

119TH CONGRESS
2^D SESSION

H. R. 9397

To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments, and to direct the Secretary of Health and Human Services to issue guidance on the provision of certain insurance information.

IN THE HOUSE OF REPRESENTATIVES

JUNE 23, 2026

Mr. PFLUGER (for himself and Mr. MORAN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments, and to direct the Secretary of Health and Human Services to issue guidance on the provision of certain insurance information.

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

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Premium Trans-
3 parency Act”.

4 **SEC. 2. ENSURING HEALTH INSURER ACCOUNTABILITY**
5 **THROUGH PUBLISHING OF OVERHEAD COSTS**
6 **AND CLAIM PAYMENTS.**

7 (a) IN GENERAL.—Section 2718(a) of the Public
8 Health Service Act (42 U.S.C. 300gg–18(a)) is amend-
9 ed—

10 (1) by redesignating paragraphs (1) through
11 (3) as subparagraphs (A) through (C), and adjust-
12 ing the margins accordingly;

13 (2) by striking “A health insurance issuer” and
14 inserting the following:

15 “(1) IN GENERAL.—A health insurance issuer”;
16 and

17 (3) by adding at the end the following new
18 paragraph:

19 “(2) OVERHEAD COSTS AND CLAIM PAYMENT
20 INFORMATION.—

21 “(A) IN GENERAL.—A health insurance
22 issuer offering group or individual health insur-
23 ance coverage (including a grandfathered health
24 plan) shall, with respect to each plan year be-
25 ginning on or after January 1, 2027, submit to
26 the Secretary (and, in the case such coverage

1 was offered through an Exchange established
2 under subtitle D of title I of the Patient Protec-
3 tion and Affordable Care Act, to such Ex-
4 change) and publish on the public website of
5 such issuer the following information in a con-
6 sumer-friendly format specified by the Sec-
7 retary:

8 “(i) the percentage of total premium
9 revenue expended for each category de-
10 scribed in subparagraphs (A) through (C)
11 of paragraph (1);

12 “(ii) the explanation described in
13 paragraph (1)(C); and

14 “(iii) the percentage of total premium
15 revenue not expended and retained by such
16 issuer.

17 “(B) MANNER OF PUBLICATION.—Infor-
18 mation submitted and published by a health in-
19 surance issuer under subparagraph (A) shall be
20 so submitted and published at the coverage level
21 and shall in addition, if determined appropriate
22 by the Secretary, be so submitted and published
23 in the aggregate in such manner as specified by
24 the Secretary (such as across all such coverage
25 offered by such issuer that are offered within

1 the same insurance market (as specified in sub-
2 clause (I), (II), (III), or (IV) of section 2799A-
3 1(a)(3)(E)(iv)).”.

4 (b) MEDICARE ADVANTAGE.—Section 1857(e) of the
5 Social Security Act (42 U.S.C. 1395w-27(e)) is amended
6 by adding at the end the following new paragraph:

7 “(7) OVERHEAD COSTS AND CLAIM PAYMENT
8 INFORMATION.—

9 “(A) IN GENERAL.—Beginning with plan
10 years beginning on or after January 1, 2027, a
11 contract under this section with an MA organi-
12 zation shall require the organization, with re-
13 spect to each MA plan offered by such organi-
14 zation during such plan year, to submit to the
15 Secretary and publish on the public website of
16 such organization the following information in a
17 consumer-friendly format specified by the Sec-
18 retary:

19 “(i) The amount of total revenue (as
20 determined under section 422.2420(c) of
21 title 42, Code of Federal Regulations (or a
22 successor regulation)) collected under such
23 plan.

24 “(ii) The amount and percentage of
25 such revenue expended on incurred claims

1 (as determined in accordance with para-
2 graphs (2) through (4) of section
3 422.2420(b) of title 42, Code of Federal
4 Regulations (or a successor regulation)).

5 “(iii) The amount and percentage of
6 such revenue expended on non-claims costs
7 (as defined in section 422.2401 of title 42,
8 Code of Federal Regulations (or a suc-
9 cessor regulation)).

10 “(iv) The amount of the difference be-
11 tween the MLR numerator (as determined
12 under paragraph (b) of section 422.2420
13 of title 42, Code of Federal Regulations (or
14 a successor regulation)) and the MLR de-
15 nominator (as determined under paragraph
16 (c) of such section (or a successor regula-
17 tion)).

18 “(v) The amount described in clause
19 (iv), expressed as a percentage of such rev-
20 enue.

21 “(B) MANNER OF PUBLICATION.—Infor-
22 mation submitted and published by an MA or-
23 ganization under subparagraph (A) shall be so
24 submitted and published at the MA plan level
25 and shall in addition, if determined appropriate

1 by the Secretary, be so submitted and published
2 in the aggregate in such manner as specified by
3 the Secretary (such as across all MA plans of-
4 fered by such organization).”.

5 **SEC. 3. PROMOTING COMPARABILITY OF QUALIFIED**
6 **HEALTH PLANS OFFERED THROUGH AN EX-**
7 **CHANGE.**

8 Section 1311(d)(4)(C) of the Patient Protection and
9 Affordable Care Act (42 U.S.C. 18031(d)(4)(C)) is
10 amended—

11 (1) by striking “website through which” and in-
12 serting the following: “website—

13 “(i) through which”;

14 (2) in clause (i), as so inserted, by striking the
15 semicolon and inserting “; and”; and

16 (3) by adding at the end the following new
17 clause:

18 “(ii) that includes, as part of such
19 comparative information for enrollments
20 for plan years beginning on or after Janu-
21 ary 1, 2029, in the case a qualified health
22 plan offered through such Exchange for
23 such plan year was offered through such
24 Exchange for a previous plan year, the
25 most recent information submitted to such

1 Exchange with respect to such plan by the
2 health insurance issuer of such plan under
3 section 2718(a)(2) of the Public Health
4 Service Act;”.

5 **SEC. 4. GUIDANCE ON PROVISION OF CERTAIN INSURANCE**
6 **INFORMATION IN STANDARDIZED, PLAIN**
7 **ENGLISH FORMAT.**

8 (a) IN GENERAL.—Not later than January 1, 2028,
9 the Secretary shall issue guidance to group health plans,
10 health insurance issuers offering group or individual
11 health insurance coverage, and Medicare Advantage orga-
12 nizations offering an MA plan on providing information
13 on the benefits and coverage available under the applicable
14 plan or coverage, consistent with the relevant require-
15 ments under section 2715 of the Public Health Service
16 Act (42 U.S.C. 300gg–15), section 1851(d) of the Social
17 Security Act (42 U.S.C. 1395w–21(d)), and section
18 1852(e) of such Act (42 U.S.C. 1395w–22(e)). Such guid-
19 ance shall include standards for providing information in
20 a standardized, plain English format with respect to the
21 following aspects of the plan or coverage (to the extent
22 applicable):

- 23 (1) Any monthly premium.
24 (2) Any annual deductible.

1 (3) Any maximum limitations on out-of-pocket
2 expenses.

3 (4) The type of provider network used by the
4 plan or coverage.

5 (5) The plan or coverage share of the total al-
6 lowed costs of benefits provided under the plan or
7 coverage.

8 (6) The standard cost-sharing amounts for in-
9 network care, including for the following types of
10 care:

11 (A) Primary care.

12 (B) Specialist care.

13 (C) Urgent care.

14 (D) Emergency department care.

15 (E) Imaging.

16 (F) Inpatient hospital care.

17 (G) Outpatient facility care.

18 (H) Laboratory services.

19 (I) Preferred brand name drugs.

20 (J) Generic drugs.

21 (7) Additional features of the plan or coverage,
22 including the following:

23 (A) Specialist referral policies.

24 (B) The availability of wellness programs.

1 (C) The availability of disease management
2 programs.

3 (D) Whether an individual enrolled in such
4 plan or coverage is an eligible individual for
5 purposes of section 223 of the Internal Revenue
6 Code of 1986 (relating to health savings ac-
7 counts).

8 (E) Coverage of preventive care services.

9 (8) Such other aspects of the plan or coverage
10 as the Secretary may specify.

11 (b) CONSULTATION.—In developing the guidance
12 under subsection (a), the Secretary shall consult with the
13 Secretary of Labor and the Secretary of the Treasury.

14 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed as requiring a group health plan,
16 a health insurance issuer offering group or individual
17 health insurance coverage, or a Medicare Advantage orga-
18 nization offering an MA plan to offer any of the plan fea-
19 tures described in subsection (a).

20 (d) DEFINITIONS.—In this section:

21 (1) MEDICARE ADVANTAGE TERMS.—The terms
22 “Medicare Advantage organization” and “MA plan”
23 have the meanings given each such term for pur-
24 poses of part C of title XVIII of the Social Security
25 Act (42 U.S.C. 1395w–21 et seq.).

1 (2) PRIVATE HEALTH INSURANCE TERMS.—The
2 terms “group health plan”, “health insurance cov-
3 erage”, “health insurance issuer”, “group health in-
4 surance coverage”, and “individual health insurance
5 coverage” have the meanings given each such term
6 in section 2791 of the Public Health Service Act (42
7 U.S.C. 300gg–91).

8 (3) SECRETARY.—The term “Secretary” means
9 the Secretary of Health and Human Services.

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