

EMPLOYEE BENEFITS COMPLIANCE ALERT!

Agencies Finalize Significant Updates to "Transparency in Coverage" Rules



October 13, 2026

On October 6, 2026, the U.S. Departments of Labor, Health and Human Services and Treasury/IRS ("the Agencies") published a final regulation on health plan transparency called the Transparency in Coverage (or "TiC") rule ("Final Rule"). The Final Rule implements significant changes to the pre-existing TiC rules, which generally apply to most non-grandfathered group health plans and health insurance issuers.¹ The Agencies also published an accompanying Fact Sheet.

The Final Rule was designed to address challenges that have emerged since the original TiC regulation took effect in 2020, including inaccessibility due to exceptionally large machine-readable files (MRFs), data usability concerns, lack of contextual files to help understand the content of the MRFs, and inconsistencies between this initial TiC rule's regulatory framework and other federal healthcare transparency initiatives.

The Final Rule substantially modifies the existing MRF requirements, introduces additional consumer disclosure options and aligns certain TiC obligations with the No Surprises Act. While many of the operational requirements will fall on insurance carriers and third-party administrators ("TPAs"), self-insured plan sponsors should understand these changes and coordinate with vendors to ensure compliance with the new standards and implementation timelines.

ACTION REQUIRED

Determine whether your carrier will handle compliance with the revised machine-readable file requirements.

Review carrier agreements and other vendor contracts to ensure Transparency in Coverage compliance.

Evaluate whether systems, reporting processes, or data feeds need updates to meet the new file structure requirements.

¹ The TiC rules generally do not apply to ACA-defined grandfathered plans, health reimbursement arrangements (HRAs), health FSAs, excepted benefits or short-term limited-duration insurance (STLDI). As discussed further in this Alert, however, the new telephone-based cost-sharing disclosure requirement applies for No Surprises Act purposes, even to certain grandfathered plans.

BACKGROUND

The original TiC regulation, finalized in 2020, was intended to provide consumers with access to healthcare pricing information and promote more informed healthcare purchasing decisions. Since implementation, regulators administering the initial TiC rule have received feedback that the MRFs required to be disclosed (i.e., made available on a public website) are often so large and complex that they are difficult to access and use effectively.

In response, the Agencies proposed amendments in December 2025 aimed at improving accessibility, reducing file size, increasing data consistency, and better aligning TiC requirements with hospital price transparency initiatives. The Final Rule largely adopts those proposed changes, and implements portions of [Executive Order 14221](#), "Making America Healthy Again by Empowering Patients With Clear, Accurate, and Actionable Healthcare Pricing Information," issued on February 25, 2025, which directed federal agencies to improve healthcare price transparency and make pricing information more accurate, accessible, and actionable for consumers, employers, researchers and healthcare technology innovators. Viewed together, the changes reflect a broader federal effort focused less on increasing the sheer volume of pricing information disclosed, and more on whether that information can be readily located, understood, and used by consumers and employers.

SIGNIFICANT CHANGES TO MACHINE-READABLE FILES

Reduced Update Frequency. One of the most notable changes is a reduction in the frequency of updates required for most MRFs. Beginning with the first calendar-year quarter following the March 6, 2027 start date, plans and insurers will generally be required to update and publish "in-network rate" files and "out-of-network allowed amount" files on a quarterly basis rather than monthly. (As discussed below, prescription drug MRFs remain on a monthly update schedule, but those files are not yet operational.).

Consolidated Network-Based Reporting. The Final Rule also significantly changes how in-network pricing information must be organized. Rather than producing separate files for each plan or policy, plans and insurers must create a single in-network rate file for each provider network they maintain or utilize. To improve usability and context, these files must include the common provider network name, a provider network identifier, and the applicable product type (such as HMO or PPO). This approach is aimed at reducing duplication, decreasing file sizes, and making the data easier for users and technology vendors to analyze.

Removal of Improbable Provider-Service Combinations. Plans and insurers will no longer be required to report reimbursement rates for provider-service combinations that are unlikely to occur in practice, based on provider specialty classifications and the plan's or insurer's internal taxonomy or other rules used in claims adjudication. For example, reimbursement rates associated with procedures that would not ordinarily be performed by a particular provider specialty may be excluded from the published files. This adjustment is intended to eliminate large amounts of unnecessary data that provide limited value to consumers.

Changes to "Out-of-Network Allowed Amount" Reporting. The Final Rule revises several key reporting parameters for "out-of-network allowed amount" files. Among other changes, the Final Rule reduces the minimum claims threshold for reporting from 20 claims to 11 claims, expands the reporting period from 90 days to six months, increases the look-back period from 180 days to nine months, and requires reporting at the health insurance market level (such as the large group or small group market) rather than at the individual plan or policy level. These modifications are intended to improve the completeness and usefulness of reported out-of-network payment information.

Reporting of Percentage-of-Billed-Charges Arrangements. The Final Rule clarifies that in-network rates must be reported as a dollar amount, except where the contractual arrangement sets payment as a percentage of billed charges and a dollar amount cannot be determined before the bill is generated. In that case, the plan or insurer must instead report the applicable percentage.

New Executive Attestation. Importantly, the Final Rule adds a new requirement that an executive of the plan or issuer attest to the accuracy and completeness of the MRFs. The attestation applies to the in-network rate file, the allowed amount file, the prescription drug file, and the new utilization and taxonomy files. Where a TPA or other service provider owns or maintains the provider network and negotiated rates, the party responsible for producing the file would ordinarily make the attestation. Accordingly, plan sponsors should confirm with their vendors who will sign.

Required File Format for MRFs. The Final Rule designates "JSON" as the required format for the machine-readable files, codifying the format already used by the large majority of plans and issuers and improving consistency across disclosures.

Website Transparency / "Findability." Plans and insurers will be required to include a clearly labeled link in the footer of their website homepage directing users to the relevant transparency information and MRFs. The link must be labeled either "Price Transparency" or "Transparency in Coverage." The Final Rule also requires plans and issuers to maintain a standardized text file to improve findability of the MRFs. These requirements are intended to address longstanding concerns that MRFs were difficult to locate and access, even when plans were technically compliant with existing disclosure rules.

EXPANDED COST-SHARING DISCLOSURE OPTIONS

New Telephone-Based Disclosure Method:

The Final Rule expands how participants may obtain personalized cost-sharing information. Beginning with plan years starting on or after January 1, 2027, plans and insurers must make cost-sharing information available by telephone upon request, in addition to the existing internet-based self-service tool and paper disclosures. The required telephone number is the same consumer assistance number that already must appear on participant identification cards under the No Surprises Act. Plans and insurers may impose reasonable limits on telephone inquiries, provided they respond to requests covering no fewer than 20 providers per operational day.

Integration with No Surprises Act Requirements:

The Final Rule simplifies compliance by coordinating TiC disclosure obligations with requirements imposed under the No Surprises Act. Notably, compliance with the TiC individualized cost-sharing disclosure requirements, including the new telephone disclosure method, will satisfy the separate price comparison tool requirement under the No Surprises Act. This change eliminates the need for plans and insurers to maintain duplicative tools serving substantially similar purposes. Additionally, it should be noted that the telephone disclosure requirement applies for this purpose even to grandfathered group health plans that are not otherwise subject to the Final Rule.

Contextual Data Files:

To improve usability and provide additional context for the machine-readable file data, the Final Rule creates several new supporting files, including taxonomy, utilization and text files. These files are intended to help users better interpret pricing information and improve consistency across disclosures.

Updated Balance Billing Notices:

The Final Rule further updates the balance billing protection statement that must accompany cost-sharing disclosures. These revisions bring the disclosure language into alignment with the consumer protections established by the No Surprises Act.

Prescription Drug Files — Not Yet Operational:

Although the Final Rule retains the monthly reporting cadence for prescription drug machine-readable files, those files are not yet in production. The Agencies have indicated that they will begin developing the reporting schema for the prescription drug file, and do not expect plans to begin publishing these files, until approximately December 2027, following finalization of the schema. Accordingly, plan sponsors should not expect prescription drug files to be produced in the near term.

WHEN WILL THE FINAL RULE GO INTO EFFECT?

The Final Rule is effective December 7, 2026, with key operational requirements phased in through 2027. The amendments related to the "in-network rate" and "out-of-network allowed amount" files, together with the new executive attestation, generally apply beginning March 6, 2027 (with the quarterly cadence starting with the first calendar-year quarter after that date). The amendments related to the new contextual files (taxonomy, utilization and text), and the website footer link, apply beginning September 6, 2027. The telephone-based cost-sharing disclosure requirement applies for plan years (in the individual market, policy years) beginning on or after January 1, 2027. The following table summarizes the key dates:

Key Compliance Dates	
Date	Requirement
December 7, 2026	Final Rule becomes effective
Plan years beginning on or after January 1, 2027	Telephone-based cost-sharing disclosure requirement goes into effect; updated balance billing statement required
March 6, 2027	New "in-network rate" file and "out-of-network allowed amount" file requirements and executive attestation obligation go into effect (quarterly updates begin the first calendar-year quarter after this date).
September 6, 2027	New contextual files (taxonomy, utilization and text) and website footer link requirement go into effect.
Approximately December 2027	Prescription drug file implementation expected, following finalization of the reporting schema.

WHAT DOES THIS MEAN FOR EMPLOYERS AND PLAN SPONSORS?

Although many transparency requirements are administered by carriers and TPAs, employers and plan sponsors sponsoring self-insured health plans should not assume these changes are solely a vendor responsibility. Although TPAs and network vendors will typically perform the operational compliance functions, the legal obligation to satisfy the Transparency in Coverage requirements ultimately remains with the self-insured group health plan. Accordingly, plan sponsors should:

- confirm whether their carrier or TPA will assume responsibility for compliance with the revised machine-readable file requirements, and which party will sign the new executive attestation;
- review current vendor and administrative services agreements to verify the allocation of TiC compliance responsibilities;
- determine whether system or reporting changes will be necessary to accommodate the new file-structure requirements, and ensure participant-facing materials, websites and customer-service resources reflect the new disclosure processes; and
- monitor implementation timelines and vendor readiness throughout 2027, given the varying applicability dates

NEXT STEPS

While the Agencies' changes are primarily intended to improve the usability and effectiveness of healthcare pricing data, the Final Rule represents the most significant revision to the Transparency in Coverage framework since the rules were initially implemented. Plan sponsors should begin discussions with their carriers, TPAs, and transparency and reporting-related vendors now to understand how compliance responsibilities will be handled and whether any contractual or administrative changes are needed before the new requirements take effect. The phased implementation schedule provides time for preparation, but employers that rely on third-party vendors for transparency compliance should seek assurances that operational updates are already underway. As always, your trusted benefits specialists at Foundation Risk Partners are ready to assist you with implementing these new requirements. If you have any questions or concerns about the Final Rule and its disclosure requirements, or need assistance developing a compliance plan, please contact your Corporate Synergies Account Manager at 866.CSG.1719.

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