

February 23, 2026

Submitted Electronically via: 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 ERISA Industry Committee (“ERIC”) 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 that were originally published in the Federal Register on November 12, 2020.¹ As the Departments of Health and Human Services, Labor, and the Treasury (the “Departments”) explained in the preamble to this NPRM, these proposed rules 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 data inputted in the TiC MRFs.²

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.

¹ See 85 Fed. Reg. 72158 (Nov. 12, 2020).

² See 90 Fed. Reg. 60432, 60433 - 60435 (Dec. 23, 2025).

COMMENTS

I. Self-Insured Plan Sponsors Will Be Exposed to ERISA Fiduciary Liability If They Do Not Have Access to Complete and Accurate Pricing Information

The importance of being able to access complete and accurate pricing information cannot be overstated.

The plan sponsor of a self-insured group health plan is considered a fiduciary under ERISA.³ As an ERISA fiduciary, a plan sponsor must:⁴

- Keep health plan costs low;
- Act in the best interests of plan participants;
- Make prudent decisions; and
- 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 entity that owns the medical provider network (referred to as the “owner of the provider network”);
- Act in participants’ best interest 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; or
- 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 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 health benefit plan needs access to complete and accurate pricing information to satisfy their ERISA fiduciary duties. Without access, plan sponsors are exposed to fiduciary liability.⁵

The Departments have the power to help self-insured plan sponsors satisfy their ERISA fiduciary obligations. And that power is through ensuring that the “owners of the provider networks” (defined more fully below) produce TiC MRFs that are complete and accurate and in compliance with the TiC regulatory requirements.

³ See Section 3(21)(A) of the Employee Retirement Income Security Act (“ERISA”).

⁴ See ERISA section 404(a)(1).

⁵ The employee benefits community has witnessed various lawsuits filed by a participant-employee against a self-insured plan sponsor claiming that the plan sponsor breached its 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). Without access to complete and accurate pricing information, plan sponsors cannot reasonably be expected to analyze and evaluate how much the plan and its participants should be paying for covered 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.

A. Why Is the Owner of the Provider Network So Important?

The owner of the provider network is the entity that possesses and controls the pricing information that is required to be input into the TiC MRFs.

Specifically, the owner of the provider network negotiates the rates for medical items and services and prescription drugs covered under, for example, a self-insured health benefit plan. As a result, the owner of the provider network controls and possesses the self-insured health benefit plan's in-network negotiated ("INN") rates.

The owner of the provider network also possesses and controls the self-insured health benefit plan's claims data, and thus, possesses and controls the plan's out-of-network ("OON") allowed amount payments.

B. Who Is the Owner of the Provider Network In the Case of a Self-Insured Health Benefit Plan?

In the case of a self-insured health benefit plan, the owner of the provider network will typically be a licensed insurance carrier that "rents" out the provider network that the carrier has created. As noted above, in this case, the insurance carrier negotiates the INN rates for the plan's covered medical items and services and prescription drugs and adjudicates claims for the plan's OON payment amounts.

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 plan. Here, the 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 its own provider network independent of an insurance carrier, and contract with the self-insured plan's plan sponsor to allow for plan participants to access to this network. Here, this third-party would be considered the owner of the provider network servicing the self-insured health benefit plan directly.

In more limited cases, the plan sponsor 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 establish OON allowed amount payments, while usually contracting with a third-party to adjudicate the plan's claims.

II. The Same “Attestation” Requirement Imposed on Hospitals Should Be Imposed on Owners of the Provider Network

Now that we have established (1) why the owner of the provider network is so important and (2) who is the owner of the provider network, we recommend that the Departments require the CEO or authorized representative of the owner of the provider network to “attest” that any TiC MRF produced by this provider network owner is complete and accurate and in compliance with the TiC regulatory requirements.

A. An “Attestation” Requirement Is Needed to Stop Non-Compliance with the TiC Rule

Although the TiC regulatory requirements have been in effect since July 1, 2022, the pricing information entered into the TiC MRFs by the owners of the provider networks remains outdated, inaccurate, and incomplete.

This problem is most acute in cases where the owner of the provider network is a licensed insurance carrier posting the carrier’s own TiC MRFs for the carrier’s fully-insured health benefit plans, as well as developing TiC MRFs for self-insured plan sponsors that “rent” the carrier’s provider network or access the carrier’s provider network through a third-party.

This rampant non-compliance with the TiC regulatory requirements – which is resulting in the development of the outdated, inaccurate, and incomplete TiC MRFs – would be less likely to continue if the owner of said provider networks were required to attest to the accuracy of the MRFs.

B. The Departments Agree That an “Attestation” Requirement Could Effectively Stop This Non-Compliance

While civil and monetary penalties may be an effective way to stop rampant non-compliance, a more effective way to ensure compliance with the TiC regulatory requirements is to impose an attestation requirement on the CEO or authorized representative of the owner of the provider network to ensure that the owner of the provider network’s TiC MRFs are complete, accurate, and compliant with the TiC Rule.

The Departments have decided to impose this very same 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 Price Transparency Rule.⁶ According to the Departments, the requirement is appropriate and necessary:⁷

“[W]e believe the attestation requirement...would mandate significantly heightened hospital recognition of their responsibilities than what we presently require” (referring to the fact that the new “attestation” requirement is “significantly stronger” than the previously required MRF “affirmation” statement).

⁶ See 45 CFR section 180.50(a)(3)(iii), (iv) (added to the Hospital Price Transparency Rule in the recently finalized Medicare Hospital Outpatient Prospective Payment System regulation at 90 Fed. Reg. 53448, 54087 - 88 (Nov. 25, 2025)).

⁷ See 90 Fed. Reg. at 53999 (Nov. 25, 2025).

The Departments further explained that:⁸

“[W]e believe [the] attestation requirement...would reduce public confusion related to [the pricing data] included within the MRF...” and

“[W]e believe this [attestation requirement] would provide the necessary reassurance that hospitals have provided in their MRFs meaningful, accurate information to MRF users about [the pricing data].”

Furthermore, the Departments emphasized that:⁹

“[W]e...adopted this attestation to make clear to hospitals and MRF users our expectations that the hospital will accurately and completely encode all [pricing data].”

And most importantly, when speaking about the requirement that the CEO or an authorized representative of the hospital must provide the attestation, the Departments stated that:¹⁰

“[W]e intend this public declaration to establish for MRF users and for CMS actionable certainty on the accuracy and completeness of the [pricing data] displayed...” and

“[W]e also intend that this public declaration will increase hospital accountability to MRF users that the data is complete...” and

“[W]e believe [this attestation requirement] will result in the public display by hospitals of more meaningful data for MRF users.”

Because the Departments believe that imposing this type of attestation requirement on hospitals will ensure the accuracy and completeness of the hospital MRFs, the same logic applies for ensuring the accuracy and completeness of the TiC MRFs. As a result, the Departments should impose this same type of attestation requirement on the CEO or authorized representative of an owner of the provider network to ensure the accuracy and completeness of the pricing data included in the TiC MRFs.

C. The Departments Also Want to Align the TiC Rule with the Hospital Price Transparency Rule

As further justification for imposing the same attestation requirement imposed on hospitals in the Hospital Price Transparency rule to the owners of the provider networks through these proposed TiC regulations, we know that the Departments want to align the TiC Rule with the Hospital Price Transparency Rule based on the Departments’ comments in the preamble of this NPRM, stating:¹¹

“[T]he Departments intend in these proposed rules, along with Schema 2.0, to help align the Hospital Price Transparency reporting requirements and the 2020 final [TiC] rules, as well as to fulfill the directive under Executive Order 14221.”

⁸ *Id.*

⁹ *Id.* at 54000.

¹⁰ *Id.*

¹¹ *See* 90 Fed. Reg at 60435 (Dec. 23, 2025).

The Departments even titled a sub-section of the preamble “Better Alignment With Hospital Price Transparency Reporting” (under the section explaining the proposal to organize INN Rate Files by provider network), in which the Departments noted:¹²

“Organizing in-network rates by provider network would also promote standardization and streamlined comparison of pricing information across hospitals and health plans, consistent with Executive Order 14221.”

With respect to the proposal to require the owners of the provider networks that produce the MRFs to create a text file that would include a web link to the internet website that hosts the INN Rate File and the OON Allowed Amount File (discussed below), the Departments also explained:¹³

“The 2023 Hospital Price Transparency rule, which went into effect on January 1, 2024, requires certain hospitals to include a Text File in the root folder of the hospital’s public website that includes a direct link to the hospital’s [MRF]...” and

“In proposing to adopt a similar requirement [for the TiC MRF], the Departments would align this requirement with the 2023 Hospital Price Transparency rule requirement to improve [TiC MRF] accessibility for the public.”

Regarding this same text file requirement, the Departments further stated:¹⁴

“This proposed new requirement [for the TiC MRF] would align with similar provisions under the 2023 Hospital Price Transparency rule...and is intended to enhance the discoverability, usability, and consistency of pricing information for participants, beneficiaries, and enrollees, third-party developers, researchers, and regulators.”

In summary, to accomplish the Departments’ stated goal of aligning the TiC Rule with the Hospital Price Transparency Rule – and to ensure the accuracy and completeness of the pricing data in *both* the Hospital MRFs and TiC MRFs – the Departments should impose this 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.

D. Congress Also Believes That an Attestation Requirement Is a Good Idea

Bipartisan legislation under congressional consideration would require an officer or executive of the entity producing the TiC MRFs (e.g., the owner of the provider network) to attest to the accuracy and completeness of the information in the TiC MRF.¹⁵ This is additional evidence that policymakers on both sides of the aisle believe that this type of attestation is appropriate and necessary.

¹² *Id.* at 60449.

¹³ *Id.* at 60460.

¹⁴ *Id.* at 60482.

¹⁵ See S. 2355, Sec. 6. Strengthening Health Coverage Transparency Requirements, *The Patients Deserve Price Tags Act* (sponsored by Senators Marshall (R-KS) and Hickenlooper (D-CO)).

It serves as yet another reason why the Departments should not bypass an opportunity to impose this type of attestation requirement on the owner of the provider network when these proposed regulations are finalized.

In addition, requiring an attestation from an employer—rather than from the entity that actually controls and generates the pricing data—would do little to improve the accuracy or reliability of the TiC MRFs. Employers do not possess or manage the data sets that populate the files. As a result, an employer’s attestation would merely serve as a formal statement about information it cannot meaningfully verify. This approach would not enhance data integrity and would instead shield the true owner of the provider network from accountability. Ultimately, shifting the attestation obligation to employers would be counterproductive, as it would neither incentivize compliance nor result in higher-quality or more accurate pricing information.

III. Self-Insured Plan Sponsors Must Not Be Held Liable for Non-Compliance When the Plan Sponsor Is Not the Owner of the Provider Network

According to the existing TiC Rule, if a self-insured plan sponsor posts a TiC MRF that is not compliant with the TiC regulatory regulations, the liability for non-compliance rests with the plan sponsor.

This is unfair to the plan sponsor – except when a plan sponsor directly contracts with medical providers and is the owner of the provider network. Typically, plan sponsors themselves do *not* possess and control pricing information and claims data. It is the owner of the provider network that produces a TiC MRF for a self-insured plan sponsor that is either “renting” the carrier’s provider network or contracting with a third-party to access a provider network.

Therefore, if the owner of the provider network produces a TiC MRF that is non-compliant, the liability for such non-compliance should *not* rest with the plan sponsor, but instead any liability should rest with the entity that is producing the TiC MRFs in the first place (i.e., any liability should rest with the owner of the provider network).

To this end, we suggest two ways to change the existing liability structure. First, impose an “attestation” requirement on the owner of the provider network, as discussed above. Second, develop a safe harbor, similar to what Congress added to the statute in Section 6702 of the *Consolidated Appropriations Act of 2026* (“CAA 2026”) (included as part of the rebate pass-through requirements of CAA 2026), and similar to the Department of Labor’s (DOL’s) existing fiduciary provision set forth in DOL regulations.¹⁶ For example, in cases where a self-insured plan sponsor expects that the plan’s TiC MRF is compliant, but does not know that the owner of the provider network produced a non-compliant TiC MRF, the plan sponsor would not be subject to liability for the provider network owner’s non-compliance if the plan sponsor does the following:

- (1) Upon discovering that the TiC MRF is not compliant, the plan sponsor immediately contacts the owner of the provider network and demands that the non-compliant aspects of the MRF be fixed; and

¹⁶ See 29 CFR section 2550.408b-2(c)(1)(ix).

(2) If, after contacting the owner of the provider network, the owner does not fix the non-compliant aspects of the MRF within 90 days (or some other specified time period), the plan sponsor notifies the DOL and informs the DOL about the owner of the provider network's continued non-compliance.

These actions are reasonable for plan sponsors who rely on the owner of the provider network's compliance.

IV. ERIC Supports the Proposed Changes to the INN Rate Files

The Departments have emphasized that the transparency of INN rates is vital for plan sponsors, researchers, and policymakers to analyze health care spending, benchmark costs, and inform future policy decisions. Based on the Departments' internal assessments – and in response to external industry stakeholder feedback over the last four years of implementation of the TiC regulatory requirements – the Departments have determined that making the following changes to the INN Rate File should help achieve these goals:

A. Organizing INN Rate Files by Provider Network

Insurance carriers and self-insured plans may use the same provider network for participants covered under their plans. This is a function of the insurance carrier acting as the owner of the provider network, not only for the carrier's fully-insured plans, but also for self-insured plans that "rent" the carrier's provider network. The proposed regulations would require the owner of the provider network to prepare one INN Rate File that may then be used by all these different policies and plans, instead of preparing multiple files for each policy and plan. This proposed change would decrease the size of the INN Rate Files and reduce the total number of files because there are far more available plans and policies than there are distinct, separately managed provider networks.

Furthermore, by organizing the INN Rate File by provider network, it may be easier for plan sponsors to analyze the INN rates of different provider networks to make informed decisions about which plans to offer their employees, potentially favoring provider networks with more competitive pricing, in addition to opening the door for plan sponsors to bring health care purchasing decisions in-house through direct contracting with provider groups.

In addition, by organizing INN rate information by provider network, it may help those entities providing services to self-insured plans to advise their plan sponsor-clients on provider network selection and cost management strategies.

B. Dollar Amounts and Percentage of Billed Charges

ERIC generally supports the proposal to require the owner of the provider network to input INN rates that are reflected as a dollar amount. We also agree that in cases where reimbursements are made as a percentage of billed charges (where the payer cannot assign a dollar amount prior to the bill being generated), the owner of the provider network should be required to report a percentage number in the INN Rate File.

However, the Departments should require the owners of the provider network to allow MRF users to derive a dollar amount for a particular INN rate wherever possible. To this end, we recommend that the Departments consider adopting the same methodology required of hospitals for deriving an amount when an INN rate is based on a percentage or algorithm.¹⁷

More specifically, in cases where an INN rate is based on a percentage of billed charges, we recommend that the owner of the provider network be required to disclose: (1) the median allowed amount that is paid for a particular medical item or service; (2) the 10th percentile of this allowed amount; (3) the 90th percentile of this allowed amount; 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 for a particular medical item or service provides a much more accurate basis for understanding the INN rate. In addition, requiring the disclosure of the 10th and 90th percentiles of allowed amounts and, more importantly, the number of allowed claims behind those percentiles, would provide more accurate reporting of the prices associated with the specified medical item or service.

ERIC also recommends that the Departments require a new and independent field in the TiC MRF that identifies the actual reimbursement methodology for a particular INN rate (e.g., fee-for-service, DRG-based reimbursement, case rate, per diem, APC-based reimbursement, or capitation).

C. Enrollment Totals

ERIC generally supports the requirement to include current numerical enrollment totals (i.e., the number of participants, including all dependents) in each INN Rate File as of the date the file is posted for each coverage option offered through a fully-insured or self-insured plan that uses the INN rate file's provider network. Including enrollment totals in the INN Rate File would allow plan sponsors to weigh different plan and coverage options to understand their relative influence on the overall health care market. This should, in turn, enable plan sponsors to develop analytical models that prioritize INN rates for items and services based on the number of individuals covered by the corresponding plan or coverage, thereby focusing analysis on prices with the broadest impact on the insured population.

D. Eliminating "Ghost Rates"

One reason the INN Rate Files are so large is due to the inclusion of providers associated with INN rates for items or services they are not likely to furnish (e.g., rates for podiatrists to perform heart surgery), referred to as "ghost rates." The proposed regulations endeavor to eliminate the public disclosure of these rates by requiring the owner of the provider network that is producing the TiC MRFs to exclude from each INN Rate File the provider and their INN rate (i.e., the provider-rate combination) for an item or service if the owner of the provider network determines that it is unlikely that such provider would be reimbursed for the item or service based on the scope of the provider's license or area of specialty. To make such a determination, the owner of the provider network would be required to use their internal provider taxonomy that is typically used during the claims adjudication process.

¹⁷ See 90 Fed. Reg. at 53988 - 53997 (Nov. 25, 2025).

ERIC supports the elimination of ghost rates from the INN Rate Files. However, we are concerned that this requirement may be administratively burdensome for the owners of the provider networks to execute. To ensure compliance with this proposed requirement, the Departments should provide additional assistance to the owners of the provider networks and monitor whether the provider network owners are successfully eliminating these superfluous rates.

This additional assistance could include the Departments providing a step-by-step walk-through of how owners of the provider networks should go through their internal provider taxonomy mapping, or the Departments providing examples where a provider-rate combination does not match.

V. ERIC Supports the Proposed Change to Both the INN Rate and OON Files

A. *Reporting by Product Type*

The Departments propose to require the owner of the provider network that is producing the TiC MRFs to report the product type (e.g., Health Maintenance Organization (“HMO”) or Preferred Provider Organization (“PPO”)) associated with the coverage option for which data is being reported in the INN Rate File as well as the OON Allowed Amount File.

We agree that INN Rates for covered items and services differ based on product type, so requiring the owner of the provider network to include the product type for each coverage option in the INN Rate File would reflect these differences and would be extremely helpful.

We also agree that adding a product type to the OON Allowed Amount Files would allow patients, researchers, and plan sponsors to compare how historical provider reimbursements differ based on product type, enabling more accurate and actionable comparisons to better understand true market pricing for specific product types.

VI. ERIC Supports the Proposed Changes to the OON Allowed Amount File

A. *Lowering Claims Threshold Triggering Public Disclosure*

Self-insured plan sponsors and their service providers have discovered that prices for OON services are rarely publicly disclosed in the MRFs. In an attempt to address this problem, the Departments would require more disclosures of OON payments for OON services by lowering the number of claims that must be incurred before the public disclosure requirement is triggered (from 20 claims to 11 claims). The Departments also clarify that this 11-claim threshold pertains to the number of claims for a particular medical item or service, and not the number of claims for a particular item or service from a particular provider.

ERIC supports these proposed changes, especially the clarification that the claims threshold applies to the medical item or service that is furnished, and *not* the provider furnishing the service. We believe that the disclosure of OON Payments should be based on the number of claims furnished by *any* provider, *not just one* provider.

B. Increasing the Reporting and Lookback Periods

ERIC also supports the Departments' proposal to increase the reporting period from the current 90 days to 6 months and increase the lookback period from the current 180 days to 9 months. This would increase the universe of OON Payments that would be required to be disclosed on the OON Allowed Amount File, resulting in an increase in disclosures of the payments for OON services.

VII. Four New Files To Help Plan Sponsors Better Understand the Pricing Data

Over the course of the past four years, the Departments have come to realize that additional information relating to the publicly disclosed pricing data is necessary to promote a fuller understanding of pricing dynamics. In response, the Departments are proposing to require the owner of the provider network to develop and post four new files to provide what the Departments are calling "additional context" to the INN rate file. These new – and separate and distinct – files include Change Log, Text, Utilization, and Taxonomy files.

A. ERIC Supports the Creation of the Change Log

The new Change Log File must be prepared for each INN Rate File, and each respective Change Log File must identify any changes made to the pricing information in the corresponding INN Rate File since the immediately preceding publication of that INN Rate File.

ERIC supports the creation of this Change Log File, as we believe the existence of this File would effectively eliminate the need to crosswalk old INN Rate Files with new INN Rate Files to better understand what pricing data may have changed.

B. ERIC Supports the Creation of the Text File

The proposed regulations would require the website of an insurance carrier, a self-insured plan, or a service provider on behalf of a self-insured plan to prominently display a Text File that includes a web link to the internet website that hosts the INN Rate File and the OON Allowed Amount File. The Text File must also include point-of-contact information, including an up-to-date name, title, and email address for an individual who works for the carrier, plan, or service provider who can address questions and issues related to these MRFs.

ERIC supports the creation of this Text File (which would include web links to the MRFs and point-of-contact information) as it would make it easier for plan sponsors and their service providers to locate the pricing information and 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.

C. ERIC Supports the Disclosure of "Volume of Claims" In the Newly Created Utilization File

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

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, ERIC does not support the “binary approach” the Departments are proposing when it comes to identifying which providers in the network are being utilized and which providers are not. Instead, ERIC supports including the number of claims (referred to as “volume of claims”) for which a particular provider in the network was reimbursed. It is helpful to know how many times a particular provider furnished a medical item or service, as opposed to simply indicating that the provider furnished at least one claim. Stated differently, it is not helpful to merely know that a provider was utilized one time.

Instead, knowing whether the provider is being readily utilized is most helpful as it allows the plan sponsor to then look at the INN rate for a particular provider. The plan sponsor can then compare that INN rate with those providers in the network with lower volume of claims (or even higher volume of claims) to evaluate why participants sought out a particular provider relative to others. Did participants utilize a provider because the provider’s INN Rate was reasonably priced relative to other providers? What if a highly utilized provider’s INN Rate was high relative to other providers? Does this show that the provider was readily utilized because of the quality of their services, which attracted the higher utilization despite the higher price? These are all questions that can be analyzed, and in many cases answered, if the volume of claims is disclosed in the proposed Utilization File.

Second, including the volume of claims for providers in the network allows a plan sponsor 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 potential ghost rates. As a result, including volume of claims in the Utilization File makes the Utilization File a very helpful tool for identifying – and eliminating – ghost rates. Arguably, it is a better tool than the proposed Taxonomy File (discussed below). Volume of claims also helps with benchmarking rates in a geographic region and allows plan sponsors to determine whether a particular provider is an outlier and whether the INN rate associated with that outlier provider is itself an outlier (i.e., ghost rate).

Third, volume of claims would also help plan sponsors re-negotiate rates with providers who have high-cost rates and low utilization. Here, a provider may choose to lower rates, which would likely increase utilization, or the plan sponsor can choose to exclude the provider from the network altogether.

Additionally, volume of claims is often a proxy for the quality of the provider. ERIC is a staunch supporter of improving the quality of care -- doing so can reduce utilization of low-value care, eliminate medical errors and unnecessary care, improve adherence, and incentivize providers to focus on value.

While we recognize that including the volume of claims in the Utilization File is different than developing a uniform set of quality metrics that could otherwise be used to identify the quality of a particular provider (which unfortunately has been an elusive policy goal due to the difficulty in getting consensus around what metrics are true measures of quality), we believe that including the volume of claims for a particular provider is a step in the right direction and is a relatively easy, yet important metric that could signify quality of a particular provider.

Coupling this potential indicator of quality with the disclosure of the INN rate associated with the provider could allow plan sponsors to identify high-value, low-cost providers, which could in turn allow plan sponsors to develop ways to incentivize plan participants to utilize high-value, low-cost providers through value-based insurance designs or otherwise.

D. The Departments Should Refrain from Finalizing the Taxonomy File

We recognize that the primary reason for proposing the publication of a Taxonomy File is to assist in the identification – and then elimination – of ghost rates. However, we do not believe that it is necessary to finalize the proposed Taxonomy File, especially if and when the Departments require the inclusion of the volume of claims in the Utilization File, as discussed above. The owner of the provider network’s internal taxonomy for adjudicating claims could potentially help in eliminating ghost rates, if the owner of the provider network chooses to do so. Either the owner of the provider network will do so voluntarily – or may not do so, finding it too complex – based on their own use of their internal taxonomy. We do not see how the publication of the provider network owner’s internal taxonomy changes that, or enables either a plan sponsor or the Departments to clean up the file on their own.

Also, publishing an owner of the provider network’s internal taxonomy does not necessarily result in the provision of any new information that plan sponsors cannot already obtain through other, more helpful, changes included in these proposed regulations to guide a plan sponsor in future rate negotiations with the owner of the provider network or medical providers. It is even possible that the owner of the provider network will merely publish an already public taxonomy template that plan sponsors already have the ability to access, and call that compliance with this requirement.

VIII. ERIC Recommends a More Immediate Effective Date

The Departments can – and should – modify the effective date of these proposed regulations from 12 months after the date final regulations are released to 90 days after the date these proposed regulations are finalized.

First, many of the proposed changes are already being incorporated into the services that companies specializing in transparency offer to self-insured plan sponsors today. Also, in some cases, many of the proposed changes are already being incorporated into the TiC MRFs produced by owners of the provider networks. As a result, any changes to systems or other processes to comply with these proposed requirements are not overly burdensome, and therefore, do not require a long runway for compliance.

Moreover, owners of the provider networks are not required to build new systems to comply with these proposed changes. Unlike much of the heavy-lifting that was required to comply with the original TiC regulations, it is not required here. Rather, the proposed changes merely require modifications, refinements, and improvements to existing systems, which do not necessitate an extended timeline for compliance. We would offer that the Departments could consider releasing sub regulatory guidance and updated Schemas to help the owners of the provider networks modify, refine, and improve their existing systems and processes to comply.

One point of comparison: the recent changes to the Hospital Price Transparency Rule requirements were finalized on November 25, 2025, in the final Medicare Hospital Outpatient Prospective Payment System regulation, which became effective just over 1 month later on January 1, 2026. Allowing for a 90-day effective date will bring more transparency to the health care system.

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,

A handwritten signature in blue ink that reads "James P. Gelfand". The signature is written in a cursive style with a large initial "J".

James P. Gelfand
President & CEO