Patients Deserve Price Tags Act
Section-by-Section

Sec. 2. Strengthening Hospital Price Transparency Requirements
This section codifies and improves the current regulations requiring hospitals to post a machine-readable file (MRF), as well as a plain language description, of all negotiated rates and cash prices on a publicly available website. Hospitals would be required to post actual prices, not estimates, for all services, and a hospital executive must attest that all prices are accurate and complete. The Department of Health and Human Services (HHS) and the Office of the Inspector General (OIG) are required to develop a process to monitor compliance by hospitals at least annually. A hospital that has failed to comply with a corrective action plan (CAP) will be subject to a civil monetary penalty (CMP) based on size. The bill increases the annual maximum CMP for persistent non-compliance from $2 million up to $10 million.

Sec. 3. Increasing Price Transparency of Clinical Diagnostic Laboratory Tests
This section requires clinical laboratories to post a MRF, as well as a plain language description, of all negotiated rates and cash prices for clinical diagnostic laboratory tests. The bill imposes a CMP of not more than a $300 per day on non-compliant laboratories.

Sec. 4. Imaging Transparency
This section requires each provider of imaging services to post a MRF, as well as a plain language description, of all negotiated rates and cash prices. The bill imposes a CMP of not more than a $300 per day on non-compliant providers and suppliers.

Sec. 5. Ambulatory Surgical Center Price Transparency Requirements.
This section requires each ambulatory surgical center which is owned by a hospital, or a person with controlling interest in a hospital, to post a MRF as well as a plain language description, of all negotiated rates and cash prices. The bill imposes a CMP of not more than a $300 per day on non-compliant providers and suppliers.

Sec. 6. Strengthening Health Coverage Transparency Requirements.
This section will codify and improve upon the current Transparency in Coverage (TiC) rules. The bill codifies the requirement that health plans make available to enrollees information about providers in-network with their plan and the rates of those providers, information about out-of-pocket costs associated with receiving services under the plan, and information about utilization management under the plan like prior authorization. Plans must also publicly post MRF files with in-network rates for providers, the maximum allowed amount for out-of-network providers, the in-network rate for prescribed drugs and the historical net price of drugs paid by the plan The bill ensures that prices are included only for services and drugs with at least one claim in order to avoid unnecessarily large file sizes. This section adds a requirement for attestation from a plan executive that all prices are accurate and complete. A health plan that fails to comply with a corrective action plan will be subject to a CMP of not more than the lesser of $300 per member, per day or $10 million.

Sec. 7. Increasing Group Health Plan Access to Health Data

Currently, Employee Retirement Income Security Act (ERISA) and non-federal government self-insured plans have a right to access to all de-identified claims and encounter information for audit and review, but covered service providers, like third-party administrators (TPAs), continue to restrict disclosures. This section clarifies that group health plans have access to all claims and encounter data. It strengthens the "gag clause prohibition" enacted along with the No Surprises Act that forbids third parties and plan contractors from imposing contract terms that prevent plans from accessing data needed to administer the plan effectively. The information or data must be shared in a manner consistent with the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA). Group health plans must annually attest that their contracts with covered service providers comply with these requirements. Entities that block the group health plan's access to the data may be access a CMP of $10,000 per day.

Sec. 8. Oversight of Administrative Service Providers
This section applies claims and financial transaction transparency requirements to all medical services. It requires that covered service providers give plans claims and encounter data on a quarterly basis. Covered service providers must also provide information on how reimbursement amounts are calculated, any provider or supplier renumerations, and all payment data related to alternative compensation arrangements. This data is also protected by privacy, security, and breach notification regulations.

Sec. 9. Preemption Only in Event of Conflict
This section ensures the federal law does not preempt any state laws that establish, implement, or continue in effect any requirement or prohibition related to health care price transparency, except where it prevents the application of the requirements of this bill. This section does not preempt ERISA.

Sec. 10. Requirement For Explanation of Benefits
This section mandates that all commercial plans send an explanation of benefits (EOB) with specific information about services provided. It also requires that the advanced explanation of benefits include a plain language description of each item or service to be provided.

Sec. 11. Provision of Itemized Bills
This section requires health care providers or facilities billing for items or services to include a detailed itemized bill of each distinct item or service or an all-in total price for bundled items, if offered to the patient as an option. The bill must also include information on the provider or facility's charity care policies. This section prohibits a provider or facility from pursuing collections actions against a patient if they have not provided the patient with an itemized bill. Providers also are prohibited from taking collections actions against a patient if the billed amount is greater than the good faith estimate a patient receives from the provider or the amount the facility posted in its price MRF, unless the patient received medically necessary care that was unforeseen at the time they received an estimate.