ERIC | THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

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Submitted Electronically via: https://www.cms.gov/priorities/key-initiatives/hospital-price transparency/accuracy-and-completeness-rfi

Department of Health and Human Services
Centers for Medicare & Medicaid Services
"Questions for Public Comment" Webform Submission

RE: CMS Hospital Price Transparency Accuracy and Completeness Request for Information

To Whom It May Concern:

The ERISA Industry Committee ("ERIC") is pleased to submit the following comments in response to the Request for Information to gather input to identify challenges and improve compliance and enforcement processes related to the transparent reporting of complete, accurate, and meaningful pricing data by hospitals. We appreciate the Centers for Medicare & Medicaid's ("CMS's") efforts to promote transparency and empower employer-sponsors of a group health plan, group health plan participants, and other stakeholders with better access to the prices of medical items and services and related health care information.

ERIC is the only national trade association that advocates exclusively on behalf of large employers on health, retirement, and compensation public policies on the federal, state, and local levels. ERIC's member companies offer comprehensive group health benefits to their employees in compliance with the myriad federal laws including the Internal Revenue Code ("Code"), the Employee Retirement Income Security Act ("ERISA"), and the Public Health Service ("PHSA"). ERIC supports the ability of its large employer member companies to tailor retirement, health, and compensation benefits to meet the unique needs of their workforce, providing benefits to millions of workers, retirees, and their families across the country.

Below are our responses to your "Questions for the Public" about how CMS can improve compliance and enforcement processes related to the Hospital Transparency Rule and the Machine-Readable Files ("MRFs") that hospitals are required to post on a public website.

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Should CMS define "accuracy" and "completeness" in the context of HPT requirements, and, if yes, then how?

Yes – CMS should define both terms with operational clarity.

With regard to "**accuracy**," prior to the release of proposed regulations on July 15, 2025, we suggested that the allowed amounts set forth in a hospital's MRF for a particular medical item or service should reflect a payer-specific negotiated rate that is equal to the arithmetic mean of allowed amounts from EDI 835 transactions for that particular medical item or service, by line of business (e.g., Commercial, HMO, PPO, Medicare Advantage, Medicare, Medicaid).

Based on our read of the July 15th proposed regulations, it appears that CMS is adopting a similar approach. For example, the recently proposed rule would require hospitals to include in their MRFs the following four new data elements when a standard charge is based on a percentage or algorithm: (1) the median allowed amount (which would replace the estimated allowed amount), (2) the 10th percentile of the allowed amounts, (3) the 90th percentile of the allowed amounts, and (4) the count of allowed amounts used to calculate the median, 10th, and 90th percentile allowed amounts.

Requiring the disclosure of the median allowed amount that is paid for a particular medical item or service provides a much more accurate basis for understanding the payer-specific negotiated rates. In addition, requiring the disclosure of the 10th and 90th percentile of allowed amounts and, more importantly, the number of allowed claims behind those percentiles, will provide more accurate reporting of the prices associated with the specified medical item or service. This also makes it much easier to compare the actual dollar amounts that payers in the region paid to the hospital for this particular medical item or service.

And, for self-insured health plan sponsors and plan fiduciaries – who have an ERISA fiduciary duty to monitor whether the health plan is overpaying a hospital for furnished medical items and services – understanding the actual dollar amounts that all payers in the region paid to the hospital for furnished medical items or services provides plan sponsors with a helpful baseline for determining if the plan indeed overpaid for a particular claim.

With regard to "**completeness**," prior to the release of the July 15th proposed regulations, we would have recommended that a hospital's MRF must include data for all applicable CPTs/DRGs that were billed and reimbursed during a 12-month historical window, for all active contracted payers and lines of business (e.g., Commercial, HMO, PPO, Medicare Advantage, Medicare, Medicaid).

Based on our read of the proposed requirements, CMS is adopting a similar approach. More specifically, the new proposed median, 10th, and 90th percentile of allowed amounts for a particular medical item or service would be based on the total allowed amounts the hospital has historically received for the medical item or service for a time period no longer than the 12 months prior to posting the MRF.

Again, understanding the actual dollar amounts that all payers in the region paid to a hospital over a 12-month period (which is traditionally the length of a plan year for a health plan) will help self-insured plan sponsors and plan fiduciaries evaluate and analyze the plan's health care spending in a particular year, and further help the sponsor and fiduciaries estimate what the plan's health care spending may be in future years.

We applaud CMS for the development of these proposed changes.

What are your concerns about the accuracy and completeness of the HPT MRF data?

Many hospitals still treat MRFs as a "check-the-box" exercise. In some cases, hospitals will fail to input an accurate and complete dollar amount, and instead, the hospital will input a series of "999999999" as a placeholder. In other cases, hospitals will input incorrect units (e.g., per day instead of per case) or input mismatched payer lines of business (e.g., Commercial, HMO, PPO, Medicare Advantage, Medicare, Medicaid).

This lack of accuracy and completeness is concerning to self-insured plan sponsors who have an ERISA fiduciary duty to act prudently and in the best interest of plan participants when it comes to contracting with medical providers or "renting" a medical provider network owned by an insurance carrier or other third-party entity. Here, if the plan sponsor knows that a particular hospital is charging an inflated dollar amount for medical items or services furnished by this hospital as compared to another hospital in the region that is charging reasonable rates for the same medical items and services, the prudent decision is to contract with – or include in the plan's network – the hospital charging reasonable rates as opposed to the hospital charging inflated rates. However, if the plan sponsor is unable to compare the prices that each of these respective hospitals charge patients, then the plan sponsor may be unable to satisfy their ERISA fiduciary duties.

Plan sponsors also have an ERISA fiduciary duty to keep health plan costs low and monitor the plan's operation, especially when it comes to paying health claims incurred by plan participants. If, for example, the health plan has been paying inflated claims to a hospital either knowingly or negligently, the plan sponsor could be exposed to potential fiduciary liability for overpaying for covered health benefits and failing to properly monitor the plan's operations and payment of claims. The employee benefits industry is already seeing an increase in employee-participant lawsuits alleging that plan sponsors violated their ERISA fiduciary duties by, among other things, failing to act prudently and overpaying for certain benefits, failing to take available steps to re-negotiate provider contracts, and/or failing to actively manage and oversee key aspects of the plan (e.g., the process for paying claims).[1] If, however, a plan sponsor could accurately compare, evaluate, and analyze the various medical prices charged by a particular hospital, the sponsor would be able to satisfy their ERISA fiduciary duties and undertake actions that are in the best interest of the plan participants.

The bottom-line is this -- without accurate and complete pricing information on a hospital's MRF, self-insured plan sponsors are at risk of failing to satisfy their ERISA fiduciary duties.

[1] *See* Two recent lawsuits filed by employee-participants against Johnson & Johnson (J&J) and Wells Fargo (WF) as plan sponsors and the plans' fiduciaries, arguing that J&J and WF (as plan sponsors) and the plan fiduciaries (as individuals) breached their ERISA fiduciary duties by allowing the plans to over-pay for covered prescription drugs; *see also* An employee-participant lawsuit filed against the Mayo Clinic for underpaying out-of-network health claims.

Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples

As explained above, the lack of accuracy and completeness of the MRF exposes self-insured plan sponsors to ERISA fiduciary liability because the sponsors may be unable to use the hospital pricing information effectively.

With regard to additional data elements that could be added, we have recommended that CMS require each hospital to include the hospital's National Provider Identifier ("NPI") on the respective hospital's MRF. Doing this would help self-insured plan sponsors compare the medical prices publicly disclosed on a particular hospital's MRF with the MRF of a health care payer (e.g., an insurance carrier or other self-insured health plan) as required under the Transparency in Coverage ("TiC") Rule. Too often, the payer-negotiated rate disclosed in a hospital's MRF is different from the rate disclosed in that same payer's MRF. In other cases, a comparison of the standard charges for a particular hospital cannot be made because of the difficulty in matching its MRF identifier data element with the NPI that is already required as a data element in the payer's MRF. The solution here is to better align the Hospital MRFs with the TiC MRFs.

Having said that, the recently proposed regulations that were released on July 15th include a proposal to require hospitals to include their 10-digit Type 2 NPI that is active as of the date of the most recent update to the standard charge data disclosed in the hospital's MRF.

ERIC applauds this proposed requirement as this will help plan sponsors compare, evaluate, and analyze the prices charged by hospitals in the region, which will aid sponsors in their contract negotiations and decisions on how to prudently spend the plan's assets.

What specific suggestions do you have for improving the HPT compliance and enforcement processes to ensure that the hospital pricing data is accurate, complete, and meaningful? For example, are there any changes that CMS should consider making to the CMS validator tool, which is available to hospitals to help ensure they are complying with HPT requirements, so as to improve accuracy and completeness?

ERIC has consistently recommended that CMS increase the monetary penalties for non-compliance with the hospital MRF requirements. We have also argued that CMS must conduct audits on a routine basis. This includes multiple audits of hospitals of different sizes and not just audits limited to a statistical sample of hospitals in a particular region of the country. The point here is this -- If you (i.e., a hospital) know that you are likely to get audited – and you (i.e., a hospital) know that you might get hit with increased monetary penalties for non-compliance – that is going to change behavior, and compliance is likely to follow.

ERIC has also recommended that CMS require an authorized representative of the hospital to "attest" to the accuracy of the pricing information set forth in the hospital's MRF.

Under current law, self-insured plan sponsors may be liable for failing to comply with certain legal and regulatory requirements. But in many cases, self-insured plan sponsors cannot get accurate information from, for example, a hospital or insurance carrier to comply. As a result, plan sponsors are victim to what the hospital and/or the insurance carrier gives (or does not give) them.

What we are asking for is simple -- Liability for non-compliance should begin with the hospital (and in the case of the TiC MRF, the insurance carrier) and not the self-insured plan sponsor. And one way to shift the liability for non-compliance is to require the hospital's executives to ensure that the hospital's MRF is compliant with all of the regulatory requirements. Because if, for example, the hospital's CEO or Board President is liable for "attesting" to the accuracy of their hospital's MRF, it is more likely than not that they are going to make sure that their MRF is indeed compliant. Same is true for requiring the CEO of an insurance carrier to "attest" to the accuracy of the carrier's TiC MRF. Behavior will change and compliance will follow.

Based on our read of the July 15th proposed regulation, CMS would require such an "attestation" from a hospital's CEO, president, or senior official designated to oversee the encoding of the data.

ERIC applauds CMS's proposal here, and we are supportive of the CMS-developed "attestation" language that must be inputted into the hospital's MRF. We also suggest that CMS consider including the same "attestation" and CMS-developed "attestation" language in any forthcoming regulations relating to the TiC MRF.

Lastly, in lieu of utilizing CMS's validator tool, CMS may consider outsourcing efforts to develop "scorecards" or "grades" for compliance with the Hospital Rule and the MRF requirements (similar to Leapfrog's "grades" on safety). As CMS knows, there are a number of private-sector companies that are accessing hospital MRFs, aggregating the data, normalizing that data, and evaluating whether a particular hospital is compliant with the MRF requirements. And, some of these private-sector companies are already developing "grades" or a "scorecard" for hospitals based on whether a particular hospital has missing or flawed data. CMS may consider leveraging what the industry is already doing to identify non-compliance and may choose to seek corrective actions in the case of failing grades instead of imposing monetary penalties, which appears to be in line with CMS's proposed regulations that call for reducing any monetary penalties by 35% if a non-compliant hospital accepts penalties without an appeal.

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Thank you for your attention to these very important issues. Please do not hesitate to contact me at 202-789-1400 or jgelfand@eric.org with any questions or if we can serve as a resource.

Sincerely,

James P. Gelfand
President & CEO