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Transparency in Coverage: Cleaning Out the Cobwebs of Opacity in Health Care Spending

Oh my, more proposed regulations to contend with? The Departments of Labor, Treasury, and Health and Human Services have the unenviable task of trying to increase transparency when it comes to health care spending. This column explores the proposed transparency in coverage regulations issued in December 2025, and how they propose to empower consumers and reduce spending.

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You're not alone if you've experienced sticker shock after opening a medical bill. Americans spend more per capita on healthcare than their peers in similar nations—but where are all of our dollars actually going? For over a decade, legislation and regulations have attempted to shed light on America's opaque healthcare pricing arrangements. From recently proposed regulations to the Consolidated Appropriations Act, 2026 (CAA 2026), the push for price transparency continues. This column explores the proposed transparency in coverage regulations released in December 2025 (not to be confused with the January 2026 proposed regulations designed to improve transparency into compensation

received by pharmacy benefit managers), and what these rules mean to both consumers and employers.

A Brief History Lesson

The Affordable Care Act (ACA) requires non-grandfathered group health plans, and health insurance companies offering them, to comply with its "transparency in coverage" rules. [*See*, Public Health Service Act (PHSA) § 2715A; Employee Retirement Income Security Act of 1974 § 715] This means publicly releasing information about claims payment policies and practices, and providing cost-sharing information, in clear, concise, well-organized plain language. Precisely what must be released, the way it must be released, and when it must be released is determined by regulations. The first round of transparency in coverage regulations was issued in 2020 (2020 Rules). [85 Fed. Reg. 72158. Nov. 12, 2020]

The 2020 Rules generally require group health plans and health insurance issuers to disclose cost-sharing information on a publicly available website, or upon request, to give participants an understanding of their out-of-pocket expenses and allow them to "effectively shop for items and services." [85 Fed. Reg. 72158, Nov. 12, 2020] These disclosures must be made in machine-readable files posted each month that include: in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information. The 2020 Rules also required a list of 500 shoppable services be available on an Internet-based self-service tool for plan years beginning on or after January 1, 2023. For plan years beginning on or after January 1, 2024, the 2020 Rules required cost-sharing information be available for *all* items and services.

What We've Learned from All Those Years

The 2020 Rules, along with other transparency related rules (for example, Title I of Division BB of the Consolidated Appropriations Act, 2021 (No Surprises Act)), have not achieved the desired level of transparency. On February 25, 2025, the President released Executive Order 14221 aimed at combating the "opaque pricing arrangements" that have allowed insurance companies "to operate with insufficient accountability regarding their pricing practices, resulting in patients, employers, and taxpayers shouldering the burden of inflated healthcare costs." [Executive Order 14221. 90 Fed. Reg. 11005, Feb. 28, 2025] Executive Order 14221 required the Secretaries of Treasury, Labor, and Health and Human Services to take all actions necessary to fulfill the promise of "radical transparency" by rapidly implementing and enforcing the 2020 Rules and, by May 26, 2025, take action to:

1. "require the disclosure of the actual prices of items and services[;]"
2. "issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans;" and
3. "issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data." [Executive Order 14221]

The Regulations, They're Coming Back Around

Additional proposed transparency in coverage regulations amending the 2020 Rules (Proposed Regulations) were published in the Federal Register on December 23, 2025, by the Departments of Treasury, Labor, and Health and Human Services (collectively, Departments). [90 Fed. Reg. 60432, Dec. 23, 2025] According to the Fact Sheet published by the Centers for Medicare and Medicaid Services (CMS) on December 19, 2025, the goal of the Proposed Regulations is to: (1) improve the accessibility, standardization, and reliability of pricing disclosures; and (2) to align some of the requirements of both the 2020 Rules and the No Surprises Act. The Proposed Regulations aim to address the main challenges that have acted as barriers to achieving the 2020 Rules' goals, and are based on both the Departments' internal assessments and feedback from external stakeholders.

Standardized, Accurate, and Accessible Public Pricing Information

The overarching goal of the Proposed Regulations is to reduce overall healthcare spending through increased transparency, which could translate into reduced premiums. Achieving this goal is dependent on a lot of "ifs," "maybes," and usable data so price comparison tools can be placed in consumers' hands. The sheer volume of information required to be provided is a core complaint the Departments received in response to the implementation of the 2020 Rules. For example, with respect to the currently required machine-readable files for in-network rates, "file size

is the most common concern that the Departments have heard from interested parties . . . . These files are often very large, making them challenging for users to download, analyze, and store." [90 Fed. Reg. 60447, Dec. 23, 2025] The associated challenges are compounded by the fact that this information may be stored in hundreds of separate files that often contain duplicative data, making it difficult to compile. The ability to compile this data is critical to achieving the transparency in coverage rules' ultimate goal because consumers need functional tools to help them navigate all of the publicly available information. As stated in the Preamble, the changes in the Proposed Regulations, if finalized, will contribute to making the disclosed machine-readable "files easier to digest and analyze, reduce challenges for existing tool developers, and open the market to additional tool and app developers." [90 Fed. Reg. 60434, Dec. 23, 2025]

As a result, the Proposed Regulations focus on decreasing the sheer quantity of information that is provided, and instead focus on the quality and usability of this information. To this end, the Proposed Regulations will:

- Exclude information from in-network rate files related to items and services providers are unlikely to be reimbursed for, based on the provider's area of specialty.
- Provide information regarding how the in-network rate files are prepared.
- Require the publication of a new "utilization file" that will document all covered services and items represented in the in-network rate file for which a claim has been submitted and reimbursed for the 12-month period ending on six months before the in-network file is published.
- Reduce duplication of information by requiring group health plans and health insurance issuers to prepare a single in-network rate file for each provider network—rather than for each plan or policy.
- Increase required reporting to obtain transparency with respect to out-of-network pricing information (increased aggregation based on insurance market type; decreasing the claims threshold to 11; and increasing the period of reporting to six months with a nine-month lookback period).

The Proposed Regulations also will make all of this machine-readable information easier to find. Plain text files must be placed in the payer's website's root folder, along with contact information (name and email) for the individual(s) responsible for the machine-readable files. Group health plans and health insurance issuers also will be required to add links to the plan's "Price Transparency" or "Transparency in Coverage" websites at the bottom of their home pages. The Proposed Regulations also seek comment regarding the required format for publishing machine-readable files. The Departments intend to restrict the publication of machine-readable files to one type of "non-proprietary, open format" and are soliciting comments regarding whether that format should be JSON or CSV.

The Proposed Regulations' emphasis on putting standardized, usable data in the hands of app developers to create meaningful consumer tools requires several changes by health insurance issuers and group health plans—many of whom depend on third-party administrators (TPAs) to fulfill their disclosure obligations. Contracts with TPAs will need to be carefully reviewed to ensure: (1) TPAs are prepared to meet their new compliance obligations; and (2) there are appropriate contractual protections in place in the event a TPA fails to make compliant disclosures.

The amendments to the machine-readable file provisions in the Proposed Regulations will take effect 12 months after the date the final regulations are published.

Alignment of the Transparency in Coverage Rules and the No Surprises Act

The Proposed Regulations contain provisions to align the transparency in coverage rules with the No Surprises Act. The No Surprises Act, which applies to both grandfathered (those qualified to be exempt from many requirements of the ACA) and non-grandfathered group health plans, requires price comparison information be made available over the phone and provide an Internet-based price comparison tool. The Proposed Regulations integrate these requirements and provide their satisfaction will meet the requirements under the No Surprises Act.

The Proposed Regulations also contain changes to the balance billing protection notices provided by plans and health insurance issuers to consumers. The Proposed Regulations will require a statement in the balance billing protection notice stating 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 [balance] bill . . . ." [90 Fed. Reg. 60443, Dec. 23, 2025] To reflect the balance billing protections in the No Surprises Act, "[t]his 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." [*Id.*]

Aligning the required transparency in coverage disclosure and the No Surprises Act requirements recognizes the duplicative nature of these rules. This should ease compliance burdens for group health plans and health insurance issuers, and is expected to result in "an additional layer of transparency for consumers." [90 Fed. Reg, 60444, Dec. 23, 2025]

These Proposed Regulations are intended to be applicable to plan years beginning on or after January 1, 2027.

Consumers and Employers Will Ultimately Pay the Price

It is estimated compliance with the Proposed Regulations will impose a "first-year burden of roughly 7.8 million hours and $982 million in associated costs" across all plans (or their TPAs) and all health insurance issuers. [90 Fed. Reg. 60484, Dec. 23, 2025] In each subsequent year, across all plans (or their TPAs) and health insurance issuers, compliance with the Proposed Regulations is estimated to require roughly 1.4 million hours and $68.2 million. [*Id.*] These compliance costs almost certainly will be passed along to consumers, employers, and individuals alike.

Comments on the Proposed Regulations were originally due on February 23, 2026, but the comment period was extended until March 2, 2026, "[t]o address the confusion from inconsistent communication about the comment deadline and to provide an opportunity for meaningful input by commenters . . . ." [90 Fed. Reg. 60432, Dec. 23, 2025; 91 Fed. Reg. 9213, Feb. 25, 2026]

In the End, They're Still Here

Despite the Departments' best efforts, the overlapping rules created by the government's patchwork approach to promote transparency is unlikely to be solved by the Proposed Regulations. In fact, the obstacles created by this piecemeal approach is highlighted by the CAA 2026 which contains rules requiring written fee disclosures from "covered service providers" that will require changes to the January 2026 proposed pharmacy benefit manager fee disclosure regulations that were published only days before it was signed into law. [*See,* 91 Fed. Reg. 4348, Jan. 30, 2026]

At bottom, achieving transparency in healthcare pricing is a laudable goal that promises to continue to be difficult to achieve given the number of parties and interests involved. As both insurers and group health plan sponsors strive to keep up with the ever-changing regulatory landscape, maintaining open lines of communication with governmental agencies and advisors is more important than ever.

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