United States House Committee on Ways & Means
CHAIRMAN JASON SMITH

ENERGY & COMMERCE
CHAIR RODGERS

COMMITTEE ON EDUCATION & THE WORKFORCE

THE LOWER COSTS, MORE TRANSPARENCY ACT

Title I – Improving Health Care Transparency

Sec. 101. Hospital Price Transparency Requirements.

- Introduced as H.R. 3561 by Reps. Rodgers (R-WA-5) and Pallone (D-NJ-6) and H.R. 4839 by Rep. Steel (R-CA-45), this section requires hospitals to make public all standard charges for all items and services through machine-readable files as well as payer-specific negotiated charges, including for cash-paying patients, for at least 300 shoppable services.

Sec. 102. Increasing Price Transparency of Clinical Diagnostic Laboratory Tests Under Medicare.

- Introduced as H.R. 3248 by Reps. Miller-Meeks (R-IA-1) and DeGette (D-CO-1) and H.R. 4882 by Rep. Miller (R-WV-1), this section extends certain price transparency requirements to diagnostic labs. Specifically, this section requires labs to make publicly available the cash price and publish cash prices as well as the de-identified minimum and maximum insurer-negotiated rates for clinical diagnostic laboratory tests offered by the lab that are included on the list of shoppable services specified by the Centers for Medicare and Medicaid Services (CMS).

Sec. 103. Imaging Transparency.

- Introduced as H.R. 4828, by Rep. Carey (R-OH-15), this section requires providers of certain imaging services to publish cash prices as well as de-identified minimum and maximum insurer-negotiated rates.

Sec. 104. Ambulatory Surgical Center Price Transparency Requirements.

- Introduced as H.R. 4839 by Rep. Steel (R-CA-45), this section requires ambulatory surgical centers (ASCs) owned by hospitals to publish cash prices and insurer-negotiated rates for all items and services and requires publication of prices for at least 300 shoppable services or a consumer-friendly price estimator tool.

Sec. 105. Promoting Health Coverage Price Transparency.

- Introduced as H.R. 3561 by Reps. Rodgers (R-WA-5) and Pallone (D-NJ-6), H.R. 4905 by Reps. Fitzpatrick (R-PA-1) and Lee (D-NV-3), and H.R. 4507 by Reps. Good (R-VA-5) and DeSaulnier (D-CA-10), this section requires group health plans to make personalized pricing information available to enrollees and to post publicly machine-readable files containing in-network negotiated rates, prescription drug prices, and out-of-network allowed amounts.

Sec. 106. Oversight of Pharmacy Benefits Manager Services.

- Introduced as H.R. 2679 by Reps. Kuster (D-NH-2), Carter (R-GA-1), Eshoo (D-CA-16), and Guthrie (R-KY-2), H.R. 4846 by Rep. Arrington (R-TX-19), and H.R. 4507 by Reps. Good (R-VA-5) and DeSaulnier (D-CA-10), this section requires Pharmacy Benefit Managers (PBMs) to semi-annually provide employers with detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. Additionally, this section requires the Government Accountability Office (GAO) to submit a report on the practices of pharmacy networks of group health plans, including networks that have pharmacies under common ownership with group health plans.

Sec. 107. Reports on Health Care Transparency Tools and Data Requirements.

- Requires 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. 108. Report on Integration in Medicare.

- Introduced as H.R. 3282 by Reps. Harshbarger (R-TN-1) and Schrier (D-WA-8) and H.R. 4883 by Rep. Murphy (R-NC-3) this section requires Medicare Advantage organizations to report to HHS certain information relating to health care providers, PBMs, and pharmacies with which they share common ownership. Additionally, this section requires the Medicare Payment Advisory Committee (MedPAC) to study and report on vertical integration between Medicare Advantage organizations, health care providers, PBMs, and pharmacies and how this integration impacts beneficiary access, cost, quality, and outcomes.

Sec. 109. Advisory Committee.

- Introduced as H.R. 4507 by Reps. Good (R-VA-5) and DeSaulnier (D-CA-10), this section creates an advisory committee of nine members to advise the Secretaries of Labor, HHS, and Treasury on how to improve the accessibility and usability of information collected through sections 105 and 106 of this Act and Section 204 of the Consolidated Appropriations Act of 2021, which requires insurance companies and employer-based health plans to submit information about prescription drugs and health care spending to CMS. The advisory committee sunsets on January 1, 2028.

Sec. 110. Report on Impact of Medicare Regulations on Provider and Payer Consolidation.

- Introduced as H.R. 3284 by Reps. Burgess (R-TX-26), Ferguson (R-GA-3), Bilirakis (R-FL-12), and Dingell (D-MI-6), this section requires the Secretary of Health and Human Services (HHS) to submit an annual report on the impact of Medicare regulations on health care consolidation and to analyze the effects of Centers for Medicare and Medicaid Innovation demonstrations on health care consolidation.

Sec. 111. Implementation Funding.

- This section provides HHS, Treasury, and Department of Labor $25 million to implement Title I of the legislation with reporting to Congress annually.

Title II – Reducing Health Care Costs for Patients

Sec. 201. Increasing Transparency in Generic Drug Applications.

- Introduced as H.R. 3839 by Reps. Dunn (R-FL-2) and Kuster (D-NH-2), requires the Food and Drug Administration (FDA) to disclose to new generic drug applicants what ingredients, if any, cause a drug to be quantitatively or qualitatively different from the listed "brand" drug for purposes of establishing sameness in formulation.
- For generic drug applications that include quantitative differences in an ingredient, the FDA would be required to provide directional guidance (i.e., whether the amount of the ingredient should be higher or lower) to establish sameness.

Sec. 202. Improving Transparency and Preventing the Use of Abusive Spread Pricing and Related Practices in Medicaid.

- Introduced as H.R. 1613 by Reps. Carter (R-GA-1), Gonzalez (D-TX-34), Stefanik (R-NY-21), Ross (D-NC-2), Allen (R-GA-12), and Auchincloss (D-MA-4), this section would ban spread pricing in Medicaid and ensure the accuracy of the National Average Drug Acquisition Cost (NADAC) survey in Medicaid.
- Specifically, this section would prohibit PBMs that contract with Medicaid Managed Care Organizations (MCOs) from spread pricing.
- In lieu of spread pricing, the language would clarify that states should reimburse PBMs contracting with MCOs for an administrative fee for managing the pharmacy benefit for Medicaid beneficiaries.
- Additionally, this section supports NADAC pricing in Medicaid. Many states use the NADAC price survey to determine actual acquisition costs, with accuracy of the survey contingent on pharmacies filling out the data requested by the survey.
- The policy would require pharmacies to complete the survey and report actual acquisition costs for drugs.

Sec. 203. Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus.

- Introduced as part of H.R. 3561 by Reps. Rodgers (R-WA-5) and Pallone (D-NJ-6), this section ensures that Medicare beneficiaries and Medicare are paying the same rates for physician-administered drugs in off-campus hospital outpatient departments as beneficiaries and Medicare do in physician offices.

Sec. 204. Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department of a Provider.

- Introduced as H.R. 3237 by Reps. Joyce (R-PA-13) and Sarbanes (D-MD-3), H.R. 3417 by Reps. Hern (R-OK-1) and Kuster (D-NH-2), and H.R. 4509 by Reps. Foxx (R-NC-5) and Scott (D-VA-3), this section requires each off-campus outpatient department of a Medicare provider to obtain and include a national provider identifier on billings for claims for services. Additionally, this section requires the HHS Office of the Inspector General to review the compliance of a previous Medicare payment revision.

Title III – Supporting Patients, Health Care Workers, Community Health Centers, and Hospitals

Sec. 301. Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers that Operate GME Programs.

- Introduced as H.R. 2559 by Reps. Joyce (R-PA-13), Blunt Rochester (D-DE-At-Large), Stefanik (R-NY-21), and Fletcher (D-TX-7), this section would extend the Community Health Center Fund through calendar year 2025 at $4.2 billion per year and National Health Service Corps through calendar year 2025 at $350 million per year.
- This section would also extend the Teaching Health Center Graduate Medical Education Program for FY24-29, beginning at $175 million in FY24 and increasing to $275 million in 2029. This section also allows HRSA to utilize carryover funds for the THCGME program for FY24 and FY25.

Sec. 302. Special Diabetes Programs.

- Introduced as H.R. 2550 by Reps. DeGette (D-CO-1) and Bilirakis (R-FL-12), this section would extend the Special Diabetes Program through calendar year 2025 at $170 million a year.
- Introduced as H.R. 2547 by Reps. Cole (R-OK-4) and Ruiz (D-CA-25), this section would extend the Special Diabetes for Indians Program through calendar year 2025 at $170 million a year.

Sec. 303. Delaying Certain Disproportionate Share Hospital Payment Reductions Under Medicaid.

- Introduced as H.R. 2665 by Reps. Clarke (D-NY-9), Crenshaw (R-TX-2), DeGette (D-CO-1), and Burgess (R-TX-26), this section would eliminate the Medicaid Disproportionate Share Hospital (DSH) cuts for FY24-25.
- The cuts equate to $8 billion per year in Medicaid funding that is otherwise meant to support high-need hospitals that provide care for high rates of Medicaid and uninsured patients.

Sec. 304. Medicaid Improvement Fund.

- Would eliminate $7 billion in funds in the Medicaid Improvement Fund.

Title IV – Increasing Access to Quality Health Data and Lowering Hidden Fees

Sec. 401. Increasing Plan Fiduciaries' Access to Health Data.

- Introduced as H.R. 4527 by Reps. Chavez-DeRemer (R-OR-5), Takano (D-CA-39), and Manning (D-NC-6), this section ensures health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan.

Sec. 402. Hidden Fees Disclosure Requirements.

- Introduced as H.R. 4508 by Reps. Courtney (D-CT-2) and Houchin (R-IN-9), this section strengthens requirements that PBMs and Third-Party Administrators disclose compensation to plan fiduciaries.

Sec. 403. Information on Prescription Drugs.

- This section confirms that existing law banning gag clauses applies to all private health plans. (Gag clauses prevent pharmacists from communicating lower-cost drug options to patients.)