

119TH CONGRESS
2D SESSION

H. R. 9228

To amend the Employee Retirement Income Security Act of 1974 to ensure plan fiduciaries have access to de-identified information relating to health claims, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 2026

Mr. ONDER introduced the following bill; which was referred to the Committee on Education and Workforce

A BILL

To amend the Employee Retirement Income Security Act of 1974 to ensure plan fiduciaries have access to de-identified information relating to health claims, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Data Access,
5 Transparency, and Affordability Act of 2026”.

1 **SEC. 2. INCREASING GROUP HEALTH PLAN ACCESS TO**
2 **HEALTH DATA.**

3 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
4 TION.—

5 (1) DEFINITION.—Section 3 of the Employee
6 Retirement Income Security Act of 1974 (29 U.S.C.
7 1002) is amended by adding at the end the fol-
8 lowing:

9 “(46) NETWORK SERVICE PROVIDER.—

10 “(A) IN GENERAL.—The term ‘network
11 service provider’ means—

12 “(i) any person or entity that has an
13 arrangement or contract, direct or indirect,
14 to provide services to a group health plan
15 (as defined in section 733(a)), including a
16 health care provider, health care facility,
17 network or association of providers, service
18 provider offering access to a network of
19 providers, third party administrator, health
20 insurance issuer (as defined in section
21 733(b)), entity providing pharmacy benefit
22 management services, or any other service
23 provider; and

24 “(ii) any person or entity acting as an
25 intermediary between the group health

1 plan and a person or entity described in
2 subparagraph (A).

3 “(B) HEALTH CARE PROVIDER.—Notwith-
4 standing subparagraph (A), no health care pro-
5 vider shall be considered a network service pro-
6 vider solely in its capacity as a provider of
7 health care services.”.

8 (2) IN GENERAL.—Section 408(b)(2) of such
9 Act (29 U.S.C. 1108(b)(2)) is amended by adding at
10 the end the following:

11 “(D) No contract or arrangement for services,
12 whether direct or indirect, and no extension or re-
13 newal of such contract or arrangement, between a
14 group health plan (as defined in section 733(a)) and
15 any other person or entity, including a network serv-
16 ice provider, is reasonable within the meaning of this
17 paragraph unless such contract or arrangement—

18 “(i) allows the responsible plan fiduciary
19 (as that term is defined in subparagraph
20 (B)(ii)(I)) and the designated agent (which may
21 include the plan sponsor, the plan adminis-
22 trator, or a business associate (other than such
23 other party or entity (or its subsidiaries or af-
24 filiates))) of such fiduciary access to all claims
25 and encounter information described in section

1 724(a)(1)(B), and any documentation, includ-
2 ing medical records and policy documents, sup-
3 porting claim payments; and

4 “(ii) does not—

5 “(I) limit or delay access by the re-
6 sponsible plan fiduciary or designated
7 agent to claims and encounter information
8 or data for longer than 15 days or a period
9 determined appropriate by the Secretary,
10 whichever is shorter;

11 “(II) limit the amount of claims and
12 encounter information or data that the re-
13 sponsible plan fiduciary or designated
14 agent may access pursuant to any request
15 for such information or data;

16 “(III) limit access by the responsible
17 plan fiduciary or designated agent to prie-
18 ing terms for alternative payment arrange-
19 ments or capitated payment arrangements,
20 including—

21 “(aa) payment calculations and
22 formulas;

23 “(bb) quality measurements or
24 indicators;

25 “(cc) contract terms;

- 1 “(dd) payment amounts;
- 2 “(ee) measurement periods for all
- 3 incentives; and
- 4 “(ff) other payment methodolo-
- 5 gies;
- 6 “(IV) limit access by the responsible
- 7 plan fiduciary or designated agent to infor-
- 8 mation regarding overpayments, including
- 9 terms for recovery of overpayments;
- 10 “(V) limit the ability of the group
- 11 health plan, the plan sponsor, or the plan
- 12 administrator of such plan to select an
- 13 auditor and define the scope and frequency
- 14 of audits;
- 15 “(VI) otherwise limit or delay the re-
- 16 sponsible plan fiduciary or designated
- 17 agent from accessing such claims and en-
- 18 counter information or data in a daily
- 19 batch or on a daily basis;
- 20 “(VII) limit the disclosure to the re-
- 21 sponsible plan fiduciary or designated
- 22 agent of fees charged to the group health
- 23 plan related to plan administration and
- 24 claims processing, including renegotiation

1 fees, access fees, repricing fees, or en-
2 hanced review fees;

3 “(VIII) limit the ability of the respon-
4 sible plan fiduciary or designated agent to
5 request action on any claims or claim pay-
6 ments that such fiduciary or agent identi-
7 fies as potentially erroneous or fraudulent;

8 “(IX) limit public disclosure of de-
9 identified or aggregated information; or

10 “(X) limit access by the responsible
11 plan fiduciary or designated agent to any
12 extra-contractual terms containing claims
13 payment calculations and formulas, pricing
14 methodologies, and other information used
15 to determine the dollar value of provider
16 reimbursement.

17 “(E)(i) A person or entity shall provide infor-
18 mation or data under this paragraph in a manner
19 consistent with the privacy and security regulations
20 promulgated under the Health Insurance Portability
21 and Accountability Act (referred to in this para-
22 graph as ‘HIPAA’).

23 “(ii) A group health plan that receives a disclo-
24 sure pursuant to subparagraph (B) or (C) shall com-

1 ply with the privacy and security regulations promul-
2 gated under HIPAA.

3 “(iii) Nothing in this subparagraph shall be
4 construed to modify the requirements for the cre-
5 ation, receipt, maintenance, or transmission of pro-
6 tected health information under the HIPAA privacy
7 regulation (as defined in section 1180(b)(3) of the
8 Social Security Act) as they apply directly or indi-
9 rectly to a person or an entity pursuant to this para-
10 graph.

11 “(iv) This subparagraph shall not be read to
12 abridge or limit the disclosure requirements under
13 this paragraph or to impose additional privacy or se-
14 curity requirements on network service providers or
15 plan sponsors.

16 “(F) A group health plan receiving information
17 or data under this paragraph may disclose such in-
18 formation only in a manner that is consistent with
19 HIPAA and the privacy and security regulations
20 promulgated thereunder, regardless of their direct or
21 indirect applicability to the plan or any persons or
22 entities that could be or are business associates.

23 “(G) Information made available under this
24 subparagraph shall conform to the following stand-
25 ards:

1 “(i) All claims from a healthcare provider
2 shall be provided to the group health plan in ac-
3 cordance with transaction standards adopted by
4 regulation under HIPAA, as follows:

5 “(I) Institutional, professional, and
6 dental claims shall be in ASC X12N 837
7 format or any subsequent standard ap-
8 proved by the Secretary.

9 “(II) Pharmacy claims shall be in the
10 National Council for Prescription Drug
11 Programs format or any subsequent stand-
12 ard approved by the Secretary.

13 “(III) The files shall contain unmodi-
14 fied data taken directly from the files sent
15 from the provider. In the event that paper
16 claims are sent by the provider, they shall
17 be converted to the appropriate standard
18 electronic format. The files shall be acces-
19 sible to the plan at no cost to the group
20 health plan.

21 “(ii) All claim payment (or electronic funds
22 transfer (EFT)) and electronic remittance ad-
23 vice (ERA) notices sent by a network service
24 provider shall be made available to the group
25 health plan as ASC X12N 835 files, or any

1 subsequent standard approved by the Secretary,
2 in accordance with standards adopted by regu-
3 lation under HIPAA. The files shall be unmodi-
4 fied copies of the files sent by the network serv-
5 ice provider to the healthcare provider. Files
6 shall be accessible at no cost to the group
7 health plan.

8 “(iii) All non-claim costs shall be itemized
9 and made available to the group health plan in
10 real time through a web-based portal, through
11 an Application Programming Interface and
12 through a downloadable Comma Separated
13 Value file, or any subsequent standards ap-
14 proved by the Secretary.

15 “(H) The Secretary shall have authority to im-
16 plement subparagraphs (C) through (F) through no-
17 tice and comment rulemaking in accordance with
18 section 553 of title 5, United States Code.”.

19 (3) CIVIL ENFORCEMENT.—Section 502(c) of
20 such Act (29 U.S.C. 1132(c)) is amended by adding
21 at the end the following:

22 “(14) In the case of an agreement between a group
23 health plan (as defined in section 733(a)), or the respon-
24 sible plan fiduciary, the plan sponsor, or the plan adminis-
25 trator of such plan, and any other person or entity, includ-

1 ing a network service provider that violates section 724,
2 the Secretary of Labor may assess a civil penalty against
3 such other person or entity in the amount of up to
4 \$10,000 for each day during which such violation con-
5 tinues. Such penalty shall be in addition to other penalties
6 as may be prescribed by law.”.

7 (4) EXISTING PROVISIONS VOID.—Section 410
8 of such Act (29 U.S.C. 1110) is amended by adding
9 at the end the following:

10 “(c) Any provision in an agreement or instrument
11 shall be void as against public policy if such provision—

12 “(1) delays or limits a group health plan (as de-
13 fined in section 733(a)), or the responsible plan fidu-
14 ciary, the plan sponsor, or the plan administrator of
15 such plan, from accessing the claims and encounter
16 information or data described in section
17 724(a)(1)(B); or

18 “(2) violates the requirements of section
19 408(b)(2).”.

20 (5) PROHIBITION ON INDEMNIFICATION OF
21 SERVICE PROVIDERS FOR CIVIL PENALTIES.—Sec-
22 tion 410(a) of such Act (29 U.S.C. 1110(a)) is
23 amended—

24 (A) by striking “Except” and inserting

25 “(1) Except”; and

1 (B) by adding at the end the following:

2 “(2) Except as provided in subsection
3 410(b)(2), no person or entity subject to a civil en-
4 forcement penalty under section 502(a)(13),
5 502(a)(14), 502(a)(15) or section 727(d) may be in-
6 demnified, directly or indirectly, or otherwise re-
7 lieved from liability for any penalty, responsibility,
8 obligation, or duty of such person or entity under
9 this title.

10 “(3) Any provision of a contract or agreement
11 in violation of paragraph (2) shall be void as against
12 public policy.”

13 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
14 ITY INFORMATION.—Section 724(a)(3) of such Act (29
15 U.S.C. 1185m(a)(3)) is amended to read as follows:

16 “(3) ATTESTATION.—

17 “(A) IN GENERAL.—Subject to subpara-
18 graph (C), a group health plan or health insur-
19 ance issuer offering group health insurance cov-
20 erage shall annually submit to the Secretary an
21 attestation that such plan or issuer of such cov-
22 erage is in compliance with the requirements of
23 this subsection. Such attestation shall also in-
24 clude a statement verifying that—

1 “(i) the information or data described
2 under subparagraphs (A) and (B) of para-
3 graph (1) is available upon request and
4 provided to the group health plan, the plan
5 sponsor, the plan administrator, or the
6 business associate (other than the con-
7 tracting party or entity or its subsidiaries
8 or affiliates) of such plan, or the issuer in
9 a timely manner; and

10 “(ii) there are no terms in the agree-
11 ment under such paragraph (1) that di-
12 rectly or indirectly restrict or unduly delay
13 a group health plan, the plan sponsor, the
14 plan administrator, a business associate
15 (other than the contracting party or entity
16 or its subsidiaries or affiliates) of such
17 plan, or the issuer from auditing, review-
18 ing, or otherwise accessing such informa-
19 tion.

20 “(B) LIMITATION ON SUBMISSION.—A
21 group health plan or issuer offering group
22 health insurance coverage may not enter into an
23 agreement with a third-party administrator or
24 other service provider to submit the attestation
25 required under subparagraph (A).

1 “(C) EXCEPTION.—In the case of a group
2 health plan or issuer offering group health in-
3 surance coverage that is unable to obtain the
4 information or data needed to submit the attes-
5 tation required under subparagraph (A), such
6 plan or issuer may submit a written statement
7 in lieu of such attestation that includes—

8 “(i) an explanation of why such plan
9 or issuer was unsuccessful in obtaining
10 such information or data, including wheth-
11 er such plan, the plan sponsor, or the plan
12 administrator or issuer was limited or pre-
13 vented from auditing, reviewing, or other-
14 wise accessing such information or data;

15 “(ii) a description of the efforts made
16 by the group health plan, the plan sponsor,
17 or the plan administrator to remove any
18 gag clause provisions from the agreement
19 under paragraph (1); and

20 “(iii) a description of any response by
21 the third-party administrator or other serv-
22 ice provider with respect to efforts to com-
23 ply with the attestation requirement under
24 subparagraph (A), including the name of

1 the third-party administrator or other serv-
2 ice provider.”.

3 (c) **EFFECTIVE DATE.**—The amendments made by
4 subsections (a) and (b) shall apply with respect to a plan
5 beginning with the first plan year that begins on or after
6 the date that is 1 year after the date of enactment of this
7 Act regardless of the date of execution of any contract with
8 a network service provider.

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