BRAUN AMENDMENT #3

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AMENDMENT NO.________ Calendar No.______

Purpose: To amend the Public Health Service Act to provide for hospital and insurer price transparency.

IN THE SENATE OF THE UNITED STATES—118th Cong., 1st Sess.

S. 2840

To improve access to and the quality of primary health care, expand the health workforce, and for other purposes.

Referred to the Committee on ____________________ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by ______________

Viz:

1 At the appropriate place, insert the following:

2 **SEC. ___. PRICE TRANSPARENCY REQUIREMENTS.**

3 (a) HOSPITALS.—Section 2718(e) of the Public
4 Health Service Act (42 U.S.C. 300gg–18(e)) is amend-
5 ed—

6 (1) by striking "Each hospital" and inserting
7 the following:

8 "(1) IN GENERAL.—Each hospital";

9 (2) by inserting ", in plain language without
10 subscription and free of charge, in a consumer-
11 friendly, machine-readable format," after "a list";
12 and

1 (3) by adding at the end the following: "Each
2 hospital shall include in its list of standard charges,
3 along with such additional information as the Sec-
4 retary may require with respect to such charges for
5 purposes of promoting public awareness of hospital
6 pricing in advance of receiving a hospital item or
7 service, as applicable, the following:
8 "(i) A description of each item or
9 service provided by the hospital.
10 "(ii) The gross charge.
11 "(iii) Any payer-specific negotiated
12 charge clearly associated with the name of
13 the third party payer and plan.
14 "(iv) The de-identified minimum ne-
15 gotiated charge.
16 "(v) The de-identified maximum nego-
17 tiated charge.
18 "(vi) The discounted cash price.
19 "(vii) Any code used by the hospital
20 for purposes of accounting or billing, in-
21 cluding Current Procedural Terminology
22 (CPT) code, the Healthcare Common Pro-
23 cedure Coding System (HCPCS) code, the
24 Diagnosis Related Group (DRG), the Na-

1 tional Drug Code (NDC), or other common
2 payer identifier.
3 "(2) DELIVERY METHODS AND USE.—
4 "(A) IN GENERAL.—Each hospital shall
5 make public the standard charges described in
6 paragraph (1) for as many of the 70 Centers
7 for Medicaid & Medicare Services-specified
8 shoppable services that are provided by the hos-
9 pital, and as many additional hospital-selected
10 shoppable services as may be necessary for a
11 combined total of at least 300 shoppable serv-
12 ices, including the rate at which a hospital pro-
13 vides and bills for that shoppable service. If a
14 hospital does not provide 300 shoppable services
15 in accordance with the previous sentence, the
16 hospital shall make public the information spec-
17 ified under paragraph (1) for as many
18 shoppable services as it provides.
19 "(B) DETERMINATION BY CMS.—A hos-
20 pital shall be deemed by the Centers for Medi-
21 care & Medicaid Services to meet the require-
22 ments of subparagraph (A) if the hospital main-
23 tains an internet-based price estimator tool that
24 meets the following requirements:

1 "(i) The tool provides estimates for as
2 many of the 70 specified shoppable services
3 that are provided by the hospital, and as
4 many additional hospital-selected
5 shoppable services as may be necessary for
6 a combined total of at least 300 shoppable
7 services.
8 "(ii) The tool allows health care con-
9 sumers to, at the time they use the tool,
10 obtain an estimate of the amount they will
11 be obligated to pay the hospital for the
12 shoppable service.
13 "(iii) The tool is prominently dis-
14 played on the hospital's website and easily
15 accessible to the public, without subscrip-
16 tion, fee, or having to submit personal
17 identifying information (PII), and search-
18 able by service description, billing code,
19 and payer.
20 "(3) DEFINITIONS.—Notwithstanding any other
21 provision of law, for the purpose of paragraphs (1)
22 and (2):
23 "(A) DE-IDENTIFIED MAXIMUM NEGO-
24 TIATED CHARGE.—The term 'de-identified max-
25 imum negotiated charge' means the highest

1 charge that a hospital has negotiated with all
2 third party payers for an item or service.
3 "(B) DE-IDENTIFIED MINIMUM NEGO-
4 TIATED CHARGE.—The term 'de-identified min-
5 imum negotiated charge' means the lowest
6 charge that a hospital has negotiated with all
7 third party payers for an item or service.
8 "(C) DISCOUNTED CASH PRICE.—The
9 term 'discounted cash price' means the charge
10 that applies to an individual who pays cash, or
11 cash equivalent, for a hospital item or service.
12 Hospitals that do not offer self-pay discounts
13 may display the hospital's undiscounted gross
14 charges as found in the hospital chargemaster.
15 "(D) GROSS CHARGE.—The term 'gross
16 charge' means the charge for an individual item
17 or service that is reflected on a hospital's
18 chargemaster, absent any discounts.
19 "(E) PAYER-SPECIFIC NEGOTIATED
20 CHARGE.—The term 'payer-specific negotiated
21 charge' means the charge that a hospital has
22 negotiated with a third party payer for an item
23 or service.
24 "(F) SHOPPABLE SERVICE.—The term
25 'shoppable service' means a service that can be

1 scheduled by a health care consumer in ad-
2 vance.
3 "(G) STANDARD CHARGES.—The term
4 'standard charges' means the regular rate es-
5 tablished by the hospital for an item or service,
6 including both individual items and services and
7 service packages, provided to a specific group of
8 paying patients, including the gross charge, the
9 payer-specific negotiated charge, the discounted
10 cash price, the de-identified minimum nego-
11 tiated charge, the de-identified maximum nego-
12 tiated charge, and other rates determined by
13 the Secretary.
14 "(H) THIRD PARTY PAYER.—The term
15 'third party payer' means an entity that is, by
16 statute, contract, or agreement, legally respon-
17 sible for payment of a claim for a health care
18 item or service.
19 "(4) ENFORCEMENT.—In addition to any other
20 enforcement actions or penalties that may apply
21 under subsection (b)(3) or another provision of law,
22 a hospital that fails to provide the information re-
23 quired by this subsection and has not completed a
24 corrective action plan to comply with the require-
25 ments of such subsection shall be subject to a civil

1 monetary penalty of an amount not to exceed $300
2 per day that the violation is ongoing as determined
3 by the Secretary. Such penalty shall be imposed and
4 collected in the same manner as civil money pen-
5 alties under subsection (a) of section 1128A of the
6 Social Security Act are imposed and collected.''.
7 (b) TRANSPARENCY IN COVERAGE.—Section
8 1311(e)(3) of the Patient Protection and Affordable Care
9 Act (42 U.S.C. 18031(e)(3)) is amended—
10 (1) in subparagraph (A)—
11 (A) by redesignating clause (ix) as clause
12 (xii); and
13 (B) by inserting after clause (viii), the fol-
14 lowing:
15 ''(ix) In-network provider rates for
16 covered items and services.
17 ''(x) Out-of-network allowed amounts
18 and billed charges for covered items and
19 services.
20 ''(xi) Negotiated rates and historical
21 net prices for covered prescription drugs.'';
22 (2) in subparagraph (B)—
23 (A) in the heading, by striking ''USE'' and
24 inserting ''DELIVERY METHODS AND USE'';

1 (B) by inserting "and subparagraph (C)"
2 after "subparagraph (A)";
3 (C) by inserting ", as applicable," after
4 "English proficiency"; and
5 (D) by inserting after the second sentence,
6 the following: "The Secretary shall establish
7 standards for the methods and formats for dis-
8 closing information to individuals. At a min-
9 imum, these standards shall include the fol-
10 lowing:
11 "(i) An internet-based self-service tool
12 to provide information to an individual in
13 plain language, without subscription and
14 free of charge, in a machine readable for-
15 mat, through a self-service tool on an
16 internet website that provides real-time re-
17 sponses based on cost-sharing information
18 that is accurate at the time of the request
19 that allows, at a minimum, users to—
20 "(I) search for cost-sharing infor-
21 mation for a covered item or service
22 provided by a specific in-network pro-
23 vider or by all in-network providers;
24 "(II) search for an out-of-net-
25 work allowed amount, percentage of

1 billed charges, or other rate that pro-
2 vides a reasonably accurate estimate
3 of the amount an insurer will pay for
4 a covered item or service provided by
5 out-of-network providers; and
6 "(III) refine and reorder search
7 results based on geographic proximity
8 of in-network providers, and the
9 amount of the individual's cost-shar-
10 ing liability for the covered item or
11 service, to the extent the search for
12 cost-sharing information for covered
13 items or services returns multiple re-
14 sults.
15 "(ii) In paper form at the request of
16 the individual that includes no fewer than
17 20 providers per request with respect to
18 which cost-sharing information for covered
19 items and services is provided, and dis-
20 closes the applicable provider per-request
21 limit to the individual, mailed to the indi-
22 vidual not later than 2 business days after
23 receiving an individual's request.";
24 (3) in subparagraph (C)—
25 (A) in the first sentence—

1 (i) by striking "The Exchange" and
2 inserting the following:
3 "(i) IN GENERAL.—The Exchange";
4 (ii) by inserting "or out-of-network
5 provider" after "item or service by a par-
6 ticipating provider"; and
7 (iii) by inserting before the period the
8 following: "the following information:
9 "(i) An estimate of an individual's
10 cost-sharing liability for a requested cov-
11 ered item or service furnished by a pro-
12 vider, which shall reflect any cost-sharing
13 reductions the individual would receive.
14 "(ii) A description of the accumulated
15 amounts.
16 "(iii) The in-network rate, including
17 negotiated rates and underlying fee sched-
18 ule rates.
19 "(iv) The out-of-network allowed
20 amount or any other rate that provides a
21 more accurate estimate of an amount an
22 issuer will pay, including the percent reim-
23 bursed by insurers to out-of-network pro-
24 viders, for the requested covered item or

1 service furnished by an out-of-network pro-
2 vider.
3 "(v) A list of the items and services
4 included in bundled payment arrangements
5 for which cost-sharing information is being
6 disclosed.
7 "(vi) A notification that coverage of a
8 specific item or service is subject to a pre-
9 requisite, if applicable.
10 "(vii) A notice that includes the fol-
11 lowing information:
12 "(I) A statement that out-of-net-
13 work providers may bill individuals for
14 the difference, including the balance
15 billing, between a provider's billed
16 charges and the sum of the amount
17 collected from the insurer in the form
18 of a copayment or coinsurance
19 amount and the cost-sharing informa-
20 tion.
21 "(II) A statement that the actual
22 charges for an individual's covered
23 item or service may be different from
24 an estimate of cost-sharing liability
25 depending on the actual items or serv-

1 ices the individual receives at the
2 point of care.
3 "(III) A statement that the esti-
4 mate of cost-sharing liability for a
5 covered item or service is not a guar-
6 antee that benefits will be provided
7 for that item or service.
8 "(IV) A statement disclosing
9 whether the plan counts copayment
10 assistance and other third-party pay-
11 ments in the calculation of the indi-
12 vidual's deductible and out-of-pocket
13 maximum.
14 "(V) For items and services that
15 are recommended preventive services
16 under section 2713 of the Public
17 Health Service Act, a statement that
18 an in-network item or service may not
19 be subject to cost-sharing if it is billed
20 as a preventive service in the insurer
21 cannot determine whether the request
22 is for a preventive or non-preventive
23 item or service.
24 "(VI) Any additional informa-
25 tion, including other disclaimers, that

1 the insurer determines is appropriate,
2 provided the additional information
3 does not conflict with the information
4 required to be provided by this sub-
5 section.";
6 (B) by striking the second sentence; and
7 (C) by adding at the end the following:
8 "(ii) DEFINITIONS.—Notwithstanding
9 any other provision of law, for the purpose
10 of subparagraphs (A), (B), and (C):
11 "(I) ACCUMULATED AMOUNTS.—
12 The term 'accumulated amounts'
13 means the amount of financial respon-
14 sibility an individual has incurred at
15 the time a request for cost-sharing in-
16 formation is made, with respect to a
17 deductible or out-of-pocket limit, in-
18 cluding any expense that counts to-
19 ward a deductible or out-of-pocket
20 limit, but exclude any expense that
21 does not count toward a deductible or
22 out-of-pocket limit. To the extent an
23 insurer imposes a cumulative treat-
24 ment limitation on a particular cov-
25 ered item or service independent of in-

1 dividual medical necessity determina-
2 tions, the amount that has accrued to-
3 ward the limit on the item or service.
4 "(II) HISTORICAL NET PRICE.—
5 The term 'historical net price' means
6 the retrospective average amount an
7 insurer paid for a prescription drug,
8 inclusive of any reasonably allocated
9 rebates, discounts, chargebacks, fees,
10 and any additional price concessions
11 received by the insurer with respect to
12 the prescription drug. The allocation
13 shall be determined by dollar value for
14 non-product specific and product-spe-
15 cific rebates, discounts, chargebacks,
16 fees, and other price concessions to
17 the extent that the total amount of
18 any such price concession is known to
19 the insurer at the time of publication
20 of the historical net price.
21 "(III) NEGOTIATED RATE.—The
22 term 'negotiated rate' means the
23 amount a plan or issuer has contrac-
24 tually agreed to pay for a covered
25 item or service, whether directly or in-

1 directly through a third party admin-
2 istrator or pharmacy benefit manager,
3 to an in-network provider, including
4 an in-network pharmacy or other pre-
5 scription drug dispenser, for covered
6 items or services.

7 "(IV) OUT-OF-NETWORK AL-
8 LOWED AMOUNT.—The term 'out-of-
9 network allowed amount' means the
10 maximum amount an insurer will pay
11 for a covered item or service furnished
12 by an out-of-network provider.

13 "(V) OUT-OF-NETWORK LIMIT.—
14 The term 'out-of-network limit' means
15 the maximum amount that an indi-
16 vidual is required to pay during a cov-
17 erage period for his or her share of
18 the costs of covered items and services
19 under his or her plan or coverage, in-
20 cluding for self-only and other than
21 self-only coverage, as applicable.

22 "(VI) UNDERLYING FEE SCHED-
23 ULE RATES.—The term 'underlying
24 fee schedule rates' means the rate for
25 an item or service that a plan or

1 issuer uses to determine a partici-
2 pant's, beneficiary's, or enrollee's
3 cost-sharing liability from a particular
4 provider or providers, when the rate is
5 different from the negotiated rate.";
6 (4) in subparagraph (D), by striking "subpara-
7 graph (A)" and inserting "subparagraphs (A), (B),
8 and (C)"; and
9 (5) by adding at the end the following:
10 "(F) APPLICATION OF PARAGRAPH.—In
11 addition to qualified health plans (and plans
12 seeking certification as qualified health plans),
13 this paragraph (as amended by the Health Care
14 Prices Revealed and Information to Consumers
15 Explained Transparency Act) shall apply to
16 group health plans (including self-insured and
17 fully insured plans) and health insurance cov-
18 erage (as such terms are defined in section
19 2791 of the Public Health Service Act).".