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117TH CONGRESS
1ST SESSION

H. R. 3029

To amend the Public Health Service Act to provide for hospital and insurer price transparency.

IN THE HOUSE OF REPRESENTATIVES

MAY 7, 2021

Mr. DAVIDSON (for himself, Mr. WESTERMAN, Ms. TENNEY, Mr. LAMALFA, Mr. BANKS, and Mr. CAWTHORN) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to provide for 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 ''Health Care Prices Revealed and Information to Consumers Explained Transparency Act'' or the ''Health Care PRICE Transparency Act''.

SEC. 2. PRICE TRANSPARENCY REQUIREMENTS.

(a) HOSPITALS.—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: ''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.

''(B) The gross charge.

''(C) Any payer-specific negotiated charge clearly associated with the name of the third party payer and plan.

''(D) The de-identified minimum negotiated charge.

''(E) The de-identified maximum negotiated charge.

''(F) The discounted cash price.

''(G) Any code used by the hospital for purposes of accounting or billing, including 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 common payer identifier.

''(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 Medicaid & Medicare 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 spec-

ified under paragraph (1) for as many shoppable services as it provides.

''(B) DETERMINATION BY CMS.—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 search-

able by service description, billing code, and payer.

''(3) 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 respon-

sible for payment of a claim for a health care item or service.

''(4) ENFORCEMENT.—In addition to any other enforcement actions or penalties that may apply under subsection (b)(3) or another provision of law, a hospital that fails to provide the information required by this subsection and has not completed a corrective action plan to comply with the requirements of such subsection shall be subject to a civil monetary penalty of an amount not to exceed $300 per day that the violation is ongoing as determined by the Secretary. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.''.

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

(1) in subparagraph (A)—

(A) by redesignating clause (ix) as clause (xii); and

(B) by inserting after clause (viii), the following:

''(ix) In-network provider rates for covered items and services.

''(x) Out-of-network allowed amounts and billed charges for covered items and services.

''(xi) Negotiated rates and historical net prices for covered prescription drugs.'';

(2) in subparagraph (B)—

(A) in the heading, by striking ''USE'' and inserting ''DELIVERY METHODS AND USE'';

(B) by inserting ''and subparagraph (C)'' after ''subparagraph (A)'';

(C) by inserting '', as applicable,'' after ''English proficiency''; and

(D) by inserting after the second sentence, the following: ''The Secretary shall establish standards for the methods and formats for disclosing information to individuals. At a minimum, these standards shall include the following:

''(i) An internet-based self-service tool to provide information to an individual in plain language, without subscription and free of charge, in a machine readable format, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information

that is accurate at the time of the request that allows, at a minimum, users to—

"(I) search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers;

"(II) search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount an insurer will pay for a covered item or service provided by out-of-network providers; and

"(III) refine and reorder search results based on geographic proximity of in-network providers, and the amount of the individual's cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

"(ii) In paper form at the request of the individual that includes no fewer than 20 providers per request with respect to

which cost-sharing information for covered items and services is provided, and discloses the applicable provider per-request limit to the individual, mailed to the individual not later than 2 business days after receiving an individual's request.'';

(3) in subparagraph (C)—

(A) in the first sentence—

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

''(i) IN GENERAL.—The Exchange'';

(ii) by inserting ''or out-of-network provider'' after ''item or service by a participating provider''; and

(iii) by inserting before the period the following: ''the following information:

''(i) An estimate of an individual's cost-sharing liability for a requested covered item or service furnished by a provider, which shall reflect any cost-sharing reductions the individual would receive.

''(ii) A description of the accumulated amounts.

''(iii) The in-network rate, including negotiated rates and underlying fee schedule rates.

''(iv) The out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount an issuer will pay, including the percent reimbursed by insurers to out-of-network providers, for the requested covered item or service furnished by an out-of-network provider.

''(v) A list of the items and services included in bundled payment arrangements for which cost-sharing information is being disclosed.

''(vi) A notification that coverage of a specific item or service is subject to a prerequisite, if applicable.

''(vii) A notice that includes the following information:

''(I) A statement that out-of-network providers may bill individuals for the difference, including the balance billing, between a provider's billed charges and the sum of the amount

collected from the insurer in the form of a copayment or coinsurance amount and the cost-sharing information.

''(II) A statement that the actual charges for an individual's covered item or service may be different from an estimate of cost-sharing liability depending on the actual items or services the individual receives at the point of care.

''(III) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service.

''(IV) A statement disclosing whether the plan counts copayment assistance and other third-party payments in the calculation of the individual's deductible and out-of-pocket maximum.

''(V) For items and services that are recommended preventive services under section 2713 of the Public

Health Service Act, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service in the insurer cannot determine whether the request is for a preventive or non-preventive item or service.

''(VI) Any additional information, including other disclaimers, that the insurer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this subsection.'';

(B) by striking the second sentence; and

(C) by adding at the end the following:

''(ii) DEFINITIONS.—Notwithstanding any other provision of law, for the purpose of this subparagraph and subparagraphs (A) and (B):

''(I) ACCUMULATED AMOUNTS.—The term 'accumulated amounts' means the amount of financial responsibility an individual has incurred at the time a request for cost-sharing in-

formation is made, with respect to a deductible or out-of-pocket limit, including any expense that counts toward a deductible or out-of-pocket limit, but exclude any expense that does not count toward a deductible or out-of-pocket limit. To the extent an insurer imposes a cumulative treatment limitation on a particular covered item or service independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service.

''(II) HISTORICAL NET PRICE.—The term 'historical net price' means the retrospective average amount an insurer paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the insurer with respect to the prescription drug. The allocation shall be determined by dollar value for non-product specific and product-specific rebates, discounts, chargebacks,

fees, and other price concessions to the extent that the total amount of any such price concession is known to the insurer at the time of publication of the historical net price.

''(III) NEGOTIATED RATE.—The term 'negotiated rate' means the amount a plan or issuer has contractually agreed to pay for a covered item or service, whether directly or indirectly through a third party administrator or pharmacy benefit manager, to an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items or services.

''(IV) OUT-OF-NETWORK ALLOWED AMOUNT.—The term 'out-of-network allowed amount' means the maximum amount an insurer will pay for a covered item or service furnished by an out-of-network provider.

''(V) OUT-OF-NETWORK LIMIT.—The term 'out-of-network limit' means the maximum amount that an indi-

vidual is required to pay during a coverage period for his or her share of the costs of covered items and services under his or her plan or coverage, including for self-only and other than self-only coverage, as applicable.

''(VI) UNDERLYING FEE SCHEDULE RATES.—The term 'underlying fee schedule rates' means the rate for an item or service that a plan or issuer uses to determine a participant's, beneficiary's, or enrollee's cost-sharing liability from a particular provider or providers, when the rate is different from the negotiated rate.'';

(4) in subparagraph (D), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A), (B), and (C)''; and

(5) by adding at the end the following:

''(F) APPLICATION OF PARAGRAPH.—In addition to qualified health plans (and plans seeking certification as qualified health plans), this paragraph (as amended by the Health Care Prices Revealed and Information to Consumers Explained Transparency Act) shall apply to

group health plans (including self-insured and fully insured plans) and health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).''.

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