I

119TH CONGRESS
2D SESSION

H. R. 9397

To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments, and to direct the Secretary of Health and Human Services to issue guidance on the provision of certain insurance information.

IN THE HOUSE OF REPRESENTATIVES

JUNE 23, 2026

Mr. PFLUGER (for himself and Mr. MORAN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XXVII of the Public Health Service Act and title XVIII of the Social Security Act to ensure health insurer accountability through publishing of overhead costs and claim payments, and to direct the Secretary of Health and Human Services to issue guidance on the provision of certain insurance information.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Premium Transparency Act''.

SEC. 2. ENSURING HEALTH INSURER ACCOUNTABILITY THROUGH PUBLISHING OF OVERHEAD COSTS AND CLAIM PAYMENTS.

(a) IN GENERAL.—Section 2718(a) of the Public Health Service Act (42 U.S.C. 300gg–18(a)) is amended—

(1) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), and adjusting the margins accordingly;

(2) by striking ''A health insurance issuer'' and inserting the following:

''(1) IN GENERAL.—A health insurance issuer'';

and

(3) by adding at the end the following new paragraph:

''(2) OVERHEAD COSTS AND CLAIM PAYMENT INFORMATION.—

''(A) IN GENERAL.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year beginning on or after January 1, 2027, submit to the Secretary (and, in the case such coverage

was offered through an Exchange established under subtitle D of title I of the Patient Protection and Affordable Care Act, to such Exchange) and publish on the public website of such issuer the following information in a consumer-friendly format specified by the Secretary:

''(i) the percentage of total premium revenue expended for each category described in subparagraphs (A) through (C) of paragraph (1);

''(ii) the explanation described in paragraph (1)(C); and

''(iii) the percentage of total premium revenue not expended and retained by such issuer.

''(B) MANNER OF PUBLICATION.—Information submitted and published by a health insurance issuer under subparagraph (A) shall be so submitted and published at the coverage level and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all such coverage offered by such issuer that are offered within

the same insurance market (as specified in subclause (I), (II), (III), or (IV) of section 2799A–1(a)(3)(E)(iv))).''.

(b) MEDICARE ADVANTAGE.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(7) OVERHEAD COSTS AND CLAIM PAYMENT INFORMATION.—

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2027, a contract under this section with an MA organization shall require the organization, with respect to each MA plan offered by such organization during such plan year, to submit to the Secretary and publish on the public website of such organization the following information in a consumer-friendly format specified by the Secretary:

''(i) The amount of total revenue (as determined under section 422.2420(c) of title 42, Code of Federal Regulations (or a successor regulation)) collected under such plan.

''(ii) The amount and percentage of such revenue expended on incurred claims

(as determined in accordance with paragraphs (2) through (4) of section 422.2420(b) of title 42, Code of Federal Regulations (or a successor regulation)).

''(iii) The amount and percentage of such revenue expended on non-claims costs (as defined in section 422.2401 of title 42, Code of Federal Regulations (or a successor regulation)).

''(iv) The amount of the difference between the MLR numerator (as determined under paragraph (b) of section 422.2420 of title 42, Code of Federal Regulations (or a successor regulation)) and the MLR denominator (as determined under paragraph (c) of such section (or a successor regulation)).

''(v) The amount described in clause (iv), expressed as a percentage of such revenue.

''(B) MANNER OF PUBLICATION.—Information submitted and published by an MA organization under subparagraph (A) shall be so submitted and published at the MA plan level and shall in addition, if determined appropriate

by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all MA plans offered by such organization).''.

SEC. 3. PROMOTING COMPARABILITY OF QUALIFIED HEALTH PLANS OFFERED THROUGH AN EXCHANGE.

Section 1311(d)(4)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(d)(4)(C)) is amended—

(1) by striking ''website through which'' and inserting the following: ''website—

''(i) through which'';

(2) in clause (i), as so inserted, by striking the semicolon and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(ii) that includes, as part of such comparative information for enrollments for plan years beginning on or after January 1, 2029, in the case a qualified health plan offered through such Exchange for such plan year was offered through such Exchange for a previous plan year, the most recent information submitted to such

Exchange with respect to such plan by the health insurance issuer of such plan under section 2718(a)(2) of the Public Health Service Act;''.

SEC. 4. GUIDANCE ON PROVISION OF CERTAIN INSURANCE INFORMATION IN STANDARDIZED, PLAIN ENGLISH FORMAT.

(a) IN GENERAL.—Not later than January 1, 2028, the Secretary shall issue guidance to group health plans, health insurance issuers offering group or individual health insurance coverage, and Medicare Advantage organizations offering an MA plan on providing information on the benefits and coverage available under the applicable plan or coverage, consistent with the relevant requirements under section 2715 of the Public Health Service Act (42 U.S.C. 300gg–15), section 1851(d) of the Social Security Act (42 U.S.C. 1395w–21(d)), and section 1852(c) of such Act (42 U.S.C. 1395w–22(c)). Such guidance shall include standards for providing information in a standardized, plain English format with respect to the following aspects of the plan or coverage (to the extent applicable):

(1) Any monthly premium.

(2) Any annual deductible.

(3) Any maximum limitations on out-of-pocket expenses.

(4) The type of provider network used by the plan or coverage.

(5) The plan or coverage share of the total allowed costs of benefits provided under the plan or coverage.

(6) The standard cost-sharing amounts for in-network care, including for the following types of care:

(A) Primary care.

(B) Specialist care.

(C) Urgent care.

(D) Emergency department care.

(E) Imaging.

(F) Inpatient hospital care.

(G) Outpatient facility care.

(H) Laboratory services.

(I) Preferred brand name drugs.

(J) Generic drugs.

(7) Additional features of the plan or coverage, including the following:

(A) Specialist referral policies.

(B) The availability of wellness programs.

(C) The availability of disease management programs.

(D) Whether an individual enrolled in such plan or coverage is an eligible individual for purposes of section 223 of the Internal Revenue Code of 1986 (relating to health savings accounts).

(E) Coverage of preventive care services.

(8) Such other aspects of the plan or coverage as the Secretary may specify.

(b) CONSULTATION.—In developing the guidance under subsection (a), the Secretary shall consult with the Secretary of Labor and the Secretary of the Treasury.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan, a health insurance issuer offering group or individual health insurance coverage, or a Medicare Advantage organization offering an MA plan to offer any of the plan features described in subsection (a).

(d) DEFINITIONS.—In this section:

(1) MEDICARE ADVANTAGE TERMS.—The terms ''Medicare Advantage organization'' and ''MA plan'' have the meanings given each such term for purposes of part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(2) PRIVATE HEALTH INSURANCE TERMS.—The terms ''group health plan'', ''health insurance coverage'', ''health insurance issuer'', ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings given each such term in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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