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HEALTH & WELFARE PLAN LUNCH GROUP

November 5, 2026

One Atlantic Center
1201 W. Peachtree Street
Atlanta, GA 30309-3424
(404) 881-7885
E-mail: john.hickman@alston.com

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1. Health & Welfare Benefits Monthly Update Presentation

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November 2026 Agenda

- Legislative/Regulatory Update
- HIPAA Data Incidents: Breach or No Breach? You Make the Call
- Wellness Programs You Want to Avoid
- Wellness and Wearables FAQs
- Litigation Update
- TIC or Treat: Transparency Final Rules

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Final Rules/Proposed Rules/Notices

- **Improving Transparency into Pharmacy Benefit Manager Fee Disclosure** (DOL-EBSA), Final Rule, rec'd 7/23/26; cleared 10/20/26I; Public Inspection Version; Fact Sheet
- **Transparency in Coverage**, (HHS-CMS; DOL-EBSA; TREAS-IRS), Final Rule published 10/6/26
- **Independent Dispute Resolution Operations**, (HHS-CMS; DOL-EBSA; TREAS-IRS), Final Rule published 6/4/26
- **Employer Contributions to Trump Accounts and Nondiscrimination Rules for Dependent Care Assistance Programs** (TREAS-IRS), Notice of Proposed Rulemaking published 8/11/26; comments deadline 9/25/26.
- **Electronic Disclosure by Group Health Plans Under ERISA** (DOL-EBSA), Proposed Rule published 7/23/26; comments deadline 9/21/26.
- **Excepted Fertility Benefits** (DOL-EBSA), Proposed Rule published 5/13/26; comments due by July 13, 2026.
- **Fiduciary Duties in Selecting Designated Investment Alternatives** (DOL-EBSA), Proposed Rule published March 30, 2026
- **Employee or Independent Contractor Status under the Fair Labor Standards Act, Family and Medical Leave Act, and Migrant and Seasonal Agricultural Worker Protection Act** (DOL-WHD), Notice of Proposed Rule published on 2/27/2026; comment deadline 4/28/26

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At the Office of Management and Budget (OMB)

These proposed rules are under review at OMB and are not yet publicly available:

- Proposed Rule: **HHS Notice of Benefit and Payment Parameters for 2028** (HHS-CMS), rec'd 10/19/26
- Proposed Rule: **Expanding Access to Individual Coverage Health Reimbursement Arrangements** (HHS-CMS), rec'd 10/05/26
- Final Rule: **Employee or Independent Contractor Status Under the FSLA, FMLA, and MSPA** (DOL-WHD), concluded 10/28/26
- Proposed Rule: **Definition of an "Employer" Under Section 3(5) of ERISA -- Association Health Plans** (DOL-EBSA), rec'd 8/11/26
- Proposed Rule: **Loyalty and the Exclusive Purpose Rule in Selecting Plan Investments and Exercising Shareholder Rights** (DOL-EBSA), rec'd 6/30/26
- Proposed Rule: **Short-Term, Limited-Duration Insurance** (HHS-CMS), rec'd 5/30/26
- Final Rule: **HIPAA Privacy Rule: Changes to Support Coordinated Care and Individual Engagement and Reduce Regulatory Burdens**, rec'd 4/2/2026 (HHS-OCR))

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Improving Transparency into PBM Fee Disclosure



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SEPARATE STATUTORY AND REGULATORY REQUIREMENTS

Framework	Type / Agency	What It Does (High Level)	Timing
CAA 2026, Div. J, Title VII §6702(c): Covered Service Provider Definition	Statute - amends ERISA §408(b)(2)(B)	Extends fee-disclosure duties beyond brokers/consultants to PBMs, TPAs and other plan service providers	In effect Feb. 3, 2026 (enactment)
CAA 2026: PBM-Specific Provisions (§§6701-6702)	Statute - new ERISA §726 and §408(b)(2)(C)	Semiannual drug-spend reports to plans; 100% rebate pass-through; audit rights	Later: plan years on/after Aug. 3, 2028
PBM Transparency Final Rule (today's focus)	Regulation - DOL/EBSA	Implements §408(b)(2)(B): detailed advance and semiannual PBM compensation disclosures and audit right; large self-insured plans (exclusion for plans sponsored by companies in the drug-supply chain)	Plan years on/after July 1, 2027
Transparency in Coverage (TiC) Final Rule	Regulation - tri-agency (HHS/CMS, DOL, Treasury)	Public price files (in-network rates, out-of-network amounts, Rx) posted by plans and insurers; amends 2020 TiC rule	Effective Dec. 7, 2026; phased in Mar. and Sept. 2027

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SCOPE & WHO IS COVERED

Covered Plans (Large, Self-Insured Only)

- ERISA group health plans of a **"specified large employer"** (avg. 100+ employees; §4980H counting rules) or a **"specified large plan"** (avg. 100+ participants)
- Self-insured only; **fully insured plans excluded** (reserved for future action)
- Includes limited-scope dental/vision (excepted benefits) and Taft-Hartley plans that meet the size test (and are self-insured)
- Excludes plans of drug supply chain sponsors (manufacturers, wholesalers, PBMs, rebate aggregators)

Covered Service Providers

- Any entity that contracts with the plan to provide **PBM services** - even if an affiliate, agent or subcontractor does the work (e.g., TPAs, level-funded vendors, MEWA operators)
- PBMs or their affiliates that give **advice, recommendations or referrals** on PBM services (affiliated brokers/consultants)
- Must reasonably expect **$1,000+** in direct or indirect compensation
- PBM services defined by function, not label
- Processing and payment of Rx claims, adjudicating appeals relating to Rx, Rx recordkeeping, or regulatory compliance for Rx benefits are PBM services when performed in conjunction with other listed PBM services.

Change from the proposal: the proposed rule covered all self-insured plans; the final rule covers large self-insured plans. Smaller plans, fully insured plans and non-affiliated brokers/consultants still owe/receive the general statutory §408(b)(2)(B) disclosures.

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KEY DISCLOSURE REQUIREMENTS

1 INITIAL

In writing, to the responsible plan fiduciary, reasonably in advance of contract, extension or renewal (90 days deemed reasonable for renewals)

2 SEMIANNUAL

Actual compensation within 30 days after each 6-month period (quarterly on plan request); explain any category 5% or more over estimate

3 ON REQUEST & AUDIT

Info needed for ERISA reporting (e.g., Form 5500); annual audit right with plan-chosen auditor; records due within 60 days

What PBMs must disclose (in dollar amounts; good-faith estimates allowed)

- **Services** to be provided and any **fiduciary status**
- **Direct compensation** (e.g., PEPM admin fees), by service
- **Manufacturer payments:** rebates, fees and other remuneration - amount passed through vs. retained
- **Spread compensation** (plan price vs. pharmacy reimbursement) and pharmacy recoupments/copay claw-backs
- **Price protection** and inflation protection agreements
- **Formulary incentives;** advance notice of material formulary changes
- **Net price per drug** (by NDC and pharmacy channel)
- **Termination compensation** and the plan's audit right

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EFFECTIVE DATES & COMPLIANCE DEADLINES

Jan. 30, 2026	Feb. 3, 2026	60 days after FR publication	July 1, 2027	Aug. 3, 2028
Proposed rule	**CAA 2026 enacted**	**Final rule effective**	**Final rule applies**	**CAA 2026 PBM provisions**
All self-insured plans	Expanded Covered Service Provider disclosure rules take effect; DOL good-faith enforcement policy	Submitted to the Federal Register for publication	Plan years beginning on/after; good-faith enforcement relief ends	§726 PBM reports and 100% rebate pass-through (plan years on/after)

- **Practical timing:** calendar-year plans first become subject on Jan. 1, 2028.
- **Renewals:** Consider building the 90-day advance-disclosure window into PBM renewal and RFP calendars now.
- **Until applicability:** DOL will not treat Covered Service Providers or fiduciaries as non-compliant with §408(b)(2)(B) if they act on a good-faith interpretation.

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KEY TAKEAWAYS & ACTION ITEMS

Required under the final rule and preamble

- **Monitor:** fiduciaries must periodically monitor Covered Service Provider compliance and the reasonableness of compensation (ERISA §§ 404, 408(b)(2)).
- **Termination right:** no contract is reasonable unless the plan can terminate without penalty on reasonably short notice.
- **Auditor:** the plan alone selects the auditor, and the selection must be prudent and loyal.
- **Class exemption, para. (n):** on discovering a failure, request correction in writing. If not corrected in 90 days, notify DOL (within 30 days after the earlier of refusal or day 90), then decide whether to terminate or continue and document the basis.
- **Until July 1, 2027:** act on a good-faith interpretation of § 408(b)(2)(B) obligations to rely on DOL's temporary enforcement policy.

Best practices DOL identifies

- **Formulary notice:** put negotiated advance-notice thresholds or triggers in writing (DOL calls this a "best practice").
- **Para. (n)(5) record:** not a check-the-box exercise. Capture considerations, alternatives and steps to prevent repeat failures, and keep it on file.
- **PBMs / Covered Service Providers:** to avoid fiduciary status, act within policies approved by the fiduciary. Disclaimers alone don't work.
- **Claims audits:** the preamble cites the industry practice of auditing claims, every year if noncompliance is suspected.

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HIPAA Data Incidents: Breach or No Breach? You Make The Call

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The HIPAA Breach Notification Rule

- For a HIPAA breach to occur, four requirements:
  - Unsecure PHI (written, electronic, or spoken)
  - Used or disclosed in an unauthorized manner
    - Including disclosure in excess of minimum necessary
    - Ransomware/malware infection
  - Use/disclosure does not fall under an exception
    - Unintentional access by employee of BA or CE
    - Inadvertent disclosure between similarly situated employees
    - Recipient could not reasonably retain information
  - Rebuttable presumption of breach absent showing that risk is low that unsecured PHI was compromised
    - "Significant risk of financial, reputational, or other harm" standard **no longer used**; replaced by a demonstration of low probability of compromise based on documented, four-part HIPAA risk assessment: (1) nature/extent of PHI; (2) who used/received it; (3) was PHI actually acquired/viewed; and (4) extent of risk mitigation.

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A Disclaimer …

- The scenarios we will discuss are examples of situations which should be addressed and discussed with legal counsel.
- The facts and circumstances may vary with each incident.
- We will walk through some initial thoughts that clients should contact counsel to explore; there may be additional nuances and analysis depending on actual incidents.
- Reminder: it is an "incident" or "potential breach" under investigation. Whether a HIPAA "breach" has actually occurred is a legal conclusion.

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Hypothetical #1

- Your BA's employee has a laptop that he left in his car. The car was broken into, and the laptop was stolen. His log in and password were on a post it note taped to the laptop. He reached out to the BA's IT, which confirmed the laptop had not yet been powered on. IT remotely wiped the laptop.
- Is it a HIPAA Breach? Is it reportable?

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Hypothetical #2

- You are a covered entity insurer with different lines of business. Once of your employees left paper medical records in a rideshare. The medical records are gone, and they cannot be located. The medical records involve a life insurance application.
- Is it a HIPAA Breach? Is it reportable?

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Hypothetical #3

- An unauthorized third party has hacked into your system and exfiltrated data. The exfiltrated data consists of all dummy claims data, such as for Mickey Mouse and Donald Duck, except some actual members' addresses are mixed in too.
- Is it a HIPAA Breach? Is it reportable?

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Hypothetical #4

- A hacker was in your health plan's system and exfiltrated copies of spreadsheets. Unfortunately, one of your health plan employees, "Suzy Saver", kept 20 years' worth of spreadsheets. The spreadsheets only contained members' last names, last four digits of their SSN, their full DOB, and the name of their dental or medical plan.
- Is it a HIPAA Breach? Is it reportable?

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Hypothetical #5

- You are a HIPAA covered health plan, and you always sign Business Associate Agreements (BAAs) with your vendors with access to PHI as appropriate. During an annual contract renewal, you realize that you cannot locate a signed BAA for one of those vendors for last year. There is a signed BAA for the vendor for every year but one, and the file for last year contains a blank BAA for that vendor.
- Is it a HIPAA Breach? Is it reportable?

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Wellness Programs You Want to Avoid

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Tax Treatment for Fixed Indemnity Health Benefits

- Current understanding (see Rev. Rul. 69-154):
  - Premiums paid on after-tax basis: benefits received are tax-free.
  - Premiums paid on pre-tax basis (either employer contributions or employee pretax salary reduction): tax status depends on unreimbursed medical expenses.
    - Amounts not exceeding related unreimbursed medical expenses are tax-free.
    - Amounts exceeding related unreimbursed medical expenses are taxable.

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Wellness Program Abuse Scheme

See IRS CCA 202323006 for Example:

- Employer provides comprehensive health coverage (with wellness) and a fixed indemnity health insurance policy.
- Employees pay a monthly premium of $1,200 for the fixed indemnity policy through pre-tax salary reduction.
- The policy pays a monthly benefit of $1,000 triggered by certain health or wellness activities. The wellness benefit also offers full coverage of several triggering events, including wellness counseling, nutrition counseling, and telehealth benefits, at no additional cost.
- The wellness benefit "reimbursements" are paid by the insurance company to the employer. The employer then pays the "reimbursement" to the employee through their payroll system. Payments are typically the same amount every pay period and do not depend on the employee incurring medical expenses.
- The IRS concludes that the $1,000 wellness payments are taxable **and** subject to employment taxes (e.g., FICA, FUTA), because the payments are made automatically without regard to whether the employee has incurred any unreimbursed medical expenses. Rather, the "reimbursements" are tied to the amount of salary reduction and projected tax savings.

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If it looks too good to be true . . .

- **Step 1: The employee makes a salary reduction election**.
  - *If the promised tax benefits are realized*, the salary reduction election reduces employee and employer FICA and FUTA payroll taxes and employee income taxes.
  - The pre-tax salary reduction election purportedly reduces the employee's taxable paycheck.

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If it looks too good to be true . . .

- **Step 2: Bring the employee's paycheck back up to the pre-salary reduction level**.
  - The employee receives purportedly tax-free payments ("wellness payments") equal to most of the employee's salary reduction amount. The amount of salary reduction returned to the employee is generally reduced by a promoter's fee.
- To receive the benefit payment, the employee is required to take certain actions, also referred to as "benefit triggers." These include: calling a health coach, signing up for a newsletter, getting a flu shot

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If it looks too good to be true . . .



The payments in Step 2 are taxable, which reduces the employee's take-home pay. For the payments in Step 2 to be tax-free, the payments must be reimbursements for an incurred medical expense. The benefit triggers, while perhaps health related, do not involve unreimbursed medical expenses as defined under federal tax rules. Thus, the purported tax savings evaporate.

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Your wellness program might be problematic if . . .



- The arrangement is marketed primarily as a tax savings mechanism rather than as insurance protection against unanticipated health events;
- The primary insured benefits under the arrangement consist of fixed indemnity payments triggered in the event of volitional services (e.g., voluntary wellness services) rather than payments triggered by unanticipated health events;
- Policy premiums and purported benefits vary based on salary level (or gross wages) with benefit levels approximating the premium cost (with some reduction for administration costs);
- The premium amount (or other cost of participation in the arrangement) is significant when compared to wages and/or cost of traditional supplemental benefits.

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Wellness and Wearables

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Wellness and Wearables IRS FAQs Update

- On Sept. 23, 2026, the IRS added an additional FAQ, addressing whether certain related costs of a wearable device (*e.g.*, a band, watch, ring, patch, sensor, or similar device) that tracks bodily functions or other health-related information is a medical expense under § 213 of the Internal Revenue Code that may be paid or reimbursed under a HSA, health FSA, Archer MSA, or HRA. Frequently asked questions about medical expenses related to nutrition, wellness and general health | Internal Revenue Service



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Wearables - When is a Device a Medical Expense?

- It depends on all the facts and circumstances – such as the device's functions and the reason it was purchased and used.
- The cost of a wearable devise is a permissible medical expense if the individual purchases and uses the device ***primarily*** to assist in the diagnosis, cure, mitigation, treatment, or prevention of a specific disease.
- Relevant facts and circumstances include:
  - a recommendation from a medical practitioner;
  - the individual's symptoms, diagnosis, abnormal test results, or risk factors;
  - the relationship between the information tracked and the disease being evaluated or managed; and
  - the way the information is reviewed or used.
- The cost of any accessories, add-ons, or software subscriptions used with the device is a medical expense only if those items are purchased primarily to serve that medical purpose.

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Wearables – When is a Device not a Medical Expense?

The cost of a wearable device is not a permissible medical expense if the device is purchased primarily for a generalized desire to monitor or improve health such as generalized wellness, fitness, or sleep.

If the device has both medical and nonmedical uses, it is not a medical expense merely because the device tracks information that relates to health generally, or because it tracks bodily functions like blood pressure or blood glucose levels that are or can be affected by specific diseases.

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401(h) Accounts

- IRS issued Revenue ruling 2026-22 providing that the payment of benefits from a pension plan's Code § 401(h) account to plan participants who are eligible to receive pension plan distributions under Code § 401(a)(36) [employees who have attained age 59½ and are not separated from employment at the time of the distribution] does not violate § 401(h) or 26 C.F.R. § 1.401 14, or adversely affect the plan's tax-qualified status under Code § 401(a).



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401(h) Accounts Cont'd

- The facts cited in the ruling provide:
  - Company A's pension plan's 401(h) account was substantially overfunded.
  - In addition to using funds in the 401(h) account to fund retiree medical benefits, Company A wanted to use surplus funds in the 401(h) account to fund medical benefits under its active medical plan for Code § 401(a)(36)-Eligible Participants (who are not key employees) and their spouses and dependents.
  - The pension plan allows 401(a)(36)-Eligible Participants to elect to commence receipt of payment of retirement benefits from the plan while actively employed.
  - Because a separation from employment is not a condition to receiving the retirement benefits, the 401(a)(36)-Eligible Participants are eligible to receive retirement benefits under the pension plan, ***even though they are still current employees of Company A***.
  - Accordingly, the 401(a)(36)-Eligible Participants who are still active employees satisfy the definition of "retired" as described in the second sentence of § 1.401-14(b)(1) and are not excluded from being considered eligible to receive retirement benefits under § 1.401-14(b)(1).

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Litigation Update

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ERISA Litigation Update

- Exhaustion Requirement for Statutory Claims under ERISA
- Title VII, ACA §1557, and Infertility Coverage
- ERISA §104(b) Plan Document Requests
- Tobacco Surcharge Litigation
- Non-Network Providers IDR Award Enforcement



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Transparency in Coverage

2026 Final Rule

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2026 TiC Final Rule

The 2020 Transparency in Coverage (TiC) rules require non-grandfathered group health plans and health insurance issuers (carriers) to give participants personalized cost-sharing estimates and to post pricing data publicly in machine-readable files (MRFs).

The October 6, 2026 Final Rule (effective Dec. 7, 2026) restructures the MRFs, adds a phone disclosure method and accuracy attestations, and sets 2027–2028 deadlines.

KEY DATES

Dec. 7, 2026
Final rule effective

Jan. 1, 2027
Plan years beginning on/after: phone disclosures; updated balance-billing statement

Mar. 6, 2027
Initial MRF requirements apply (i.e., file restructuring, single format, attestation)

Sept. 6, 2027
Contextual-file and website-footer requirements apply (i.e., Text File, footer, Taxonomy and Utilization Files)

July 1, 2028
First annual Utilization File posted

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Final Rule Highlights

FINALIZED (SOME WITH CHANGES) Change-log File and enrollment totals were not finalized

✓ Network-level files
One In-network Rate File per network, with common name and network ID (ID added in final rule)

✓ Product type
HMO, PPO, etc. shown in In-network Rate and Allowed Amount Files

✓ % of billed charges
Used only when no dollar amount can be set before billing

✓ Allowed Amount Files
11-claim threshold; 6-month period, 9-month lookback; market level

✓ Quarterly posting
In-network Rate and Allowed Amount Files post quarterly; Rx stays monthly

✓ Findability
Root-folder Text File with file URLs and a monitored contact email (modified), plus footer link

✓ Phone method
Estimates via ID-card number (20 providers/day); meets No Surprises Act §114

✓ Balance billing
Statement updated to reflect No Surprises Act protections

FINALIZED BUT NOT IN PROPOSED RULES--ACTION FOR PLAN SPONSORS **Accuracy Attestation**

WHO
Plan or carrier, naming its CEO, president, or designated senior official; a TPA only under a written agreement to provide the files.

ATTESTS TO WHAT
To the best of its knowledge and belief: all applicable information is included and is true, accurate, and complete as of the file date.

IN WHAT FORM
Encoded in each In-network Rate, Allowed Amount, Rx, Utilization, and Taxonomy File (not the Text File).

WHEN AND RISK
Mar. 6, 2027; First Rx File under Schema 1.0 is expected to be published in December 2027. Plan liable if a TPA's file is wrong; insured plans can shift liability to carrier.

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Refresher: Participant Cost-Sharing Disclosures

BASELINE (2020 FINAL RULES)

- **Self-service tool:** personalized, real-time estimates, accurate at the time of request, in plain language, with no fee
- **Scope:** all covered items and services, including Rx and DME (fully phased in for plan years beginning on/after Jan. 1, 2024)
- **Search:** by billing code or descriptive term, for a specific or all in-network providers; out-of-network allowed amount, % of billed charges, or other rate; in-network results sortable by distance and cost
- **Seven content elements:** cost-sharing estimate, accumulators, in-network rate, out-of-network allowed amount, bundled items, prerequisites (such as prior authorization), and a disclosure notice
- **Paper on request:** no fee; sent within 2 business days; may limit to 20 providers per request

ADDED FOR PLAN YEARS BEGINNING ON/AFTER JAN. 1, 2027

- **Phone method** using the customer-assistance number on the ID card; accurate and provided at the time of the call
- **20-provider-per-day limit** permitted, but it must be disclosed to the caller
- **Updated balance-billing statement** reflecting No Surprises Act (NSA) protections
- **Deemed compliance** with the NSA §114 price comparison requirement, including for grandfathered plans

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Refresher: Public Machine-Readable Files

THREE REQUIRED FILES (BASELINE 2020)

In-network Rate File
Negotiated rates, underlying fee schedules, or derived amounts for in-network providers

Allowed Amount File
Historical out-of-network allowed amounts and billed charges

Prescription Drug File
Negotiated rates and historical net prices by NDC

CORE RULES

- **Public website:** free and without conditions (no account, password, credentials, or personal information)
- **Timing:** Updated monthly with the last-updated date shown (In-network Rate, Allowed Amount, and Taxonomy Files move to quarterly in 2027; Utilization is annual; the Text MRF is updated within seven calendar days after relevant updates; and Rx remains monthly)
- **Scope:** plan years beginning on/after Jan. 1, 2022; excludes grandfathered plans, excepted benefits, HRAs and other account-based plans (such as health FSAs), and short-term limited-duration insurance
- **Insured plans:** a written agreement shifts liability to the carrier
- **Self-insured plans:** may delegate to a TPA, but the plan stays liable and must monitor
- **Hosting:** third-party site allowed; a plan with its own public website must link to the files (2020 rule: Allowed Amount File; 2026 rule: all files)
- **Good-faith relief:** errors corrected promptly, temporary outages, and reasonable reliance on others' data

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Where Plans Are Falling Short

- **Not truly public**
  Files behind logins, passwords, or other credentials are not "publicly available"
- **Access roadblocks**
  Requiring an EIN or HIOS ID to pull one file at a time, CAPTCHAs, and rate limiting; other cited barriers include 403 errors, download limits, and blocked cloud IP ranges.
- **Hard to find**
  Inconsistent file locations, non-standard naming, and no discoverable links.
- **Empty Allowed Amount Files**
  Many files contain little or no out-of-network data.
- **Inaccurate or incomplete data**
  Conflicting rates, missing providers and billing codes, inconsistent network identifiers, and duplication.
- **Unlikely ("zombie") rates**
  A Sept. 2024 Departments analysis found 73% of hematologists' rates were for 500 codes they were unlikely to be paid for.
- **No one answers**
  File users can't reach plans to report problems; members have had limited ability to get estimates by phone.
- **Stale data**
  Estimates that are inaccurate because they rely on outdated MRF data are noncompliant; delegating to a TPA does not shift liability.

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Questions