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32BJ Health Fund Response to CMS-9882-P
Transparency in Coverage Proposed Rule

February 23, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9882-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9882-P - Transparency in Coverage Proposed Rule

Dear Administrator Oz,

The 32BJ Health Fund is an unusually effective collaboration between a labor union and management to provide affordable, comprehensive, and innovative health coverage to working-class people. We aggregate employer contributions from 5,000 employers, ranging from many small businesses to global real estate firms, and use these contributions to provide benefits to 200,000 members of the SEIU Local 32BJ union and their families. The union members are cleaners, property maintenance workers, doorpersons, security officers, window cleaners, building engineers, school and food service workers, and airport workers in over 10 states and Washington, DC.

Our comments build upon our September 2023 response to CMS-1786-P and our July 2025 response to the Hospital Price Transparency Request for Information and reflect our ongoing learning as users of machine-readable files (MRFs) for direct contracting negotiations and member benefit design. As a self-funded purchaser of healthcare services administered by a third-party administrator, we have extensive practical experience with the challenges and opportunities of using price transparency data.

Comments Overview

We strongly support the goals of these proposed rules to improve standardization, accuracy, and accessibility of pricing information. The proposals address many of the technical and usability challenges we have encountered since implementation of the 2020 final rules. Specifically:

1. Contextual files (Change-Log, Utilization, Taxonomy) will dramatically improve usability.
2. Conditional support for quarterly reporting cadence, which we support only if accompanied by detailed Change-Log Files to track rate changes between quarters.
3. Network-level organization addresses the pervasive file duplication problem we currently face.
4. Provider-rate exclusion based on specialty taxonomy will reduce noise while maintaining completeness.

5. Improved file discoverability will reduce time spent locating data.

However, we offer specific feedback below on the proposed rule updates to ensure these regulatory changes achieve their intended impact.

(1) Contextual Machine-Readable Files

The 32BJ Health Fund supports the following contextual machine-readable proposals with the following modifications:

- **Change-Log File:** The introduction of the Change-Log File, which will substantially reduce the burden on data users by eliminating the need to download and compare entire files monthly to identify changes. However, we recommend that CMS clarify design questions regarding level of detail (whether the Change-Log should identify high-level changes such as "rates updated for Provider X" versus specific data point changes such as "Provider X's rate for CPT 99213 changed from \$150 to \$155") and materiality thresholds (whether to include all changes or only material changes). We further recommend that the Change-Log identify specific rate changes with old and new values, provider network additions/removals, and coverage changes, while excluding minor updates to billing code descriptions to keep the file focused and useful.
- **Utilization File:** The Utilization File, which addresses a gap by identifying which providers actually deliver services under a plan's network rather than just which providers have contracts. Currently, provider directories include many providers who have negotiated rates but never actually see our members, creating false impressions of network adequacy. We recommend enhancing the proposal by including claim volume ranges (such as 1-10, 11-50, 51-100, 100+) to distinguish between high-volume providers who are truly active versus low-volume providers who are incidentally used, which would provide meaningful information while protecting privacy.
- **Taxonomy File:** The Taxonomy File, as it is essential for transparency around which provider-rate combinations were excluded from In-Network Rate Files. This file allows users to verify that exclusions are clinically appropriate, understand the plan's/issuer's internal taxonomy logic, and identify potential over-exclusion of legitimate services. We recommend requiring the Taxonomy File to be updated whenever the internal taxonomy changes to ensure users have current information about exclusion decisions.
- **Text File and Footer Links:** Requiring a standardized Text File in the root folder and footer links, which will dramatically improve file discoverability by enabling automated file retrieval, reducing time spent manually navigating inconsistent site structures, standardizing access across all plans/issuers, and aligning with Hospital Price Transparency requirements. While including contact information for someone knowledgeable about the files is valuable, we recommend that CMS establish required response timeframes (e.g., 10 business days) and minimum qualifications for designated points-of-contact to ensure they have actual technical knowledge of file generation and contents and can meaningfully assist file users.

(2) Reporting Cadence

- **Quarterly vs. Monthly Reporting Cadence:** We conditionally support changing the reporting frequency from monthly to quarterly for In-Network Rate and Allowed Amount Files, contingent upon implementation of the robust quarterly Change-Log Files proposed in Section 1. With this simultaneous requirement in place, quarterly reporting will reduce storage costs for both file producers and users,

decrease bandwidth requirements, allow more time for quality assurance before posting, and reflect the reality that negotiated rates do not change monthly. While individual provider turnover within large organizations means some rates may become outdated during a quarter, this is a minor trade-off given the substantial benefits, and the combination of quarterly reporting plus a quarterly Change-Log File strikes the right balance by allowing users to efficiently identify changes without downloading entire files monthly.

(3) In-Network Rate Machine-Readable Files

The 32BJ Health Fund supports the proposed changes In-Network Rate Machine-Readable Files, noting:

- **Network-Level Reporting:** Organizing the In-Network Rate Files by provider network rather than by plan ID, which directly addresses massive duplication of identical negotiated rates across multiple plan files while reducing total file count, simplifying rate comparison analysis, and aligning with Hospital Price Transparency files. However, we recommend each network-level file include a field or list mapping which employer identification numbers (EINs) use that specific network to maintain the ability to identify specific employer groups and support direct contracting analysis
- **Product Type Field:** Adding the product type (HMO, PPO, etc.) in both In-Network Rate and Allowed Amount Files for crucial rate comparison context. However, as a self-funded plan with characteristics of both HMO and PPO structures, we recommend CMS publish explicit guidance on product type classification for self-funded and hybrid plan designs, including examples that align with existing regulatory definitions.
- **Enrollment Totals:** Noting enrollment totals for each coverage option, which will help us focus analysis on rates affecting the most people, understand relative market power in negotiations, and identify meaningful comparisons to our membership size.
- **Percentage-of-Billed-Charges Reporting:** Codifying the approach for percentage-of-billed-charges arrangements, which removes ambiguity and aligns with current enforcement guidance for circumstances where dollar amounts cannot be determined in advance.
- **Excluding Unlikely Provider-Rate Combinations:** Excluding provider-rate combinations where providers are unlikely to be reimbursed based on specialty taxonomy, which addresses file size problems from clinically implausible rates. However, the proposal lacks specificity on when combinations should be considered "unlikely," instead leaving this determination up to each plan or issuer. We recommend establishing a frequency threshold (if a service occurred at least once in 3 years by any provider with that specialty, include it; for example, exclude a cardiologist delivering a baby but include rare heart transplants) and requiring attestation that exclusions follow this standard. The required Taxonomy File is essential for transparency, but we recommend that CMS establish audit procedures to verify that exclusions are appropriate, require documentation of clinical basis for taxonomy mappings, and provide mechanisms for users to challenge inappropriate exclusions to prevent plans/issuers from over-excluding legitimate but infrequent services to reduce file size.

(4) Out-of-Network Allowed Amount Files

The 32BJ Health Fund supports the proposed changes to the Out-of-Network Rate Allowed Amounts Files, noting:

- **Lower Claims Threshold (20 to 11):** Lowering the threshold from 20 to 11 claims, which will increase the volume of out-of-network data available while maintaining privacy protections, as current files have

too many gaps where services fall below the 20-claim threshold, making meaningful analysis impossible.

- **Extended Reporting and Lookback Periods:** Extending the reporting period from 90 days to 6 months and the lookback period from 180 days to 9 months, which will increase the likelihood that services exceed the 11-claim threshold, provide more complete historical data, and better capture low-frequency but significant out-of-network services, without significant implementation burden as it primarily involves adjusting date parameters in existing queries.

(5) Prescription Drug Price Transparency

The 32BJ Health Fund strongly urges the Departments to finalize implementation of the prescription drug machine-readable file requirement in the 2020 final rules. Pharmacy costs are a significant and growing portion of our spend, yet this area remains opaque, hindering effective benefit management for our 200,000 members. Specifically, we recommend that the Departments:

- **Disclose Actual Net Prices:** Machine-readable files should reflect the actual net prices paid after all price concessions and rebates are applied.
- **Establish a 2027 Implementation Timeline:** The Departments should release a finalized drug schema immediately to ensure drug transparency does not continue to lag years behind medical price transparency.

(6) Proposed Requirements for Disclosures to Participants, Beneficiaries, or Enrollees

The 32BJ Health Fund supports the proposed changes to the disclosures to participants, beneficiaries, or enrollees, noting:

- **Balance Billing Disclaimer Update:** We support updating the balance billing disclaimer to reflect Federal protections under the No Surprises Act. The original 2020 final rules required balance billing disclaimers only when permitted by state law. The proposed amendment appropriately recognizes that Federal balance billing protections now exist under the No Surprises Act, which prohibits balance billing for emergency services, out-of-network services at in-network facilities, and air ambulance services. The proposed disclaimer will inform members that cost estimates do not account for potential additional amounts in situations where applicable State and Federal law allow out-of-network providers to bill for the difference between billed charges and allowed amounts. We agree with CMS that the disclaimer exception (for States that categorically prohibit all balance billing for all items and services) is effectively a universal requirement, as no States currently meet this threshold. This amendment provides an important layer of transparency for members by clarifying both Federal No Surprises Act protections and remaining balance billing exposure. The January 1, 2027 applicability date for plan years provides adequate implementation time.
- **Phone-Based Cost-Sharing Information:** Requiring cost-sharing information via telephone to expand access for members with limited digital literacy. However, we are concerned about TPA readiness to provide real-time, accurate information, potential underestimation of call volumes, and TPAs passing compliance costs to plans via increased administrative fees rather than absorbing these reasonable costs.

(7) Method and Format Requirements

The 32BJ Health Fund suggests improvements to the method and formatting requirements including:

- **File Format Standardization:** Specifying a single, non-proprietary open format in technical guidance rather than regulation, with JSON being appropriate for the complex hierarchical structure of

transparency data, as CSV's flat structure would create massive files with extensive data repetition. We recommend specifying JSON as the required format with clear schema specifications and consider developing simplified CSV extracts for specific high-value subsets to improve accessibility for non-technical users.

- **API Access:** We encourage CMS to explore requiring data availability via standardized APIs in addition to file downloads, which would enable real-time queries without downloading massive files, reduce storage and bandwidth requirements, allow more targeted data retrieval, align with modern data access standards, and build on the Interoperability and Prior Authorization Final Rule precedent. We recommend that CMS issue guidance on API standards and explore requiring API access in future rulemaking.
- **Prohibition of Access Barriers:** Requiring that files be accessible to automated scripts without CAPTCHAs, passwords, or other barriers to enable automated data collection, support consumer-facing tools, reduce manual effort, and ensure consistent access. While we acknowledge security concerns from potential bad actors, the proposed Text File and standardized paths actually reduce security risks by eliminating hard-coded paths, and public data should be publicly accessible without artificial barriers. We recommend maintaining the prohibition on CAPTCHAs as proposed.

(8) Rules for Self-Insured Plans

As a self-funded purchaser of healthcare services, the 32BJ Health Fund notes support for:

- **Third Party Administrator (TPA)-Level Aggregation for In-Network Rate Files:** Allowing TPAs to aggregate In-Network Rate Files across multiple self-insured plans using the same provider network, including across different sponsors and market types, which will reduce total file count, eliminate duplication where multiple employer groups use identical contracts, and simplify analysis for researchers and other users. However, we recommend that aggregated files include a field or list mapping which employer identification numbers (EINs) or plan identifiers are included in each aggregated network file to maintain traceability to specific employer groups and support direct contracting analysis. The requirement that corresponding Change-Log, Utilization, and Taxonomy Files include data from the same aggregated set of plans is appropriate to maintain coherence.
- **TPA-Level Aggregation for Allowed Amount Files:** Allowing TPAs to aggregate Allowed Amount Files across multiple self-insured plans from different sponsors, with the 11-claim threshold applied to the aggregated dataset rather than to each individual plan, which will maximize out-of-network data volume, improve privacy protection, and reduce file proliferation. However, similar to In-Network Rate Files, we recommend aggregated Allowed Amount Files include metadata identifying which employer groups or plan types are included in the aggregation to maintain analytical utility while preserving the privacy and efficiency benefits of aggregation.

(9) Additional Recommendations

In response to the call for additional methods for reducing administrative burden while maintaining data accuracy, the 32BJ Health Fund recommends:

- **Data Retention Requirements:** Currently, plans/issuers replace files with each reporting period, making historical data unavailable unless users proactively download and archive files. We recommend requiring plans/issuers to retain machine-readable files publicly available for a minimum of 3 years. This would enable longitudinal analysis of rate trends, provide historical context for current rates, allow researchers to study rate changes over time, and create accountability for rate trajectory. The quarterly

cadence reduces (but does not eliminate) this problem. However, explicit retention requirements would ensure historical data remains accessible.

- **File Validation Requirements:** Require all machine-readable files to pass JSON validation before posting, similar to our recommendation for Hospital Price Transparency files. This would eliminate basic formatting errors that prevent file parsing, reduce burden on users who encounter malformed files, demonstrate basic quality control by file producers, and create a minimum quality standard.

In conclusion, the 32BJ Health Fund strongly supports these proposed rules with some proposals for modification and appreciates the opportunity to provide input based on our practical experience using transparency data for direct contracting negotiations and benefit design. As a self-funded plan serving 200,000 working-class union members and their families, improving the quality and usability of price transparency data is important for our ability to benchmark and negotiate the prices we pay for healthcare services.

The proposals to organize In-Network Rate Files by provider network, exclude clinically implausible provider-rate combinations, add contextual files (Change-Log, Utilization, Taxonomy, Text), improve file discoverability, and shift to quarterly reporting will substantially improve data usability while reducing burden on both file producers and users.

We strongly urge the Departments to finalize these rules with three modifications: (1) extend implementation to 18 months, (2) establish clear frequency thresholds for provider-rate exclusions, and (3) require 3-year data retention for longitudinal analysis. These changes will maximize utility for direct contracting, benefit design, and informed consumer decision-making.

Respectfully submitted,



Cora Opsahl

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