
Departments Issue Final Rules Updating Transparency in Coverage Requirements

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Key Takeaways

- The Departments of Labor, Health and Human Services, and Treasury (the Departments) issued final rules updating the Transparency in Coverage (TiC) rules. These rules require group health plans and health insurers to publish negotiated rates and allowed amounts for medical services in machine-readable files (MRFs).
- The final rules address feedback by stakeholders on the original rules related to the need to address certain gaps in the reporting, shrink the size of the files by reducing duplication and removing unnecessary data, and to improve the usability of the data.
- For group health plan sponsors, one of the significant changes under the final rules is an attestation requirement.
- Employers should ensure that service providers for their group health plan, including third-party administrators (TPAs), update the MRFs they are posting on behalf of the employer group health plan, as well as implement other requirements, to comply with the new rules.

Overview

On October 6, 2026, the Departments issued final rules amending the final TiC rules that were issued in 2020 during the first Trump Administration. These final rules address challenges reported by stakeholders with the 2020 rules and are designed to improve the disclosure of price information by making the information more accessible, standardized, and reliable.

Under the 2020 final rules, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage were required to post two MRFs monthly for each plan or coverage they offer: (1) an in-network rate file disclosing in-network rates for all covered items and services (the In-Network Rate File); and (2) an allowed amount file disclosing out-of-network allowed amounts and the associated billed charges for covered items and services (the Allowed Amounts File). These requirements became applicable in July 2022.

The 2020 final rules also require plans and issuers to publish a third file for disclosing in-network rates and historical net prices for covered prescription drugs (the Prescription Drug File), but that file has not yet been implemented.

CPC Comment: *Aon's Health Solutions practice provided comments on the proposed rule, expressing support for the Departments' increased focus on transparency to provide group health plan sponsors and participants with information regarding benefits and pricing to better evaluate*

their overall options and potentially lower overall healthcare costs for both employers and employees. Aon also provided feedback on the Departments' proposals to address the size and accessibility of the data to make it more useful for actionable analysis.

TiC Final Rules

These final rules modify the 2020 requirements related to the In-Network Rate File and the Allowed Amounts File, and are designed to improve standardization, accuracy, and accessibility of the MRFs. The final rules do not implement the prescription drug MRF that has been on hold, but the Departments announced in [guidance](#) on October 7, 2026, that they expect to issue technical guidance on the prescription drug MRF on or about May 2027.

Changes to MRFs

Among other provisions, the final rules would require health insurers and group health plans to implement the following:

- Exclude from in-network reporting those items and services that a provider would be unlikely to furnish.
 - For example, rates for podiatrists to perform heart surgery would be excluded.
- Prepare one In-Network Rate File for each provider network maintained by an issuer or plan, rather than for each separate plan or policy offered as is currently required.
 - This is intended to improve consistency with the requirements of the hospital price transparency reporting.
- For the out-of-network Allowed Amounts File:
 - Require payers to aggregate the Allowed Amounts Files by insurance market type (large group, small group, individual, and self-insured);
 - Lower the claims threshold for reporting payment of out-of-network allowed amounts from 20 claims to 11 claims; and
 - Change the reporting period from 90 days to six months, as well as the look-back period from 180 days to nine months.
- Reduce the frequency of posting the In-Network Rate File and the out-of-network Allowed Amounts Files to quarterly postings rather than monthly postings beginning after March 6, 2027 (so, as of April 1, 2027).
 - The prescription drug MRFs will still be required to be updated and posted monthly when fully implemented.
- Create and post two new “contextual” MRFs, the Utilization File and the Taxonomy File, which contain pricing and plan and provider identifying data, and a plain text file containing links to the MRFs and contact information.

- The Utilization File must be posted by July 1, 2028, and updated annually thereafter.
- The Taxonomy File must be posted by April 1, 2027, and updated quarterly thereafter.
- The plain text file must be posted by April 1, 2027, and updated within seven days of a change in the information in the file.

Attestation Requirement

The final rules require group health plans or issuers to provide an attestation for each MRF that to the best of their knowledge and belief, all required information has been included and that the information is true, accurate, and complete as of the date reflected in the file. The attestation must be encoded in the MRF, as well as the name of the plan's or issuer's chief executive officer, president, or senior official designated to oversee the encoding of the data.

CPC Comment: *The final rules allow group health plans to enter into a written agreement for another party, such as insurers or a TPA, to satisfy the MRF requirements, including making the required attestation. However, if the other party fails to comply with the requirements, the self-insured group health plan may still be responsible for any noncompliance.*

Cost-Sharing Information

The final rules also finalize the requirement that, for cost-sharing information that is made available through an internet-based tool, the information must also be made available by phone.

The final rules clarify that compliance with the TiC cost-sharing disclosures satisfies the price comparison tool requirements under the No Surprises Act. The final rules also amend the notice requirement related to potential balance billing.

These requirements related to the cost-sharing information apply for plan years beginning on or after January 1, 2027.

Employer Actions

Most of the compliance with the final rules will lie with group health plans' medical TPAs and insurers. However, employers should talk with their service providers to understand the changes to the MRFs and confirm which party will be responsible for implementing the requirements and ensure compliance by the relevant applicability dates. In addition, self-insured plans should review and update any written agreements with their service providers as necessary to reflect responsibility for compliance with these requirements.

The final rules can be found [here](#).

Please contact the CPC Team with any questions.



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