Week of September 8, 2025

This article provides general information and is not legal advice. If you have specific questions about compliance with the Affordable Care Act or the Consolidated Appropriations Act, 2021, please contact your legal counsel.

Transparency in Coverage

In late 2020, federal agencies responsible for overseeing the implementation of the Affordable Care Act (ACA) – the Departments of Labor, Health and Human Services, and Treasury (the Departments) – issued the Transparency in Coverage (TiC) final rule. The TiC final rule requires issuers and non-grandfathered group health plans in the commercial market to provide pricing information to the public in machine-readable files and to members through a pricing tool.

Separately, the Consolidated Appropriations Act, 2021 (CAA), includes a provision that requires group health plans and issuers to maintain an online price comparison tool and provide price comparison information by telephone.

This article provides an overview of requirements and refreshes information originally provided in the Health Care Reform Update for the week of June 27, 2022. It also provides new information related to recent guidance and other activity. Frequently Asked Questions can be found at the end of the article.

Machine-Readable Files

A machine-readable file (MRF) is a digital representation of data that can be imported or read by a computer system without human intervention. The final rule requires three machine-readable files that must be posted to a publicly-available website and updated monthly:

- In-network negotiated rates (other than prescription drugs)
- Out-of-network allowed amounts
- In-network prescription drug negotiated rates and historical net prices

The files must be accessible to any user free of charge and without conditions, such as establishing a user ID and password.

The TiC final rule and related guidance required the in-network negotiated rates and out-of-network allowed amounts MRFs to be posted starting July 1, 2022. The Departments issued FAQ 49 on Aug. 20, 2021, that, in part, delayed requirements related to the in-network prescription drug file as the Departments considered whether this file was still necessary given new pharmacy data reporting

required by the CAA.[1] FAQ 61, issued on Sep. 27, 2023, updated FAQ 49 and states that the enforcement delay no longer applies for the in-network prescription drug file and that the Departments intend to develop technical requirements and an implementation timeline in future guidance. To date, no such guidance or implementation timeline has been issued.

Recent Activity Related to MRFs

On May 22, 2025, the Departments issued FAQ 70, which shares the Departments' intent to release schema version 2.0, which will revise technical requirements for the in-network negotiated rates and out-of-network allowed amounts MRFs. The tentative timeframe to finalize the new schema is Oct. 1, 2025, with a compliance date of Feb. 1, 2026.

The Departments are also considering rulemaking to further refine and improve upon the MRF requirements.

On June 2, 2025, the Departments issued a request for information (RFI) asking for ways to effectively implement or amend the disclosure requirements related to in-network prescription drug file. The RFI focuses on the required data elements, including potential additional or alternative data elements and other general implementation concerns.

Pricing Tool

The TiC final rule also requires price transparency for members through an internet-based self-service pricing tool or paper on request.

The internet-based pricing tool must provide free, real-time responses based on cost-sharing information that is accurate at the time of the request. For a given service, the pricing tool will display information that includes an estimate of the member's cost-sharing liability, accumulated deductible and out-of-pocket amounts, the in-network rate, out-of-network allowed amount if applicable, notification that the item or service is subject to any prerequisites (such as prior authorization or step therapy), and a general disclaimer and limitations on the information provided.

Members who request paper versions of cost-sharing information will receive the same information for up to 20 providers on request via the mail. Issuers and group health plans may also make information available over the phone or email if the member agrees to such an approach.

The CAA price comparison provision requires group health plans and issuers to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that allows members to compare the amount of cost-sharing they will be responsible for paying with respect to the furnishing of a specific item or service. The CAA doesn't include a specific exemption related to grandfathered plans and, absent regulations or guidance to the contrary, it appears that this CAA provision applies to grandfathered plans.

FAQ 49 addresses the overlap between the CAA and TiC final rule requirements. The FAQ states that the Departments intend to propose rulemaking regarding, among other issues, whether compliance with the internet-based pricing tool requirements of the TiC final rules satisfies the analogous requirements of the CAA provision. The CAA includes a requirement that was not imposed under the TiC final rules: that price information also must be provided over the telephone upon request. Therefore, the proposed

[1] The CAA imposed a new reporting requirement known as the Pharmacy Data Collection or RxDC.

rulemaking will require that the same pricing information available through the online tool or in paper form, as described in the TiC final rule, must also be provided over the telephone upon request. To date, a proposed rule has not been issued on this topic.

What is BlueCross Doing?

BlueCross continues to monitor regulations and guidance related to MRFs and other TiC topics, including the MRF schema version 2.0 that should be released soon.

To comply with existing MRF requirements, BlueCross developed a specific webpage for this purpose, www.bcbst.com/tcr. Files are created in a JavaScript Object Notation (JSON) file format and updated monthly. URLs to the files are posted to this site.

The in-network file contains contracted rates. Separate in-network files are created for different networks (e.g. P, S, L, and E). The out-of-network file applies a 20-claim minimum rule to determine services that need to be reported, as permitted by regulations.

For insured plans, different files are created based on whether the plan is an "essential health benefit" (EHB) plan (individual and small group) or a non-EHB plan (large group). For EHB plans, a file is created based on a 10-digit HIOS ID number, a number specific to EHB plans. All other insured plans are grouped together and reported by 5-digit HIOS ID, a number specific to BlueCross.

For self-funded plans, including level-funded, files are created at the group level. Groups have the option of hosting files on their website or directing users to the bcbst.com website. Self-funded groups that want to host their own files should contact their Account Executive as soon as possible. Once we're notified, it will take at least 60 days to coordinate with the group to host their own files.

For the online pricing tool, we leveraged our existing online tool, Health Care Cost Estimator, to meet requirements of the final rule regarding medical plan benefits, along with our online pharmacy pricing tool for pharmacy benefits.

Our Heath Care Cost Estimator has been available for several years for members enrolled in individual coverage and insured and self-funded group health plans when they log into their BlueCross member account. The TiC requirements do not impact the service estimates we've historically provided on Health Care Cost Estimator, which provides care estimates for 1600 procedures for specific in-network providers. The information required for TiC is accessed through separate functionality within the Health Care Cost Estimator. Disclosure information is included as part of the online experience.

One difference between our standard pricing tool and the information provided under the TiC final rule is that the standard pricing estimates are for episodes of care and include related services members commonly receive for a given procedure. The TiC final rule requires us to provide an estimate for the specific billing code selected. The estimate will be specific to only this code and not include any other related services a member may receive.

Members with pharmacy coverage through BlueCross can also access the pharmacy pricing tool that's available through single sign-on from their BlueCross member account. Members will be able to select a pharmacy and drug and then see the price of a drug and their cost-share specific to that pharmacy. Of course, prices can change frequently so the price given will be based on the time the info is requested, which is disclosed in the tool.

Members can print their medical and/or pharmacy estimates from the online tools. Members can also call our consumer advisors using the number on the back of their ID card to request a paper version of an estimate or to discuss an estimate over the phone. Our consumer advisors will provide disclosure information during the call or as part of the paper estimate.

Frequently Asked Questions

Q1: Where are the machine-readable files?
A: We've created a landing page for our files at www.bcbst.com/tcr. MRFs are updated monthly. The file name includes the date to which the file applies, which means the file names are also changed monthly.

Q2: What is the 20-claim minimum rule related to the out-of-network file?
A: For the out-of-network file, entities are required to report historical allowed amounts and billed charges for specific items and services by provider. To protect privacy, regulations require that this data be omitted if there are fewer than 20 different claims for a particular item or service and provider combination for a plan.

Very few plans meet the 20-claim minimum threshold for out-of-network reporting. However, regulations require that we post a file even if no data is reported.

Q3: Is there a cost for hosting the machine-readable files?
These files are very, very large – terabytes of data. There is a cost to BlueCross for creating, hosting, and maintaining files of this size, and a cost to us when users import the data. Whether we host the files, or a group health plan does, there's a cost. Costs of this nature are included in premiums for our insured plans and ASO fees for SF plans.

Q4. Can an employer host the machine-readable files on their company website?
We assume self-funded plans want BlueCross to host the files, but if a self-funded group wants to host the files on its own website, please contact your BlueCross Account Executive. Once we're notified, it will take at least 60 days to coordinate with the group to host their own files.

Q5: Does self-funded plan ASA language include support for machine readable files?
Yes. The group's administrative services agreement (ASA) includes language to address Transparency in Coverage requirements.

Q6: Will BlueCross include data in machine-readable files or the price comparison tool for coverage they don't administer?
No. BlueCross includes only data/information for coverage we administer.

Q7: Does the TiC final rule apply to all types of coverage?
The TiC final rule applies to non-grandfathered individual and group health plans. The rule does not apply to grandfathered plans or excepted benefits like stand-alone dental and vision coverage, Medicare supplement policies, hospital indemnity, and other similar limited benefit plans. The rule also doesn't apply to programs outside of the commercial market like Medicare Advantage and Medicaid.

Note, however, that the CAA requirement for a price comparison tool is not limited to non-grandfathered plans. Absent regulations or guidance to the contrary, it appears that grandfathered plans are subject to the requirements of this CAA provision.

Q8: How can groups access their in-network and out-of-network machine readable files once they are on BlueCross's TCR landing page?
The landing page includes two active hyperlinks – one for non-ASO and one for ASO. Clicking on a link will download a Directory file. Once the download is complete, users will see either one URL (non-ASO) or a list of group names with a URL below each group name (ASO). These URLs are called Table of Contents files. If a user copies and pastes their group's Table of Contents file into their browser, it will take the user to the Table of Contents schema, which includes URLs for BlueCross negotiated rates as well as negotiated rates for other Blue plans that our members may access when they see out-of-state providers, along with a URL for the out-of-network file. All of these files are machine readable – the Directory file, the Table of Contents files, and the in-network and out-of-network files.

If a user copies and pastes an in-network URL into their browser, the computer will begin to download a large quantity of data, which could take several minutes or more to complete. The resulting download will include data in JSON format, which may not be readable or meaningful for typical users.

Step-by-step instructions for self-funded groups:

1. From the landing page, www.bcbst.com/tcr, click on the link for ASO. This will download a Directory JSON File for self-funded plans.
2. After the Directory download completes, a list of Group Names and their associated Table of Contents URLs will display.
3. Search the Directory file by Group Name to identify the Table of Contents URL for a specific self-funded plan.
4. Copy and paste the appropriate Table of Contents URL into your browser to extract the Table of Contents schema, which includes the Group's in-network and out-of-network MRFs.

Q9: Will BlueCross communicate to members that the MRFs are available?
No. The MRFs are not intended for general users to view. An MRF is a digital representation of data that can be imported or read by a computer system without human intervention. In addition, the files will be in JSON format, a common format used for transmitting data in web applications. The data will not be in excel files or pdfs that are easily downloaded and understood by individual users, but rather in formats for computer systems to read.

Q10: How can a member find the comparison of individual services at the billing code level?
Members can follow these steps to obtain estimates based on billing codes:

- Log in to their **bcbst.com** account
- In the "Get Care" drop-down, select "Estimate Costs"
- The member will arrive on the "Browse or Search for Care" page and can click on the "Search by Billing Code" link

After clicking the "Search by Billing Code" link, members will be able to search for a specific billing code using either the actual alphanumeric code or the billing code short description. The billing codes include Current Procedural Terminology (CPT) codes, Healthcare Common procedure Coding System (HCPCS)

codes, and DRG (Diagnostic Related Group) codes. The online tool will allow members to select providers they wish to consider and return the required information for the specific billing code including member cost-sharing, accumulated deductible and out-of-pocket amounts, and disclosure information.

Q11: How are the results based on a billing code different from the cost estimates based on an episode of care?

When using a billing code estimate, members will be able to search for a specific billing code or a brief description of the billing code. The estimated cost of care will be shown using the negotiated rates that the member's health plan has agreed to pay a provider (doctor, medical facility, lab, etc.) for the billing code that was entered. A billing code is used to identify a single service. A complete visit or procedure may include multiple billing codes and negotiated rates.

When using the estimate based on an episode of care, members will be able to search for procedures by name (rather than by billing code). The estimated cost of care will be based on historical claims information from actual claims paid by the member's health plan.