



February 23, 2026

*Submitted Electronically via:* [www.regulations.gov](http://www.regulations.gov)

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9882-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Comments In Response to the Proposed Transparency in Coverage Regulations (CMS-9882-P)**

To Whom It May Concern:

The Self-Insurance Institute of America, Inc. (“SIIA”) respectfully submits the following comments in response to the Notice of Proposed Rulemaking (“NPRM”), setting forth proposed requirements that would amend the final Transparency in Coverage (“TiC”) regulations and which are intended to improve the standardization, accuracy, and accessibility of the TiC’s public pricing disclosures and to reduce the size and number of TiC Machine-Readable Files (“MRFs”), along with reducing the duplication of the pricing information inputted into the TiC MRFs.

SIIA is a member-based association dedicated to protecting and promoting the business interests of companies involved in the self-insurance/alternative risk transfer marketplace. SIIA’s membership includes self-insured health plan sponsors and entities providing services to self-insured health plans, including third-party administrators, stop-loss insurance and reinsurance companies, and other entities ranging from companies furnishing price transparency tools and data analysis of a self-insured plan’s health claims data to companies providing cost-containment management services and securing contracts with medical providers and Pharmacy Benefit Managers.

SIIA supports the Trump Administration’s efforts to increase the disclosure of in-network negotiated (“INN”) rates and out-of-network (“OON”) allowed amounts through a MRF posted on a public website in accordance with the TiC Rule. We also support the development of a regulation implementing a unique and separate Prescription Drug MRF and the public disclosure of the net historical price of a covered prescription drug. SIIA is ready, willing, and able to assist the Departments of Health and Human Services, Labor, and Treasury (referred to as the “Departments”) in continuing to improve and strengthen the TiC regulatory requirements, implementing the Prescription Drug MRF, and also, assisting in the continued development of rules and enforcement policies related to the Hospital Transparency Rule (referred to as the “Hospital Rule”).

## **I. Unfortunately, Patients Are Not Being Empowered By the Publicly Disclosed Pricing Information**

The Trump Administration is interested in hearing stories about how the public disclosure of medical and prescription drug prices through the TiC MRFs has empowered patients and helped them better understand the cost of the health care that they utilize.

Unfortunately, the self-insurance industry does not have detailed stories to share. This is due to the fact that the pricing information inputted into the TiC MRFs is unusable – and not understandable – by sophisticated service providers and the plan sponsors they serve, let alone the average patient.

Importantly, before patients can be empowered, plan sponsors must be able to access, evaluate, and analyze the pricing information. Once plan sponsors can readily access and make sense of the data, SIIA believes that then – and only then – can the patient be empowered through actions taken by the plan sponsor by, for example, providing access to consumer tools that can provide up-to-the-minute complete and accurate pricing information for plan participants. As a result, the Departments must help plan sponsors and their service providers empower themselves, so plan sponsors and their service providers can empower patients.

SIIA believes that the most effective way to empower plan sponsors and their service providers is to ensure that the pricing information is complete and accurate. And the most effective way to ensure that the pricing information is complete and accurate is to enforce the TiC regulatory requirements to ensure compliance among the “owners of the provider networks” (defined more fully below) that are responsible for producing the TiC MRFs.

## **II. Why Is the Pricing Information Inputted Into the TiC MRFs Unusable and Not Understandable?**

The core reasons are (1) completeness and (2) accuracy.

The Departments must understand that while an owner of the provider network may be posting a TiC MRF that is compliant with the MRF Schema, this MRF is traditionally incomplete and inaccurate. In addition, the National Provider Identifier or Employer Identification Number of a medical provider is missing in cases where a particular INN Rate for a particular medical item or service is disclosed. This does not allow the plan sponsor or its service provider to understand which providers are furnishing a particular medical item or service at a specified price.

Here is yet another problem: The original TiC regulations require that for any given provider in the network furnishing any given medical item or service, there should only be 1 price. However, the owners of the provider networks that are responsible for producing the TiC MRFs list multiple INN Rates with different values, and despite the fact that CMS guidance gives provider network owners the ability to explain why there might be multiple INN Rates with different values in the “additional\_information field,” provider network owners are *not* writing an explanation in this field.

Enforcement here should be straightforward: If you are listing multiple rates for the same provider and medical item or service, and you do not have a distinct explanation in the field, you should fail compliance with the TiC requirements.

Self-insured plan sponsors experienced similar problems with the Hospital Rule. However, with increased penalties for non-compliance and a process for enforcing compliance with the Hospital Rule, these actions led to more precise and complete pricing information in the Hospital MRFs.

We believe that if similar actions are taken in the context of enforcing compliance with the TiC requirements (e.g., increased penalties for non-compliance and an enforcement process), more precise and complete pricing information will be disclosed by owners of the provider networks in the TiC MRFs.

Having said that though: SIIA does not believe that increased enforcement should be viewed as a punishment. Instead, increased enforcement and penalties are merely a means to ensuring a properly functioning market. For example, increased enforcement would normalize compliance as a base-line cost of participation in the market. Increased enforcement would also establish data reliability sufficient for review and benchmarking.

SIIA believes that there is a difference between simply producing and posting a TiC MRF, which most owners of the provider networks are doing as a “check-the-box” exercise. There must be accountability for the completeness and the accuracy of the pricing information set forth in the TiC MRFs. Today, there is *no* accountability, and this lack of accountability prevents patients from getting the pricing information that this Administration wants them to get.

### **III. Accountability Can Be Accomplished Through an “Attestation” Requirement Imposed on the Owner of the Provider Network**

#### ***A. Who Is the Owner of the Provider Network In the Case of a Self-Insured Health Plan?***

In the case of a self-insured health plan, the owner of the provider network will typically be a licensed insurance carrier that “rents” to the self-insured plan the provider network that the carrier has built for the carrier’s fully-insured plans, or specifically for self-insured plan-clients. Here, the insurance carrier negotiates the self-insured plan’s INN Rates for covered medical items and services and prescription drugs, and the carrier also adjudicates the plan’s OON Allowed Amount Payments.

In some cases, a third-party entity will obtain access to an insurance carrier’s provider network. And then, this third-party will effectively “rent” this insurance carrier’s provider network to a self-insured health plan. Here, this third-party would be considered the owner of the provider network serving as an intermediary between the insurance carrier and the self-insured plan.

In other instances, a third-party entity may build a provider network independent of an insurance carrier, and then contract with self-insured plan sponsors so participants of the plan may access this third-party-built-provider network. Here, this third-party would be considered the owner of the provider network servicing the self-insured health plan directly.

In more limited cases, the plan sponsor of a self-insured plan may be the owner of the provider network. Here, the self-insured plan sponsor will directly contract with medical providers that the plan’s participants may access. Through these direct contracts, the plan sponsor will negotiate its own INN Rates. And, the plan sponsor will establish OON Allowed Amount Payments while contracting with a third-party to adjudicate the plan’s claims.

Based on the foregoing, SIIA recommends that the Departments clearly define who the owner of the provider network is in the case of a self-insured plan. For this purpose, the owner of the provider network is:

- A licensed insurance carrier;
- A third-party serving as the intermediary between the insurance carrier and the self-insured plan;
- A third-party independently contracting with a self-insured plan; or
- A self-insured plan sponsor that directly contracts with medical providers.

### ***B. Why Is Defining the Owner of the Provider Network So Important?***

The owner of the provider network (whether that is an insurance carrier, a third-party, or the self-insured plan sponsor itself) ***is*** the entity that ***possesses and controls*** the pricing information for a self-insured health plan.

This is of extreme import because with the exception of a self-insured health plan sponsor directly contracting with medical providers, the plan sponsor does ***not have any control*** over the pricing information that must be inputted into this self-insured health plan's TiC MRF.

Instead, total control of the pricing information ***is held by*** the insurance carrier or third-party, which means that the plan sponsor is victim to whether or not the insurance carrier or third-party produces a compliant TiC MRF for the self-insured plan. Stated differently, if the insurance carrier or third-party produces a TiC MRF that is not compliant, the existing TiC regulatory requirements hold the self-insured plan sponsor liable for this non-compliance, and this plan sponsor has no recourse against the carrier or third-party and no ability to force the carrier or third-party to correct the plan's non-compliant MRF.

This is why accountability is of extreme import, and this is why an "attestation" requirement should be imposed on the owner of the provider network producing the TiC MRFs: To ensure accountability, completeness, and the accuracy of the pricing information set forth in the TiC MRFs.

### ***C. There Is Precedent for Imposing an "Attestation" Requirement to Ensure Accountability***

Importantly, the Departments already impose an "attestation" requirement on the CEO or authorized representative of a hospital for purposes of ensuring that this hospital's MRF is complete and accurate and in compliance with the Hospital Rule.<sup>1</sup>

The Departments went so far as to explain that this "attestation" requirement will increase hospital accountability to ensure that the Hospital MRFs are complete and accurate.<sup>2</sup> The Departments also explained that this "attestation" will make clear to hospitals and MRF users the Departments' expectations that a hospital that is required to produce a Hospital MRF will accurately and completely input the pricing information into the MRF.<sup>3</sup>

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<sup>1</sup> See 45 C.F.R. section 180.50(a)(3)(iii), (iv) (added to the Hospital Rule in the recently finalized Medicare Hospital Outpatient Prospective Payment System regulation at 90 Fed. Reg. 53448, 54087 - 88 (Nov. 25, 2025)).

<sup>2</sup> See 90 Fed. Reg. at 54000 (Nov. 25, 2025).

<sup>3</sup> *Id.*

If the Departments think that imposing this type of “attestation” requirement on the CEO or authorized representative of a hospital will result in complete and accurate Hospital MRFs, the Departments ***must also agree*** that imposing this same “attestation” requirement on the owner of the provider network will result in complete and accurate TiC MRFs. Moreover, based on the fact that the Departments have already imposed this type of “attestation” requirement on hospitals producing the Hospital MRFs, the Departments clearly have the authority to impose the same “attestation” requirement on the owners of the provider networks producing the TiC MRFs to ensure accountability.

***D. The Departments Can Align the Hospital Rule With the TiC Rule By Imposing the Same “Attestation” Requirement***

The Departments have explicitly stated that they want to align the Hospital Rule with the TiC Rule whenever possible.<sup>4</sup> If this is indeed the stated policy goal of the Departments, a perfect way to align both of these Rules is by imposing the same “attestation” requirement on those entities required to produce the MRFs: Here, the hospital (in the case of the Hospital Rule), and also, the owner of the provider network (in the case of the TiC Rule).

This would not be the only instance where the Departments have endeavored to align the Hospital Rule with the TiC Rule in these proposed regulations. For example, these proposed regulations would require the owner of the provider network to create a “Text File” with a web link to the INN Rate File and the OON Allowed Amount File. Back in 2023, the Departments added this very same Text File and web link requirement to the Hospital Rule. And, in justifying this proposed new requirement for the TiC MRFs, the Departments explained that this proposed change under the TiC Rule would “align” with similar provisions under the Hospital Rule.<sup>5</sup>

***E. The Bottom-Line: The Same “Attestation” Requirement Imposed on Hospitals Must Be Imposed on the Owner of the Provider Network***

For all of the reasons discussed above, the Departments ***must*** impose the same “attestation” requirement that applies to hospitals producing Hospital MRFs to owners of the provider networks producing TiC MRFs when these proposed regulations are finalized.

**IV. Pricing Information Should Be Considered an ERISA “Plan Asset” to Ensure Accountability, Completeness, and Accuracy**

Another means to ensuring accountability – and especially ensuring the completeness and accuracy of the TiC MRFs – can be accomplished through amending ERISA’s “plan asset” regulations and confirming that pricing information that must be inputted into the TiC MRFs is an ERISA “plan asset.”

As discussed above, the pricing information inputted into the MRFs is traditionally inaccurate and incorrect. And this is a problem for self-insured plan sponsors. Why?

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<sup>4</sup> See 90 Fed. Reg. 60432, 60435 (Dec. 23, 2025).

<sup>5</sup> *Id.* at 60460 and 60482.

Because plan sponsors of self-insured group health plans are considered fiduciaries under the Employee Retirement Income Security Act (“ERISA”).<sup>6</sup> As ERISA fiduciaries, these plan sponsors must:<sup>7</sup>

- Keep health plan costs low.
- Act in the best interests of plan participants.
- Make prudent decisions.
- Monitor plan service providers.

If a plan sponsor does not have access to complete and accurate pricing information for the medical items or services and prescription drugs covered under the plan, the plan sponsor cannot:

- Keep health plan costs low because the sponsor cannot compare the medical and prescription drug prices paid by the plan with the prices negotiated by the owner of the provider network.
- Act in the best interest of participants because the sponsor cannot consider contracting with an owner of the provider network that is charging lower prices for covered benefits.
- Act prudently and re-negotiate with the plan’s existing owner of the provider network or discontinue the relationship with this entity.
- Adequately monitor the owner of the provider network to ensure that this entity is performing the services and functions the entity was hired to perform, and also, to ensure that the owner of the provider network is not purposefully or mistakenly wasting “plan assets.”

The bottom-line is that a plan sponsor of a self-insured group health plan needs access to complete and accurate pricing information to satisfy their ERISA fiduciary duties. Without access, plan sponsors are exposed to fiduciary liability.<sup>8</sup>

SIIA suggests a solution to this problem: Pricing information that must be inputted in the TiC MRFs should be considered a “plan asset” under ERISA. Why?

Because if this pricing information is an ERISA “plan asset,” then the owner of the provider network will be considered an ERISA fiduciary for purposes of the pricing information because, as discussed above, the owner of the provider network *possesses and controls* the pricing information, and thus, the owner of the provider network has **“discretionary authority”** over how to use and dispense of an ERISA “plan asset.”

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<sup>6</sup> See Section 3(21)(A) of the Employee Retirement Income Security Act (“ERISA”).

<sup>7</sup> See ERISA section 404(a)(1).

<sup>8</sup> For example, a series of lawsuits have been filed by participant-employees against self-insured plan sponsors claiming that these plan sponsors breached their ERISA fiduciary duties for making decisions – and not making decisions – relating to the cost of certain covered prescription drugs. See *Lewandowski v. Johnson & Johnson*, No. 3:24-cv-00671 (filed in Feb. 2024, dismissed for lack of standing and never ruled on the merits); see also, *Navarro v. Wells Fargo & Co.*, No. 0:24-cv-03043 (filed July 2024, dismissed for lack of standing and never ruled on the merits). Another employee-participant lawsuit claimed that the plan sponsor failed to, among other things, actively negotiate for lower prices for covered benefits. See *Barbich & Lindvall v. Northwestern University, et al.*, No. 25-cv-6849 (filed June 2025, still pending). Without access to complete and accurate pricing information, plan sponsors cannot act prudently and analyze and evaluate how much the plan and its participants should be paying for medical items and services and prescription drugs furnished by medical providers in a particular geographic region, thereby exposing plan sponsors to similar lawsuits that may or may not succeed on procedural grounds or on the merits.

And, if the owner of the provider network is an ERISA fiduciary for purposes of the TiC pricing information, the provider network owner would be subject to the same ERISA fiduciary duties applicable to plan sponsors, namely, the owner must:

- Keep health plan costs low.
- Act in the best interests of plan participants.
- Make prudent decisions.
- Monitor plan service providers..

The bottom-line is that if owner of the provider network is an ERISA fiduciary, this will compel the provider network owner to ensure that the pricing information inputted into the TiC MRFs is complete and accurate. Otherwise, the owner of the provider network would be exposed to potential fiduciary liability for breaching ERISA’s fiduciary duties.

## **V. SIIA Supports the Proposed Changes to the INN Rate File and the OON Allowed Amount File, and We Suggest Certain Changes to the TiC MRF Schema**

### ***A. Changes to the INN Rate File***

SIIA supports the Departments efforts to reduce the size of the TiC MRFs, and also, to reduce the number of the TiC MRFs through these proposed regulations. These proposed changes include the proposal to organize the INN Rate Files by provider network, the special rule for self-insured health plans that would allow plans to be aggregated at the “service provider-level” (where the plan sponsor may elect to allow their service provider to make available a single INN Rate File for each provider network used by all of the self-insured plans with which the service provider administers), along with the proposal to require the owner of the provider network that is producing the TiC MRFs to eliminate “ghost rates” if and when the provider network owner determines that it is unlikely that a medical provider would be reimbursed for the item or service based on the scope of the provider’s license or area of specialty. In addition, we support requiring the disclosure of additional data points accompanying the pricing information, including enrollment totals for each plan or coverage option that is using the INN Rate File’s provider network, as of the date the File is posted.

### ***B. Organizing INN Rates and OON Allowed Amounts By Product Type***

To date, the INN Rates are often times published without clearly identifying the associated product type. However, as the Departments know, reimbursement levels vary materially by product type due to, among other things, plan design, benefit structure, and regulatory requirements. Without product type identification, INN Rates cannot be reliably compared, and plan sponsors and their service providers cannot analyze and evaluate the reasonableness of the disclosed INN Rates. We commend the Departments for requiring the owner of the provider network that is producing the TiC MRFs to report the product type (e.g., HMO or PPO) associated with the INN Rate disclosed in the INN Rate File, along with OON Payment disclosed in the OON Allowed Amount File. We are hopeful that the Departments will update the TiC MRF Schema to include a specified field among the metadata that is dedicated to disclosing the product type that is associated with the INN Rate or OON Payment.

### ***C. Changes to the OON Allowed Amount File***

We agree with the Departments that OON pricing data offers insight into actual health care expenditures, including a window into the price of an item or service in the context of an arms-length transaction between a provider and a plan sponsor or carrier who has no negotiated rates, and therefore, we support the proposal to increase the disclosure of OON Payment data by lowering the threshold for including claims in the ONN Allowed Amount File from 20 to 11 claims. We also support the proposed clarification that the claims threshold applies to the particular medical item or service that is furnished, and *not* the particular provider furnishing the service. SIIA believes that the disclosure of OON Payments should be based on the number of claims furnished by *any* provider, *not just a single* provider. And we further support increasing the reporting and lookback periods for purposes of disclosing OON Payments because this should increase the disclosure of OON Payments.

### ***D. Require Disclosure of the Reimbursement Methodology***

With respect to updating the TiC MRF Schema with specified fields, SIIA believes that the Departments should also create a separate and independent field in the Schema that identifies the “reimbursement methodology” for the associated INN Rate. For example, owners of the provider networks producing the TiC MRFs should be required to specifically identify whether the reimbursement methodology is Fee-for-Service, or a DRG-based reimbursement, or a Case Rate, or a Per Diem, or an APC-based reimbursement, or a Capitated Rate.

The Departments are already proposing to require the owner of the provider network to explicitly specify the percentage number in cases where the reimbursement methodology is a percentage of billed charges, which we support. And, consistent with the idea of identifying a reimbursement methodology associated with an INN Rate (here, a percentage of billed charges), the Departments should require owners of the provider networks *to also* explicitly identify *all other* reimbursement methodologies that are commonly associated with an INN Rate.

It is important emphasize that a numeric value (i.e., a dollar amount) of an INN Rate is effectively meaningless without the “context” of the reimbursement methodology associated with that INN Rate. And, consistent with the Departments’ stated policy goal in these proposed regulations of trying to provide MRF users with “additional context” to better understand the pricing information set forth in the INN Rate File (through, for example, the proposed Change Log, Taxonomy, Text, and Utilization Files), requiring the identification of the reimbursement methodology in a separate and distinct field in the Schema furthers the Departments’ policy goal.

### ***E. Require Relational Alignment of the Contextual Metadata***

As a follow-on to our points related to the TiC MRF Schema, SIIA recommends that the Departments create what we call a “relational alignment” of the metadata with other specified fields. For example, this relational alignment would set forth the disclosure of the:

- Product Type
- Provider
- Service Code
- Reimbursement Methodology
- INN Rate

This would effectively standardize the metadata required to be included in the TiC MRF, which would promote a better understanding of the information that must be disclosed and resolve the current inconsistencies in interpreting the Schema which has consistently led to missing or empty contextual fields, improper nesting, and non-standard encoding of the data.

## **VI. Claims Data Is Needed to Better Understand the Pricing Information Inputted In the TiC MRFs**

The TiC MRFs (as well as the Hospital MRFs) represent a meaningful step forward when it comes to trying to understand the pricing of INN Rates and OON Payments for medical items and services and prescription drugs. However, what these MRFs cannot do – on their own – is tell a self-insured plan sponsor what the plan is actually paying for a particular medical item or service or prescription drug.

This is where the self-insured plan's health claims data is so critical. Without access to the plan's complete and accurate claims data, there is no way for a plan sponsor to confirm whether the prices disclosed in TiC MRFs reflect what the plan is actually paying. Yes, the plan sponsor may be able to see an INN Rate, but the plan sponsor cannot validate this INN Rate's application to the plan's spending on an incurred health claim.

As a result, while the proposed regulations focus appropriately on the public disclosure of pricing information, the Departments must recognize that MRFs – standing alone – have limited practical value if the pricing information is not connected to a plan sponsor's actual claims experience. When claims data is combined with TiC MRF data, however, the value of transparency expands further, allowing plan sponsors to test whether disclosed rates align with paid amounts and to identify pricing inconsistencies that would otherwise remain hidden.

Based on the foregoing, the Departments *must* take affirmative steps to require owners of the provider networks to share complete and accurate set of health claims data with a self-insured plan sponsor and their service providers. An effective way of requiring the owners of the provider networks to share complete and accurate set of health claims data is to issue guidance or regulations confirming that the existing “Gag Clause Prohibition” (which was added to the law via the Consolidated Appropriations Act of 2021)<sup>9</sup> extends to agreements between (1) an owner of the provider network and (2) the group health plan, but also agreements between (a) the owner of the provider network and (b) the plan sponsor or a third-party hired by the plan sponsor to perform plan administration functions or to assist the plan sponsor in meeting their fiduciary responsibilities. Alternatively, penalties could be imposed on an owner of the provider network that continues to restrict access to claims data on account of the provider network owner's failure to eliminate prohibited “gag clauses” in *all* of the above noted agreements.

The Departments must also consider issuing guidance that:

- Prohibits an owner of the provider network from restricting the time period over which the claims data may be collected (e.g., restrictions to 30-days worth of claims data *only* must be prohibited).

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<sup>9</sup> See ERISA section 724; *see also*, FAQs About Consolidated Appropriations Act, 2021 Implementation Part 69 (January 14, 2025).

- Prohibits an owner of the provider network from restricting the frequency and duration of an audit of the plan’s claims data.
- Allows the self-insured plan sponsor to share any and all claims data with a third-party providing services to the self-insured plan, so long as this plan service provider agrees to keep this information confidential (i.e., the plan service provider cannot share the information with a fourth party).
- Confirms that a self-insured health plan’s claims data is the property of the plan sponsor and *not* the property of owner of the provider network.

The bottom-line is this: The combined use of claims data and pricing information enables self-insured plan sponsors to validate adjudication accuracy against published INN Rates, identify coding- and modifier-driven pricing variance, detect payment errors and financial leakage, assess whether plan service providers are retaining undisclosed margins including potential spread pricing, and to take timely corrective action when outcomes diverge from plan terms and expectations. All of these actions are in accord with a plan sponsor’s fiduciary obligations under ERISA. As a result, without complete and accurate claims data and pricing information, plan sponsors are unable to undertake these actions, thereby exposing plan sponsors to potential liability for breaching their ERISA fiduciary duties.

## **VII. Four (4) New Files To Help Plan Sponsors Better Understand the Pricing Information**

SIIA generally supports the creation of the proposed 4 new Files which are intended to provide “additional context” to better understand the pricing information inputted in the INN Rate File.

### ***A. Change Log and Text Files***

In particular, SIIA supports that Change Log File as this should effectively eliminate the need to cross-walk old INN Rate Files with new INN Rate Files to figure out what pricing data may have changed from update to update. We also support the creation of a Text File, which should make it easier for plan sponsors and their service providers to locate the pricing information, and also, make it easier to contact an actual representative of the owner of the provider network who can respond to requests for assistance related to accessing and utilizing the TiC MRFs.

### ***B. Taxonomy File***

SIIA does not necessarily oppose the creation of a Taxonomy File. But, we do not believe that a Taxonomy File is the best tool for eliminating “ghost rates,” which appears to be the primary reason why the Departments are proposing the creation of the Taxonomy File in the first place. Instead, as discussed more fully below, we believe that requiring the disclosure of the number of claims (referred to here as “volume of claims”) in the Utilization File is the best means for helping owners of the provider networks determine whether a particular provider is an outlier, and also, whether the INN Rate associated with that outlier provider is itself an outlier (i.e., a “ghost rate”).

### ***C. The Proposed Utilization File Must Disclose “Volume of Claims” for Each INN Provider***

SIIA supports the creation of a Utilization File because self-insured plan sponsors and their service providers want to see (1) which providers in the network are being utilized and (2) the INN Rate for the medical items and services furnished by participating providers (i.e., the provider-rate combinations).

We also believe that it is extremely important to identify each INN provider that is being utilized – or not utilized – by the National Provider Identifier, Tax Identification Number, and Place of Service Code.

However, we do not support the Departments’ proposed approach for identifying whether a particular provider is being utilized or not. As proposed, an owner of the provider network would populate the Utilization File with 1s and 0s (referred to as a “binary approach”). Here, if a particular provider was not utilized at all, the owner of the provider network would add a 0 next to this provider, signifying no utilization. But, in the case of a particular provider that was utilized, say 200 times for a particular medical item or service, the owner of the provider network would merely put a 1 next to this provider. Compare that with a provider that was only utilized 2 times for the same medical item or service...the provider network owner would also input a 1 here.

This binary approach does not give plan sponsors or their service providers a full picture of utilization. This is problematic because plan sponsors and their service providers want to know what providers were utilized multiple times (e.g., 200 times) relative to providers who were only utilized a few times (e.g., 2 times). Having a full picture of this type of utilization would allow the plan sponsor and its service providers to analyze and evaluate why a particular provider was utilized 200 times as compared to why a particular provider was only utilized 2 times. Was the difference in provider utilization due to the highly utilized provider charging a reasonable INN Rate, while the provider that was only utilized 2 times charged an unreasonably high INN Rate? What if the highly utilized provider’s INN Rate was higher costing relative to the lower utilized provider? Is this a signal that participants were attracted to this highly utilized provider because of the “quality” of this provider’s services, while the lower utilized provider was avoided due to low “quality” of their services?

As the Departments can see, with the proposed binary approach, plan sponsors and their service providers have no way of even asking these questions, let alone trying to analyze and answer them. Yet, trying to analyze and answer these questions is of extreme import when plan sponsors are trying to keep plan costs low and monitor plan service providers, both of which are ERISA fiduciary obligations. Also, understanding the gap between utilization among the various providers would allow plan sponsors to identify high-value, low-cost providers which could in turn allow plan sponsors to develop ways to incentivize participants to utilize these high-value, low-cost providers through value-based plan designs or otherwise. In addition, analyzing and answering these questions could help plan sponsors re-negotiate rates with those providers who are identified as having high-costs and low utilization, or alternatively, the plan sponsor could choose to exclude these providers from the network altogether.

Lastly, and to the point noted above regarding the Taxonomy File, we believe that including “volume of claims” in the Utilization File makes the Utilization File a very helpful tool for identifying – and eliminating – “ghost rates”...actually a better tool than the proposed Taxonomy File. More specifically, we believe that including the “volume of claims” for providers in the network would allow the owner of the provider network to identify under-utilized or non-utilized providers, and in these cases, such under- and non-utilization is a flag for INN Rates that are “ghost rates.” And for this reason, we believe that coupling the “volume of claims” set forth in the Utilization File with the owner of the provider network’s own internal taxonomy is a more effective way of eliminating “ghost rates,” thereby negating the need for the publication of the Taxonomy File.

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Thank you in advance for considering these comments. Please do not hesitate to contact me if you have questions, or if members of SIIA can serve as a resource on these very important matters.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael W. Ferguson", with a long horizontal flourish extending to the right.

Michael W. Ferguson  
President and Chief Executive Officer  
Self-Insurance Institute of America, Inc.