - Taxonomy File and Meaningful Rates
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 INR 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?

[AND]

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.

Turquoise Response
As stated above, Turquoise supports both of the proposed requirements to create both a Utilization and Taxonomy File. We affirm the need to remove clinically implausible provider/rate combinations, such as a heart surgery rate associated with a chiropractor taxonomy, as a crucial step toward reducing unnecessary file size and ensuring that TiC data most accurately reflects services a patient could reasonably expect to receive from a given provider. If implemented correctly, this approach would meaningfully improve data quality and usability by limiting noise and better aligning published rates with real-world adjudication expectations.

From an operational standpoint, Turquoise agrees the proposal laid out in the Proposed Rule is feasible. In our experience, payers already maintain logic within their claims adjudication systems that maps provider specialty or taxonomy to billing codes and prevents payment when a service is inconsistent with the rendering provider’s credentials. These internal controls demonstrate that specialty-to-service mapping is technically achievable. However, there is meaningful risk associated with implementing exclusions incorrectly or too aggressively. Over-exclusion could undermine transparency and create gaps that misrepresent legitimate contracting arrangements.

The Turquoise team cautions against employing a claims-only methodology to determine plausibility. Specifically relying solely on historical claims would almost certainly result in

over-exclusion. For example, a newly contracted provider group may have limited or no historical claims data but still be fully credentialed and contractually permitted to render and bill for a defined set of services. A historical claims-driven scrub would suppress legitimate negotiated rates simply because utilization has not yet occurred.

Thus, Turquoise recommends the Departments issue additional clarification regarding the level at which such exclusions would be applied. In many current implementations, a multi-specialty physician group that shares a set of negotiated rates is represented by a single provider reference object in the file. However, that group may include multiple specialties, and certain services may only be rendered by a subset of clinicians within the group. If a negotiated rate object is tied to the group-level provider reference under the revised design, then, by implication, all providers associated with that reference would need to be plausibly able to render and receive reimbursement for the service. Systematically scrubbing implausible rates under this structure would require either creating provider references segmented by taxonomy or introducing distinctions within the group representation to identify which specialties the rates apply to.

If multiple provider references are created for a single practice to support taxonomy-level granularity, it is critical that the Departments define a clear mechanism to indicate these references belong to the same overarching organization and are differentiated by specialty or geography. Clear naming conventions would materially improve interpretability. For example, “ABC Medical Group – Anesthesiology” and “ABC Medical Group – Dermatology" rather than repeating “ABC Medical Group” without distinction across specialties or locations. Without this clarity, file users may incorrectly assume the entities are unrelated. A cleaner approach to preventing unnecessary or unclear entries in this field would be to introduce an additional data element alongside the EIN-level name that provides further clarification. For example, this field could specify the specialty of the relevant subgroup within a multispecialty practice, allowing for greater precision without overloading the primary name field.

Turquoise has found that within MRFs, it is also common for a single group to have differentiated negotiated rates by specialty. In that respect, the subsequent TiC final rule could serve as a constructive forcing function to improve granularity and more accurately align rates with the specific providers or taxonomies to which they apply, which is an area that is challenging under current MRF structures and requirements. **Turquoise recommends the Departments document a detailed approach to including only relevant rates in the final rule. If implemented with safeguards against over-exclusion and with clear structural guidance, this change will meaningfully enhance transparency while preserving completeness and contractual accuracy.**

Excerpt from the Proposed Rule - Text File

The Departments also propose to add paragraphs…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)&(2);
(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)

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.

Turquoise Response
We support the Departments' proposal to require a standardized plain text (.txt) file to be placed in the root directory of each plan's or issuer's website identifying the location of required machine-readable files. This approach mirrors the evolution of the Hospital Price Transparency framework and would materially improve discoverability. A predictable, root-level file containing the source page URL and direct machine-readable file links would substantially reduce friction in locating files and promote consistent automation across issuers.

Also in alignment with hospital MRF attestation requirements, Turquoise also supports requiring clear point-of-contact information. As of 4/1/26, hospitals must encode the name of a "chief executive officer, president, or senior official designated to oversee the encoding of true, accurate and complete data." Including an updated name, title, and email address would improve accountability and enable more efficient issue resolution. While formal service-level standards may not be necessary, ensuring that a responsible contact is clearly designated would meaningfully improve responsiveness and transparency. The more hospital and payer MRF standards converge, the more the industry will be held to alignment and accountability as the norm, rather than the exception.

With respect to self-funded employers, we note it may not be feasible to require every employer to independently maintain a root-level .txt file. As noted previously in our comment, most self-funded plans rely on carrier or third-party administrator partners to publish files on their behalf. Given this operational reality, compliance through the carrier's web infrastructure likely addresses the majority of cases. The Departments may still wish to consider alternative compliance mechanisms to ensure accountability for self-funded plans, such as requiring attestation of TiC compliance through existing reporting channels such as via Form 5500 or similar established ERISA reporting mechanisms.

We strongly recommend that the TOC file become a mandatory component of the TiC framework. As noted throughout this comment, the ability to clearly connect plans, their attributes, and the applicable INR and Allowed Amount files is foundational to making the data usable. Without a structured mechanism to define these relationships, file users are left to infer linkages across disparate files, which introduces ambiguity and inefficiency.

The TOC file provides the cleanest and most structured method for representing these relationships. It allows plans, plan-level attributes, and the corresponding In-network and Out-of-network files to be explicitly tied together in a single, machine-readable structure. This relational clarity is critical, particularly as reporting evolves toward network-level files, market-level aggregation for Allowed Amount data, and the inclusion of additional plan attributes such as enrollment totals and product type.

There are also practical advantages as they relate to file discovery and retrieval. In the context of the proposed root-level .txt file requirement, it is operationally efficient for the root file to point to a single TOC file rather than to potentially dozens, hundreds, or thousands of individual INR files. The TOC can serve as an index that organizes and references all underlying machine-readable files in a predictable and scalable manner. This reduces clutter at the root level and provides a standardized entry point for both human users and automated systems.

While TOC files are currently optional, we believe making them mandatory would significantly improve organization, usability, and structural integrity across the ecosystem. A required TOC file would establish a consistent indexing mechanism for all publishers and materially enhance the transparency and navigability of TiC data.

Finally, **in an ideal state, MRF creation teams would be required to submit the root-level .txt file, or at least at a minimum the MRF path information contained within the root-level .txt file, to a centralized federal or state repository.** Centralized indexing would dramatically improve file discoverability, reduce redundant web crawling, which we explore further down in our comment, and enhance oversight. A standardized submission process would preserve decentralized hosting while enabling a unified registry of machine-readable file locations for regulators and data users alike.

Excerpt from the Proposed Rule - JSON format

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.

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 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.

Turquoise Response

Turquoise strongly supports JSON as the only acceptable format to be used for TiC reporting. As stated in the Proposed Rule, over 90% of payer MRFs are already formatted as JSON files.

Excerpt from the Proposed Rule - Public MRF Accessibility

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.

The Departments seek comment on these proposals.

Turquoise Response

Turquoise fully supports removing technical barriers that impede automated retrieval. Any mechanisms that restrict, throttle, or condition access, such as CAPTCHA challenges, download limits, credential requirements, firewall restrictions, or other blocking configurations, undermine the purpose of publicly-available MRFs. Explicitly requiring accessibility to both human users and automated scripts aligns with the statutory intent and improves reliability for downstream data users.

Excerpt from the Proposed Rule - Applicability Date

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.

Turquoise Response
As noted in a number of responses above, **Turquoise strongly believes there should be continuity between hospital and payer MRF requirements.** We observe that the 2026 OPPS Final Rule that was released on November 21, 2025, included changes to hospital MRF requirements that will be enforced on April 1, 2026. Based on those dates, hospitals have roughly four months to prepare their MRFs to be compliant with the new requirements. Payers should thus be held to a similar timeline, which means at a maximum, the applicability date for changes included in the final rule should be five months after the final rule publication date.

With respect to implementation timelines, the industry acknowledged that the initial rollout of both hospital and TiC MRF requirements warranted substantial lead time. Moving from no MRF infrastructure to a fully operational reporting framework required significant system development, vendor coordination, and internal governance buildout. That level of runway was appropriate.

At this stage, however, the industry has demonstrated the ability to adapt to schema changes, including the Version 2 release in February 2026, largely due to the fact that a substantive MRF creation process has been established. In some cases, issuers implemented Version 2 enhancements ahead of required timelines. This signals that MRF creation teams now have mature pipelines, schema management processes, and publication workflows capable of accommodating incremental rule changes without the same degree of disruption experienced during initial implementation.

Based on the expertise of our team's experience creating payer MRFs, Turquoise observes that a number of the key proposed enhancements build directly on infrastructure that already exists. The transition to network-level files, for example, is facilitated by the Version 2 schema's formal introduction of the network construct. Because MRF creation teams have already incorporated the concept of a network into their data models, breaking files out at the network level is operationally feasible and does not require a foundational redesign.

We also note that proposed modifications to the Allowed Amount Files primarily involve expanding thresholds and aggregating data at the market level. These changes do not materially alter the structural composition of the files. Instead, they expand the volume of included claims. Given existing quarterly posting requirements and established claims extraction pipelines, incorporating a broader claims universe should not represent a significant implementation burden.

Similarly, a Utilization File can be built using claims data feeds that already support Allowed Amount reporting, with relatively modest additional transformation logic. This requirement evolution mirrors the hospital MRF transition from Estimated Allowed Amount to Percentile Allowed Amount reporting. **While taxonomy mappings and enrollment data may reside in**

separate systems and require incremental integration work, these data elements are already maintained operationally by plans and issuers. Introducing them into the reporting workflow should be feasible without substantial architectural overhaul.

We do not believe that the core structural components of the INR Files or Allowed Amount Files are being fundamentally altered should this Proposed Rule get finalized with the requirements largely as currently written. As a result, implementation timelines should reflect the incremental nature of the changes rather than treating them as a ground-up rebuild. Moreover, the transition from monthly to quarterly publication cadence may offset some implementation costs through reduced operational overhead.

The principal exception is the proposed Change-log File, which would introduce a materially more complex architectural requirement and ongoing system maintenance burden. As noted previously, this element would likely require more nuanced system redesign and should be evaluated separately from the other proposed updates.

Overall, given the maturity of current TIC infrastructure and demonstrated adaptability to prior schema revisions, we believe the proposed changes—excluding the Change-log File—can be implemented within a reasonable and measured timeline without necessitating extended multi-year transition periods.

Excerpt from the Proposed Rule - Future API Plans
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.

Turquoise Response
Turquoise is supportive of an API as a future solution to accessing pricing data; however, we encourage the Departments to focus specifically on the improvements to the payer MRFs as a priority in this final rule. The Turquoise team will be writing more about where an API solution could best fit within the MRF landscape separate from this comment.

Turquoise

Conclusion

We look forward to collaborating on these continued efforts to increase clarity, utility, and accuracy within payer price transparency reporting.

Sincerely,
Chris Severn - CEO, Turquoise Health

[1]Outlier estimate derived from three sources: HHS Outlier payments[1], Segal SHAPE claims[2], and Turquoise Health contracts and claims. Scaled to national spend using CMS NHE[3] and Dieleman et al[4]. Source inputs combined via equal-weighted average to reduce bias from any single source.

1. https://oig.hhs.gov/documents/evaluation/2959/OEI-06-10-00520-Complete%20Report.pdf
2. https://www.segalco.com/consulting-insights/medical-stop-loss-premiums-increase-nearly-10-percent
3. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected
4. https://jamanetwork.com/journals/jama/fullarticle/2830568