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(Original Signature of Member)

118TH CONGRESS
1ST SESSION

H. R. _____

To amend the Internal Revenue Code of 1986, the Public Health Service Act, and the Employee Retirement Income Security Act of 1974 to promote group health plan price transparency.

IN THE HOUSE OF REPRESENTATIVES

Mr. Fitzpatrick introduced the following bill; which was referred to the Committee on

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A BILL

To amend the Internal Revenue Code of 1986, the Public Health Service Act, and the Employee Retirement Income Security Act of 1974 to promote group health plan 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 Insurance Price Transparency Act of 2023".

SEC. 2. PROMOTING GROUP HEALTH PLAN PRICE TRANSPARENCY.

(a) PRICE TRANSPARENCY REQUIREMENTS.—

(1) IRC.—

(A) IN GENERAL.—Section 9819 of the Internal Revenue Code of 1986 (26. U.S.C. 9816) is amended to read as follows:

"SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.

"(a) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, a group health plan shall permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such individual through a self-service tool that meets the requirements of paragraph (3) or, at the option of such individual, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual)

that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan furnished by a health care provider to a participant or beneficiary of such plan, the following:

"(A) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subsection (c)) for such item or service.

"(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum amount described in such subparagraph).

"(D) The amount the participant or beneficiary has already accumulated with respect to

any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items and services furnished by a provider that is not a participating provider, under the plan (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

"(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall

be treated as information specified in this paragraph, if determined appropriate by the Secretary.

"(3) SELF-SERVICE TOOL.—For purposes of paragraph (1), a self-service tool established by a group health plan meets the requirements of this paragraph if such tool—

"(A) is based on an Internet website;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

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

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

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

"(iii) a provider that is not described in clause (ii);

"(E) 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; and

"(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

"(b) RATE AND PAYMENT INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e))) shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

"(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate

and payment information described in this paragraph is, with respect to a group health plan, the following:

"(A) 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 with each provider 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 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan.

"(B) 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 publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than such an amount paid to a provider that, during such period,

submitted fewer than 20 claims for such drug to such plan.

"(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan during such period.

"(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such requirements shall ensure that such files are limited to

an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group health plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(4) USER INSTRUCTIONS.—Each group health plan shall make available to the public instructions written in plain language explaining how individuals may search for information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish a template that such a plan may use in developing instructions for purposes of the preceding sentence.

"(5) ATTESTATION.—Each group health plan shall post, along with rate and payment information made public by such plan, an attestation that such information is complete and accurate.

"(c) DEFINITIONS.—In this paragraph:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 9816.

"(2) 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.".

(B) CLERICAL AMENDMENT.—The item relating to section 9819 of the table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended to read as follows:

''Sec. 9819. Price transparency requirements.''.

(2) PHSA.—Section 2799A–4 of the Public Health Service Act (42 U.S.C. 300gg–114) is amended to read as follows:

"SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.

"(a) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual

would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such individual through a self-service tool that meets the requirements of paragraph (3) or, at the option of such individual, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group or individual health insurance coverage furnished by a health care provider to a participant or beneficiary of such plan, or enrollee in such coverage, the following:

"(A) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subsection (c)) for such item or service.

"(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum amount described in such subparagraph).

"(D) The amount the participant, beneficiary, or enrollee has already accumulated with respect to any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items and services furnished by a provider that is not a participating provider, under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants, beneficiaries or enrollees enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

"(E) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant, beneficiary, or enrollee has accrued towards such limitation with respect to such item or service.

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall be treated as information specified in this paragraph, if determined appropriate by the Secretary.

"(3) SELF-SERVICE TOOL.—For purposes of paragraph (1), a self-service tool established by a group health plan or group or individual health insurance coverage meets the requirements of this paragraph if such tool—

"(A) is based on an Internet website;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

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

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

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

"(iii) a provider that is not described in clause (ii);

"(E) 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; and

"(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Sec-

retary determines that the billing codes to be so linked correspond to similar items and services.

"(b) RATE AND PAYMENT INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e))) or group or individual health insurance coverage, shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

"(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group or individual health insurance coverage, the following:

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-net-

work rate in effect with each provider 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 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan or coverage.

"(B) 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 or coverage (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 publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such

item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

"(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group

health plans and group and individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(4) USER INSTRUCTIONS.—Each group health plan and group or individual health insurance coverage shall make available to the public instructions written in plain language explaining how individuals may search for information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish a template that such a plan or coverage may use in developing instructions for purposes of the preceding sentence.

"(5) ATTESTATION.—Each group health plan and group or individual health insurance coverage shall post, along with rate and payment information made public by such plan or coverage, an attestation that such information is complete and accurate.

"(c) DEFINITIONS.—In this paragraph:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 2791A–1(a)(3)(G)(ii).

"(2) IN-NETWORK RATE.—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.''.

(3) ERISA.—

(A) IN GENERAL.—Section 719 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185h) is amended to read as follows:

"SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.

"(a) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, a group health plan or a health insurance issuer offering group health insurance coverage shall permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual. At a minimum, such information shall include the information specified in paragraph (2) and shall be made

available to such individual through a self-service tool that meets the requirements of paragraph (3) or, at the option of such individual, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group health insurance coverage furnished by a health care provider to a participant or beneficiary of such plan, or enrollee in such coverage, the following:

"(A) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subsection (c)) for such item or service.

"(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will

incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum amount described in such subparagraph).

"(D) The amount the participant, beneficiary, or enrollee has already accumulated with respect to any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items and services furnished by a provider that is not a participating provider, under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants, beneficiaries or enrollees enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

"(E) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant, beneficiary, or enrollee has accrued towards such limitation with respect to such item or service.

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall be treated as information specified in this paragraph, if determined appropriate by the Secretary.

"(3) SELF-SERVICE TOOL.—For purposes of paragraph (1), a self-service tool established by a group health plan or group health insurance coverage meets the requirements of this paragraph if such tool—

"(A) is based on an Internet website;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

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

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

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

"(iii) a provider that is not described in clause (ii);

"(E) 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; and

"(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

"(b) RATE AND PAYMENT INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this section, each group health plan (other than a grandfathered health plan (as de-

fined in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(e))) or group health insurance coverage, shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

"(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group health insurance coverage, the following:

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate in effect with each provider 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 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan or coverage.

"(B) 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 or coverage (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 publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

"(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group health plans and group and individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(4) USER INSTRUCTIONS.—Each group health plan and group health insurance coverage shall make available to the public instructions written in plain language explaining how individuals may search for

information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish a template that such a plan or coverage may use in developing instructions for purposes of the preceding sentence.

"(5) ATTESTATION.—Each group health plan and group health insurance coverage shall post, along with rate and payment information made public by such plan or coverage, an attestation that such information is complete and accurate.

"(c) DEFINITIONS.—In this paragraph:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 2791A–1(a)(3)(G)(ii).

"(2) IN-NETWORK RATE.—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.".

(B) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended

by striking the item relating to section 719 and inserting the following new item:

''Sec. 719. Price transparency requirements.''.

(b) ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing the amendments made by subsection (a), the Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall take reasonable steps to ensure the accessibility of information made available pursuant to such amendments, including reasonable steps to ensure that such information is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided by group health plans and health insurance issuers offering group or individual health insurance coverage to make such information accessible to those with limited English proficiency and those with disabilities.

(c) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by subsection (a) may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158) for any plan year beginning before the date that is 2 years after the date of the enactment of this Act.