April 15, 2026

Submitted Electronically via: *www.regulations.gov*

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N–5655
Attn: RIN 1210–AB37
Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: Comments In Response to the Proposed ERISA Section 408(b)(2)(B) Compensation Disclosure Regulations (RIN 1210–AB37)

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, requiring service providers of "pharmacy benefit management services" to disclose information about their compensation to fiduciaries of self-insured group health plans subject to the Employee Retirement Income Security Act ("ERISA"). These disclosures – which are required under ERISA section 408(b)(2)(B) – are needed so that plan fiduciaries can assess the reasonableness of the contracts with these service providers, including the reasonableness of the service providers' compensation and identifying conflicts of interest with other plan service providers.

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 ("PBMs").

OVERVIEW OF COMMENTS

- SIIA **supports these proposed regulations** – which would require ***any*** entity providing "pharmacy benefit management services" to a self-insured group health plan to disclose specified compensation streams this entity receives to the plan's fiduciary – and we **recommend that the Department finalize** the proposed regulatory requirements.

- As discussed in **Section I below**, we also recommend that the Department **develop and release a proposed regulation that would require entities providing "third-party administrative services"** to a self-insured group health plan to disclose specified compensation streams that flow within and throughout the ERISA-covered health plan ecosystem.

- In **Section II below**, we applaud the Department for **prohibiting a plan service provider from limiting the plan's and plan sponsor's right to audit** this service provider to make sure that this entity is fully disclosing the required compensation information. This includes prohibiting the service provider from placing limits on (1) the period of the audit, (2) the location of the audit, and (3) the number of records that the plan/plan sponsor can review during the audit. SIIA recommends that the Department **extend these same protections of audit rights to all plan service providers and all monitoring functions** that the plan sponsor must engage in to satisfy the sponsor's fiduciary duties under ERISA.

- Similarly, in **Section III below**, we applaud the Department for allowing the plan and plan sponsor **to share the disclosed compensation information with other plan service providers**, so long as these third-party service provider recipients agree not to share the information with fourth parties. Consistent with prohibiting limits on audit rights, we ask that the Department **extend this information-sharing requirement to other aspects of the administration of a self-insured plan**, including the ability to share the plan's health claims data with other plan service providers.

- In **Section IV below**, we recommend that the Department require entities providing "pharmacy benefit management services" – as well as "third-party administrative services" – to **disclose the self-insured health plan's claims data to the plan fiduciary**. In our opinion, a self-insured health plan's claims data is valuable, and any entity providing "pharmacy benefit management services" *and* "third-party administrative services" derives an economic benefit from the plan's claims data. This economic benefit can rightly be considered **"compensation" under ERISA section 408(b)(2)(B)** and the Department should therefore require these entities to disclose a complete and accurate set of the plan's claims to the plan fiduciary.

- Lastly, in **Section V below**, we request that the Department modify the existing "plan asset" regulations to (1) clarify that **health claims data is an ERISA "plan asset"** and (2) confirm that a plan service provider that **possesses and controls a plan's health claims data has discretionary authority to use and dispense of an ERISA "plan asset,"** thus confirming that this service provider is an ERISA fiduciary and subject to the same ERISA fiduciary duties applicable to plan sponsors of a self-insured health plan.

COMMENTS

I. TPAs Are Subject to ERISA Section 408(b)(2)(B)'s Compensation Disclosure Requirements

A. *Congressional Intent and Mandate*

Through the enactment of Consolidated Appropriations Act of 2026 ("CAA 2026"), Congress confirmed that ***any*** entity providing services to a self-insured group health plan must disclose "direct" and "indirect" compensation that this entity receives when providing services to the plan.[1]

This recent law change is consistent with Congress's original intent to subject, for example, PBMs and Third-Party Administrators ("TPAs") to ERISA section 408(b)(2)(B)'s Compensation Disclosure requirements (originally enacted through the Consolidated Appropriations Act of 2021 ("CAA 2021")), evidenced by a December 14, 2022 letter sent by the Chair and Ranking Member of the House Education & the Workforce Committee to the Department.[2]

More specifically, the House Committee with jurisdiction over ERISA explicitly told the Department that Congress always intended to impose ERISA section 408(b)(2)(B)'s Compensation Disclosure requirements on PBMs and TPAs that provide the following services:

- Negotiating prescription drug or medical rates.
- Developing a prescription drug or medical provider network.
- Processing prescription drug or medical claims.
- Maintaining records relating to prescription drug or medical claims.

The Committee Chair and Ranking Member go on to specifically ask the Department to develop and release additional guidance to make explicit the scope of entities subject to ERISA section 408(b)(2)(B), including PBMs and TPAs.

The Department finally heeded Congress's call to develop and release this type of guidance (at least with respect to PBMs), evidenced by these proposed regulations that confirm that entities – including PBMs – providing "pharmacy benefit management services" must disclose specified compensation streams in accordance with ERISA section 408(b)(2)(B).[3]

And now, with the advent of the enactment of CAA 2026, the Department has a clear Congressional directive to develop and release regulations confirming that TPAs and other entities that, for example, provide "third-party administrative services" to a self-insured plan must disclose specified compensation streams in accordance with ERISA section 408(b)(2)(B).

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[1] *See* Section 6702 of the Consolidated Appropriations Act of 2026.

[2] Congressional Letter from the House Education & the Workforce Committee to the Department, December 14, 2022 at https://files.constantcontact.com/8ede1c26901/d4145872-d74c-4ff6-b05b-1122e270f519.pdf.

[3] Although these proposed regulations target PBMs, SIIA commends the Department for making clear that a plan service provider does not need to specifically be a PBM to be subject to these proposed Compensation Disclosure requirements. ***Any*** entity providing "pharmacy benefit management services" to a self-insured plan triggers these proposed Compensation Disclosure requirements, including TPAs, consultants, and other types of plan service providers.

B. *Defining "Third-Party Administrative Services" In Regulations*

In these proposed regulations, the Department acted on its authority under ERISA section 505 to define an otherwise undefined statutory term in regulations. Here, that undefined statutory term is "pharmacy benefit management services," which is listed as a "type" of service in ERISA section 408(b)(2)(B)'s enumerated "list of services" that, if performed by a plan service provider, triggers 408(b)(2)(B)'s Compensation Disclosure requirements. SIIA supports the "types" of services that would otherwise be considered "pharmacy benefit management services" that the Department has included as examples in these proposed regulations.

As a next step in rulemaking, we recommend that the Department similarly act on its authority under ERISA section 505 and further define "third-party administrative services" (which, similar to "pharmacy benefit management services," is an undefined statutory term) in regulations. Here, the Department would similarly develop examples of the "types" of services that would otherwise be considered "third-party administrative services" that, if performed by a plan service provider, would require this service provider to disclose specified compensation streams to the plan fiduciary.

The Department should consider defining "third-party administrative services" as including the following examples of services provided to, or on behalf of, a self-insured plan:

- Negotiating the prices of medical items and services covered under the plan.
- Establishing and maintaining a network of medical providers utilized by plan participants.
- Adjudicating health claims incurred by plan participants.
- Possessing and controlling the plan's pricing data for purposes of inputting this data into a self-insured health plan's Machine-Readable Files in accordance with the Transparency in Coverage regulations.
- Performing enrollment services.
- Providing cost-containment management services.
- Evaluating Requests For Information sent to potential plan service providers prior to making a final determination on whether or not to hire a particular plan service provider.

We recommend that the Department also make clear in regulations that ***any*** entity – not just TPAs – that provide these "types" of "third-party administrative services" to a self-insured plan must disclose the specified compensation streams in an ERISA section 408(b)(2)(B) Compensation Disclosure.

C. *Defining Specified Compensation Streams In Regulations*

Similar to how the Department is requiring entities providing "pharmacy benefit management services" to disclose specified compensation streams that flow within and throughout the prescription drug supply chain, the Department should require entities providing "third-party administrative services" to disclose specified compensation streams that flow within and throughout the ERISA-covered health plan ecosystem.

The Department should consider requiring the disclosure of the following compensation streams as "direct" or "indirect" compensation for these purposes:

- Amounts received through a "Shared Savings Program."
- Network access fees.
- Fees from medical providers participating in the service provider's network.
- Spread compensation.
- Claims processing fees.
- Bundled pricing.
- Overrides and contingent commissions.
- Referral fees from other plan service providers.
- Revenue-sharing arrangements with other plan service providers.

It is important to emphasize that ERISA section 505 gives the Department the authority to provide a functional definition of what it means to be "direct" or "indirect" compensation for purposes of ERISA section 408(b)(2)(B)'s Compensation Disclosure requirements. As such, the Department is well within their authority (1) to develop an enumerated list of compensation streams that should be disclosed by entities providing "third-party administrative services" and (2) to further define each of these compensation streams in regulations.

II. Prohibiting ALL Service Providers from Limiting Audit Rights

A. *We Support These Proposed Regulations*

These proposed regulations provide that an entity performing "pharmacy benefit management services" must allow the plan and plan sponsor to audit this entity at least once per year to make sure that this service provider is fully disclosing the required compensation streams that they receive. These proposed regulations would also prohibit the entity performing "pharmacy benefit management services" from placing restrictions on (1) the period of the audit, (2) the location of the audit, and (3) the number of records to be audited. And, these proposed regulations would prohibit a service provider from charging the plan/plan sponsor a fee for any information and records associated with the audit, and the plan/plan sponsor would maintain the right to select an auditor of its choosing.

We commend the Department for including these prohibitions against audit limitations. Too often, an administrative service agreement between (1) a service provider and (2) the plan or plan sponsor will include contractual provisions that limit the plan's/plan sponsor's ability to audit the functions of this service provider. However, the plan sponsor has a fiduciary obligation to monitor the functions of a plan service provider to make sure that this entity is performing the services they were hired to perform. And, performing an audit of this service provider's functions is the most effective way to satisfy the plan sponsor's ERISA fiduciary duty to monitor and to make sure that plan assets are being spent properly. However, placing specified limits on the plan's and plan sponsor's audit rights arbitrarily prevents the plan sponsor from doing their job and satisfying their fiduciary obligation.

B. *This Same Prohibition on Limiting Audit Rights Should Be Extended to the Plan Sponsor's Obligation to Monitor the Functions of ALL Plan Service Providers*

As stated, a plan sponsor has an ERISA fiduciary duty to monitor the plan's service providers. This includes not only monitoring those entities providing "pharmacy benefit management services," but also monitoring the plan's broker, benefit consultant, owner of the provider network, and TPAs providing claims adjudication services, management services, enrollment services, cost-containment services, as well as any other entities hired to assist in administering the plan.

Such monitoring requires ongoing determinations that, among other things, the service provider is charging – and is actually being paid – reasonable fees, and that there are no conflicts of interest and potential self-dealing arrangements involving other service providers. Such monitoring is also required to identify pricing distortions such as spread pricing or undisclosed administrative markups and to determine if the plan's health claims are being properly paid. For purposes of determining whether the plan's health claims are being properly paid, the plan sponsor must have an unfettered right to audit the plan's health claims data to identify and recover mistaken payments and/or overpayments of claims, and also, to detect fraud, waste, abuse, and improper billing practices.

However, as noted above, the vast majority of plan service providers seek to limit a plan's and plan sponsor's ability to monitor their functions by contractually limiting the plan's/plan sponsor's ability to audit the service provider in their administrative services agreements. The Department needs to step-in and end this arbitrary practice. As such, the Department must extend these same prohibitions against limiting a plan's/plan's sponsor's audit rights to ***all*** plan service providers and to ***all*** service provider functions, especially prohibiting audit limitations on the plan's/plan sponsor's ability to perform a full and complete audit of the plan's health claims data.

III. Allowing the Plan and Plan Sponsor to Share Disclosed Information With Other Plan Service Providers

A. *We Support These Proposed Regulations*

These proposed regulations prohibit an entity providing "pharmacy benefit management services" from restricting the plan and plan sponsor from sharing the disclosed compensation information with other plan service providers. More specifically, these proposed regulations prohibit any confidentiality agreements between (1) the entity providing "pharmacy benefit management services" and (2) the plan or plan sponsor that would otherwise restrict the plan's or plan sponsor's ability to share the disclosed compensation information with another service provider, so long as this third-party service provider recipient agrees not to share the disclosed information with a fourth party.

We believe that the Department struck the right balance by allowing the plan and plan sponsor to share the disclosed compensation information (which will allow the plan sponsor to keep health plan costs low and satisfy their ERISA fiduciary duties) while restricting the third-party service provider recipient from sharing the disclosed information with a fourth party (which will protect the business interests of the entity providing "pharmacy benefit management services").

B. *This Same Information-Sharing Requirement Must Be Extended to Health Claims Data*

SIIA is – and has been – a staunch advocate for increasing a plan's and plan sponsor's ability to access a complete and accurate set of the plan's health claims data, as well as the ability to share the plan's claims data with other service providers hired to assist in the plan's administration. For example, over the past 5 years, SIIA has implored Congress to enact legislation that would increase such access to claims data and information-sharing (e.g., enacting the *Lower Cost More Transparency Act*, and more recently the *Patients Deserve Price Tags Act*).

We have also continually encouraged the Department to develop and release guidance to accomplish these same policy goals. Case-in-point: In SIIA's recent comments on the proposed Transparency in Coverage ("TiC") regulations we told the Department the following:[4]

- The Departments ***must*** take affirmative steps to require "owners of the provider networks" (i.e., entities that possess and control the pricing and health claims data on account of establishing and maintaining the medical provider networks utilized by self-insured plans and adjudicating claims on behalf of self-insured plans) to share a complete and accurate set of health claims data with the self-insured plan sponsor and their service providers.
- An effective way of requiring the owners of the provider networks to share a 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 CAA 2021)[5] not only 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 obligations.

The agreements noted in (a) and (b) above are confidentiality agreements that restrict the plan sponsor and a third-party service provider from accessing the plan's health claims data, and also, restrict the sharing of any claims data that the plan sponsor and/or service provider may be lucky enough to get their hands on. These confidentiality agreements have yet to be prohibited by the Department, hence our suggestion in our comment letter on the proposed TiC regulations that the Gag Clause Prohibition should be extended to these types of confidentiality agreements.

And now, with the advent of the Department prohibiting confidentiality agreements in the context of compensation disclosed by entities providing "pharmacy benefit management services" in these proposed regulations, we implore the Department to extend this same prohibition on restricting information-sharing to accessing and sharing claims data through clarifying guidance or regulations. Stated differently, we encourage the Department to issue guidance or regulations allowing the plan and plan sponsor to share any portion of the plan's claims data with other plan service providers in the same manner as permitted in these proposed regulations.

IV. Claims Data Should Be Treated as "Compensation" For Purposes of ERISA Section 408(b)(2)(B)

A. *A Plan Service Provider Does Not Own a Self-Insured Plan's Claims Data, But the Claims Data Is Valuable to the Service Provider and Should Be Disclosed to the Plan Fiduciary*

SIIA and the Department agree: The plan sponsor of a self-insured health plan owns the plan's health claims data that is generated by participants covered under the plan.

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[4] *See* SIIA Comment Letter on the Proposed Transparency in Coverage (TiC) Regulations at https://files.constantcontact.com/8ede1c26901/607bf7e6-aa12-4c0d-bf40-0c50225fbbf4.pdf.

[5] Despite the Gag Clause Prohibition being effective for the past 5 years, TPAs and owners of the provider networks ***continue to refuse*** to share pricing and health claims data with a self-insured health plan and its plan sponsor. These TPAs and owners of the provider networks also ***continue to restrict*** access to the data through agreements (i.e., confidentiality agreements) these entities have with the plan sponsor or companies hired to help administer the plan.

However, those service providers that adjudicate health claims on behalf of the plan believe that they own the plan's health claims data. Why? Because these service providers argue that when they (1) negotiate the prices for the medical items or services covered under the plan and ultimately (2) adjudicate the claims incurred for these covered medical items or services, these service providers add their own intellectual property (like pricing logic, risk scores, and benchmarks) to the claims data, which changes the raw claims data into a commercialized dataset that belongs to the service provider.

Again, SIIA and the Department firmly disagree with this argument because the plan is the rightful owner of its health claims data even in cases when the service provider mixes their intellectual property with the raw claims data. Despite this disagreement, one thing is clear: A self-insured plan's claims data is valuable to this service provider, thereby making it appropriate for the plan's claims data to be considered "compensation" received by this service provider. As "compensation" received by this service provider, it is well within the Department's authority to require this service provider to disclose the plan's claims data to the plan fiduciary in accordance with ERISA section 408(b)(2)(B).

B. *A Service Provider Derives an Economic Benefit from the Plan's Claims Data*

There is no disagreement that a service provider that adjudicates health claims on behalf of a self-insured plan derives an economic benefit from the claims data generated by the self-insured plan's participants. For example, a service provider derives an economic benefit by selling the plan's claims data to a for-profit database or clearinghouse (like FAIR Health, MarketScan Datasets, and Optum Clinformatics Data Mart) wherein the for-profit database/clearinghouse effectively re-sells the claims data, charging substantial fees for access to researchers, data analytic firms, start-up companies, and even other self-insured plan sponsors. Alternatively, this service provider may sell the claims data directly to researchers, data analytic firms, start-up companies, and other self-insured plan sponsors for substantial dollar amounts. In all cases, this service provider is deriving an economic benefit from the claims data.

The service provider may also use the plan's claims data to negotiate rates for specified medical items and services furnished by specified medical providers in a geographic region, then build a proprietary network of these providers, and then "rent" this provider network to a self-insured plan or a third-party intermediary for a fee. Similar to the scenario noted above, this service provider uses a plan's claims data to derive an economic benefit that would not exist but for the service provider's relationship with the self-insured plan.

A plan's claims data also produces an economic benefit for a service provider in cases where the service provider uses the claims data as revenue-generating sources to protect and increase the service provider's profit margins. For example, service providers that adjudicate claims on behalf of the plan will contract with the plan to provide, among other things, care management programs, utilization review, and claims integrity audits conducted by the service provider for substantial fees.

In cases where a service provider also has a stop-loss insurance line of business or the service provider is vertically integrated with a PBM, this service provider will use the plan's claims data and the analytics derived from the data to cross-sell other products and services to generate increased revenue. Here, a plan's claims data is essential for selling these products and services, and claims data allows the service provider to turn a low-margin service (i.e., adjudicating claims only) into a profit-generating enterprise (i.e., selling multiple products and services all driven by monetizing a plan's claims data for the benefit of the service provider).

C. *Claims Data Originates With the Self-Insured Health Plan and Its Participants and Is "Compensation" That Must Be Disclosed In a 408(b)(2)(B) Compensation Disclosure*

Health claims data originates with the self-insured health plan and its participants. That is, health claims data would not be generated, and thus, not even be available but for the existence of the self-insured plan and the coverage it provides to plan participants when they incur a health claim. Moreover, a plan's claims data would not provide an economic benefit to a service provider but for the existence of the service provider's relationship with the plan.

As a result, the economic benefit that is generated on account of the service relationship with the plan can appropriately be considered "compensation" to the service provider. As "compensation," this entity providing services to the plan can appropriately be required to disclose the plan's claims data to the plan's fiduciary under ERISA section 408(b)(2)(B).

As stated above, the Department has the authority to define "direct" compensation and "indirect" compensation for purposes of ERISA section 408(b)(2)(B). And therefore, we believe that it is well within the Department's authority to treat an economic benefit to a service provider that is generated on account of the service provider's relationship with the plan as "compensation," thereby requiring the service provider to disclose the plan's claims data to the plan fiduciary in a 408(b)(2)(B) Compensation Disclosure.

V. Claims Data Should Be Considered an ERISA "Plan Asset"

As noted above, Congress enacted the Gag Clause Prohibition to require an owner of the provider network (i.e., the entity that possesses and controls the plan's health claims data on account of establishing and maintaining the plan's provider network and adjudicating claims on behalf of the plan) to share the plan's health claims data with the health plan's sponsor. However, despite this legal requirement being effective since 2021, insurance carriers (who are typically the owners of the provider networks) continue to refuse to share a complete and accurate set of health claims data with plan sponsors, which is contrary to Congress's original intent.

As also discussed, plan sponsors are ERISA fiduciaries and these plan sponsors must make prudent decisions, act in the best interests of plan participants, keep health plan costs low, and monitor plan service providers. However, if a plan sponsor does not have access to a complete and accurate set of health claims data, the plan sponsor cannot:

- 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.
- Keep health plan costs low because the sponsor has no insight into the utilization of the medical items and services and prescription drugs covered under the plan.
- Act in the best interest of participants because the sponsor is unable to adopt programs to help participants with chronic conditions and to direct participants to high-value, low-cost health services.
- Act prudently and make sure that the plan's service providers are not mis-using and/or wasting the plan assets.

The bottom-line is that a plan sponsor needs access to a complete and accurate set of health claims data to satisfy their ERISA fiduciary duties. Without access, plan sponsors are exposed to fiduciary liability.[6]

SIIA suggests a solution to this problem: A health plan's claims data should be considered a "plan asset" under ERISA. Why? Because if a plan's claims data is an ERISA "plan asset," then the insurance carrier-owner of the provider network will be considered an ERISA fiduciary for purposes of the claims data because this plan service provider ***possesses and controls*** the claims data, and thus, the carrier-owner has ***"discretionary authority"*** over how to use and dispense of an ERISA "plan asset."

If an insurance carrier-owner of the provider network is an ERISA fiduciary for this purpose, the carrier-owner will be subject to the same ERISA fiduciary duties applicable to plan sponsors, namely, the carrier-owner must make prudent decisions, act in the best interests of plan participants, and keep health plan costs low.

The bottom-line is that if an insurance carrier-owner of the provider network is an ERISA fiduciary, this will compel this plan service provider to share a complete and accurate set of claims data with the plan sponsor because failure to do so will expose the carrier-owner to potential fiduciary liability for breaching ERISA's fiduciary duties. As such, the Department should modify the existing "plan asset" regulations to (1) clarify that claims data is an ERISA "plan asset" and (2) confirm that a plan service provider that possesses and controls a plan's health claims data (i.e., the owner of the provider network) has discretionary authority to use and dispense of an ERISA "plan asset."

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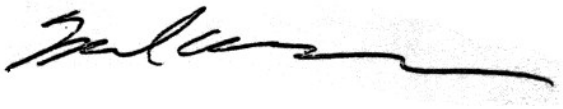
Thank you in advance for considering these comments. Please do not hesitate to contact me if you have questions, or if members of SIIA can serve as a resource on these very important matters.

Sincerely,



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

[6] 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 a complete and accurate set of claims data, 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, thereby exposing plan sponsors to similar lawsuits that may or may not succeed on procedural grounds or on the merits.