

McGohan Brabender's Compliance IN MOTION

November 2026

Transparency in Coverage: 2026 Final Rule

The Transparency in Coverage (TiC) rules, issued under Public Health Service (PHS) Act § 2715A and incorporated into ERISA § 715 and Internal Revenue Code (IRC) § 9815, require group health plans to (1) give participants personalized cost-sharing estimates and (2) post public machine-readable files (MRFs) of in-network rates, out-of-network allowed amounts, and prescription drug pricing.

On October 6, 2026, the Departments of the Treasury, Labor, and Health and Human Services (the Departments) published a [final rule](#) that overhauls the MRF formats, reduces update frequency for the in-network and out-of-network files from monthly to quarterly, adds new contextual files and an accuracy attestation, and requires cost-sharing estimates to be available by phone. The rules are effective December 7, 2026, with requirements phasing in from plan years starting January 1, 2027 through July 1, 2028. The Departments also provided a [fact sheet](#) to summarize the changes.

On October 7, 2025, the Departments also published [FAQs Part 75](#) announcing some of the new file formats and that the Prescription Drugs MRF format should be finalized by May 2027, with the goal that plans start posting monthly Prescription Drug MRFs with attestations by December 1, 2027.

For nearly all employers, the insurance carrier or third-party administrator (TPA) builds and posts the MRFs and runs the price tool with real-time cost-sharing via web, paper, and phone. Employers with written fully insured carrier agreements can shift liability to the carrier for compliance. However, when the plan is self-funded, the employer can contractually delegate responsibility for MRFs and price tools but cannot absolve the employer of ultimate liability. Therefore, the employer should retain sufficient records demonstrating the carrier or TPA is regularly complying with TiC requirements for their self-funded plans.

WHO THIS APPLIES TO:

- Non-grandfathered group health plans of any size, both fully insured and self-funded. There is no small-employer exemption.

- **Grandfathered plans:** Exempt from the MRF requirements, but the phone price comparison requirement under No Surprises Act (NSA) § 114 (IRC § 9819, ERISA § 719) still applies. The final rules confirm that meeting the TiC phone, online, and paper disclosure rules also satisfies NSA § 114.
- **Not subject to TiC:** Excepted benefits (e.g., stand-alone dental and vision, health FSAs), account-based plans such as HRAs, short-term limited-duration insurance, and retiree-only plans.



GO DEEPER:

The rules implement Executive Order 14221 (February 25, 2025), which directed the Departments to make pricing data standardized, accurate, and enforceable. Regulators and data users found the original 2022 files too large, duplicative, and inconsistent for use. The final rules respond by reorganizing files around provider networks, trimming implausible data, adding files that explain the data, and holding plans accountable through a signed attestation in each file.

What's Changing:

Requirement	What Changes	Applies Beginning
Participant price comparison tool with real-time cost-sharing estimates	Estimates must now be available by phone at the customer service number displayed on the ID card, in addition to the online tool and paper. Like paper requests, the plan may limit phone requests to 20 providers per day, but must tell the caller. Updated balance-billing disclaimer is also required.	Plan years beginning on or after January 1, 2027
In-network rate file (<i>a prospective contracted pricing file</i>)	One file per provider network (rather than per plan) which must show network name and ID. Each network's participating plans' names, HIOS ID or EIN, and product type (e.g., PPO) must be reported, and CMS guidance calls for a Table of Contents File to be used for this requirement. Most carriers/TPAs will likely need to build or rebuild this file accordingly. Updated quarterly instead of monthly. Contracted rates for providers unlikely to perform a service are removed, and a new Taxonomy File shows which provider types were excluded from which services (see below). A proposed Change-log File for each In-network Rate File was not finalized, and a proposal to add enrollment counts was not finalized.	March 6, 2027; first quarterly posting April 1, 2027 (still updated monthly until then)

Requirement	What Changes	Applies Beginning
Out-of-network allowed amount file (<i>a retroactive billed and allowed pricing file</i>)	One file per market (individual, small group insured, large group insured, and self-funded) instead of per plan (although plans represented in the data are still named). Claims threshold drops from 20 to 11 different claims per item or service in a given market. The reporting window widens from the 90-day period that begins 180 days before the file is published, to the 6-month period that begins 9 months before the file is published. Moving from plan data to market data, lowering the claim threshold, and increasing the reporting period length and lookback period should result in more data appearing without compromising privacy concerns, making the files more useful. Updated quarterly instead of monthly.	March 6, 2027; first quarterly posting April 1, 2027 (still updated monthly until then)
Attestation (<i>for the In-network Rate File, the Allowed Amount File, the Prescription Drug File, the Utilization File, and the Taxonomy File</i>)	Similar to the Hospital Price Transparency required attestation today, each file must attest that the data is true, accurate, and complete and encode the identity of a senior official. A TPA may attest on the plan's behalf under a written agreement, but the self-funded plan sponsor bears ultimate liability for missing or inaccurate data files.	Files published on/after March 6, 2027
Prescription drug file	Content not substantively changed by this rule; remains a monthly update as drug prices change too often for quarterly files to be meaningful. The new attestation applies	This file has been delayed. Per FAQs Part 75, new file format should be ready in May 2027 for first posting December 1, 2027.
Taxonomy file (<i>new</i>)	Explains which provider specialties were excluded from which services in the in-network file. Updated quarterly.	September 6, 2027; first posting October 1, 2027
Text file (<i>new</i>)	A .txt file in the website's root folder with the page URL, a direct link to the files, and a monitored contact email. Updated within 7 days of any change.	September 6, 2027; first posting October 1, 2027
Website footer link (<i>new</i>)	Home page footer link labeled "Price Transparency" or "Transparency in Coverage" pointing to the page that hosts the files.	September 6, 2027



Requirement	What Changes	Applies Beginning
Utilization file (<i>new</i>)	For each In-network Rate File, a new Utilization File lists services actually paid (whether paid by the plan or member) and the in-network providers who were paid, for the most recent plan year ending at least 6 months earlier.	First posting July 1, 2028; annually each July 1 thereafter

Who Does What:

	Fully Insured Plans	Self-Insured Plans
Who builds and posts the files	Carrier	TPA or other service provider (usually), under a written agreement
Who runs the phone, paper, and online price tool with real-time cost-sharing	Carrier	TPA (and PBM for drug pricing)
Who is liable if not done	Carrier only, if a written agreement requires it to comply	The plan remains liable even when the TPA agrees to do the work and agrees to the attestations
Employer's role	Confirm the written agreement exists	Confirm the agreement, monitor the TPA, and document follow-up

Self-insured plans and their sponsors carry the most risk. The written agreement allows delegating the responsibility for the work but not the legal accountability; so, periodic monitoring is part of prudent plan oversight. If the employer maintains a public health plan website and the MRFs are hosted on the TPA's site, the rules call for a link from the plan's own website to the files.

How to Spot-Check Compliance:

Employers are not expected to read or validate the files themselves; they are often too large to open, and the Departments are standardizing them to be in JSON format going forward. The checks below can be performed periodically.

Check	What to Look For
Written agreement	The carrier or TPA contract (or a TiC addendum) states the vendor will provide the MRFs and contextual files, the price tool, the phone and paper price tool disclosures with balance bill warning, and the attestation in compliance with the 2026 rules.
Vendor confirmation	Get written confirmation of the vendor's implementation plan for the March 6, 2027 and September 6, 2027 dates and the January 1, 2027 phone requirement.
Plan is listed	Ask the vendor for the URL of its TiC page. Confirm your plan appears (by plan name and EIN) in the Table of Contents File with proper reference to the posted in-network file for your network.



Check	What to Look For
Files are current	Starting April 1, 2027, the posted date on the in-network and out-of-network files should fall in the current calendar quarter.
Attestation present	Ask the vendor to confirm each file carries the attestation and the name of the signing senior official signing.
Phone test	After your 2027 plan year begins, call the number on an ID card and ask for a cost estimate for a common service at a named provider. The representative should give an estimate during the call and disclose any 20-provider daily limit.
Online tool test	Log in as a test member and confirm the tool returns an estimate and shows the balance-billing disclaimer.
Footer and text file	After September 6, 2027, confirm the vendor's home page has a "Price Transparency" or "Transparency in Coverage" footer link and the text file lists a working contact email.
Prescription drug file	Starting December 1, 2027, occasionally verify this file is posted monthly with the required attestation.
Keep records	Save screenshots, emails, and dates of each check in the plan's compliance file.

If any check fails, notify the vendor in writing, request a correction date, and follow up. Documenting this response may provide the plan sponsor with important protections.

Action Items for Employers:

- Before 2027 renewals, review carrier and TPA contracts for TiC language and request an amendment reflecting the 2026 final rules if needed.
- Ask whether the vendor will charge new fees for the added files and phone requirement. The Departments expect most costs will fall on service providers, which may be passed through to plans.
- Let HR and benefits staff know that participants can now get cost estimates by calling the ID card number, and direct price questions to the website, phone, or mailing options.
- Calendar spot-checks beginning in April 2027, plus checks after September 6, 2027, December 2027, and July 2028.

Consequences of Non-Compliance:

- Self-insured plans remain liable for their TPA's failures. Fully insured plans with a written agreement shift liability to the carrier.
- IRC § 4980D excise tax of \$100 per day per affected individual for failures to meet group health plan requirements, including IRC § 9815, self-reported on IRS Form 8928.
- Department of Labor enforcement for ERISA plans, including audits and corrective action; HHS civil money penalties for non-federal governmental plans; and state insurance department enforcement against carriers.
- Executive Order 14221 directed the Departments to increase enforcement, and the new attestation requirement gives regulators a clearer basis to act against inaccurate files.



Prepare to Address Unsubstantiated FSA/HRA Debit Card Claims

When an employer's Flexible Spending Arrangement (FSA) or Health Reimbursement Arrangement (HRA) offers a debit card for employee convenience, some debit card transactions cannot be auto-substantiated and require the employee to submit a receipt. The FSA/HRA administrator will make two requests for the receipt and if still not received will make a third and final request while turning off the employee's debit card. If the employee's substantiation does not come through, then the employee owes the employer a receipt or repayment. So, the employer must get involved before it is time to close out the tax year and issue Forms W-2.

WHO THIS APPLIES TO:

- Employer of any size sponsoring a Health FSA or HRA with a debit card.



GO DEEPER:

Substantiation Is Required

FSA/HRA administrators are key partners in helping ensure substantiation rules are followed for FSAs and HRAs, including for integrated debit cards. Strict adherence to IRS rules is required or the FSA/HRA can be deemed non-compliant and all reimbursements become taxable.

Unsubstantiated Debit Card Claims

When it comes to debit card claims that could not be auto-substantiated, the FSA/HRA administrator will request receipts each month until received and disable the debit card on the third and final outreach.

If the employee still fails to submit required receipts, the employer must become engaged before year-end to work with the employee on submitting either a receipt or repayment. The employer should have access to an unsubstantiated debit card claims report to help accomplish this important year-end task.

HIPAA Privacy and Security

As a reminder, this report contains Protected Health Information (PHI), so the employer must follow their written HIPAA policies and procedures in accessing this report, storing it, and using and disclosing the data. For example, the employer should only grant the internal staff responsible for FSA/HRA oversight with permission to download the report, should require multi-factor authentication before accessing the system where the report can be retrieved, establish an encrypted firewalled part of the server for storing the data, never sending data to an employee's work email that can be read by



their supervisor, never discuss their overdue receipts with their supervisor, and adhere to all the other applicable HIPAA protocols.

Collecting Receipts (or Repayment)

The designated employer contact will want to verify if the employee has the required receipt or needs help understanding how to secure a compliant receipt, as sometimes the issue is the receipt they have does not show all the required content elements. Offering the employee instructions on how to set up a profile on a carrier or TPA website to download an Explanation of Benefits (EOB) is typically all that is necessary to help the employee obtain a compliant substantiation receipt.

Sometimes the employee will communicate that they have been trying to submit the receipt, but the FSA/HRA administrator's system has not been able to receive it, in which case the employer may want to help interface with the administrator to identify and resolve any technological issue.

Sometimes it simply is not possible to track down a compliant receipt. For example, IRS FAQs addressing all sorts of "general health" expenses recently added a new [FAQ for wearable health tech](#) which are often advertised as reimbursable medical expenses without explaining the IRS's rules for such a device to be deductible. Such misunderstandings are common and can result in owing repayment to the plan.

When this occurs, the employee should agree in writing to withhold the amount from future manual FSA submissions before year-end, or from the next paycheck(s) until fully repaid by year-end.

Last Resort Debt Collection (or W-2 Reporting)

When an employee does not cooperate with providing such written authorization, they are considered to owe the employer a debt. Usually there is a dollar threshold at which an organization will pursue debts in small claims court, and the IRS requires following that standard procedure here. If the amount owed is not enough to trigger such procedures, the employer does have a last resort option of forgiving the debt and reporting as taxable income on the W-2, but this method should be used very sparingly as a last resort (and hopefully based on the advice of legal counsel). If too many individuals are getting around the FSA use-it-or-lose-it rules by swiping a debit card without submitting required substantiation receipts, then the IRS can determine the FSA is no longer valid and can no longer be sponsored on a tax-favored basis. Similarly, HRAs are not permitted to provide tax-free compensation to employees for expenses that are not medical care. So, care should be taken to avoid tax-free reimbursements for various kinds of "general health" items the IRS warns about in the FAQ link provided above.



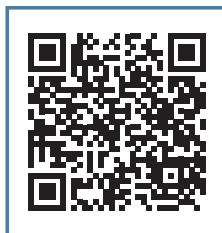
IRS “General Health” FAQ Site Adds New Q&A Regarding Wearable Tech

There are a host of general health expenses which may be able to qualify as tax-favored reimbursable medical expenses only if certain conditions are met. The IRS has a dedicated webpage addressing such expenses at [IRS Medical Expense FAQ](#).

On September 23, 2026, the newest Q&A added to the list addresses [wearable tech](#). As with most of the other “general health” FAQs on the list, consumer wearable tech is not a reimbursable medical expense unless it meets certain medical criteria specific to the individual and their physician’s treatment plan. So, the default should be that it is not a valid medical expense until the employee can substantiate that it meets the IRS’s rules to be reimbursable.

This can cause some frustration for employees, as these products are often advertised as qualifying for such tax-favored medical expense treatment without the caveats of what the IRS requires for that item or service to officially be reimbursable.

Employers sponsoring a health FSA or HRA may want to confirm that their plan administrator is applying these rules when reviewing claims for wearable devices, and consider a brief reminder to employees before they make a purchase. In most cases, the employee will need a letter of medical necessity from their physician connecting the device to the diagnosis or treatment of a specific medical condition.



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