



EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

October 13, 2026

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New Transparency in Coverage Rules Overhaul Price Disclosure Requirements for Group Health Plans

On October 6, 2026 the U.S. Departments of Health and Human Services, Labor and the Treasury (the “Departments”) published final rules amending the Transparency in Coverage (“TiC”) regulations (the “Final Rules”). The Final Rules restructure the machine-readable files that group health plans must post, add new contextual files and an accuracy attestation requirement, and require cost-sharing estimates by phone. The Final Rules are effective December 7, 2026, with compliance dates phased in between January 1, 2027 and July 1, 2028.

Background

The Departments originally issued the TiC rules in 2020. As discussed in our [previous Client Alert](#), the 2020 rules required plans to provide personalized cost-sharing estimates through an online self-service tool (or on paper upon request) and to publish three machine-readable files disclosing in-network negotiated rates, out-of-network allowed amounts and billed charges, and prescription drug pricing. While those disclosures released an enormous amount of previously hidden pricing data, users reported the files were too large and difficult to compare.

Who Must Comply With the Final Rules?

The Final Rules apply to non-grandfathered group health plans, both insured and self-insured (including non-federal governmental and church plans), and to health insurance issuers.

Key Requirements

Machine-Readable File Changes

The most significant changes affect the “In-network Rate File” and the “Allowed Amount File”:

- **Network-level reporting.** In-network Rate Files must be produced for each provider network, rather than each coverage option. Files also must identify the provider network name and identifier and each plan’s product type (for example, HMO or PPO).
- **Removal of unlikely rates.** Plans must exclude rates for services a provider is unlikely to be reimbursed for given the provider’s specialty.
- **Expanded out-of-network data.** The claims threshold for the Allowed Amount Files drops from 20 to 11 claims, and the reporting period expands from 90 days to six months, using a nine-month lookback. Allowed Amount File data will be aggregated by health insurance market rather than reported plan by plan.
- **Quarterly cadence.** In-network Rate and Allowed Amount Files will be updated quarterly instead of monthly; the prescription drug file remains a monthly requirement.
- **Attestation.** In each In-network Rate, Allowed Amount, prescription drug, Utilization, and Taxonomy File, the plan’s chief executive officer, president or other senior official designated to oversee the data must include a specific attestation to the truthfulness, accuracy and completeness of the file. That person’s name also must be encoded in the file. A third-party administrator (“TPA”) may provide the attestation if it agrees to do so in writing and has also agreed to provide the files on the plan’s behalf.
- **Single file format.** Files must be posted in a single non-proprietary, open-standards format specified in technical guidance (expected to be JSON).



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New Contextual Files and Findability Requirements

The Final Rules add a new Utilization File identifying covered items and services, a new Taxonomy File showing specialty-mapping rules, and a new Text File identifying where files are posted and a contact email address. Plans must also include a website footer link to the files.

Cost-Sharing Disclosures and the Price Comparison Tool

For plan years beginning on or after January 1, 2027, personalized cost-sharing estimates must also be available by phone through the number on participant ID cards. A plan that provides these disclosures satisfies the No Surprises Act price comparison tool requirement. Plans may limit phone responses to no fewer than 20 providers per day but must disclose that limit to the caller. Plans must also update the balance billing statement that accompanies cost-sharing estimates to reflect federal balance billing protections under the No Surprises Act.

Phased Compliance Dates

- **Plan Years Beginning on or After January 1, 2027:** Phone disclosure, revised balance billing statement, and deemed compliance with the No Surprises Act's price comparison methods.
- **March 6, 2027 (Phase 1):** Restructured In-network Rate and Allowed Amount Files, rate exclusions, and attestations.
- **September 6, 2027 (Phase 2):** Taxonomy File, Text File, and website footer requirements.
- **July 1, 2028:** First annual Utilization File posting.

Until the applicable dates, plans must continue to comply with the existing TiC rules.

How Does This Impact Plan Sponsors?

Fully Insured Plans

An insured plan satisfies the TiC requirements if the insurer agrees in writing to provide the required information, including the attestation; if the insurer fails to comply, the insurer, not the plan, is in violation.

Self-Insured Plans

Self-insured plans may contract with a TPA, pharmacy benefits manager ("PBM"), or other vendor to produce, attest to, and post the files. However, if the vendor fails to comply, the plan remains in violation. The Departments noted that a plan sponsor concerned about its TPA's ability to comply "should take all necessary steps to address such concern in its contract with the TPA." Plans with carve-out vendors will need to coordinate so that each vendor reports its portion of coverage, and employers with a public website must link to the files' location if the files are hosted on a vendor's website. The Departments also noted that the new Utilization File can help employer plan sponsors better understand provider service patterns within their networks.

Important Action Items

Employers should take the following steps to prepare for the new requirements:

- Identify all plans and carve-out vendors and confirm who is responsible for each file and disclosure.
- For insured plans, obtain written confirmation that the carrier will satisfy the amended requirements, including the attestation.
- For self-insured plans, amend TPA, PBM and other agreements to require compliance with the Final Rules and include indemnification and audit rights.
- Request vendor implementation timelines keyed to each compliance date.
- Confirm the ID card phone number can deliver cost-sharing estimates by January 1, 2027.
- Document fiduciary oversight of vendor compliance.
- Review TPA and other service agreements to confirm the plan can access the data needed to comply, keeping in mind the Consolidated Appropriations Act, 2021 prohibition on gag clauses that restrict access to de-identified claims data.

If you have questions about the Transparency in Coverage Final Rules or the compliance obligations created by the Final Rules, please contact a member of Kutak Rock's [Employee Benefits and Executive Compensation practice group](#).