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Chart: Key Provisions of Legislative Proposals on Health Care Price Transparency Requirements for Providers, Plans, and Issuers

A potential health package that could be advanced with the fiscal year 2024 spending bill due January 19 may include legislative proposals to improve price transparency. In this memo, we present a comparison of legislative proposals that would codify and improve the **2019 Hospital Price Transparency rule (84 FR 65524)** and the **2020 Transparency in Coverage rule (85 FR 72158)**:

- **Lower Costs, More Transparency (LCMT) Act (H.R. 5378)**, passed by the House on December 11, 2023 by a 320-71 vote; and
- **Health Care PRICE Transparency Act 2.0 (S. 3548)**, introduced by Senate Health, Education, Labor and Pensions Committee Chair Bernie Sanders (I-VT) and Sen. Mike Braun (R-IN) on December 11, 2023.

Both bills also include proposals to require that contracts between a group health plan and any other entity (including health care providers, pharmacy benefit managers, and others) allow the responsible plan access to claims and encounter information and data. Sec. 401 of the LCMT Act requires entities to allow the "responsible plan fiduciary" to audit or review all de-identified claims and encounter information and data. Sec. 7 of Health Care PRICE Transparency Act 2.0 requires entities to allow the "responsible group health plan" greater access to health data – specifically, all claims and encounter information, and any documentation supporting claims documents, such as medical records and policy documents. Both bills propose a $10,000 per day penalty for noncompliance.

Unlike the LCMT Act, Health Care PRICE Transparency Act 2.0 does not include transparency proposals for pharmacy benefit managers.

I. Provider Price Transparency Requirements

The LCMT Act and Health Care PRICE Transparency Act 2.0 propose to codify key provisions of the Hospital Price Transparency Rule – specifically, requirements for hospitals to post standard charges in (1) machine-readable files and (2) a consumer-friendly internet-based price estimator tool displaying at least 300 "shoppable services" (or as many as the hospital provides if less than 300). The machine-readable file contains the following standard charges for all items and services provided by the hospital: gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. The price estimator tool contains plain language descriptions of services and groups them with ancillary services, and provides the discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges.

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In addition, both bills propose changes to address concerns with reporting requirements; increase compliance with the rule; and broaden price transparency to clinical diagnostic laboratories, ambulatory surgical centers, and imaging centers.

Both bills direct the HHS Secretary to establish a standard, uniform method and format for public disclosure of standard charges in machine-readable files. Under 45 CFR 180.50(c), the Centers for Medicare and Medicaid Services (CMS) currently does not require hospitals to follow any formatting requirements. Beginning July 1, 2024, hospitals will be required to conform to a CMS template layout, data specifications, and data dictionary in the technical implementation guide – all of which are currently optional. Hospitals will also be required to include additional data elements in its machine-readable file, such as hospital license number and method used to establish the standard charge (45 CFR 180.50(b)). Beginning January 1, 2025, hospitals will be required to include additional details, such as the algorithm used for standard charges and billing code modifiers.

As detailed in Table 1, the bills diverge on implementation dates, monitoring and enforcement, and alternatives to discounted cash prices.

- **Effective Dates.** Health Care PRICE Transparency Act 2.0 proposes price transparency requirements for all settings beginning 2025. The LCMT Act proposes a 2026 effective date for most settings, with a 2028 start for imaging centers.

- **Monitoring and Enforcement.** Overall, the Health Care PRICE Transparency Act 2.0 proposes a more rigorous approach – requiring a compliance review at least once every year (compared to every three years in the LCMT Act), requiring an attestation from senior officials at hospitals, and prohibiting the HHS Secretary from granting any waivers to penalties. In contrast, the LCMT Act allows the Secretary to waive or reduce penalties for hospitals and ambulatory surgical centers. Both bills propose increased penalties for hospitals that are noncompliant for a 1-year period or longer, as well as even higher penalties for hospitals with more than 30 beds that are determined to be "knowingly and willfully noncompliant…two or more times during a 1-year period." The bills propose slightly different penalty amounts for medium-sized hospitals, detailed in Table 2.

- **Alternatives to Discounted Cash Prices.** If a hospital does not offer a discounted cash price (which is required for the machine-readable file and price estimator tool), then a hospital is allowed, under federal regulations, to list its undiscounted gross charge. Each bill proposes a different alternative to discounted cash prices. The LCMT Act proposes hospitals and ambulatory surgical centers list the median cash price charged to self-pay individuals for the previous three years. In contrast, Health Care PRICE Transparency Act 2.0 proposes hospitals, clinical diagnostic laboratories, ambulatory surgical centers, and imaging centers list the minimum cash price accepted from self-pay individuals. Both bills require the inclusion of a consumer-friendly document that clearly explains the hospital's charity care policy.

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Table 1. Comparison of Provider Transparency Requirements in Federal Regulations and Legislative Proposals

Provision	Hospital Price Transparency Rule	Lower Costs, More Transparency Act (H.R. 5378)	Health Care PRICE Transparency Act 2.0 (S. 3548)
Applicable Setting and Effective Dates	Hospitals, effective January 1, 2021	Hospitals (Sec. 101), clinical diagnostic laboratories (Sec. 102), and ambulatory surgical centers (Sec. 104), beginning January 1, 2026 Imaging centers (Sec. 103), beginning January 1, 2028	Hospitals (Sec. 2), clinical diagnostic laboratories (Sec. 3), imaging centers (Sec. 4), and ambulatory surgical centers (Sec. 5), beginning January 1, 2025
Uniform Method and Format	Formatting requirements for machine readable file begin July 1, 2024 (45 CFR 180.5(c)). In the meantime, CMS has provided suggestions for formatting and other tools.	Requires HHS Secretary to establish a standard, uniform method and format for public disclosure of standard charges in machine-readable file by January 1, 2026	Requires HHS Secretary to establish a standard, uniform method and format for public disclosure of standard charges in machine-readable file by January 1, 2025
Monitoring Compliance	The process for monitoring and enforcement has been established through rulemaking (45 CFR Subpart C). There is no minimum frequency for reviews. Beginning July 1, 2024, hospitals are required to "affirm in its machine-readable file" that the data is true, accurate, and complete.	Requires HHS Secretary, through notice and comment rulemaking and in consultation with HHS Office of the Inspector General (OIG), to establish a process to monitor compliance of applicable providers and ensure provider's compliance is reviewed at least once every three years	Requires HHS Secretary, in consultation with HHS OIG, to establish a process to monitor compliance of applicable providers and ensure provider's compliance is reviewed at least once every year (notice and comment rulemaking is not required) Requires senior official from each hospital to attest to accuracy and completeness of disclosures (attestation not required for other settings)

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Provision	Hospital Price Transparency Rule	Lower Costs, More Transparency Act (H.R. 5378)	Health Care PRICE Transparency Act 2.0 (S. 3548)
			States that the availability of a price estimator will not be considered to deem compliance with requirements; the use of a price estimator tool will not be used for purposes of compliance
Enforcement	CMS may take any of the following actions to address noncompliance, which generally, but not necessarily, occur in the following order: (1) provide a written warning notice of specific violation(s); (2) request a corrective action plan; and (3) impose a civil monetary penalty. The timeline and deadlines are not specified in regulations and instead may vary on a case-by-case basis. The HHS Secretary has the authority to increase penalty amounts through rulemaking. There are no waivers or hardship exemptions.	Establishes process for noncompliance: (1) send notification; (2) request corrective action plan (optional); and (3) impose civil monetary penalty (timeline and penalty amounts vary by provider) Allows HHS Secretary to increase civil monetary penalties in second year of implementation (2027 for hospitals, clinical diagnostic laboratories, and ambulatory surgical centers; 2029 for imaging centers) Allows HHS Secretary to waive or reduce penalty by not more than 75 percent and not more than once in a 6-year period for hospitals and ambulatory surgical centers (penalty can be both waived and reduced in a 6-year period); no flexibility for clinical diagnostic laboratories and imaging centers	Establishes process for noncompliance: (1) send notification; (2) request corrective action plan (mandatory); and (3) impose civil monetary penalty (timeline and penalty amounts vary by provider) Allows HHS Secretary to increase civil monetary penalties in second year of implementation (2027 for hospitals, clinical diagnostic laboratories, and ambulatory surgical centers; 2029 for imaging centers) Prohibits HHS Secretary from granting any waiver to penalty

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Provision	Hospital Price Transparency Rule	Lower Costs, More Transparency Act (H.R. 5378)	Health Care PRICE Transparency Act 2.0 (S. 3548)
Civil Monetary Penalties	The amounts range from $300 per day to $5,500 per day, depending on the number of beds (45 CFR 180.90). CMS may impose additional penalties for continuing violations. There are no higher penalty amounts for persistent noncompliance.	Allows HHS Secretary to impose higher penalties for a hospital that has been noncompliant for a 1-year period or longer Allows HHS Secretary to impose even higher penalties for a hospital with more than 30 beds that has been determined to be "knowingly and willfully noncompliant…two or more times during a 1-year period"	Allows HHS Secretary to impose higher penalties for a hospital that has been noncompliant for a 1-year period or longer Allows HHS Secretary to impose even higher penalties for a hospital with more than 30 beds that has been determined to be "knowingly and willfully noncompliant…two or more times during a 1-year period"

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Table 2. Comparison of Civil Monetary Penalties for Hospitals

Number of Beds	Hospital Price Transparency Rule	Lower Costs, More Transparency Act (H.R. 5378)			Health Care PRICE Transparency Act 2.0 (S. 3548)		
	Regardless of number of violations	Noncompliant one time for less than 1 year	Noncompliant one time for a 1-year period or longer	Noncompliant two or more times during 1-year period	Noncompliant one time for less than 1 year	Noncompliant one time for a 1-year period or longer	Noncompliant two or more times during 1-year period
30 or fewer beds	$300 per day	$300 per day	$400 per day		$300 per day		
More than 30 but fewer than 550 beds	$10 per bed per day						
More than 30 but fewer than 101 beds		$12.50 per bed per day	$15 per bed per day	$500,000 to $1 million	$10 per bed per day	$12.50 per bed per day	$500,000 to $1 million
More than 100 but fewer than 201 beds		$17.50 per bed per day	$20 per bed per day				
More than 100 but fewer than 301 beds				$1 million+ to $2 million	$15 per bed per day	$17.50 per bed per day	$1 million+ to $2 million
More than 200 but fewer than 501 beds		$20 per bed per day	$25 per bed per day				
More than 300 but fewer than 501 beds				$2 million+ to $4 million	$20 per bed per day	$25 per bed per day	$2 million+ to $4 million
More than 500 beds		$25 per bed per day	$35 per bed per day	$5 million to $10 million	$25 per bed per day	$35 per bed per day	$5 million to $10 million
More than 550 beds	$5,500 per day						

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II. Health Plan Price Transparency

The LCMT Act and Health Care PRICE Transparency Act 2.0 propose to codify key provisions of the Transparency in Coverage Rule – specifically, requirements for group health plans and issuers of group or individual health insurance to disclose pricing information in (1) machine-readable files containing in-network rates for covered items and services and allowed amounts for, and billed charges from, out-of-network providers; and (2) an internet-based price comparison tool (self-service tool) and in paper form, upon request, allowing an individual to receive an estimate of their cost-sharing responsibility for 500 items and services. Beginning January 1, 2024, the self-service tool is required to provide an estimate of their cost-sharing responsibility for all items and services (Phase 3). CMS has not provided any details about Phase 3 implementation on its Health Plan Price Transparency webpage. In addition, both bills propose changes to improve the usability of publicly disclosed price and rate information.

As detailed in Table 3, the bills diverge on implementation dates, some new requirements for the price comparison tool and public disclosures, and monitoring and enforcement. The LCMT Act also requires several reports that signal areas for potential policymaking in the future.

- **Effective Date.** Health Care PRICE Transparency Act 2.0 proposes changes to take effect in 2025, while the LCMT Act proposes a 2026 effective date.

- **New Requirements.** Both bills propose additional disclosures. Notably, Health Care PRICE Transparency Act 2.0 includes a provision requiring plans and issuers to hold individuals harmless for the balance if the amount ultimately billed or charged to the individual exceeds the cost-sharing amount generated by the self-service tool. This bill would also require the self-service tool to allow individuals to search for cost-sharing information for a covered item or service provided by out-of-network providers. Currently, the self-service only provides cost-sharing information on in-network providers. Another key difference is a provision in the LCMT Act that would require the average amount paid to each provider for each drug dispensed. Currently, plans and issuers are required to disclosure the negotiated rate and historical net prices for prescription drugs. Additionally, the LCMT Act would require plans and issuers to make public a data file (downloadable standard spreadsheet) containing a summary of all rate and payment information made public by such plan during such plan year, along with an attestation that information is complete and accurate. It would require the following:

    - Mean, median, and interquartile range of the in-network rate, and the amount allowed for out-of-network item or service, broken down by the type of provider furnishing the item or service and by the geographic area;
    - Trends in payment rates for items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same;

- The name of such plan, a description of the type of network of participating providers used by such plan, and description of whether such plan is self-insured or fully insured;
- For each item or service which is paid as part of a bundled rate, a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such bundle, and the list of the items and services included in such bundle; and
- Percentage of items and services that are paid on a fee-for-service basis and the percentage of items that are paid as part of a bundled rate, capitated payment rate, or other alternative payment model.

- **Monitoring and Enforcement.** Health Care PRICE Transparency Act 2.0 proposes a requirement for HHS and Labor to audit a minimum number of plans and issuers. The LCMT Act does not propose changes to enforcement. However, it requires several reports to Congress, including a report on compliance.

  - Use of standard-based application program interfaces (APIs) to facilitate access to health care price transparency information and the interoperability of other medical information – due January 1, 2025;
  - Usefulness and feasibility of the establishment of a provider tool by plans and issuers in facilitating provision of cost-sharing information – due one year after enactment;
  - Compliance with requirements and recommendations for improvements – due January 1, 2027;
  - Assessment of differences in negotiated prices in the private market between different types of markets (individual, large), hospitals (nonprofit, for-profit), insurers (local, national), areas (rural, urban, consolidated) – due January 1, 2028; and
  - Feasibility of including quality data with price transparency requirements – due one year after enactment.

Table 3. Comparison of Health Plan Price Transparency Requirements in Federal Regulations and Legislative Proposals

	Transparency in Coverage	Lower Costs, More Transparency Act (H.R. 5378), Sec. 105	Health Care PRICE Transparency Act 2.0 (S. 3548), Sec. 6
Effective Date	January 1, 2023	January 1, 2026	January 1, 2025
Cost-Sharing Information	The final rules require the self-service tool to provide: (1) an estimate of the individual's cost-sharing responsibility; (2) accumulated amounts; (3) in-network rate; (4) out-of-network allowed amount; (5) a list of items and	Adds new disclosures for required cost-sharing information provided in self-service tool: • Amount accrued towards any frequency or volume limitations	Requires self-service tool to allow individuals to search for cost-sharing information for a covered item or service provided by out-of-network providers

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	Transparency in Coverage	Lower Costs, More Transparency Act (H.R. 5378), Sec. 105	Health Care PRICE Transparency Act 2.0 (S. 3548), Sec. 6
	services included in a bundled payment arrangement; (6) any prior authorization or similar requirements; and (7) several notices (such as possibility of balance billing, cost-sharing responsibility may vary). The self-service tool allows individuals to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers.	• Any shared savings (such as credit) available to the participant at time of request	Requires plans and issuers to hold individuals harmless for the balance if the amount ultimately billed or charged to the individual exceeds the cost-sharing amount generated by the self-service tool Adds new disclosure for required cost-sharing information provided in self-service tool: • Amount accrued towards any frequency or volume limitations
Rate and Payment Information	The final rules require public disclosure of the following information in three machine-readable files available on the internet: (1) in-network provider rates for covered items and services; (2) out-of-network allowed amounts and billed charges for covered items and services; and (3) negotiated rates and historical net prices for covered prescription drugs.	Makes changes to the required prescription drug machine-readable file: • Requires disclosure of average amount paid to each provider for each drug dispensed or administered during the 90-day period beginning 180 days before such date of publication (does not apply to providers who submitted fewer than 20 claims for such drug) Requires plans and issuers to make public a data file (downloadable standard spreadsheet) containing a summary of all rate and payment	Makes changes to the required in-network rate machine-readable file: • Requires inclusion of rate and payment information on prescription drugs • Requires inclusion of additional details, such as code modifiers and national provider identifier Makes changes to the required prescription drug machine-readable file: • Requires the in-network rate to include the individual and total amounts for any bundled rates

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	Transparency in Coverage	Lower Costs, More Transparency Act (H.R. 5378), Sec. 105	Health Care PRICE Transparency Act 2.0 (S. 3548), Sec. 6
		information made public by such plan during such plan year, along with an attestation that information is complete and accurate	
Monitoring and Enforcement	CMS began enforcing applicable price transparency requirement on July 1, 2022. Enforcement actions may include requiring corrective actions and/or imposing a civil money penalty up to $100 per day, adjusted annually, for each violation and for each individual affected by the violation (45 CFR Part 150 B and C).	No proposed changes to enforcement authority Requires several reports to Congress, including a report on compliance due January 1, 2027	Requires audits of the three machine-readable files: • At least 20 group health plans or health insurance issuers, by HHS Secretary • At least 200 group health plans or service providers furnishing third-party administrators to a group health plan, by Labor Secretary Findings, conclusions, and enforcement actions taken based on audits are due annually to Congress by July 1 of the calendar year during which the files were audited