Policy Update

A Look into House Efforts on Hospital and Health Plan Price Transparency

Background: In the 118th Congress, the US House of Representatives is keenly interested in price transparency in healthcare. Three House committees—Energy and Commerce, Ways and Means and Education and the Workforce—each approved legislation that would advance price transparency objectives. Generally, these bills seek to codify (and in some respects, modify) the requirements around hospital and health plan price transparency as previously implemented by the Centers for Medicare & Medicaid Services (CMS).

While there are many similarities in the three bills, the committees and House leadership will need to negotiate certain key differences before a bill is brought to the House floor for a vote. For hospital price transparency, these issues include what information about enforcement actions against hospitals is made public, where information about enforcement actions is posted and maximum penalties for noncompliance. For health plan price transparency, these include any exemptions or limitations on compliance, frequency of required updates, the definition of participating provider and effective dates.

The bills also include key differences from current regulations. Both the Energy and Commerce and Ways and Means Committee bills would eliminate deemed compliance with consumer-friendly file requirements if a hospital maintains a price estimator tool. The bills also include penalties for a hospital's "persistent" noncompliance with the requirements.

This +Insight compares the hospital and health plan transparency provisions of these primary pieces of legislation and compares them with current regulations. These bills also include provisions related to the role of pharmacy benefit managers, common ownership and integration and certain site neutrality requirements, which are not discussed in this article.

Key Takeaways

- The House is keenly interested in price transparency.
- Three House committees have considered legislation to address hospital and health plan price transparency.
- Committee and House leadership will need to negotiate the differences in their approaches.
- Floor consideration is likely, but it remains unclear which of the competing bills might get a vote.

Background on Hospital Price Transparency Rules Issued by CMS

In 2019, CMS finalized rules requiring that, effective January 1, 2020, hospitals make public their standard charges for all items and services provided in a comprehensive machine-readable file, and make public their standard charges for 300 "shoppable services" in a consumer-friendly format. The rules implement Section 2718(e) of the Public Health Service Act, which requires each hospital operating within the United States, for each year, to establish, update and make public a list of the standard charges for items and services

provided by the hospital. In 2022, following lackluster compliance, CMS updated these regulations to increase the penalties for noncompliance. The agency recently proposed further updates to standardize the machine-readable file format and make public enforcement actions taken against hospitals.

Background on Health Plan Price Transparency Rules Issued by CMS

In 2020, the US Departments of Health and Human Services, Treasury and Labor issued a joint final rule requiring group health plans and health insurance issuers in the individual and group market to disclose certain pricing information to enrollees. The required disclosures include cost-sharing and out-of-pocket costs, and disclosures must be made available through a website. The rule also requires health plans to provide their in-network negotiated rates, historical out-of-network allowed amounts and drug pricing information. These must be posted publicly through three separate, widely accessible files.

Comparison of Hospital Price Transparency Regulations and Primary Provisions in House Bills

	Current and Proposed Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
File of Prices for All Services	Yes. Must be machine-readable. Proposed: Beginning March 1, 2024, must use CMS template.	Yes. Must be machine-readable. Format specified by Secretary, may be template.	Yes. Format specified by Secretary, may be machine-readable, may be template.
Consumer-Friendly File for Shoppable Services	Yes, for 300 services. Deemed compliance if hospital maintains a price estimator tool.	Yes, for 300 services. Format specified by Secretary, may be template. Deemed compliance if hospital maintains a price estimator tool only through CY 2024.	Yes, for 300 services. Deemed compliance if hospital maintains a price estimator tool only until effective date of advanced explanation of benefits regulations.
Required Information for Machine-Readable File	For each item or service: - Description - Gross charge - Payer-specific negotiated charge - De-identified minimum and maximum negotiated charge - Discounted cash price - Any code used by the hospital for purposes of accounting or billing.	For each item or service: - Plain language description - Gross charge, expressed as a dollar amount - Payer-specific negotiated charge - De-identified minimum and maximum negotiated charge - Discounted cash price, expressed as dollar amount - Any code used by the hospital for purposes of accounting or billing - Any other information required by the Secretary.	For each item or service: - Description - Gross charge, expressed as dollar amount - Discounted cash price, expressed as dollar amount - Any code used by the hospital for purposes of accounting or billing - Any other information required by the Secretary.

	Current and Proposed Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
Required Information for Consumer-Friendly File	For each item or service: - Plain language description - Indicator if service is not offered - Payer-specific negotiated charge - De-identified minimum and maximum negotiated charge - Location where the service is provided (*i.e.*, inpatient, outpatient) - Any code used by the hospital for purposes of accounting or billing.	For each item or service: - Plain language description - Gross charge, expressed as a dollar amount - Payer-specific negotiated charge - De-identified minimum and maximum negotiated charge - Discounted cash price, expressed as dollar amount - Any code used by the hospital for purposes of accounting or billing - Any other information required by the Secretary.	For each item or service: - Description - Indicator if service is not offered - Gross charge, expressed as dollar amount - Discounted cash price, expressed as dollar amount - Any code used by the hospital for purposes of accounting or billing - Any other information required by the Secretary.

Definitions

	Current Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
Gross Charge	The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.	The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.	The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
Payer-Specific Negotiated Charge	The charge that a hospital has negotiated with a third-party payer for an item or service.	The charge that a hospital has negotiated with a third-party payer for an item or service.	The charge that a hospital has negotiated with a third-party payer for an item or service.
De-Identified Minimum/ Maximum Negotiated Charge	The lowest/highest charge that a hospital has negotiated with all third-party payers for an item or service.	The lowest/highest charge that a hospital has negotiated with all third-party payers for an item or service.	Not specified.
Discounted Cash Price	The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.	The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.	The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.

	Current Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
Shoppable Service	A service that can be scheduled by a healthcare consumer in advance.	A service that can be scheduled by a healthcare consumer in advance.	A service that can be scheduled by a healthcare consumer in advance; includes all ancillary items and services customarily furnished as part of such service
Hospital	An institution in any state in which state or applicable local law provides for the licensing of hospitals that is licensed as a hospital pursuant to such law or is approved by the agency of such state or locality responsible for licensing hospitals as meeting the standards established for such licensing.	Not specified.	A hospital (as defined in section 1861(e)), a critical access hospital (as defined in section 1861(mmm)(1)) or a rural emergency hospital (as defined in section 1861(kkk)) of the Social Security Act.

Maximum Civil Monetary Penalties, Per Hospital Per Day

Number of Beds	Current Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
30 or fewer	$300.	$300. Secretary may increase.	$300 through CY 2029 for hospitals with 30 beds or fewer and critical access hospitals. Secretary may increase thereafter.
31 to 550	$310–$5,500.	$5,500 for violations occurring before 2024. Secretary may increase thereafter.	Not specified.
More than 550	$5,500.	$5,500 for violations occurring before 2024. Secretary may increase thereafter.	Not specified.

Maximum Civil Monetary Penalties, Per Hospital Per Year

Number of Beds	Current Regulations	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)
30 or fewer	$109,500.	Not specified.	$2 million through CY 2029. Secretary may increase thereafter.
31 to 550	$113,150–$2,007,500.	Not specified.	$2 million through CY 2029. Secretary may increase thereafter.
More than 550	$2,007,500.	Not specified.	$2 million through CY 2029. Secretary may increase thereafter.

Comparison of Health Plan Transparency Regulations and Primary Provisions in House Bills

Required Information for Items or Services

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
In-Network Rate	Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for a requested covered item or service.	In-network rate for participating provider; maximum allowed amount for non-participating provider.	In-network rate for participating provider; maximum allowed amount for non-participating provider.	In-network rate for participating provider; maximum allowed amount for non-participating provider, along with notice to enrollee on possible additional charges.
Cost-Sharing	Cost-sharing (deductibles, co-pays and coinsurance).	Cost-sharing (deductibles, co-pays and coinsurance).	Cost-sharing (deductibles, co-pays and coinsurance).	Cost-sharing (deductibles, co-pays and coinsurance).
Accumulated Amount	Amount individual has accumulated for deductible or out-of-pocket maximum.	Amount individual has accumulated for deductible or out-of-pocket maximum.	Amount individual has accumulated for deductible or out-of-pocket maximum for participating and non-participating providers.	Amount individual has accumulated for deductible or out-of-pocket maximum.

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
Frequency Limitations	Frequency or volume limitations, and individual accrual toward these.	Frequency or volume limitations, and individual accrual toward these.	Frequency or volume limitations, and individual accrual toward these.	Frequency or volume limitations, and individual accrual toward these.
Medical Management Techniques	Prior authorization, concurrent review, step therapy, fail first, *etc*.	Prior authorization, concurrent review, step therapy, fail first, *etc*.	Prior authorization, concurrent review, step therapy, fail first, *etc*.	Prior authorization, concurrent review, step therapy, fail first, *etc*.
Other	List of items or services subject to bundled payment arrangements for which a cost-sharing liability estimate is being disclosed.	N/A	N/A	Any shared savings or other benefit available to the enrollee with respect to such item or service.

Consumer and Provider Tools

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
Self-Service Tool	Real-time website to request the information above; request can originate from individual and/or provider.	Real-time website to request the information above; request can originate from individual and/or provider.	Real-time website to request the information above; request can originate from individual and/or provider.	Real-time website to request the information above; request can originate from individual and/or provider.
Provider Tool	N/A	N/A	N/A	Requests from provider to health plan on coverage and/or cost sharing for patient seeing a different provider.

Rate and Payment Information

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
In-Network Rate	Estimate of cost-sharing liability for each item or service, including prescription drugs.	In-network rate for items and services for participating provider with more than 10 claims.	In-network rate for items and services for participating providers, unless no claims submitted the prior year.	In-network rate for items and services for participating providers.
Cost of Drugs	Out-of-pocket cost liability for prescription drugs, and the negotiated rate of drugs with more than 20 claims.	Average amount paid by plan for drugs dispensed and administered (for 90-day period beginning 180 days before submission) with more than 20 claims.	Average amount paid by plan for drugs dispensed and administered (for 90-day period beginning 180 days before submission) with more than 20 claims.	In-network rate and average amount paid for drugs dispensed or administered (for 90-day period beginning 180 days before submission) with more than 20 claims.
Out-of-Network	Maximum amount a group health plan or health insurance issuer would pay for a covered item or service furnished by an out-of-network provider with more than 20 claims.	Amount billed and amount allowed by non-participating providers with more than 20 claims.	Amount billed and amount allowed by non-participating providers with more than 20 claims.	Amount billed and amount allowed by non-participating providers with more than 20 claims.
Format	Submit via three separate files in format that is widely available**	Submit via three separate files in format that is widely available.	Submit via three separate files in format that is widely available.	Submit via three separate files in format that is widely available.
Misc.	N/A	N/A	Health plan submits attestation on accuracy.	Health plan submits attestation on accuracy.
Frequency of Required Data Updates	Update every three months.	Update every three months.	Update every three months.	Update monthly.

** While three separate files is consistent across current regulations and the proposed legislation, the content of the three files varies slightly in current regulation: One file requires disclosure of payment rates negotiated between plans or issuers and providers for all covered items and services. The second file discloses the unique amounts a plan or issuer allowed, as well as associated billed charges, for covered items or services furnished by out-of-network providers during a specified time period. The third file includes pricing information for prescription drugs.

Definitions

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
Definition of Participating Provider	An in-network provider means any provider of items and services with which the plan or issuer, or a third party for a plan or issuer, has a contract setting forth the terms under which a covered item or service may be provided to a participant, beneficiary or enrollee.	References No Surprises Act definition for "participating provider" which is as follows: The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other healthcare provider who is acting within the scope of practice of that provider's license or certification under applicable state law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.	References No Surprises Act definition for "participating provider" which is as follows: The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other healthcare provider who is acting within the scope of practice of that provider's license or certification under applicable state law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.	Referenced No Surprises Act definitions for "participating provider" and "participating facility" which are as follows: The term "participating provider" means, with respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other healthcare provider who is acting within the scope of practice of that provider's license or certification under applicable state law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively. The term "participating healthcare facility" means, with respect to an item or service and a group health plan or health insurance issuer

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
				offering group or individual health insurance coverage, a healthcare facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.
Definition of In-Network Rate	The negotiated rate, reflected as a dollar amount, for an in-network provider or providers for a requested covered item or service.	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.	The term "in-network rate" means, with respect to a health plan or coverage 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 or coverage and such provider for such item or service.	The term "in-network rate" means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.

Effective Dates, Enforcement and Exemptions

	Current Regulations (Transparency in Coverage – Issued November 12, 2020)	H.R. 3561, the PATIENT Act (Energy and Commerce)	H.R. 4822, the Health Care Price Transparency Act (Ways and Means)	H.R. 4507, Transparency in Coverage Act (Education and the Workforce)
Effective Dates	- January 1, 2022, for three machine readable files - January 1, 2023, for 500 shoppable items and services (as specified in the rule) - January 1, 2024, for all items and services.	- None specified for items and services - January 1, 2025, for rate and payment information.	- Plan years on or after two years from enactment.	- Plan years beginning on or after January 1, 2025 - January 1, 2026, for rate and payment information available through an application programming interface.
Enforcement	State regulators.	None specified.	None specified.	None specified.
Exemptions	None specified.	None specified.	None specified.	Plans with fewer than 500 enrollees.

For more information, please contact Rachel Stauffer or Leigh Feldman.