I

118TH CONGRESS
1ST SESSION

H. R. 2691

To promote hospital and insurer price transparency.

IN THE HOUSE OF REPRESENTATIVES

APRIL 18, 2023

Mrs. RODGERS of Washington (for herself and Mr. PALLONE) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To promote hospital and insurer price transparency.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Transparent Prices Required to Inform Consumer and Employers Act'' or the ''Transparent PRICE Act''.

SEC. 2. PRICE TRANSPARENCY REQUIREMENTS.

(a) IN GENERAL.—Section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)) is amended—

(1) by striking ''Each hospital'' and inserting the following:

''(1) IN GENERAL.—Each hospital'';

(2) by inserting '', in plain language without subscription and free of charge, in a consumer-friendly, machine-readable format,'' after ''a list''; and

(3) by adding at the end the following: ''Beginning January 1, 2024, each hospital shall include in its list of standard charges, along with such additional information as the Secretary may require with respect to such charges for purposes of promoting public awareness of hospital pricing in advance of receiving a hospital item or service, as applicable, the following:

''(A) A description of each item or service provided by the hospital, accompanied by, as applicable, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other payer identifier used or approved by the Centers for Medicare & Medicaid Services.

''(B) The gross charge, expressed as a dollar amount, for each such item or service, when

provided in, as applicable, the hospital inpatient setting and outpatient department setting.

''(C) Any current payer-specific negotiated charges, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

''(D) The discounted cash price, expressed as a dollar amount, for each such item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. If the discounted cash price is a percentage of another value provided, the calculated value must be entered as a dollar amount. If the discounted cash price equates to the gross charge, the gross charge shall be re-entered to indicate that no cash discount is available.

''(E) The average negotiated rate and acquisition cost paid by the hospital for each drug or biological product—

''(i) for which payment would be made under part B of title XVIII of the Social

Security Act if the individual administered such drug or biological product were enrolled under such part B; and

''(ii) that is administered by the hospital or an entity with a direct financial relationship to the hospital during the previous year,

which, in the case of such a drug or biological product that is first administered in the hospital during the previous 12-month period, shall be included in such list of standard charges beginning not later than 30 days after the date of such first administration.

''(2) DELIVERY METHODS AND USE.—

''(A) IN GENERAL.—Each hospital shall make public the standard charges described in paragraph (1) for as many of the 70 Centers for Medicare & Medicaid Services-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as may be necessary for a combined total of at least 300 shoppable services, including the rate at which a hospital provides and bills for that shoppable service. If a hospital does not provide 300 shoppable services

in accordance with the previous sentence, the hospital shall make public the information specified under paragraph (1) for as many shoppable services as it provides.

''(B) DETERMINATION BY CMS.—With respect to a year before 2025, a hospital shall be deemed by the Centers for Medicare & Medicaid Services to meet the requirements of subparagraph (A) if the hospital maintains an internet-based price estimator tool that meets the following requirements:

''(i) The tool provides estimates for as many of the 70 specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as may be necessary for a combined total of at least 300 shoppable services.

''(ii) The tool allows health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.

''(iii) The tool is prominently displayed on the hospital's website and easily

accessible to the public, without subscription, fee, or having to submit personal identifying information (PII), and searchable by service description, billing code, and payer.

"(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2025, the Secretary shall implement a standard, uniform method and format for hospitals to use in order to satisfy the requirements of this subsection for disclosing directly to the public charge and price information. Such method and format may be similar to any template established by the Centers for Medicare & Medicaid Services as of the date of the enactment of this paragraph for reporting such information under this subsection and shall meet such standards as determined appropriate by the Secretary.

"(4) MONITORING OF PRICING INFORMATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall, through notice and comment rulemaking, establish a process to regularly monitor the accuracy and validity of pricing information displayed by each hospital pursuant to paragraph (1).

"(5) DEFINITIONS.—Notwithstanding any other provision of law, for the purpose of paragraphs (1) and (2):

"(A) DE-IDENTIFIED MAXIMUM NEGOTIATED CHARGE.—The term 'de-identified maximum negotiated charge' means the highest charge that a hospital has negotiated with all third party payers for an item or service.

"(B) DE-IDENTIFIED MINIMUM NEGOTIATED CHARGE.—The term 'de-identified minimum negotiated charge' means the lowest charge that a hospital has negotiated with all third party payers for an item or service.

"(C) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service. Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross charges as found in the hospital chargemaster.

"(D) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

"(E) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that a hospital has negotiated with a third party payer for an item or service.

"(F) SHOPPABLE SERVICE.—The term 'shoppable service' means a service that can be scheduled by a health care consumer in advance.

"(G) STANDARD CHARGES.—The term 'standard charges' means the regular rate established by the hospital for an item or service, including both individual items and services and service packages, provided to a specific group of paying patients, including the gross charge, the payer-specific negotiated charge, the discounted cash price, the de-identified minimum negotiated charge, the de-identified maximum negotiated charge, and other rates determined by the Secretary.

"(H) THIRD PARTY PAYER.—The term 'third party payer' means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

"(6) ENFORCEMENT.—

"(A) IN GENERAL.—In the case of a hospital that fails to provide the information required by this subsection—

"(i) the Secretary shall notify such hospital of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

"(ii) not later than 90 days after the date of such notification, the hospital shall complete a corrective action plan to comply with such requirements.

"(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under subsection (b)(3) or another provision of law, a hospital that has received a notification under subparagraph (A)(i) and fails to satisfy the requirement under subparagraph (A)(ii) or otherwise comply with the requirements of this subsection not later than 90 days after such notification, shall be subject to a civil monetary penalty of an amount—

"(I) in the case the hospital provides not more than 30 beds (as determined under section 180.90(c)(2)(ii)(D) of title 45, Code of Federal Regulations, as in effect on the date of the enactment of this paragraph), not to exceed $300 per day that the violation is ongoing as determined by the Secretary; and

"(II) in the case the hospital provides more than 30 beds (as so determined), equal to—

"(aa) subject to item (bb), $10 per bed per day that the violation is ongoing as determined by the Secretary, but for violations occurring before January 1, 2024, not to exceed $5,500 per each such day; or

"(bb) in the case such hospital has failed to satisfy the requirement under subparagraph (A)(ii) or otherwise comply with the requirements of this subsection for any continuous 1-year

period beginning on or after January 1, 2024, and the amount otherwise imposed under item (aa) for such failure for such period would be less than $5,000,000, an amount not less than $5,000,000.

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to violations occurring in 2025 or a subsequent year, the Secretary may through notice and comment rulemaking increase any dollar amount applied under this subparagraph by an amount specified by the Secretary.

''(iii) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under clause (i) in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.''.

(b) PUBLICATION OF LIST OF HOSPITALS.—

(1) LIST OF HOSPITALS.—Beginning not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish and maintain a publicly available list, on the website of the Centers for Medicare & Medicaid Services and updated in real time, of—

(A) each hospital that—

(i) is not in compliance with the hospital price transparency rule implementing section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)), and that, with respect to such noncompliance—

(I) has been issued a civil monetary penalty;

(II) has received a warning notice; or

(III) has received a request for a corrective action plan; or

(ii) has received any written communication by the Secretary regarding potential noncompliance with such hospital price transparency rule; and

(B) each hospital that is in compliance with respect to such hospital price transparency

rule and has not received any written communication described in paragraph (1)(B).

(2) FOIA REQUESTS.—Any penalty, notice, request, or other communication described in subsection (a) shall be subject to public disclosure, in full and without redaction, under section 552 of title 21, United States Code, notwithstanding any exemptions or exclusions otherwise available under such section 552.

(3) REPORTS TO CONGRESS.—Not later than 1 year after the date of enactment of this Act and each year thereafter, the Secretary of Health and Human Services shall submit to Congress, and make publicly available, a report that contains information regarding complaints of alleged violations of law and enforcement activities by the Secretary under the hospital price transparency rule implementing section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)). Such report shall be made available to the public on the website of the Centers for Medicare & Medicaid Services. Each such report shall include, with respect to the year involved—

(A) the number of compliance and enforcement inquiries opened by the Secretary pursuant to such section;

(B) the number of notices of noncompliance issued by the Secretary based on such inquiries;

(C) the identity of each hospital entity that received a notice of noncompliance and the nature of the failure giving rise to the Secretary's determination of noncompliance;

(D) the amount of civil monetary penalty assessed against the hospital entity;

(E) whether the hospital entity subsequently corrected the noncompliance; and

(F) an analysis of factors contributing to increasing health care costs.

(4) GAO REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate a report on the compliance and enforcement with the hospital price transparency rule implementing section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)). The report shall include recommendations related to—

(A) improving price transparency to patients, employers, and the public; and

(B) increased civil monetary penalty amounts to ensure compliance.

(5) REQUEST FOR INFORMATION.—Not later than January 1, 2025, the Secretary of Health and Human Services shall issue a public request for information as to the best method through which hospitals may be required to publish quality data (such as data required to be reported under the Medicare Hospital Compare program) alongside data required to be reported under section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)).

SEC. 3. STRENGTHENING HEALTH INSURANCE TRANSPARENCY REQUIREMENTS.

(a) COST SHARING TRANSPARENCY.—Section 1311(e)(3)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

(1) by striking ''The Exchange'' and inserting the following:

''(i) IN GENERAL.—The Exchange'';

(2) in clause (i), as inserted by paragraph (1)—

(A) by striking ''participating provider'' and inserting ''provider'';

(B) by inserting ''shall include the information specified in clause (ii) and'' after ''such information'';

(C) by striking ''an Internet website'' and inserting ''a self-service tool that meets the requirements of clause (iii)''; and

(D) by striking ''and such other'' and all that follows through the period and inserting ''or, at the option such individual, through a paper disclosure (provided at no cost to such individual) that meets such requirements as the Secretary may specify.''; and

(3) by adding at the end the following new clauses:

''(ii) SPECIFIED INFORMATION.—For purposes of clause (i), the information specified in this clause is, with respect to an item or service for which benefits are available under a health plan furnished by a health care provider, the following:

''(I) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subparagraph (F)) for such item or service.

''(II) If such provider is not described in subclause (I), the maximum amount the plan will recognize as payment for such item or service.

''(III) The amount of cost sharing (including deductibles, copayments, and coinsurance) that the individual will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subclause (II), shall be calculated using the maximum amount described in such subclause).

''(IV) The amount the individual has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to separate individuals enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(V) In the case such plan imposes any frequency or volume limita-

tions with respect to such item or service (excluding medical necessity determinations), the amount that such individual has accrued towards such limitation with respect to such item or service.

''(VI) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan.

''(iii) SELF-SERVICE TOOL.—For purposes of clause (i), a self-service tool established by a health plan meets the requirements of this clause if such tool—

''(I) is based on an Internet website;

''(II) provides for real-time responses to requests described in such clause;

''(III) is updated in a manner such that information provided through such tool is timely and accurate;

"(IV) allows such a request to be made with respect to an item or service furnished by—

"(aa) a specific provider that is a participating provider with respect to such item or service;

"(bb) all providers that are participating providers with respect to such plan and such item or service; or

"(cc) a provider that is not described in item (bb); and

"(V) provides that such a request may be made with respect to an item or service through use of the billing code for such item or service or through use of a descriptive term for such item or service.

The Secretary may require such tool, as a condition of complying with subclause (V), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to items and services with no more

than a de minimis difference in patient experience in receiving such items and services and cost sharing imposed under such plan for such items and services.''.

(b) DISCLOSURE OF ADDITIONAL INFORMATION.—Section 1311(e)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)) is amended by adding at the end the following new subparagraphs:

''(E) RATE AND PAYMENT INFORMATION.—

''(i) IN GENERAL.—Not later than January 1, 2024, and every 3 months thereafter, each health plan shall submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, the rate and payment information described in clause (ii) in accordance with clause (iii).

''(ii) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of clause (i), the rate and payment information described in this clause is, with respect to a health plan, the following:

''(I) With respect to each item or service (other than a drug) for which

benefits are available under such plan, the in-network rate in effect as of the date of the submission of such information with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service, other than such a rate in effect with a provider that, during the 1-year period ending on such date, submitted fewer than 10 claims for such item or service to such plan.

''(II) With respect to each drug (identified by national drug code) for which benefits are available under such plan, the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national pro-

vider identifier), other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan.

"(III) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount recognized by the plan, for each such item or service furnished during the 1-year period ending on such date by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than amounts billed by, and amounts recognized by a plan with respect to, a provider that, during such period, submitted fewer than 10 claims for such item or service to such plan.

"(iii) MANNER OF SUBMISSION.—Rate and payment information required to be submitted and made available under this subparagraph shall be so submitted and so

made available in 3 separate machine-readable files corresponding to the information described in each of subclauses (I) through (III) of clause (ii) that meet such requirements as specified by the Secretary through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, are made available in a widely-available format that allows for information contained in such files to be compared across health plans, and are accessible to individuals at no cost and without the need to establish a user account or provider other credentials.

''(iv) USER GUIDE.—Each health plan shall make available to the public instructions written in plain language explaining how individuals may search for information described in clause (ii) in files submitted in accordance with clause (iii).

''(F) DEFINITIONS.—In this paragraph:

''(i) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 2799A–1(a)(3) of the Public Health Service Act.

''(ii) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service.''.

(c) REPORTS.—

(1) COMPLIANCE.—Not later than January 1, 2025, the Comptroller General of the United States shall submit to Congress a report containing—

(A) an analysis of health plan compliance with the amendments made by this section;

(B) an analysis of enforcement of such amendments by the Secretaries of Health and Human Services, Labor, and the Treasury;

(C) recommendations relating to improving such enforcement; and

(D) recommendations relating to improving public disclosure, and public awareness, of information required to be made available by such plans pursuant to such amendments.

(2) PRICES.—Not later than January 1, 2028, the Comptroller General of the United States shall

submit to Congress a report containing an assessment of differences in negotiated prices (and any trends in such prices) in the private market between—

(A) rural and urban areas;

(B) the individual, small group, and large group markets;

(C) consolidated and nonconsolidated health care provider areas (as specified by the Secretary);

(D) nonprofit and for-profit hospitals;

(E) nonprofit and for-profit insurers; and

(F) insurers serving local or regional areas and insurers serving multistate or national areas.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning January 1, 2024.

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