

119TH CONGRESS
1ST SESSION

H. R. 267

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

IN THE HOUSE OF REPRESENTATIVES

JANUARY 9, 2025

Mr. DAVIDSON introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Care Prices
5 Revealed and Information to Consumers Explained Trans-
6 parency Act” or the “Health Care PRICE Transparency
7 Act”.

1 **SEC. 2. PRICE TRANSPARENCY REQUIREMENTS.**

2 (a) HOSPITALS.—Section 2718(e) of the Public
3 Health Service Act (42 U.S.C. 300gg–18(e)) is amend-
4 ed—

5 (1) by striking “Each hospital” and inserting
6 the following:

7 “(1) IN GENERAL.—Each hospital”;

8 (2) by inserting “, in plain language without
9 subscription and free of charge, in a consumer-
10 friendly, machine-readable format,” after “a list”;
11 and

12 (3) by adding at the end the following: “Each
13 hospital shall include in its list of standard charges,
14 along with such additional information as the Sec-
15 retary may require with respect to such charges for
16 purposes of promoting public awareness of hospital
17 pricing in advance of receiving a hospital item or
18 service, as applicable, the following:

19 “(A) A description of each item or service
20 provided by the hospital.

21 “(B) The gross charge.

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

25 “(D) The de-identified minimum nego-
26 tiated charge.

1 “(E) The de-identified maximum nego-
2 tiated charge.

3 “(F) The discounted cash price.

4 “(G) Any code used by the hospital for
5 purposes of accounting or billing, including
6 Current Procedural Terminology (CPT) code,
7 the Healthcare Common Procedure Coding Sys-
8 tem (HCPCS) code, the Diagnosis Related
9 Group (DRG), the National Drug Code (NDC),
10 or other common payer identifier.

11 “(2) DELIVERY METHODS AND USE.—

12 “(A) IN GENERAL.—Each hospital shall
13 make public the standard charges described in
14 paragraph (1) for as many of the 70 Centers
15 for Medicaid & Medicare Services-specified
16 shoppable services that are provided by the hos-
17 pital, and as many additional hospital-selected
18 shoppable services as may be necessary for a
19 combined total of at least 300 shoppable serv-
20 ices, including the rate at which a hospital pro-
21 vides and bills for that shoppable service. If a
22 hospital does not provide 300 shoppable services
23 in accordance with the previous sentence, the
24 hospital shall make public the information spec-

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

3 “(B) DETERMINATION BY CMS.—A hos-
4 pital shall be deemed by the Centers for Medi-
5 care & Medicaid Services to meet the require-
6 ments of subparagraph (A) if the hospital main-
7 tains an internet-based price estimator tool that
8 meets the following requirements:

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

16 “(ii) The tool allows health care con-
17 sumers to, at the time they use the tool,
18 obtain an estimate of the amount they will
19 be obligated to pay the hospital for the
20 shoppable service.

21 “(iii) The tool is prominently dis-
22 played on the hospital’s website and easily
23 accessible to the public, without subscrip-
24 tion, fee, or having to submit personal
25 identifying information (PII), and search-

1 able by service description, billing code,
2 and payer.

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

6 “(A) DE-IDENTIFIED MAXIMUM NEGO-
7 TIATED CHARGE.—The term ‘de-identified max-
8 imum negotiated charge’ means the highest
9 charge that a hospital has negotiated with all
10 third party payers for an item or service.

11 “(B) DE-IDENTIFIED MINIMUM NEGO-
12 TIATED CHARGE.—The term ‘de-identified min-
13 imum negotiated charge’ means the lowest
14 charge that a hospital has negotiated with all
15 third party payers for an item or service.

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

23 “(D) GROSS CHARGE.—The term ‘gross
24 charge’ means the charge for an individual item

1 or service that is reflected on a hospital's
2 chargemaster, absent any discounts.

3 “(E) PAYER-SPECIFIC NEGOTIATED
4 CHARGE.—The term ‘payer-specific negotiated
5 charge’ means the charge that a hospital has
6 negotiated with a third party payer for an item
7 or service.

8 “(F) SHOPPABLE SERVICE.—The term
9 ‘shoppable service’ means a service that can be
10 scheduled by a health care consumer in ad-
11 vance.

12 “(G) STANDARD CHARGES.—The term
13 ‘standard charges’ means the regular rate es-
14 tablished by the hospital for an item or service,
15 including both individual items and services and
16 service packages, provided to a specific group of
17 paying patients, including the gross charge, the
18 payer-specific negotiated charge, the discounted
19 cash price, the de-identified minimum nego-
20 tiated charge, the de-identified maximum nego-
21 tiated charge, and other rates determined by
22 the Secretary.

23 “(H) THIRD PARTY PAYER.—The term
24 ‘third party payer’ means an entity that is, by
25 statute, contract, or agreement, legally respon-

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

3 “(4) ENFORCEMENT.—In addition to any other
4 enforcement actions or penalties that may apply
5 under subsection (b)(3) or another provision of law,
6 a hospital that fails to provide the information re-
7 quired by this subsection and has not completed a
8 corrective action plan to comply with the require-
9 ments of such subsection shall be subject to a civil
10 monetary penalty of an amount not to exceed \$300
11 per day that the violation is ongoing as determined
12 by the Secretary. Such penalty shall be imposed and
13 collected in the same manner as civil money pen-
14 alties under subsection (a) of section 1128A of the
15 Social Security Act are imposed and collected.”.

16 (b) TRANSPARENCY IN COVERAGE.—Section
17 1311(e)(3) of the Patient Protection and Affordable Care
18 Act (42 U.S.C. 18031(e)(3)) is amended—

19 (1) in subparagraph (A)—

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

22 (B) by inserting after clause (viii), the fol-
23 lowing:

24 “(ix) In-network provider rates for
25 covered items and services.

1 “(x) Out-of-network allowed amounts
2 and billed charges for covered items and
3 services.

4 “(xi) Negotiated rates and historical
5 net prices for covered prescription drugs.”;

6 (2) in subparagraph (B)—

7 (A) in the heading, by striking “USE” and
8 inserting “DELIVERY METHODS AND USE”;

9 (B) by inserting “and subparagraph (C)”
10 after “subparagraph (A)”;

11 (C) by inserting “, as applicable,” after
12 “English proficiency”; and

13 (D) by inserting after the second sentence,
14 the following: “The Secretary shall establish
15 standards for the methods and formats for dis-
16 closing information to individuals. At a min-
17 imum, these standards shall include the fol-
18 lowing:

19 “(i) An internet-based self-service tool
20 to provide information to an individual in
21 plain language, without subscription and
22 free of charge, in a machine readable for-
23 mat, through a self-service tool on an
24 internet website that provides real-time re-
25 sponses based on cost-sharing information

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

3 “(I) search for cost-sharing infor-
4 mation for a covered item or service
5 provided by a specific in-network pro-
6 vider or by all in-network providers;

7 “(II) search for an out-of-net-
8 work allowed amount, percentage of
9 billed charges, or other rate that pro-
10 vides a reasonably accurate estimate
11 of the amount an insurer will pay for
12 a covered item or service provided by
13 out-of-network providers; and

14 “(III) refine and reorder search
15 results based on geographic proximity
16 of in-network providers, and the
17 amount of the individual’s cost-shar-
18 ing liability for the covered item or
19 service, to the extent the search for
20 cost-sharing information for covered
21 items or services returns multiple re-
22 sults.

23 “(ii) In paper form at the request of
24 the individual that includes no fewer than
25 20 providers per request with respect to

1 which cost-sharing information for covered
2 items and services is provided, and dis-
3 closes the applicable provider per-request
4 limit to the individual, mailed to the indi-
5 vidual not later than 2 business days after
6 receiving an individual's request.”;

7 (3) in subparagraph (C)—

8 (A) in the first sentence—

9 (i) by striking “The Exchange” and
10 inserting the following:

11 “(i) IN GENERAL.—The Exchange”;

12 (ii) by inserting “or out-of-network
13 provider” after “item or service by a par-
14 ticipating provider”; and

15 (iii) by inserting before the period the
16 following: “the following information:

17 “(i) An estimate of an individual's
18 cost-sharing liability for a requested cov-
19 ered item or service furnished by a pro-
20 vider, which shall reflect any cost-sharing
21 reductions the individual would receive.

22 “(ii) A description of the accumulated
23 amounts.

1 “(iii) The in-network rate, including
2 negotiated rates and underlying fee sched-
3 ule rates.

4 “(iv) The out-of-network allowed
5 amount or any other rate that provides a
6 more accurate estimate of an amount an
7 issuer will pay, including the percent reim-
8 bursed by insurers to out-of-network pro-
9 viders, for the requested covered item or
10 service furnished by an out-of-network pro-
11 vider.

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

16 “(vi) A notification that coverage of a
17 specific item or service is subject to a pre-
18 requisite, if applicable.

19 “(vii) A notice that includes the fol-
20 lowing information:

21 “(I) A statement that out-of-net-
22 work providers may bill individuals for
23 the difference, including the balance
24 billing, between a provider’s billed
25 charges and the sum of the amount

1 collected from the insurer in the form
2 of a copayment or coinsurance
3 amount and the cost-sharing informa-
4 tion.

5 “(II) A statement that the actual
6 charges for an individual’s covered
7 item or service may be different from
8 an estimate of cost-sharing liability
9 depending on the actual items or serv-
10 ices the individual receives at the
11 point of care.

12 “(III) A statement that the esti-
13 mate of cost-sharing liability for a
14 covered item or service is not a guar-
15 antee that benefits will be provided
16 for that item or service.

17 “(IV) A statement disclosing
18 whether the plan counts copayment
19 assistance and other third-party pay-
20 ments in the calculation of the indi-
21 vidual’s deductible and out-of-pocket
22 maximum.

23 “(V) For items and services that
24 are recommended preventive services
25 under section 2713 of the Public

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

8 “(VI) Any additional informa-
9 tion, including other disclaimers, that
10 the insurer determines is appropriate,
11 provided the additional information
12 does not conflict with the information
13 required to be provided by this sub-
14 section.”;

15 (B) by striking the second sentence; and

16 (C) by adding at the end the following:

17 “(ii) DEFINITIONS.—Notwithstanding
18 any other provision of law, for the purpose
19 of this subparagraph and subparagraphs
20 (A) and (B):

21 “(I) ACCUMULATED AMOUNTS.—

22 The term ‘accumulated amounts’
23 means the amount of financial respon-
24 sibility an individual has incurred at
25 the time a request for cost-sharing in-

1 formation is made, with respect to a
2 deductible or out-of-pocket limit, in-
3 cluding any expense that counts to-
4 ward a deductible or out-of-pocket
5 limit, but exclude any expense that
6 does not count toward a deductible or
7 out-of-pocket limit. To the extent an
8 insurer imposes a cumulative treat-
9 ment limitation on a particular cov-
10 ered item or service independent of in-
11 dividual medical necessity determina-
12 tions, the amount that has accrued to-
13 ward the limit on the item or service.

14 “(II) HISTORICAL NET PRICE.—

15 The term ‘historical net price’ means
16 the retrospective average amount an
17 insurer paid for a prescription drug,
18 inclusive of any reasonably allocated
19 rebates, discounts, chargebacks, fees,
20 and any additional price concessions
21 received by the insurer with respect to
22 the prescription drug. The allocation
23 shall be determined by dollar value for
24 non-product specific and product-spe-
25 cific rebates, discounts, chargebacks,

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

6 “(III) NEGOTIATED RATE.—The
7 term ‘negotiated rate’ means the
8 amount a plan or issuer has contrac-
9 tually agreed to pay for a covered
10 item or service, whether directly or in-
11 directly through a third party admin-
12 istrator or pharmacy benefit manager,
13 to an in-network provider, including
14 an in-network pharmacy or other pre-
15 scription drug dispenser, for covered
16 items or services.

17 “(IV) OUT-OF-NETWORK AL-
18 LOWED AMOUNT.—The term ‘out-of-
19 network allowed amount’ means the
20 maximum amount an insurer will pay
21 for a covered item or service furnished
22 by an out-of-network provider.

23 “(V) OUT-OF-NETWORK LIMIT.—
24 The term ‘out-of-network limit’ means
25 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

1 group health plans (including self-insured and
2 fully insured plans) and health insurance cov-
3 erage (as such terms are defined in section
4 2791 of the Public Health Service Act).”.

○