CLIENT MEMORANDUM

June 26, 2026

H.R. 9393 Compared with Current Federal Price-Transparency Requirements

Overview

This memorandum compares H.R. 9393, the *Lower Costs, More Transparency Act of 2026*, with federal health care price-transparency regulations currently in effect. The analysis identifies provisions that largely codify existing policy, provisions that materially expand current requirements, and implementation questions that would need to be resolved by the Department of Health and Human Services (HHS).

EXECUTIVE SUMMARY

- H.R. 9393 preserves the core federal hospital and health-plan transparency framework but places substantial portions of it directly into statute.
- The bill's most consequential provider-side expansion is the creation of public price-posting requirements for ambulatory surgical centers (ASCs), independent clinical laboratories, and freestanding imaging providers.
- The bill materially strengthens hospital enforcement through higher graduated daily penalties and additional penalties for knowing, willful, and persistent noncompliance.
- For health plans and pharmacy benefit managers (PBMs), the bill would add prescription-drug net-price information, utilization indicators, spread-pricing disclosures, and annual statistical summaries intended to make raw pricing data more useful.
- Most major provisions would take effect January 1, 2028. HHS would need to reconcile the new statutory language with several details of existing CMS regulations.

Legislative Status and Effective Date

As of June 26, 2026, H.R. 9393 has been introduced but has not been enacted. Existing CMS, Department of Labor, and Department of the Treasury regulations therefore remain controlling. The bill generally establishes January 1, 2028, as the effective date for its principal transparency requirements.

At-a-Glance Comparison

Policy Area	Current Federal Requirements	H.R. 9393
Hospitals	Machine-readable files, payer-specific negotiated rates, discounted cash prices, and consumer-friendly information for at least 300 shoppable services under 45 C.F.R. Part 180.	Codifies and strengthens the framework; adds a three-year median self-pay price when no cash price exists, a charity-care policy link, stronger attestations, and enhanced enforcement.
ASCs	No federal public-posting system equivalent to the hospital rule; patient-specific good-faith estimates may apply.	Creates a new public machine-readable file and consumer-friendly disclosure program for ASC items and services.
Laboratories	No general federal public price file; individualized good-faith estimates may apply to uninsured or self-pay patients.	Requires public prices for CMS-designated shoppable laboratory tests and related ancillary charges.
Imaging	No general federal public price file for freestanding providers; hospital-based imaging may appear in hospital files.	Requires public prices for CMS-designated shoppable imaging services.
Plan comparison tools	Plans must provide internet-based cost-comparison tools for all covered items and services.	Adds detailed utilization-management information, financial incentives, geographic searching, and PBM spread-pricing information.

Policy Area	Current Federal Requirements	H.R. 9393
Plan machine-readable files	Public in-network and out-of-network files; prescription-drug file enforcement has been deferred.	Adds claims-utilization indicators, prescription-drug net prices, rebates and concessions, and pharmacy-specific spread information.
Enforcement	Hospital penalties are generally capped at $300 per day for small hospitals and $5,500 per day for the largest hospitals.	Raises graduated daily penalties and authorizes additional one-time penalties of up to $10 million for persistent noncompliance.

Detailed Comparison

1. Hospital Price Transparency

Current requirements. Federal regulations require hospitals to publish a machine-readable file containing standard charges for all hospital items and services. Required data include gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges. Hospitals must also make consumer-friendly information available for at least 300 shoppable services or use a qualifying price-estimator tool. CMS has recently added organizational NPI, attestation, and allowed-amount data requirements for certain percentage- or algorithm-based rates.

H.R. 9393. The bill would place much of the current framework directly into statute and require Medicare-participating hospitals to disclose plain-language descriptions and billing codes; gross charges; discounted cash prices; payer- and plan-specific negotiated dollar amounts; de-identified minimum and maximum negotiated charges; Type 2 NPIs; an annual completeness and accuracy attestation; and consumer-friendly information for at least 300 shoppable services. It would also require a link to the hospital's charity-care or financial-assistance policy and, when no discounted cash price exists, the median price charged to self-pay patients during the preceding three years.

- Largely codifies existing federal hospital disclosures.
- Adds a three-year median self-pay price and a charity-care policy link.
- Potentially narrows the statutory coverage language to Medicare-paid hospitals, while current regulations use a broad federal definition of "hospital."
- Does not expressly reproduce every technical data field added by CMS for 2026, although HHS could preserve or add fields through rulemaking.
- Does not expressly preserve the current price-estimator-tool alternative, creating an issue for implementing regulations.

2. Hospital Enforcement and Penalties

Current requirements. Current maximum civil monetary penalties generally range from $300 per day for hospitals with 30 or fewer beds to $5,500 per day for hospitals with more than 550 beds, with intermediate penalties calculated on a per-bed basis.

H.R. 9393. The bill establishes higher graduated penalties and increases the daily amount after one year of continuing noncompliance. It also authorizes additional one-time penalties for knowing, willful, and persistent violations.

Hospital Size	Initial Daily Penalty	After One Year
30 beds or fewer	$300 per day	$400 per day
31–100 beds	$12.50 per bed per day	$15 per bed per day
101–200 beds	$17.50 per bed per day	$20 per bed per day
201–500 beds	$20 per bed per day	$25 per bed per day
More than 500 beds	$25 per bed per day	$35 per bed per day

Additional penalties: The bill permits one-time penalties ranging from $500,000 to $10 million, depending on hospital size, for knowing, willful, and persistent noncompliance. It also authorizes reduced penalties or waivers based on access-to-care concerns, hardship, rural or underserved status, or waiver of a hearing.

3. Ambulatory Surgical Centers

Current requirements. ASCs do not currently operate under a federal public price-transparency system equivalent to the hospital machine-readable file and shoppable-services requirements. They may have patient-specific good-faith-estimate obligations under the No Surprises Act framework.

H.R. 9393. Medicare-paid ASCs would have to publish standard charges for all ASC items and services in a machine-readable file and provide consumer-friendly information for at least 300 shoppable services, or all services if the ASC furnishes fewer than 300. Required fields would include plain-language descriptions, billing codes, gross charges, discounted cash prices, and a three-year median self-pay price when no cash price exists. The ASC provisions do not expressly require payer-specific negotiated rates.

- This is a new federal public-posting program for ASCs.
- The ASC program is narrower than the hospital program because negotiated commercial rates are not expressly required.
- The general maximum penalty would be $300 per day, subject to waiver or reduction authority.

4. Clinical Laboratories and Imaging Providers

Current requirements. Independent laboratories and freestanding imaging providers generally do not have to maintain public federal price files comparable to hospital machine-readable files. They may be required to furnish individualized good-faith estimates to uninsured or self-pay patients when care is scheduled or requested. Prices may also appear indirectly in a hospital file or a health plan's Transparency in Coverage files.

H.R. 9393. Beginning in 2028, Medicare-paid laboratories would have to publicly disclose prices for CMS-designated shoppable clinical diagnostic laboratory tests, excluding advanced diagnostic laboratory tests. Medicare providers and suppliers furnishing designated shoppable imaging services would face comparable obligations. Required information would generally include the discounted cash price, the gross charge when no discounted cash price exists, related ancillary charges where applicable, and an annual completeness and accuracy attestation.

- These are materially new direct federal disclosure requirements.
- The provisions focus on cash and gross prices, not commercial payer-specific negotiated rates.
- Duplicate posting would not be required when the same price is already included in a hospital or ASC file.
- The general maximum penalty would be $300 per day, with potential access-to-care relief.

5. Health-Plan Consumer Price-Comparison Tools

Current requirements. Most non-grandfathered group health plans and insurers must provide an internet-based cost-comparison tool covering all covered items and services. The tool must generally display estimated member cost-sharing, negotiated rates, out-of-network allowed amounts, accumulated deductible and out-of-pocket spending, and applicable coverage prerequisites or limitations. Paper information must also be available upon request.

H.R. 9393. The bill would make these tools more prescriptive. In addition to current information, plans would have to disclose progress toward frequency or volume limits; prior authorization, concurrent review, step therapy, and fail-first requirements; financial incentives affecting the service; and whether a prescription drug is subject to PBM spread pricing, including the spread amount and an explanation. Search capabilities would have to include billing code, descriptive term, provider, and geographic area, with access through internet, telephone, paper, and other electronic methods.

- The basic consumer-tool mandate already exists.
- The bill materially expands the required detail, especially for utilization management and PBM spread pricing.

6. Health-Plan Machine-Readable Files

Current requirements. The Transparency in Coverage regulations require public machine-readable files for in-network negotiated rates and out-of-network allowed amounts and billed charges. The agencies contemplated a separate prescription-drug file, but enforcement has been deferred while technical and implementation issues are addressed.

H.R. 9393. The bill would require provider-specific in-network dollar rates and an indicator showing whether the provider submitted a claim during a specified historical period. For prescription drugs identified by National Drug Code, plans would have to disclose in-network rates, average amounts actually paid net of rebates and other price

concessions, and pharmacy-specific PBM spread-pricing amounts, subject to minimum-claim thresholds. Out-of-network files would include provider-specific billed and allowed amounts, generally with suppression when fewer than 11 claims are available.

- Operationalizes prescription-drug transparency that is not currently enforced under the federal rules.
- Adds utilization indicators to help distinguish real, used rates from "ghost" or inactive negotiated rates.
- Adds net drug-payment, rebate, concession, and spread-pricing information.
- Would update in-network and drug files quarterly, while out-of-network information would remain monthly.
- Generally lowers the out-of-network suppression threshold to 11 claims.

7. Annual Plan Summaries, Attestations, and PBM Reporting

H.R. 9393 adds reporting layers beyond the existing raw machine-readable files. Plans and insurers would have to publish annual summaries containing mean and median prices, interquartile price ranges, historical trends, market and network characteristics, self-funded status, bundled and capitated payment methodologies, and the proportion of payments made through fee-for-service versus alternative payment arrangements. Plans would also submit annual attestations identifying the public location of their files. PBMs would have to report spread-priced drugs and spread revenue to plan and insurer clients.

- These requirements are intended to make large pricing datasets more understandable and useful to employers, researchers, regulators, and consumers.
- The PBM reporting provisions add direct visibility into spread-pricing arrangements that current public transparency rules do not provide.

Bottom Line

H.R. 9393 would not replace the existing federal transparency architecture so much as codify, broaden, and strengthen it. The hospital posting provisions largely reflect requirements already in force, although the bill adds new self-pay, charity-care, and enforcement elements. The more significant policy changes are the extension of direct price-posting obligations to ASCs, laboratories, and imaging providers; the substantially stronger hospital penalty framework; and the deeper disclosure of prescription-drug, PBM, utilization, and health-plan payment information.

Principal Sources

1. H.R. 9393, Lower Costs, More Transparency Act of 2026 (introduced bill text)
2. Hospital Price Transparency, 45 C.F.R. Part 180
3. CMS Hospital Price Transparency Resources
4. CMS CY 2026 OPPS/ASC Final Rule Hospital Price Transparency Changes
5. Transparency in Coverage, 45 C.F.R. Part 147
6. Department of Labor Transparency in Coverage FAQs
7. No Surprises Act Good-Faith Estimate Requirements, 45 C.F.R. Part 149, Subpart G