February 23, 2026

The Honorable Robert F. Kennedy Jr.
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: Transparency in Coverage Proposed Rule (CMS 9882-P)

Dear Secretary Kennedy and Administrator Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on December 19, 2025, regarding payer price transparency regulations. These rules, proposed jointly by the Department of Health and Human Services, Department of Labor, and the Department of Treasury, would amend the regulations under the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code regarding price transparency reporting requirements for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual health insurance coverage.

To strengthen transparency in coverage, the AAFP recommends the Departments:

- Finalize the proposed definition of "health insurance market";
- Finalize the requirement for plans to make cost-sharing estimates available by phone and consider establishing associated performance standards (i.e., tracking and reporting call wait times);
- Finalize the proposed updates to the No Surprises Act-aligned cost-sharing disclaimer;
- Finalize the proposed revisions to machine-readable file requirements;
- Remove implausible provider–service pairings and protect primary care by requiring issuers to disclose their provider taxonomy methodology, establish a clear appeals pathway for erroneously excluded providers, and verify classifications using utilization data.

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Primary care is the entry point into the health system for millions of Americans, yet family physicians and patients routinely encounter opaque pricing structures, inconsistent network information, and incomplete data that make costs difficult to anticipate.[i] When plan data lacks accuracy or context, patients face unnecessary financial risks and policymakers cannot identify true cost drivers. The AAFP believes that transparency in health care must be supported by all stakeholders who hold information related to the payment, coverage, or evaluation of health care services, including but not limited to public and private payers, hospital systems, and other care delivery organizations. Therefore, **we support the Departments' joint efforts to make meaningful progress toward a more transparent health care ecosystem through this proposed rule.**

Transparency in Coverage—Definitions

The proposed rule adds a definition of "health insurance market" to clarify how issuers must separately organize out-of-network allowed amount files. The definition delineates four separate markets—individual, small-group, large-group, and self-insured group health plans—and excludes short-term limited-duration insurance, excepted benefits, and account-based self-insured arrangements.

The AAFP supports adding this definition, as it will improve the organization, comparability, and analytic value of out-of-network allowed amount files. Currently, mixing individual, fully-insured group, and self-insured data in a single file obscures real differences in patient exposure to out-of-network costs. Requiring separate files for each market will enable more accurate evaluation of affordability, network adequacy, and cost drivers across the system without imposing new administrative burdens on physicians. Thus, the **AAFP recommends the Departments finalize this definition as proposed.**

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

The proposed rule would require plans to make cost-sharing estimates available by phone, in addition to existing online tools and paper disclosures. It also updates the 2020 Transparency in Coverage requirement for cost-sharing estimates to reflect the No Surprises Act, which now prohibits balance-billing in most covered scenarios. Accordingly, the proposal removes outdated language suggesting that out-of-network providers might balance bill and clarifies that the estimate excludes any balance-billing charges still permitted under federal or state law.

As family physicians are often patients' first point of contact within the health care system, they are also frequently the clinicians who must field questions about costs, coverage, and potential billing risks from concerned patients. Requiring plans to provide cost-sharing estimates by phone will meaningfully reduce barriers for older adults, lower-income enrollees, and individuals with limited digital access and literacy.[ii] **The AAFP therefore**

encourages the Departments to finalize this requirement and consider establishing clear performance expectations, such as tracking and reporting call wait times, to ensure that phone-based access is reliable and truly meets patients' needs.

We also support the Departments' proposal to update the cost-sharing disclaimer. Prior to the No Surprises Act, roughly one in five insured adults received a surprise medical bill after an out-of-network emergency visit or an in-network hospital admission involving an out-of-network clinician, underscoring the need for clearer safeguards. Although the No Surprises Act has significantly reduced unexpected out-of-pocket charges, high medical cost burdens remain unchanged.[iii] Clearer disclosures will reduce patient confusion and improve trust, but **we encourage the Departments to pursue additional affordability policies beyond transparency to address persistent medical cost burdens.**

While we acknowledge that the elimination of patient cost-sharing for evidence-based primary care services is outside the scope of this Transparency in Coverage rule, the issue is inseparable from any discussion on cost-sharing disclosures. Even the most accurate estimate can still signal a financial barrier that deters patients from seeking high-value primary care. For that reason, the **AAFP** reiterates **that exempting evidence-based primary care from cost-sharing remains essential to achieving the broader goals of improved access, better outcomes, and a more efficient health care system**, even as we support the Departments' efforts in this proposed rule to strengthen the clarity and delivery of cost-sharing information.

Transparency in Coverage—Requirements for Public Disclosure for In-Network Rates and Out-of-Network Allowed Amounts

If finalized, this provision of the proposed rule would revise machine-readable file requirements, including adding contextual files, requiring a text-based index, shifting to quarterly updates, creating network-level in-network rate files, expanding data elements, removing implausible provider-service pairings, and improving out-of-network historical data.

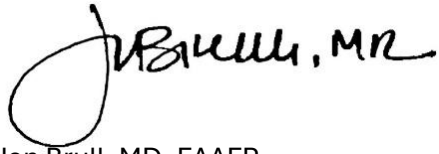
The AAFP supports the proposed revisions to machine-readable file requirements and encourages the Departments to finalize as proposed, as they meaningfully improve how pricing and network data are organized, interpreted, and used. For family physicians, these changes translate into more reliable, easier-to-navigate information about how plans reimburse care. Requiring issuers to establish a single in-network rate file per provider network reflects how primary care physicians realistically contract with plans and will significantly reduce confusion created by duplicative or inconsistent plan-level files. This also allows physicians and practices to track rate changes over time, verify that referrals remain in-network, and better understand how plans structure their networks.

We also support adding contextual files and a plain-text index, which will make price and network data far easier to locate and interpret. The proposed shift from monthly to quarterly updates is likewise beneficial. Because negotiated rates are set through multi-year, payer–provider contracts and do not meaningfully change from month to month, quarterly updates are sufficient to capture real rate variation.[iv] This proposed shift to quarterly reporting is also generally aligned with recent updates to Hospital Price Transparency policies. While the proposed quarterly cadence for payers is not identical to hospitals' reporting requirements, the OPPS and Ambulatory surgical center final rule's use of standardized percentiles based on a defined 12–15-month lookback period reflects a similarly periodic approach. Together, these changes should make payer and hospital files more comparable, easier to find, and more analytically useful, while preserving the distinct scopes and enforcement tracks of each rule. Greater reporting stability will also improve the accuracy and consistency of the cost and network information available during primary care encounters, reducing the time family physicians spend resolving discrepancies during care planning and referrals.

We also support the Departments' proposal to remove implausible provider–service pairings, as doing so will enhance the accuracy of the underlying data and improve its usefulness for physicians, patients, and policymakers. However, given the breadth of services provided in primary care, it is essential to ensure that legitimate primary care activities are not inadvertently excluded. **Accordingly, we support finalizing this provision. Concurrently, we also encourage the Departments to explore requiring issuers to transparently disclose the methodology used to develop their internal provider taxonomy, establish a clear process for providers to request corrections if they are erroneously omitted, and consider cross-referencing classifications against actual utilization data to ensure ongoing accuracy.**

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org.

Sincerely,



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