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Health Plan Transparency in Coverage and Machine-Readable File Rules: Not So Transparent

On Oct. 6, 2026, the U.S. Departments of Labor, Treasury, and Health and Human Services finalized sweeping changes to the machine-readable file (MRF) and cost-sharing disclosure rules that have applied to group health plans since 2022. FAQs followed the next day, adding technical and timing details.

Note, special rules permit self-insured plans to aggregate data with other plans in the same network for MRFs described below.

In-Network Rate Files. These reports move from a per-plan to a per-provider-network structure, adding new data points (network name, ID, product type) and requiring plans to exclude "ghost rates." These are negotiated rates for providers unlikely to be reimbursed for services that fall outside of their specialty. *Effective March 6, 2027; first files due April 1, 2027.*

Out-of-Network Allowed Amount Files. These reports shift from plan-level to market-level reporting (large group, small group, individual, self-insured), with a lower claims threshold (11 claims instead of 20 claims) and a longer reporting window (six months, with a nine-month lookback). *Effective March 6, 2027; first files due April 1, 2027.*

Three New Files. Taxonomy, utilization, and text files now must be created, posted, and updated at various intervals. Notably, the taxonomy file requires plans to publicly disclose for the first time the internal provider-specialty logic used to decide which rates to exclude. *Effective Sept. 6, 2027 (Taxonomy and Text Files), Effective July 1, 2028 (Utilization File).*

Attestations. The new rules require attestation, meaning a senior official of the plan must personally certify that the data in each file is true, accurate, and complete.

Website and Format Changes. These are still being finalized. They include a required footer link and a move to a single standardized technical format (expected to be JSON), governed by updated "schemas" – the technical specifications dictating exactly how the data must be structured.

Phone-Based Price Comparison. The new rules require phone-based price comparisons in addition to online and paper disclosures. Plans also must update their balance-billing disclosure language. *Effective for plan years beginning on or after Jan. 1, 2027.*

Prescription Drug Files. These reports remain in limbo while the agencies work out separate technical specifications.

Over the next two years, group health plan sponsors will need to roll up their sleeves and roll out these updated disclosures. The Spencer Fane Employee Benefits team can help you sort out what these changes mean for your plan.

This blog post was drafted by Laura L. Fischer, an attorney in the Spencer Fane Denver, Colorado office. For more information, visit www.spencerfane.com.

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