United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

H.R. 4822, The Health Care Price Transparency Act of 2023

Title I – Health Care Price Transparency for Patients

Sec. 101: Requiring Certain Facilities Under the Medicare Program to Disclose Certain Information Relating to Charges and Prices

(a) Adds a new section to Part E of the Medicare statute, "Health Care Provider Price Transparency," which includes price publication requirements for the following health care providers:

Hospital Price Transparency

- Requires hospitals publish gross and cash prices for all items and services and requires publication of prices for at least 300 shoppable services or a consumer-friendly price estimator tool.
    - Requires hospitals to certify the accuracy and completeness of estimates provided through a consumer-friendly estimator tool.
    - Sunsets a hospital's ability to fulfill the requirement with an estimator tool upon finalization of rules implementing the Advanced Explanation of Benefits from the *No Surprises Act*.
- Requires HHS to review each hospital's website at least once every three years.
    - CMS must provide a notification of noncompliance, then request a corrective action plan, and if noncompliance persists, may issue civil monetary penalties (CMPs) of up to $300 per day for hospitals with fewer than 30 beds (only counting beds that are available for admission, not any in an unused wing), and an annual maximum of $2 million for hospitals with more than 30 beds.
    - CMS may increase CMPs to an annual maximum of $3 million for hospitals that are repeatedly and "knowingly and willfully" noncompliant.
    - CMS may waive CMPs for facilities located in rural or underserved areas if it would result in significant hardship, including reducing patient access to care.
- Reduces existing duplicative and burdensome reporting requirements by eliminating the current regulatory requirement that hospitals publish minimum and maximum insurer-negotiated rates and allows for the requirement for hospitals to publish insurer-negotiated rates.
- Effective January 1, 2026.

Ambulatory Surgical Center Price Transparency

- Requires ambulatory surgical centers (ASCs) to publish gross and cash prices for all items and services and requires publication of prices for at least 300 shoppable services or a consumer-friendly price estimator tool.
    - Requires ASCs to certify the accuracy and completeness of estimates provided through a consumer-friendly estimator tool.
    - Sunsets an ASC's ability to fulfill the requirement with an estimator tool upon finalization of rules implementing the Advanced Explanation of Benefits from the *No Surprises Act*.
- Requires HHS to review each ASC's website at least once every three years.
    - CMS must provide a notification of noncompliance, then request a corrective action plan, and if noncompliance persists, may issue CMPs of up to $300 per day.

    - CMS may waive CMPs for facilities located in rural and underserved areas if it would result in significant hardship, including reducing patient access to care.
- Allows for the requirement for ASCs to publish insurer-negotiated rates.
- Effective January 1, 2028

Imaging Services Price Transparency

- Requires providers of certain imaging services to publish cash prices and allows for the requirement for imaging providers to publish de-identified minimum and maximum insurer-negotiated rates. Failure to meet these requirements results in a warning notification and a 90-day window during which compliance may be attained. Continued noncompliance can result in a CMP of up to $300 each day of noncompliance.
    - CMS may waive CMPs for facilities located in rural or underserved areas if it would result in significant hardship, including reducing patient access to care.
- Requires the Secretary to develop a list of 50 shoppable imaging services subject to price transparency.
- Effective January 1, 2028.

Clinical Laboratory Price Transparency

- Requires clinical laboratories to publish cash prices and allows HHS to require the publication of de-identified minimum and maximum insurer-negotiated rates. Failure to meet these requirements results in a warning notification and a 90-day window during which compliance may be attained. Continued noncompliance can result in a CMP of up to $300 each day of noncompliance.
    - CMS may waive CMPs for facilities located in rural or underserved areas if it would result in significant hardship, including reducing patient access to care.
- Effective January 1, 2028.

(b) Requires HHS to post hospital compliance status on the CMS Care Compare website.

(c) Sunsets of Sec. 2718(e) of the Public Health Service Act beginning January 1, 2026.

(d) Provides CMS $10,000,000 for implementation and compliance monitoring and requires CMS to provide a report on how it spends the funds.

(e) Requires CMS to ensure through rulemaking that health care price transparency information is made available in plain language and that providers ensure access to individuals with limited English proficiency and disabilities. Requires CMS to provide technical assistance to health care providers.

Sec. 102: Health Insurer Price Transparency

- Requires health insurance plans to make personalized pricing information available to enrollees, and to post machine-readable files containing in-network negotiated rates, prescription drug prices, and out-of-network allowed amounts and billed charges.
- Limits downloadable files to an appropriate size to ensure accessibility.
- Adds flexibility for future technologies beyond machine readable files.

Sec. 103: PBM Transparency in Reporting

- Requires pharmacy benefit managers (PBMs) to report to plan sponsors and employers data relating to copayments, rebates, discounts, net payments, and costs of covered drugs.
- Requires every drug, regardless of number in the class, to have its net price reported.
- Requires the Government Accountability Office (GAO) to report on vertical integrations between health insurance plans, PBMs, and pharmacies.

Sec. 104: GAO Report on Harmonization of Transparency Requirements

- Requires the Government Accountability Office (GAO) to report on existing and new health care price transparency requirements, compliance, enforcement, patient utilization, and whether requirements can be harmonized to reduce burden and duplication.

Sec. 105: MedPAC Report on Vertical Integration in Medicare

- Requires Medicare Advantage Organizations to report to HHS certain information relating to health care providers, pharmacy benefit managers (PBMs), and pharmacies with which they share common ownership.
- Requires MedPAC to study and report on vertical integration between Medicare Advantage Organizations, health care providers, PBMs, and pharmacies and how it impacts beneficiary access, cost, quality, and outcomes.

Title II – Fair Prices for Patients

Sec. 201: Patient Cost-Sharing Fairness in Medicare Part D

- Prohibits prescription drug plans (PDPs) and PBMs in Medicare Part D or Medicare Advantage from charging patients more in cost-sharing than the net price of a drug.

Sec. 202: Ensuring Fair Billing Practices

- Requires off-campus hospital outpatient departments (HOPDs) to obtain and use separate national provider identification numbers (NPIs) when billing Medicare.
- Requires the HHS Office of the Inspector General to review the compliance of previous Medicare site-neutral payment policies.
- Effective January 1, 2026.

Sec. 203: Parity in Medicare Part B Drug Payments

- Requires Medicare to reimburse off-campus hospital outpatient departments (HOPDs) administering Medicare Part B drugs at the same rate it reimburses physicians under the Medicare Physician Fee Schedule.
- Effective beginning in 2025, with a four-year phase-in to the complete rate in 2028, and an additional one-year delay for off-campus HOPDs located in rural or health professional shortage areas (HPSAs) and for the 11 specially designated cancer hospitals.

Title III – Patient-Focused Investments

Sec. 301: Improving Seniors Timely Access to Care Act

- Requires Medicare Advantage plans to establish an electronic prior authorization process to streamline approvals and denials.
- Requires HHS to establish a process for Medicare Advantage plans to provide “real time decisions” for prior authorization requests of items and services that are routinely approved.

Sec. 302: Extension of Certain Direct Spending Reductions

- Extends the Medicare sequester for two additional months in 2032 at a rate of 1.5 percent.