

Departments Finalize Transparency in Coverage Rules: What Health Plans and Issuers Need to Know

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VIEWPOINT TOPICS

- Health Care

On October 5, 2026, the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) announced changes to the Transparency in Coverage (TIC) **final rules**, overhauling the 2020 **regulatory framework** for group health plans and health insurance issuers. The changes aim to standardize the TIC machine-readable files (MRFs) for greater accuracy and accessibility. The rules take effect **December 7, 2026**, with requirements phased in through July 2028.

Bottom line: HHS is tightening TIC requirements to make pricing data usable, comparable, and reliable, while imposing greater accountability through executive attestation requirements. Congress is moving bills to put price transparency into statute. Group health plans and health insurance issuers face new compliance obligations to improve consumer access to data; providers should expect their networks, utilization, and rates to be easier to see and compare.

HHS Focus: From Data Dumps to Usable Tools

Building on **Executive Order 14221** "Making America Healthy Again by Empowering Patients With Clear, Accurate, and Actionable Healthcare Pricing Information," HHS concluded that the existing TIC requirements have not fully achieved their intended purpose because publicly available pricing data is difficult for consumers to access, navigate, and use. At an HHS hearing announcing the final rules, Secretary Robert F. Kennedy, Jr. observed that "publishing enormous quantities of data does not necessarily produce useful information." Centers for Medicare & Medicaid Services (CMS) Administrator Dr. Mehmet Oz **said** the rule will power "a one-stop-shop for cost comparison." HHS **cites** a 6.3% annual decline in the most expensive services following earlier transparency initiatives, and the Departments project **\$174.5 million in additional annual savings** as a result of the TIC final rules. Enforcement will use existing tools, including penalties and corrective action.

Changes to Existing Requirements

The final rules revise existing TIC requirements, changing how group health plans and health insurance issuers will structure, report, and publish MRF data to make the information more uniform, useful, and accessible while balancing administrative burden.

REQUIREMENT	WHAT CHANGES	APPLICABLE DATE
In-Network Files	One file per provider network, organized by billing code, with a plain language description identifying the network name, ID, and product type; unlikely provider-rate combinations excluded	March 6, 2027

REQUIREMENT	WHAT CHANGES	APPLICABLE DATE
Out-of-Network Files	Reported at the health insurance market level; claims threshold cut from 20 to 11 claims; reporting period extended to six months with a nine-month lookback	March 6, 2027
JSON Format	Single open format replaces the use of multiple different formats (including .CSV and .XML) permitted under the existing framework	March 6, 2027
Quarterly Updates	In-network rate and out-of-network files move from monthly to quarterly (drug file reporting will stay monthly)	April 1, 2027

New Compliance Obligations

The final rules also introduce several new transparency and disclosure requirements governing how group health plans and health insurance issuers account for reported data and inform consumers about personalized pricing. These new requirements aim to increase accountability, deliver greater value to consumers, and strengthen regulatory oversight of the reported data.

REQUIREMENT	WHAT IS BEING ADDED	APPLICABLE DATE
Executive Attestation	In-network rate, allowed amount, and prescription drug MRFs must identify senior officials who must attest the MRF data is true, accurate, and complete	March 6, 2027 (September 6, 2027, for new files)
New Files	The final rules introduce three new types of reporting files: • taxonomy files (with exclusion logic); • utilization files (listing paid providers); and • text files (with point of contact information) All MRFs must be linked in a website footer titled "Price Transparency" or "Transparency in Coverage"	Taxonomy files September 6, 2027; text files before October 1, 2027; utilization files July 1, 2028
Phone Access	Personalized cost sharing information must be available through the consumer assistance telephone number listed on the participant's ID card; this requirement satisfies the No Surprises Act Section 114 requirements	Plan years from January 1, 2027

The Road Ahead for Regulators and Congress

Regulators will next turn to the Prescription Drug File. **Schema** work begins in November 2026, with publication of **Schema 3.0** expected December 2027. Change-log files and enrollment-total reporting were not finalized this round.

For Congress, codification is next. Congress views the rules as a floor rather than the culmination of health care transparency reform. Ways and Means Chairman Jason Smith (R-MO) **said**, "The hospital knows the price. The insurance company knows the price. The only person who doesn't is the patient." Rep. Diana Harshbarger (R-TN) noted that "for the first time, insurers will have to attest" to their data. Pending bills:

- **H.R. 9393, Lower Costs, More Transparency Act:** cleared Energy and Commerce 45-0; adds disclosure duties for plans, Medicare Advantage, and PBMs.
- **H.R. 9645, Health Care Price Certainty for All Americans Act:** advanced from Ways and Means on party lines; would codify transparency and hold insurance executives responsible for reported prices.
- **H.R. 9390, Prices on the Wall Act:** cash price posting at hospitals and ASCs; cleared Energy and Commerce 24-21.
- **S. 2355, Patients Deserve Price Tags Act:** cleared Senate HELP 21-1; would phase out estimators in favor of actual prices.

What to watch: Future administrations can revise regulations, but not statutes. Stakeholders should engage now while the committee text is still under consideration by Congress.

Key Takeaways for Stakeholders

- **Health Plans and Health Insurance Issuers Should Build for March 2027.** Group health plans and health insurance issuers should prepare for the revised reporting requirements and identify the executives responsible for making the required attestations.
- **Self-Insured Plans Should Evaluate TPA Contracts.** Self-insured plans that rely on third-party administrators (TPAs) to meet updated reporting requirements should review their TPA and vendor contracts to confirm they clearly assign responsibility for timely reporting, posting, and attestation of MRFs. Under the final rules, an insured group health plan may shift liability to its issuer through a written agreement, but a self-insured plan that contracts with a TPA remains liable if the TPA fails to comply.
- **Current Provisions Still Apply.** Until the new provisions become applicable, group health plans and health insurance issuers must continue to comply with the current regulations.
- **Providers Should Expect Increased Transparency.** New pricing and utilization reporting requirements may make negotiated rates, network participation, and provider payment data more readily comparable and easier to analyze.

March 2027 is closer than it looks, and Congress may raise the stakes further. We will continue to monitor implementation, enforcement, and legislative action to keep payors and providers ahead of the curve.

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