Turquoise Health

Public Comment

Request for Information Regarding the Prescription Drug Machine-Readable File Requirement in the Transparency in Coverage Final Rule

File Code 1210-AC30

45 CFR Part 147

CMS-9882-NC

RIN 0938-AV64

Introduction

Turquoise Health 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 the Request for Information (RFI) regarding File Code 1210-AC30, which, in part, seeks comments on "implementation of the prescription drug machine-readable file disclosure requirements under the Transparency in Coverage final rules, including what modifications to the disclosure requirements or additional technical implementation guidance might be necessary to better ensure the accurate and timely completion of the prescription drug file."

Turquoise Health is in full support of the Departments' commitment to broadening price transparency requirements to include prescription drugs. Since July 1, 2022, Turquoise has mined, enriched, and leveraged the Transparency in Coverage (TiC) MRFs for contract negotiations between payers/providers and for use by patients in our platform designed to create transaction efficiency.

Overall themes

- Transparency is ultimately about reducing the financial complexity of healthcare and creating a healthcare ecosystem that allows patients to shop for care in advance. Transparent reporting of prescription drug rates is a critical step in building infrastructure that enables patients to receive a comprehensive cost of care before an appointment occurs.
- Turquoise Health supports the Departments creating and sharing a required prescription drug schema on October 1, 2025, and enforcing prescription drug MRFs on February 2, 2026, which aligns with the dates set in the FAQs About Affordable Care Act Implementation Part 70.
- The prescription drug file requirements were originally included in TiC and two additional TiC file requirements have been in effect since July 1, 2022; however, enforcement of the prescription drug file has been indefinitely delayed. Given the Departments' stated intent to develop technical requirements for the files, we believe the industry will have sufficient time to finalize and post these rates by February 2, 2026. We've already seen prescription drug files posted by three payers, which showcase the ability to post these rates with burden commensurate with other stakeholders already posting their rates.

Turquoise Health Responses to Questions About Required Data Elements, Including Potential Additional or Alternative Data Elements

1. Improvements to disclosure requirements: Are there existing data elements described in 26 CFR 54.9815-2715A3(b)(1)(iii), 29 CFR 2590.715-2715A3(b)(1)(iii), and 45 CFR 147.212(b)(1)(iii) that would be more useful if reported in a different form or manner? Are there ways to simplify the reporting schema to streamline disclosure to relieve reporting burdens? What are the appropriate metadata elements that should be required to be associated with the public disclosure file? Are there any improvements to disclosure requirements that would be particularly useful to interested parties including consumers, employers, and other purchasers of health care?

Our complete recommended modifications can be found in the second attachment included in our RFI response, which includes our Prescription Drug Schema Proposal. Our proposed adjustments ensure that the data is helpful to interested parties, including consumers and employers. These recommendations strike a balance between what is critical for patients and what is feasible for payers to post accurately.

In addition, we recommend removing the existing 20-claim minimum reporting threshold. This could hide the rates for specialty and high-cost drugs.

Please see our attachment entitled "Prescription Drug Schema Proposal" for more details and recommended improvements to disclosure requirements.

2. Unnecessary or irrelevant disclosures: Are there any data elements that are currently in the public disclosure requirement with respect to prescription drugs that are not relevant or useful and could be removed in order to simplify the reporting schema while maintaining the integrity of the prescription drug pricing disclosure requirements? Should the Departments remove any data elements, and why? Are there ways to reduce the volume of redundant or duplicative data?

In our Prescription Drug Schema Proposal, we note the importance of requiring all rates to be posted, regardless of the claims threshold, to avoid missing data. The files are inherently machine-readable and intended to serve as a foundation for the industry to develop patient-centric transactions. If information is missing or incomplete, that foundation will be weakened.

The Departments can consider removing duplicative per-pharmacy prices & plans with the same contracted rate. These duplicative rates could significantly increase the file size.

3. Disclosure of dosage units: How do plans, issuers, and PBMs store and manage pricing information for dosage units of prescription drugs? Should the Departments require a standardized format for disclosing dosage units and supply periods for prescription drugs (e.g., by 7-day, 30-day, or 90-day supply, by each dosage, or some other standardized dosage unit)? Should the Departments require disclosure of the quantity of the drug on which the price is reported?

The Departments should require a standardized format for disclosing dosage units and supply periods for prescription drugs and leverage the National Drug Code (NDC) product unit which is standardized by the FDA. The Departments should also require disclosure of the quantity of the drug on which the price is reported.

See our Prescription Drug Schema Proposal for more details.

4. Remuneration details: What specific data elements should the Departments require to provide meaningful disclosure of pre-rebate and post-rebate pricing? Should the Departments require plans and issuers to provide specific data pertaining to bundled payment arrangements or any alternative payment models in a manner that shows actual prices?

See our attached Prescription Drug Schema Proposal for more details.

5. Identification of entities: Should the Departments require plans and issuers to identify the PBM or other service provider, if any, that manages a plan's or coverage's pharmacy benefits, to facilitate better comparison of prices and data between plans and coverages? Would there be any benefit or burden associated with requiring a plan or issuer to identify pharmacies that are affiliated with the plan's or coverage's PBM and would such benefit be worth the added burden?

Yes. There is a significant benefit to disclosing PBM identifiers and PBM-affiliated pharmacies within the MRFs. This is what made the original disclosures of pricing data in the Hospital Price Transparency Rule and TiC so powerful. The Departments should not remove that requirement due to concerns about added burden.

6. Exclusions: Are there any items or services that are typically processed under a plan's or coverage's pharmacy benefits that should be excluded from the prescription drug machine-readable file for any reason? For example, are there items or services typically processed under a pharmacy benefit that are not prescription drugs, that are already published in one of the other machine-readable files, or that may be omitted because they constitute confidential business data or intellectual property?

There should not be any exclusions in the data. For example, drugs that are already posted in the in-network or out-of-network files should still be posted in the pharmacy drug file.

7. Benefits structure: Are there any prescription drugs that are typically processed under a plan's or coverage's medical benefits or under its pharmacy benefits depending on the setting in which the items or services are provided? To the extent that prescription drugs that are processed under a plan's or coverage's medical benefits are disclosed in the in-network or out-of-network machine-readable files, are there benefits to requiring that such drugs be disclosed in the prescription drug machine-readable file in addition to the other machine-readable files? For example, would such duplication reveal disparities in pricing of prescription drugs based on the setting in which they are administered or the vendor that processes the benefit?

Drugs that are expensive and heavily utilized, as well as generics, should be disclosed in both the prescription drug file and the In-Network file. For drugs that are covered under both medical and pharmacy benefits, we advocate for the reporting of any and all drugs that have a pathway for reimbursement under the pharmacy benefit (i.e., multiple formulations).

8. Alignment: Are there ways the Departments should align the TiC prescription drug reporting requirements with the prescription drug data reporting requirements under the Hospital Price Transparency rule? [49]

Concerning alignment, refer to our answer to question #3 above.

Turquoise Health Responses to General Implementation Questions

1. Implementation timeline: Have any plans or issuers begun building the infrastructure needed and if so, to what extent has that been completed?

Turquoise Health has ingested nearly 215 payer MRFs as of June 2025. Over the course of a year, we've seen prescription drug files posted by Optum, Blue Cross Blue Shield of Texas, and Avera. While few plans or issuers have opted to post prescription drug rates, all understand that the prescription drug files were required by TiC before enforcement was delayed. Plans or issuers can leverage the existing infrastructure used to create their current TiC files (both in- and out-of-network rates) to efficiently build their prescription drug file.

2. Operational feedback: Are there operational, formatting, or technical considerations that would improve and quicken the Departments' ability to begin enforcement of the required prescription drug machine-readable file while maintaining data integrity?

We've attached a full Prescription Drug Schema Proposal that we believe balances operational, formatting, and technical considerations while ensuring rapid deployment of a prescription drug MRF. We strongly recommend that The Departments remove the 20 claims threshold from the prescription drug schema and instead have plans and issuers post all prescription drug-related data, regardless of utilization. There are a handful of extremely expensive drugs that are used to treat a very small patient population. The claims threshold risks the industry's ability to access transparency data on those drugs.

3. Leveraging existing infrastructure: Are plans and issuers able to leverage the infrastructure used to implement the in-network rates and out-of-network allowed amounts machine-readable files to comply with these requirements, and to what extent are they able to do so?

Given the handful of plans and issuers that voluntarily posted prescription drug rates referenced in question #1 of this section, plans and issuers can and should be asked to deploy prescription drug data rapidly. Our prescription drug schema recommendations are built by leveraging existing infrastructure from in and out-of-network rates. Hospital MRFs have now been through four separate iterations of requirements since the files were first posted in 2021, so there's no reason plans and issuers shouldn't expect their own requirements to evolve as we better understand utility and file accuracy.

4. File format: What challenges and advantages would result from requiring that machine-readable prescription drug files be delivered in JSON or CSV file formats?

Machine-readable files are inherently not meant for human consumption in their rawest form, and we recommend that the files be posted in a JSON format, given the large amount of data that will be posted. Due to the hierarchical and nested nature of the information that is required to be reported, JSON is the optimal format for these disclosures. The .CSV file format is not conducive to supporting prescription drug files.

5. State approaches and innovation: Are there state laws with requirements similar to the prescription drug machine-readable file disclosure requirements that could serve as models for implementing or amending the requirements under 26 CFR 54.9815-2715A3(b)(1)(iii), 29 CFR 2590.715-2715A3(b)(1)(iii), and 45 CFR 147.212(b)(1)(iii)? If so, in what ways are these state laws directly comparable to 26 CFR 54.9815-2715A3(b)(1)(iii), 29 CFR 2590.715-2715A3(b)(1)(iii), and 45 CFR 147.212(b)(1)(iii)? Are there other innovations that states have employed with respect to prescription drug reporting that the Departments should consider implementing?

At this point, we are aware of no similar state laws that the Departments should consider implementing.

6. File size optimization: Are there steps that the Departments can take, either in regulations, technical implementation guidance, or otherwise, to minimize the size of the prescription drug machine-readable files while ensuring data therein remains useful and relevant?

Effective strategies to reduce the size of prescription drug MRFs must balance the inclusion of all data elements that enhance pricing transparency with practical constraints like storage and computing costs to publish and produce MRFs.

- Schema Design: Optimize schemas to remove redundancy through reference-based structures that preserve relationships and enable full data reconstruction. Please refer to our attached prescription drug schema proposal to understand the optimal reporting structure. It is especially important to implement the network references object and contract_id field in order to maximize file size efficiency.
- PBM-Level Aggregation: For drugs with low pharmacy-level claim volumes, aggregate data at the PBM level to maintain pricing visibility while reducing file complexity.
- Geographic Aggregation: Apply similar aggregation for low-volume drug-geography combinations to enable meaningful market insights without bloating file size.
- External Metadata: Store metadata in reference files to reduce repetition within pricing files while preserving data integrity.
- Redundancy Standards: Define reporting requirements that prevent posting entities from posting redundant data. If two or more MRFs are entirely identical from a pharmacy and pricing data perspective, the posting entity should be compelled to consolidate the MRFs to a single file.

7. Compliance costs: What actions could the Departments take to minimize the compliance costs of implementing and maintaining the prescription drug machine-readable file disclosure requirements of the TiC final rules?

Requiring plans and issuers to post their prescription drug data in a standardized schema would minimize implementation and maintenance costs.

Conclusion

We look forward to a collaborative plan, issuer, third-party innovator, and government effort on bolstered efforts to increase clarity around prescription drug cost and price transparency.

Sincerely,
Chris Severn - CEO, Turquoise Health