



1     **TITLE I—HEALTH CARE PRICE**  
2     **TRANSPARENCY FOR PATIENTS**

3     **SEC. 101. REQUIRING CERTAIN FACILITIES UNDER THE**  
4                   **MEDICARE PROGRAM TO DISCLOSE CERTAIN**  
5                   **INFORMATION RELATING TO CHARGES AND**  
6                   **PRICES.**

7           (a) IN GENERAL.—Part E of title XVIII of the Social  
8 Security Act (42 U.S.C. 1395x et seq.) is amended by add-  
9 ing at the end the following new section:

10    **“SEC. 1899C. HEALTH CARE PROVIDER PRICE TRANS-**  
11                   **PARENCY.**

12           “(a) HOSPITAL PRICE TRANSPARENCY.—

13                   “(1) IN GENERAL.—Beginning January 1,  
14 2026, each specified hospital (as defined in para-  
15 graph (6)) that receives payment under this title for  
16 furnishing items and services shall comply with the  
17 price transparency requirement described in para-  
18 graph (2).

19                   “(2) REQUIREMENT DESCRIBED.—

20                           “(A) IN GENERAL.—For purposes of para-  
21 graph (1), the price transparency requirement  
22 described in this paragraph is, with respect to  
23 a specified hospital, that such hospital, in ac-  
24 cordance with a method and format established  
25 by the Secretary under subparagraph (C), com-

1 pile and make public (without subscription and  
2 free of charge) for each year—

3 “(i) one or more lists, in a format  
4 specified by the Secretary (which may be a  
5 machine-readable format), of the hospital’s  
6 standard charges (including the informa-  
7 tion described in subparagraph (B)) for  
8 each item and service furnished by such  
9 hospital; and

10 “(ii) information in a consumer-  
11 friendly format (as specified by the Sec-  
12 retary)—

13 “(I) on the hospital’s prices (in-  
14 cluding the information described in  
15 subparagraph (B)) for as many of the  
16 Centers for Medicare & Medicaid  
17 Services-specified shoppable services  
18 that are furnished by the hospital,  
19 and as many additional hospital-se-  
20 lected shoppable services (or all such  
21 additional services, if such hospital  
22 furnishes fewer than 300 shoppable  
23 services) as may be necessary for a  
24 combined total of at least 300  
25 shoppable services; and

1                   “(II) that includes, with respect  
2                   to each Centers for Medicare & Med-  
3                   icaid Services-specified shoppable  
4                   service that is not furnished by the  
5                   hospital, an indication that such serv-  
6                   ice is not so furnished.

7                   “(B) INFORMATION DESCRIBED.—For pur-  
8                   poses of subparagraph (A), the information de-  
9                   scribed in this subparagraph is, with respect to  
10                  standard charges and prices (as applicable)  
11                  made public by a specified hospital, the fol-  
12                  lowing:

13                  “(i) A description of each item or  
14                  service, accompanied by, as applicable, the  
15                  Healthcare Common Procedure Coding  
16                  System code, the diagnosis-related group,  
17                  the national drug code, or other identifier  
18                  used or approved by the Centers for Medi-  
19                  care & Medicaid Services.

20                  “(ii) The gross charge, expressed as a  
21                  dollar amount, for each such item or serv-  
22                  ice, when provided in, as applicable, the in-  
23                  patient setting and outpatient department  
24                  setting.

1           “(iii) The discounted cash price, ex-  
2           pressed as a dollar amount, for each such  
3           item or service when provided in, as appli-  
4           cable, the inpatient setting and outpatient  
5           department setting (or, in the case no dis-  
6           counted cash price is available for an item  
7           or service, the median price charged by the  
8           hospital for such item or service when pro-  
9           vided in such settings for the previous  
10          three years, expressed as a dollar amount).

11          “(iv) Any other information the Sec-  
12          retary may require for purposes of pro-  
13          moting public awareness of specified hos-  
14          pital standard charges or prices in advance  
15          of receiving an item or service from such  
16          a hospital, except information that is dupli-  
17          cative of any other reporting requirement  
18          under this section. Such information may  
19          include any current payer-specific nego-  
20          tiated charges, clearly associated with the  
21          name of the third party payer and plan  
22          and expressed as a dollar amount, that  
23          apply to each such item or service when  
24          provided in, as applicable, the inpatient  
25          setting and outpatient department setting.

1           “(C) METHOD AND FORMAT.—Not later  
2           than January 1, 2026, the Secretary shall es-  
3           tablish one or more methods and formats for  
4           specified facilities to use in compiling and mak-  
5           ing public standard charges and prices (as ap-  
6           plicable) pursuant to subparagraph (A). Any  
7           such method and format—

8                   “(i) may be similar to any template  
9                   made available by the Centers for Medicare  
10                  & Medicaid Services as of the date of the  
11                  enactment of this subparagraph;

12                   “(ii) shall meet such standards as de-  
13                  termined appropriate by the Secretary in  
14                  order to ensure the accessibility and  
15                  usability of such charges and prices; and

16                   “(iii) shall be updated as determined  
17                  appropriate by the Secretary, in consulta-  
18                  tion with stakeholders.

19           “(3) DEEMED COMPLIANCE WITH SHOPPABLE  
20           SERVICES REQUIREMENT FOR HOSPITALS WITH A  
21           PRICE ESTIMATOR TOOL.—

22                   “(A) IN GENERAL.—With respect to each  
23                  year until the effective date of regulations im-  
24                  plementing the provisions of sections 2799A-  
25                  1(f) and 2799B-6 of the Public Health Service

1 Act (relating to advanced explanations of bene-  
2 fits), including regulations on establishing data  
3 transfer standards to effectuate such provisions,  
4 a specified hospital shall be deemed to have  
5 complied with the requirement described in  
6 paragraph (2)(A)(ii)(I) (relating to shoppable  
7 services) if such hospital maintains a price esti-  
8 mator tool described in subparagraph (B).

9 “(B) PRICE ESTIMATOR TOOL DE-  
10 SCRIBED.—For purposes of subparagraph (A),  
11 the price estimator tool described in this sub-  
12 paragraph is, with respect to a specified hos-  
13 pital, a tool that meets the following require-  
14 ments:

15 “(i) Such tool allows an individual to  
16 immediately obtain a price estimate (tak-  
17 ing into account whether such individual is  
18 covered under any plan, coverage, or pro-  
19 gram described in clause (iv)(III)) and the  
20 discounted cash price charged by a speci-  
21 fied hospital, for each Centers for Medicare  
22 & Medicaid Services-specified shoppable  
23 service that is furnished by such hospital,  
24 and for each additional shoppable service  
25 as such hospital may select, such that price

1 estimates are available through such tool  
2 for at least 300 shoppable services (or for  
3 all such services, if such hospital furnishes  
4 fewer than 300 shoppable services).

5 “(ii) Such tool allows an individual to  
6 obtain such an estimate by billing code and  
7 by service description.

8 “(iii) Such tool is prominently dis-  
9 played on the public internet website of  
10 such hospital.

11 “(iv) Such tool does not require an in-  
12 dividual seeking such an estimate to create  
13 an account or otherwise input personal in-  
14 formation, except that such tool may re-  
15 quire that such individual provide informa-  
16 tion specified by the Secretary, which may  
17 include the following:

18 “(I) The name of such individual.

19 “(II) The date of birth of such  
20 individual.

21 “(III) In the case such individual  
22 is covered under a group health plan,  
23 group or individual health insurance  
24 coverage, a Federal health care pro-  
25 gram, or the program established



1 under chapter 89 of title 5, United  
2 States Code, an identifying number  
3 assigned by such plan, coverage, or  
4 program to such individual.

5 “(IV) In the case of an individual  
6 described in subclause (III), an indi-  
7 cation as to whether such individual is  
8 the primary insured individual under  
9 such plan, coverage, or program (and,  
10 if such individual is not the primary  
11 insured individual, a description of the  
12 individual’s relationship to such pri-  
13 mary insured individual).

14 “(V) Any other information spec-  
15 ified by the Secretary.

16 “(v) Such tool contains a statement  
17 confirming the accuracy and completeness  
18 of information presented through such tool  
19 as of the date such request is made.

20 “(vi) Such tool meets any other re-  
21 quirement specified by the Secretary.

22 “(4) MONITORING COMPLIANCE.—The Sec-  
23 retary shall, through notice and comment rule-  
24 making and in consultation with the Inspector Gen-  
25 eral of the Department of Health and Human Serv-

1       ices, establish a process to monitor compliance with  
2       this subsection. Such process shall ensure that each  
3       specified hospital's compliance with this subsection  
4       is reviewed not less frequently than once every 3  
5       years.

6               “(5) ENFORCEMENT.—

7                       “(A) IN GENERAL.—In the case of a speci-  
8                       fied hospital that fails to comply with the re-  
9                       quirements of this subsection—

10                               “(i) the Secretary shall notify such  
11                               hospital of such failure not later than 30  
12                               days after the date on which the Secretary  
13                               determines such failure exists; and

14                               “(ii) upon request of the Secretary,  
15                               the hospital shall submit to the Secretary,  
16                               not later than 45 days after the date of  
17                               such request, a corrective action plan to  
18                               comply with such requirements.

19               “(B) CIVIL MONETARY PENALTY.—

20                               “(i) IN GENERAL.—In addition to any  
21                               other enforcement actions or penalties that  
22                               may apply under another provision of law,  
23                               a specified hospital that has received a no-  
24                               tification under subparagraph (A)(i) and  
25                               fails to comply with the requirements of

1           this subsection by the date that is 90 days  
2           after such notification (or, in the case of  
3           such a hospital that has submitted a cor-  
4           rective action plan described in subpara-  
5           graph (A)(ii) in response to a request so  
6           described, by the date that is 90 days after  
7           the Secretary identifies the failure of such  
8           hospital to satisfactorily complete such cor-  
9           rective action plan) shall be subject to a  
10          civil monetary penalty of an amount speci-  
11          fied by the Secretary for each subsequent  
12          day during which such failure is ongoing.  
13          Such amount shall not exceed—

14                   “(I) in the case of a specified  
15                   hospital that is a hospital or critical  
16                   access hospital with 30 or fewer beds,  
17                   \$300 per day; and

18                   “(II) in the case of any specified  
19                   hospital and except as provided in  
20                   clause (iii), \$2,000,000 for a 1-year  
21                   period.

22                   “(ii) INCREASE AUTHORITY.—In ap-  
23                   plying this subparagraph with respect to  
24                   violations occurring in 2029 or a subse-

1                   quent year, the Secretary may through no-  
2                   tice and comment rulemaking increase—

3                   “**(I)** the limitation on the per day  
4                   amount of any penalty applicable to a  
5                   specified hospital that is a hospital or  
6                   critical access hospital with 30 or  
7                   fewer beds under clause **(i)(I)**;

8                   “**(II)** the limitation on the  
9                   amount of any penalty applicable for  
10                  a 1-year period under clause **(i)(II)**;  
11                  and

12                  “**(III)** the limitation on the in-  
13                  crease of any penalty applied under  
14                  clause **(iii)**.

15                  “**(iii)**     **PERSISTENT     NONCOMPLI-**  
16                  **ANCE.**—In the case of a specified hospital  
17                  (other than a specified hospital that is a  
18                  hospital or critical access hospital with 30  
19                  or fewer beds) that the Secretary has de-  
20                  termined to be knowingly and willfully non-  
21                  compliant with the provisions of this sub-  
22                  section two or more times during a 1-year  
23                  period, the Secretary may increase any  
24                  penalty otherwise applicable under this  
25                  subparagraph by not more than

1                   \$1,000,000 and may require such hospital  
2                   to complete such additional corrective ac-  
3                   tions plans as the Secretary may specify.

4                   “(iv) APPLICATION OF CERTAIN PRO-  
5                   VISIONS.—The provisions of section 1128A  
6                   (other than subsections (a) and (b) of such  
7                   section) shall apply to a civil monetary  
8                   penalty imposed under this subparagraph  
9                   in the same manner as such provisions  
10                  apply to a civil monetary penalty imposed  
11                  under subsection (a) of such section.

12                  “(v) AUTHORITY TO WAIVE OR RE-  
13                  DUCE PENALTY.—The Secretary may  
14                  waive or reduce any penalty otherwise ap-  
15                  plicable with respect to a specified hospital  
16                  under this subparagraph if the Secretary  
17                  determines that imposition of such penalty  
18                  would result in a significant hardship for  
19                  such hospital (such as in the case of a hos-  
20                  pital located in a rural or underserved area  
21                  where imposition of such penalty may re-  
22                  sult in, or contribute to, a lack of access  
23                  to care for individuals in such area).

24                  “(C) PUBLICATION OF HOSPITAL PRICE  
25                  TRANSPARENCY INFORMATION.—Beginning on

1           January 1, 2026, the Secretary shall make pub-  
2           licly available on the public website of the Cen-  
3           ters for Medicare & Medicaid Services informa-  
4           tion with respect to compliance with the re-  
5           quirements of this subsection and enforcement  
6           activities undertaken by the Secretary under  
7           this subsection. Such information shall be up-  
8           dated not less than annually and include, with  
9           respect to each year—

10                   “(i) the number of reviews of compli-  
11                   ance with this subsection undertaken by  
12                   the Secretary;

13                   “(ii) the number of notifications de-  
14                   scribed in subparagraph (A)(i) sent by the  
15                   Secretary;

16                   “(iii) the identify of each specified  
17                   hospital that was sent such a notification  
18                   and a description of the nature of such  
19                   hospital’s noncompliance with this sub-  
20                   section;

21                   “(iv) the amount of any civil monetary  
22                   penalty imposed on such hospital under  
23                   subparagraph (B);

1                   “(v) whether such hospital subse-  
2                   quently came into compliance with this  
3                   subsection; and

4                   “(vi) any other information as deter-  
5                   mined by the Secretary.

6                   “(6) DEFINITIONS.—For purposes of this sub-  
7                   section:

8                   “(A) 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 specified hospital-fur-  
12                  nished item or service.

13                  “(B) FEDERAL HEALTH CARE PROGRAM.—  
14                  The term ‘Federal health care program’ has the  
15                  meaning given such term in section 1128B.

16                  “(C) GROSS CHARGE.—The term ‘gross  
17                  charge’ means the charge for an individual item  
18                  or service that is reflected on a specified hos-  
19                  pital’s chagemaster, absent any discounts.

20                  “(D) GROUP HEALTH PLAN; GROUP  
21                  HEALTH INSURANCE COVERAGE; INDIVIDUAL  
22                  HEALTH INSURANCE COVERAGE.—The terms  
23                  ‘group health plan’, ‘group health insurance  
24                  coverage’, and ‘individual health insurance cov-

1           erage’ have the meaning given such terms in  
2           section 2791 of the Public Health Service Act.

3           “(E)     PAYER-SPECIFIC     NEGOTIATED  
4           CHARGE.—The term ‘payer-specific negotiated  
5           charge’ means the charge that a specified hos-  
6           pital has negotiated with a third party payer for  
7           an item or service.

8           “(F)     SHOPPABLE     SERVICE.—The term  
9           ‘shoppable service’ means a service that can be  
10          scheduled by a health care consumer in advance  
11          and includes all ancillary items and services  
12          customarily furnished as part of such service.

13          “(G)     SPECIFIED     HOSPITAL.—The term  
14          ‘specified hospital’ means a hospital (as defined  
15          in section 1861(e)), a critical access hospital (as  
16          defined in section 1861(mmm)(1)), or a rural  
17          emergency hospital (as defined in section  
18          1861(kkk)).

19          “(H)     THIRD PARTY PAYER.—The term  
20          ‘third party payer’ means an entity that is, by  
21          statute, contract, or agreement, legally respon-  
22          sible for payment of a claim for a health care  
23          item or service.

24          “(b)     AMBULATORY     SURGICAL     CENTER     PRICE  
25          TRANSPARENCY.—



1           “(1) IN GENERAL.—Beginning January 1,  
2           2028, each ambulatory surgical center that receives  
3           payment under this title for furnishing items and  
4           services shall comply with the price transparency re-  
5           quirement described in paragraph (2).

6           “(2) REQUIREMENT DESCRIBED.—

7           “(A) IN GENERAL.—For purposes of para-  
8           graph (1), the price transparency requirement  
9           described in this subsection is, with respect to  
10          an ambulatory surgical center, that such sur-  
11          gical center in accordance with a method and  
12          format established by the Secretary under sub-  
13          paragraph (C)), compile and make public (with-  
14          out subscription and free of charge), for each  
15          year—

16                 “(i) one or more lists, in a format  
17                 specified by the Secretary (which may be  
18                 machine-readable), of the ambulatory sur-  
19                 gical center’s standard charges (including  
20                 the information described in subparagraph  
21                 (B)) for each item and service furnished by  
22                 such surgical center;

23                 “(ii) information on the ambulatory  
24                 surgical center’s prices (including the in-  
25                 formation described in subparagraph (B))

1 for as many of the Centers for Medicare &  
2 Medicaid Services-specified shoppable serv-  
3 ices that are furnished by such surgical  
4 center, and as many additional ambulatory  
5 surgical center-selected shoppable services  
6 (or all such additional services, if such sur-  
7 gical center furnishes fewer than 300  
8 shoppable services) as may be necessary  
9 for a combined total of at least 300  
10 shoppable services; and

11 “(iii) with respect to each Centers for  
12 Medicare & Medicaid Services-specified  
13 shoppable service that is not furnished by  
14 the ambulatory surgical center, an indica-  
15 tion that such service is not so furnished.

16 “(B) INFORMATION DESCRIBED.—For pur-  
17 poses of subparagraph (A), the information de-  
18 scribed in this subparagraph is, with respect to  
19 standard charges and prices (as applicable)  
20 made public by an ambulatory surgical center,  
21 the following:

22 “(i) A description of each item or  
23 service, accompanied by, as applicable, the  
24 Healthcare Common Procedure Coding  
25 System code, the diagnosis-related group,

1 the national drug code, or other identifier  
2 used or approved by the Centers for Medi-  
3 care & Medicaid Services.

4 “(ii) The gross charge, expressed as a  
5 dollar amount, for each such item or serv-  
6 ice.

7 “(iii) The discounted cash price, ex-  
8 pressed as a dollar amount, for each such  
9 item or service (or, in the case no dis-  
10 counted cash price is available for an item  
11 or service, the gross charge for such item  
12 or service for the previous three years, ex-  
13 pressed as a dollar amount).

14 “(iv) Any other information the Sec-  
15 retary may require that is not duplicative  
16 of any other reporting requirement under  
17 this subsection for purposes of promoting  
18 public awareness of ambulatory surgical  
19 center prices in advance of receiving an  
20 item or service from such an ambulatory  
21 surgical center, which may include any  
22 current payer-specific negotiated charges,  
23 clearly associated with the name of the  
24 third party payer and plan and expressed

1 as a dollar amount, that applies to each  
2 such item or service.

3 “(C) METHOD AND FORMAT.—Not later  
4 than January 1, 2028, the Secretary shall es-  
5 tablish one or more methods and formats for  
6 ambulatory surgical centers to use in making  
7 public standard charges and prices (as applica-  
8 ble) pursuant to subparagraph (A). Any such  
9 method and format—

10 “(i) may be similar to any template  
11 made available by the Centers for Medicare  
12 & Medicaid Services as of the date of the  
13 enactment of this paragraph;

14 “(ii) shall meet such standards as de-  
15 termined appropriate by the Secretary in  
16 order to ensure the accessibility and  
17 usability of such charges and prices; and

18 “(iii) shall be updated as determined  
19 appropriate by the Secretary, in consulta-  
20 tion with stakeholders.

21 “(3) DEEMED COMPLIANCE WITH SHOPPABLE  
22 SERVICES REQUIREMENT FOR AMBULATORY SUR-  
23 GICAL CENTERS WITH A PRICE ESTIMATOR TOOL.—

24 “(A) IN GENERAL.—With respect to each  
25 year until the effective date of regulations im-

1           plementing the provisions of sections 2799A–  
2           1(f) and 2799B–6 of the Public Health Service  
3           Act (relating to advanced explanations of bene-  
4           fits), including regulations on establishing data  
5           transfer standards to effectuate such provisions,  
6           an ambulatory surgical center shall be deemed  
7           to have complied with the requirement de-  
8           scribed in subsection (b)(2)(A) (relating to  
9           shoppable services) if such surgical center main-  
10          tains a price estimator tool described in sub-  
11          paragraph (B).

12           “(B) PRICE ESTIMATOR TOOL DE-  
13          SCRIBED.—For purposes of subparagraph (A),  
14          the price estimator tool described in this sub-  
15          paragraph is, with respect to an ambulatory  
16          surgical center, a tool that meets the following  
17          requirements:

18                   “(i) Such tool allows an individual to  
19                   immediately obtain a price estimate (tak-  
20                   ing into account whether such individual is  
21                   covered under any plan, coverage, or pro-  
22                   gram described in clause (iv)(III)) for each  
23                   Centers for Medicare & Medicaid Services-  
24                   specified shoppable service that is fur-  
25                   nished by such surgical center, and for

1 each additional shoppable service as such  
2 surgical center may select, such that price  
3 estimates are available through such tool  
4 for at least 300 shoppable services (or for  
5 all such services, if such surgical center  
6 furnishes fewer than 300 shoppable serv-  
7 ices).

8 “(ii) Such tool allows an individual to  
9 obtain such an estimate by billing code and  
10 by service description.

11 “(iii) Such tool is prominently dis-  
12 played on the public internet website of  
13 such ambulatory surgical center.

14 “(iv) Such tool does not require an in-  
15 dividual seeking such an estimate to create  
16 an account or otherwise input personal in-  
17 formation, except that such tool may re-  
18 quire that such individual provide informa-  
19 tion specified by the Secretary, which may  
20 include the following:

21 “(I) The name of such individual.

22 “(II) The date of birth of such  
23 individual.

24 “(III) In the case such individual  
25 is covered under a group health plan,

1 group or individual health insurance  
2 coverage, a Federal health care pro-  
3 gram, or the program established  
4 under chapter 89 of title 5, United  
5 States Code, an identifying number  
6 assigned by such plan, coverage, or  
7 program to such individual.

8 “(IV) In the case of an individual  
9 described in subclause (III), an indi-  
10 cation as to whether such individual is  
11 the primary insured individual under  
12 such plan, coverage, or program (and,  
13 if such individual is not the primary  
14 insured individual, a description of the  
15 individual’s relationship to such pri-  
16 mary insured individual).

17 “(V) Any other information spec-  
18 ified by the Secretary.

19 “(v) Such tool contains a statement  
20 confirming the accuracy and completeness  
21 of information presented through such tool  
22 as of the date such request is made.

23 “(vi) Such tool meets any other re-  
24 quirement specified by the Secretary.

1           “(4) MONITORING COMPLIANCE.—The Sec-  
2           retary shall, through notice and comment rule-  
3           making and in consultation with the Inspector Gen-  
4           eral of the Department of Health and Human Serv-  
5           ices, establish a process to monitor compliance with  
6           this subsection. Such process shall ensure that each  
7           ambulatory surgical center’s compliance with this  
8           subsection is reviewed not less frequently than once  
9           every 3 years.

10           “(5) ENFORCEMENT.—

11           “(A) IN GENERAL.—In the case of an am-  
12           bulatory surgical center that fails to comply  
13           with the requirements of this subsection—

14           “(i) the Secretary shall notify such  
15           ambulatory surgical center of such failure  
16           not later than 30 days after the date on  
17           which the Secretary determines such fail-  
18           ure exists; and

19           “(ii) upon request of the Secretary,  
20           the ambulatory surgical center shall submit  
21           to the Secretary, not later than 45 days  
22           after the date of such request, a corrective  
23           action plan to comply with such require-  
24           ments.

25           “(B) CIVIL MONETARY PENALTY.—



1           “(i) IN GENERAL.—In addition to any  
2           other enforcement actions or penalties that  
3           may apply under another provision of law,  
4           an ambulatory surgical center that has re-  
5           ceived a notification under subparagraph  
6           (A)(i) and fails to comply with the require-  
7           ments of this subsection by the date that  
8           is 90 days after such notification (or, in  
9           the case of an ambulatory surgical center  
10          that has submitted a corrective action plan  
11          described in subparagraph (A)(ii) in re-  
12          sponse to a request so described, by the  
13          date that is 90 days after such submission)  
14          shall be subject to a civil monetary penalty  
15          of an amount specified by the Secretary for  
16          each subsequent day during which such  
17          failure is ongoing (not to exceed \$300 per  
18          day).

19          “(ii) INCREASE AUTHORITY.—In ap-  
20          plying this subparagraph with respect to  
21          violations occurring in 2029 or a subse-  
22          quent year, the Secretary may through no-  
23          tice and comment rulemaking increase the  
24          limitation on the per day amount of any

1 penalty applicable to an ambulatory sur-  
2 gical center under clause (i).

3 “(iii) APPLICATION OF CERTAIN PRO-  
4 VISIONS.—The provisions of section 1128A  
5 (other than subsections (a) and (b) of such  
6 section) shall apply to a civil monetary  
7 penalty imposed under this subparagraph  
8 in the same manner as such provisions  
9 apply to a civil monetary penalty imposed  
10 under subsection (a) of such section.

11 “(iv) AUTHORITY TO WAIVE OR RE-  
12 DUCE PENALTY.—The Secretary may  
13 waive or reduce any penalty otherwise ap-  
14 plicable with respect to an ambulatory sur-  
15 gical center under this subparagraph if the  
16 Secretary determines that imposition of  
17 such penalty would result in a significant  
18 hardship for such ambulatory surgical cen-  
19 ter (such as in the case of an ambulatory  
20 surgical center located in a rural or under-  
21 served area where imposition of such pen-  
22 alty may result in, or contribute to, a lack  
23 of access to care for individuals in such  
24 area).

1           “(6) DEFINITIONS.—For purposes of this sec-  
2           tion:

3                   “(A) DISCOUNTED CASH PRICE.—The  
4                   term ‘discounted cash price’ means the charge  
5                   that applies to an individual who pays cash, or  
6                   cash equivalent, for a item or service furnished  
7                   by an ambulatory surgical center.

8                   “(B) FEDERAL HEALTH CARE PROGRAM.—  
9                   The term ‘Federal health care program’ has the  
10                  meaning given such term in section 1128B.

11                  “(C) GROSS CHARGE.—The term ‘gross  
12                  charge’ means the charge for an individual item  
13                  or service that is reflected on a specified sur-  
14                  gical center’s chargemaster, absent any dis-  
15                  counts.

16                  “(D) GROUP HEALTH PLAN; GROUP  
17                  HEALTH INSURANCE COVERAGE; INDIVIDUAL  
18                  HEALTH INSURANCE COVERAGE.—The terms  
19                  ‘group health plan’, ‘group health insurance  
20                  coverage’, and ‘individual health insurance cov-  
21                  erage’ have the meaning given such terms in  
22                  section 2791 of the Public Health Service Act.

23                  “(E) PAYER-SPECIFIC NEGOTIATED  
24                  CHARGE.—The term ‘payer-specific negotiated  
25                  charge’ means the charge that a specified sur-

1 gical center has negotiated with a third party  
2 payer for an item or service.

3 “(F) SHOPPABLE SERVICE.—The term  
4 ‘shoppable service’ means a service that can be  
5 scheduled by a health care consumer in advance  
6 and includes all ancillary items and services  
7 customarily furnished as part of such service.

8 “(G) THIRD PARTY PAYER.—The term  
9 ‘third party payer’ means an entity that is, by  
10 statute, contract, or agreement, legally respon-  
11 sible for payment of a claim for a health care  
12 item or service.

13 “(c) IMAGING SERVICES PRICE TRANSPARENCY.—

14 “(1) IN GENERAL.—Beginning January 1,  
15 2028, each provider of services and supplier that re-  
16 ceives payment under this title for furnishing a spec-  
17 ified imaging service shall—

18 “(A) make publicly available (in a form  
19 and manner specified by the Secretary) on an  
20 Internet website the information described in  
21 paragraph (2) with respect to each such service  
22 that such provider of services or supplier fur-  
23 nishes; and

24 “(B) ensure that such information is up-  
25 dated not less frequently than annually.

1           “(2) INFORMATION DESCRIBED.—For purposes  
2 of paragraph (1), the information described in this  
3 subsection is, with respect to a provider of services  
4 or supplier and a specified imaging service, the fol-  
5 lowing:

6           “(A) The discounted cash price for such  
7 service (or, if no such price exists, the gross  
8 charge for such service).

9           “(B) If required by the Secretary, the  
10 deidentified minimum negotiated rate in effect  
11 between such provider or supplier and any  
12 group health plan or group or individual health  
13 insurance coverage for such service and the  
14 deidentified maximum negotiated rate in effect  
15 between such provider or supplier and any such  
16 plan or coverage for such service.

17           “(3) METHOD AND FORMAT.—Not later than  
18 January 1, 2028, the Secretary shall establish one  
19 or more methods and formats for each provider of  
20 services and supplier to use in compiling and making  
21 public standard charges and prices (as applicable)  
22 pursuant to paragraph (1). Any such method and  
23 format—

24           “(A) may be similar to any template made  
25 available by the Centers for Medicare & Med-

1           icaid Services as of the date of the enactment  
2           of this subsection;

3           “(B) shall meet such standards as deter-  
4           mined appropriate by the Secretary in order to  
5           ensure the accessibility and usability of such  
6           charges and prices; and

7           “(C) shall be updated as determined ap-  
8           propriate by the Secretary, in consultation with  
9           stakeholders.

10          “(4) MONITORING COMPLIANCE.—The Sec-  
11          retary shall, through notice and comment rule-  
12          making and in consultation with the Inspector Gen-  
13          eral of the Department of Health and Human Serv-  
14          ices, establish a process to monitor compliance with  
15          this subsection.

16          “(5) SPECIFICATION OF SERVICES.—Not later  
17          than January 1, 2028, the Secretary shall publish a  
18          list of at least 50 imaging services that the Sec-  
19          retary determines are shoppable (or all such services,  
20          if the Secretary determines that fewer than 50 such  
21          services are shoppable) between providers of services  
22          and suppliers of such services. The Secretary shall  
23          update such list as determined appropriate by the  
24          Secretary.

25          “(6) ENFORCEMENT.—

1           “(A) IN GENERAL.—In the case that the  
2           Secretary determines that a provider of services  
3           or supplier is not in compliance with paragraph  
4           (1)—

5                   “(i) not later than 30 days after such  
6                   determination, the Secretary shall notify  
7                   such provider or supplier of such deter-  
8                   mination;

9                   “(ii) upon request of the Secretary,  
10                  such provider or supplier shall submit to  
11                  the Secretary, not later than 45 days after  
12                  the date of such request, a corrective ac-  
13                  tion plan to comply with such paragraph;  
14                  and

15                  “(iii) if such provider or supplier con-  
16                  tinues to fail to comply with such para-  
17                  graph after the date that is 90 days after  
18                  such notification is sent (or, in the case of  
19                  such a provider or supplier that has sub-  
20                  mitted a corrective action plan described in  
21                  clause (ii) in response to a request so de-  
22                  scribed, after the date that is 90 days after  
23                  such submission), the Secretary may im-  
24                  pose a civil monetary penalty in an amount  
25                  not to exceed \$300 for each subsequent

1           day during which such failure to comply or  
2           failure to submit is ongoing.

3           “(B) INCREASE AUTHORITY.—In applying  
4           this paragraph with respect to violations occur-  
5           ring in 2029 or a subsequent year, the Sec-  
6           retary may through notice and comment rule-  
7           making increase the amount of the civil mone-  
8           tary penalty under subparagraph (A)(iii).

9           “(C) APPLICATION OF CERTAIN PROVI-  
10          SIONS.—The provisions of section 1128A (other  
11          than subsections (a) and (b) of such section)  
12          shall apply to a civil monetary penalty imposed  
13          under this paragraph in the same manner as  
14          such provisions apply to a civil monetary pen-  
15          alty imposed under subsection (a) of such sec-  
16          tion.

17          “(D) AUTHORITY TO WAIVE OR REDUCE  
18          PENALTY.—The Secretary may waive or reduce  
19          any penalty otherwise applicable with respect to  
20          a provider of services or supplier under this  
21          subparagraph if the Secretary determines that  
22          imposition of such penalty would result in a sig-  
23          nificant hardship for such provider or supplier  
24          (such as in the case of a provider or supplier  
25          located in a rural or underserved area where



1 imposition of such penalty may result in, or  
2 contribute to, a lack of access to care for indi-  
3 viduals in such area).

4 “(E) CLARIFICATION OF NONAPPLICA-  
5 BILITY OF OTHER ENFORCEMENT PROVI-  
6 SIONS.—Notwithstanding any other provision of  
7 this title, this paragraph shall be the sole  
8 means of enforcing the provisions of this sub-  
9 section.

10 “(7) DEFINITIONS.—In this subsection:

11 “(A) GROUP HEALTH PLAN; GROUP  
12 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
13 HEALTH INSURANCE COVERAGE.—The terms  
14 ‘group health plan’, ‘group health insurance  
15 coverage’, and ‘individual health insurance cov-  
16 erage’ have the meaning given such terms in  
17 section 2791 of the Public Health Service Act.

18 “(B) SPECIFIED IMAGING SERVICE.—the  
19 term ‘specified imaging service’ means an imag-  
20 ing service that is included on the list published  
21 by the Secretary under subsection (e).

22 “(d) CLINICAL LABORATORY PRICE TRANS-  
23 PARENCY.—

24 “(1) IN GENERAL.—Beginning January 1,  
25 2028, each applicable laboratory that receives pay-

1           ment under this title for furnishing a specified clin-  
2           ical diagnostic laboratory test shall—

3                   “(A) make publicly available (in a manner  
4                   and form specified by the Secretary) on an  
5                   Internet website the information described in  
6                   paragraph (2) with respect to each such speci-  
7                   fied clinical diagnostic laboratory test that such  
8                   laboratory is so available to furnish; and

9                   “(B) ensure that such information is up-  
10                  dated not less frequently than annually.

11                 “(2) INFORMATION DESCRIBED.—For purposes  
12                 of paragraph (1), the information described in this  
13                 subsection is, with respect to an applicable labora-  
14                 tory and a specified clinical diagnostic laboratory  
15                 test, the following:

16                   “(A) The discounted cash price for such  
17                   test (or, if no such price exists, the gross  
18                   charge for such test).

19                   “(B) If required by the Secretary, the  
20                   deidentified minimum negotiated rate in effect  
21                   between such laboratory and any group health  
22                   plan or group or individual health insurance  
23                   coverage for such test and the deidentified max-  
24                   imum negotiated rate in effect between such

1 laboratory and any such plan or coverage for  
2 such test.

3 “(3) METHOD AND FORMAT.—Not later than  
4 January 1, 2028, the Secretary shall establish one  
5 or more methods and formats for each provider of  
6 services and supplier to use in compiling and making  
7 public standard charges and prices (as applicable)  
8 pursuant to paragraph (1). Any such method and  
9 format—

10 “(A) may be similar to any template made  
11 available by the Centers for Medicare & Med-  
12 icaid Services as of the date of the enactment  
13 of this subsection;

14 “(B) shall meet such standards as deter-  
15 mined appropriate by the Secretary in order to  
16 ensure the accessibility and usability of such  
17 charges and prices; and

18 “(C) shall be updated as determined ap-  
19 propriate by the Secretary, in consultation with  
20 stakeholders.

21 “(4) MONITORING COMPLIANCE.—The Sec-  
22 retary shall, through notice and comment rule-  
23 making and in consultation with the Inspector Gen-  
24 eral of the Department of Health and Human Serv-

1       ices, establish a process to monitor compliance with  
2       this subsection.

3           “(5) ENFORCEMENT.—

4           “(A) IN GENERAL.—In the case that the  
5       Secretary determines that an applicable labora-  
6       tory is not in compliance with paragraph (1)—

7           “(i) not later than 30 days after such  
8       determination, the Secretary shall notify  
9       such laboratory of such determination;

10          “(ii) upon request of the Secretary,  
11       such laboratory shall submit to the Sec-  
12       retary, not later than 45 days after such  
13       request is sent, a corrective action plan to  
14       comply with such subsection; and

15          “(iii) if such laboratory continues to  
16       fail to comply with such paragraph after  
17       the date that is 90 days after such notifi-  
18       cation is sent (or, in the case of such a  
19       laboratory that has submitted a corrective  
20       action plan described in clause(ii) in re-  
21       sponse to a request so described, after the  
22       date that is 90 days after such submis-  
23       sion), the Secretary may impose a civil  
24       monetary penalty in an amount not to ex-

1           ceed \$300 for each subsequent day during  
2           which such failure to comply is ongoing.

3           “(B) INCREASE AUTHORITY.—In applying  
4           this paragraph with respect to violations occur-  
5           ring in 2029 or a subsequent year, the Sec-  
6           retary may through notice and comment rule-  
7           making increase the amount of the civil mone-  
8           tary penalty under subparagraph (A)(iii).

9           “(C) APPLICATION OF CERTAIN PROVI-  
10          SIONS.—The provisions of section 1128A (other  
11          than subsections (a) and (b) of such section)  
12          shall apply to a civil monetary penalty imposed  
13          under this paragraph in the same manner as  
14          such provisions apply to a civil monetary pen-  
15          alty imposed under subsection (a) of such sec-  
16          tion.

17          “(D) AUTHORITY TO WAIVE OR REDUCE  
18          PENALTY.—The Secretary may waive or reduce  
19          any penalty otherwise applicable with respect to  
20          an applicable laboratory under this paragraph if  
21          the Secretary determines that imposition of  
22          such penalty would result in a significant hard-  
23          ship for such laboratory (such as in the case of  
24          an applicable laboratory located in a rural or  
25          underserved area where imposition of such pen-

1 alty may result in, or contribute to, a lack of  
2 access to care for individuals in such area).

3 “(E) CLARIFICATION OF NONAPPLICA-  
4 BILITY OF OTHER ENFORCEMENT PROVI-  
5 SIONS.—Notwithstanding any other provision of  
6 this title, this subsection shall be the sole means  
7 of enforcing the provisions of this section.

8 “(6) DEFINITIONS.—In this subsection:

9 “(A) APPLICABLE LABORATORY.—The  
10 term ‘applicable laboratory’ has the meaning  
11 given such term in section 414.502, of title 42,  
12 Code of Federal Regulations (or any successor  
13 regulation).

14 “(B) GROUP HEALTH PLAN; GROUP  
15 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
16 HEALTH INSURANCE COVERAGE.—The terms  
17 ‘group health plan’, ‘group health insurance  
18 coverage’, and ‘individual health insurance cov-  
19 erage’ have the meaning given such terms in  
20 section 2791 of the Public Health Service Act.

21 “(C) SPECIFIED CLINICAL DIAGNOSTIC  
22 LABORATORY TEST.—The term ‘specified clin-  
23 ical diagnostic laboratory test’ means a clinical  
24 diagnostic laboratory test that is included on  
25 the list of shoppable services specified by the

1 Centers for Medicare & Medicaid Services pur-  
2 suant to section 180.60 of title 45, Code of  
3 Federal Regulations (or a successor regulation),  
4 other than such a test that is an advanced diag-  
5 nostic laboratory test (as defined in section  
6 1834A(d)(5)).”.

7 (b) PUBLICATION OF HOSPITAL COMPLIANCE WITH  
8 PRICE TRANSPARENCY REQUIREMENTS.—Section 1886 of  
9 the Social Security Act (42 U.S.C. 1395ww) is amended  
10 by adding at the end the following new subsection:

11 “(u) PUBLICATION OF HOSPITAL COMPLIANCE WITH  
12 PRICE TRANSPARENCY REQUIREMENTS.—

13 “(1) IN GENERAL.—Beginning January 1,  
14 2026, the Secretary shall, for each hospital with re-  
15 spect to which the Secretary has conducted a review  
16 of such hospital’s compliance with the provisions of  
17 section 1899C(a) and found such hospital non-  
18 compliant with such provisions—

19 “(A) indicate such noncompliance on such  
20 hospital’s entry on the Hospital Compare inter-  
21 net website (or a successor website); and

22 “(B) specify whether such hospital—

23 “(i) submitted a corrective action plan  
24 described in subsection (a)(5)(A)(ii) of

1           such section (and, if so, the date such plan  
2           was received by the Secretary); or

3           “(ii) was subject to a civil monetary  
4           penalty imposed under subsection  
5           (a)(5)(B) of such section (and, if so, the  
6           date of the imposition of such penalty and  
7           the amount of such penalty).

8           “(2) ADDITIONS AND UPDATES.—The Secretary  
9           shall update any specification described in subpara-  
10          graph (A) or (B) of paragraph (1) with respect to  
11          such hospital—

12           “(A) in the case of the specification de-  
13           scribed in such paragraph (1)(A), as soon as  
14           practicable after sending the notification de-  
15           scribed in section 1899C(a)(5)(A)(i); and

16           “(B) in the case of the specification de-  
17           scribed in such paragraph (1)(B)(ii), as soon as  
18           practicable after the imposition of a civil mone-  
19           etary penalty described in such paragraph.”.

20          (c) CONFORMING AMENDMENT.—Section 2718(e) of  
21          the Public Health Service Act (42 U.S.C. 300gg–18(e))  
22          is amended by adding at the end the following new sen-  
23          tence: “The preceding sentence shall not apply beginning  
24          January 1, 2026.”.

25          (d) FUNDING.—



1           (1) IN GENERAL.—In addition to funds other-  
2           wise available, out of any moneys in the Treasury  
3           not otherwise appropriated, there are appropriated  
4           \$10,000,000 for fiscal year 2024, to remain avail-  
5           able until expended, for purposes of—

6                   (A) implementing the amendment made by  
7                   this subsection (a); and

8                   (B) monitoring the compliance of entities  
9                   with such amendment.

10          (2) REPORT ON EXPENDITURES.—Not later  
11          than 5 years after the date of the enactment of this  
12          Act, the Secretary of Health and Human Services  
13          shall submit to the Committee on Ways and Means  
14          and the Committee on Energy and Commerce of the  
15          House of Representatives and the Committee on Fi-  
16          nance of the Senate a report that—

17                   (A) describes activities undertaken funded  
18                   through funds made available under paragraph  
19                   (1), including a specification of the amount of  
20                   such funds expended for each such activity; and

21                   (B) identifies all entities with which the  
22                   Secretary has entered into contracts for pur-  
23                   poses of implementing the amendment made by  
24                   this subsection (a), monitoring compliance of  
25                   entities with such amendment, or providing

1 technical assistance to entities to promote com-  
2 pliance with such amendment.

3 (e) IMPLEMENTATION.—

4 (1) ACCESSIBILITY.—In implementing section  
5 1899C(a)(2)(A)(ii) of the Social Security Act (as  
6 added by subsection (a)), the Secretary of Health  
7 and Human Services shall through rulemaking en-  
8 sure that information made available pursuant to  
9 such amendment by an entity is so made available  
10 in plain, easily understandable language and that  
11 such entity provides access to such interpretation  
12 services, translations, and other assistive services to  
13 make such information accessible to individuals with  
14 limited English proficiency and individuals with dis-  
15 abilities.

16 (2) TECHNICAL ASSISTANCE.—The Secretary of  
17 Health and Human Services shall, to the extent  
18 practicable, provide technical assistance to entities  
19 making public standard charges and prices (as appli-  
20 cable) pursuant to the amendment made by sub-  
21 section (a).

22 **SEC. 102. PROMOTING HEALTH COVERAGE PRICE TRANS-**  
23 **PARENCY.**

24 (a) PRICE TRANSPARENCY REQUIREMENTS.—

25 (1) IRC.—

1 (A) IN GENERAL.—Section 9819 of the In-  
2 ternal Revenue Code of 1986 (26. U.S.C. 9816)  
3 is amended to read as follows:

4 **“SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.**

5 “(a) COST SHARING TRANSPARENCY.—

6 “(1) IN GENERAL.—For plan years beginning  
7 on or after the date that is 2 years after the date  
8 of the enactment of the Health Care Price Trans-  
9 parency Act of 2023, a group health plan shall per-  
10 mit individuals to learn the amount of cost-sharing  
11 (including deductibles, copayments, and coinsurance)  
12 under the individual’s plan or coverage that the indi-  
13 vidual would be responsible for paying with respect  
14 to the furnishing of a specific item or service by a  
15 provider in a timely manner upon the request of the  
16 individual. At a minimum, such information shall in-  
17 clude the information specified in paragraph (2) and  
18 shall be made available to such individual through a  
19 self-service tool that meets the requirements of para-  
20 graph (3) or, at the option of such individual,  
21 through a paper disclosure or phone or other elec-  
22 tronic disclosure (as selected by such individual and  
23 provided at no cost to such individual) that meets  
24 such requirements as the Secretary may specify.

1           “(2) SPECIFIED INFORMATION.—For purposes  
2 of paragraph (1), the information specified in this  
3 paragraph is, with respect to an item or service for  
4 which benefits are available under a group health  
5 plan furnished by a health care provider to a partici-  
6 pant or beneficiary of such plan, the following:

7           “(A) If such provider is a participating  
8 provider with respect to such item or service,  
9 the in-network rate (as defined in subsection  
10 (c)) for such item or service.

11           “(B) If such provider is not described in  
12 subparagraph (A), the maximum allowed  
13 amount for such item or service.

14           “(C) The estimated amount of cost sharing  
15 (including deductibles, copayments, and coin-  
16 surance) that the participant or beneficiary will  
17 incur for such item or service (which, in the  
18 case such item or service is to be furnished by  
19 a provider described in subparagraph (B), shall  
20 be calculated using the maximum amount de-  
21 scribed in such subparagraph).

22           “(D) The amount the participant or bene-  
23 ficiary has already accumulated with respect to  
24 any deductible or out of pocket maximum,  
25 whether for items and services furnished by a

1 participating provider or for items and services  
2 furnished by a provider that is not a partici-  
3 pating provider, under the plan (broken down,  
4 in the case separate deductibles or maximums  
5 apply to separate participants and beneficiaries  
6 enrolled in the plan, by such separate  
7 deductibles or maximums, in addition to any  
8 cumulative deductible or maximum).

9 “(E) In the case such plan imposes any  
10 frequency or volume limitations with respect to  
11 such item or service (excluding medical neces-  
12 sity determinations), the amount that such par-  
13 ticipant or beneficiary has accrued towards such  
14 limitation with respect to such item or service.

15 “(F) Any prior authorization, concurrent  
16 review, step therapy, fail first, or similar re-  
17 quirements applicable to coverage of such item  
18 or service under such plan.

19 The Secretary may provide that information de-  
20 scribed in any of subparagraphs (A) through (F) not  
21 be treated as information specified in this para-  
22 graph, and specify additional information that shall  
23 be treated as information specified in this para-  
24 graph, if determined appropriate by the Secretary.

1           “(3) SELF-SERVICE TOOL.—For purposes of  
2 paragraph (1), a self-service tool established by a  
3 group health plan meets the requirements of this  
4 paragraph if such tool—

5                   “(A) is based on an Internet website;

6                   “(B) provides for real-time responses to re-  
7 quests described in paragraph (1);

8                   “(C) is updated in a manner such that in-  
9 formation provided through such tool is timely  
10 and accurate at the time such request is made;

11                   “(D) allows such a request to be made  
12 with respect to an item or service furnished  
13 by—

14                           “(i) a specific provider that is a par-  
15 ticipating provider with respect to such  
16 item or service;

17                           “(ii) all providers that are partici-  
18 pating providers with respect to such item  
19 or service; or

20                           “(iii) a provider that is not described  
21 in clause (ii);

22                   “(E) provides that such a request may be  
23 made with respect to an item or service through  
24 use of the billing code for such item or service

1 or through use of a descriptive term for such  
2 item or service; and

3 “(F) meets any other requirement deter-  
4 mined appropriate by the Secretary.

5 The Secretary may require such tool, as a condition  
6 of complying with subparagraph (E), to link multiple  
7 billing codes to a single descriptive term if the Sec-  
8 retary determines that the billing codes to be so  
9 linked correspond to similar items and services.

10 “(b) RATE AND PAYMENT INFORMATION.—

11 “(1) IN GENERAL.—For plan years beginning  
12 on or after the date that is 2 years after the date  
13 of the enactment of the Health Care Price Trans-  
14 parency Act of 2023, each group health plan (other  
15 than a grandfathered health plan (as defined in sec-  
16 tion 1251(e) of the Patient Protection and Afford-  
17 able Care Act)) shall, not less frequently than once  
18 every 3 months (or, in the case of information de-  
19 scribed in paragraph (2)(B), not less frequently than  
20 monthly), make available to the public the rate and  
21 payment information described in paragraph (2) in  
22 accordance with paragraph (3).

23 “(2) RATE AND PAYMENT INFORMATION DE-  
24 SCRIBED.—For purposes of paragraph (1), the rate  
25 and payment information described in this para-

1 graph is, with respect to a group health plan, the  
2 following:

3 “(A) With respect to each item or service  
4 (other than a drug) for which benefits are avail-  
5 able under such plan, the in-network rate in ef-  
6 fect with each provider that is a participating  
7 provider with respect to such item or service,  
8 other than such a rate in effect with a provider  
9 that, during the 1-year period ending 10 busi-  
10 ness days before the date of the publication of  
11 such information, did not submit any claim for  
12 such item or service to such plan.

13 “(B) With respect to each drug (identified  
14 by national drug code) for which benefits are  
15 available under such plan, the average amount  
16 paid by such plan (net of rebates, discounts,  
17 and price concessions) for such drug dispensed  
18 or administered during the 90-day period begin-  
19 ning 180 days before such date of publication  
20 to each provider that was a participating pro-  
21 vider with respect to such drug, broken down by  
22 each such provider, other than such an amount  
23 paid to a provider that, during such period,  
24 submitted fewer than 20 claims for such drug  
25 to such plan.



1           “(C) With respect to each item or service  
2           for which benefits are available under such  
3           plan, the amount billed, and the amount al-  
4           lowed by the plan, for each such item or service  
5           furnished during the 90-day period specified in  
6           subparagraph (B) by a provider that was not a  
7           participating provider with respect to such item  
8           or service, broken down by each such provider,  
9           other than items and services with respect to  
10          which fewer than 20 claims for such item or  
11          service were submitted to such plan during such  
12          period.

13          “(3) MANNER OF PUBLICATION.—Rate and  
14          payment information required to be made available  
15          under this subsection shall be so made available in  
16          dollar amounts through 3 separate machine-readable  
17          files (or any successor technology, such as applica-  
18          tion program interface technology, determined ap-  
19          propriate by the Secretary) corresponding to the in-  
20          formation described in each of subparagraphs (A)  
21          through (C) of paragraph (2) that meet such re-  
22          quirements as specified by the Secretary. Such re-  
23          quirements shall ensure that such files are limited to  
24          an appropriate size, do not include disclosure of un-  
25          necessary duplicative information contained in other

1 files made available under this subsection, are made  
2 available in a widely-available format through a pub-  
3 licly-available website that allows for information  
4 contained in such files to be compared across group  
5 health plans, and are accessible to individuals at no  
6 cost and without the need to establish a user ac-  
7 count or provide other credentials.

8 “(4) USER INSTRUCTIONS.—Each group health  
9 plan shall make available to the public instructions  
10 written in plain language explaining how individuals  
11 may search for information described in paragraph  
12 (2) in files submitted in accordance with paragraph  
13 (3). The Secretary shall develop and publish a tem-  
14 plate that such a plan may use in developing in-  
15 structions for purposes of the preceding sentence.

16 “(5) ATTESTATION.—Each group health plan  
17 shall post, along with rate and payment information  
18 made public by such plan, an attestation that such  
19 information is complete and accurate.

20 “(c) DEFINITIONS.—In this section:

21 “(1) PARTICIPATING PROVIDER.—The term  
22 ‘participating provider’ has the meaning given such  
23 term in section 9816.

24 “(2) IN-NETWORK RATE.—The term ‘in-net-  
25 work rate’ means, with respect to a health plan and

1 an item or service furnished by a provider that is a  
2 participating provider with respect to such plan and  
3 item or service, the contracted rate in effect between  
4 such plan and such provider for such item or serv-  
5 ice.”.

6 (B) CLERICAL AMENDMENT.—The item re-  
7 lating to section 9819 of the table of sections  
8 for subchapter B of chapter 100 of the Internal  
9 Revenue Code of 1986 is amended to read as  
10 follows:

“Sec. 9819. Price transparency requirements.”.

11 (2) PHSA.—Section 2799A–4 of the Public  
12 Health Service Act (42 U.S.C. 300gg–114) is  
13 amended to read as follows:

14 **“SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.**

15 “(a) COST SHARING TRANSPARENCY.—

16 “(1) IN GENERAL.—For plan years beginning  
17 on or after the date that is 2 years after the date  
18 of the enactment of the Health Care Price Trans-  
19 parency Act of 2023, a group health plan or a  
20 health insurance issuer offering group or individual  
21 health insurance coverage shall permit individuals to  
22 learn the amount of cost-sharing (including  
23 deductibles, copayments, and coinsurance) under the  
24 individual’s plan or coverage that the individual  
25 would be responsible for paying with respect to the

1       furnishing of a specific item or service by a provider  
2       in a timely manner upon the request of the indi-  
3       vidual. At a minimum, such information shall in-  
4       clude the information specified in paragraph (2) and  
5       shall be made available to such individual through a  
6       self-service tool that meets the requirements of para-  
7       graph (3) or, at the option of such individual,  
8       through a paper disclosure or phone or other elec-  
9       tronic disclosure (as selected by such individual and  
10      provided at no cost to such individual) that meets  
11      such requirements as the Secretary may specify.

12           “(2) SPECIFIED INFORMATION.—For purposes  
13      of paragraph (1), the information specified in this  
14      paragraph is, with respect to an item or service for  
15      which benefits are available under a group health  
16      plan or group or individual health insurance cov-  
17      erage furnished by a health care provider to a par-  
18      ticipant or beneficiary of such plan, or enrollee in  
19      such coverage, the following:

20           “(A) If such provider is a participating  
21      provider with respect to such item or service,  
22      the in-network rate (as defined in subsection  
23      (c)) for such item or service.

1           “(B) If such provider is not described in  
2           subparagraph (A), the maximum allowed  
3           amount for such item or service.

4           “(C) The estimated amount of cost sharing  
5           (including deductibles, copayments, and coin-  
6           surance) that the participant, beneficiary, or  
7           enrollee will incur for such item or service  
8           (which, in the case such item or service is to be  
9           furnished by a provider described in subpara-  
10          graph (B), shall be calculated using the max-  
11          imum amount described in such subparagraph).

12          “(D) The amount the participant, bene-  
13          ficiary, or enrollee has already accumulated  
14          with respect to any deductible or out of pocket  
15          maximum, whether for items and services fur-  
16          nished by a participating provider or for items  
17          and services furnished by a provider that is not  
18          a participating provider, under the plan or cov-  
19          erage (broken down, in the case separate  
20          deductibles or maximums apply to separate par-  
21          ticipants, beneficiaries or enrollees enrolled in  
22          the plan or coverage, by such separate  
23          deductibles or maximums, in addition to any  
24          cumulative deductible or maximum).

1           “(E) In the case such plan or coverage im-  
2           poses any frequency or volume limitations with  
3           respect to such item or service (excluding med-  
4           ical necessity determinations), the amount that  
5           such participant, beneficiary, or enrollee has ac-  
6           crued towards such limitation with respect to  
7           such item or service.

8           “(F) Any prior authorization, concurrent  
9           review, step therapy, fail first, or similar re-  
10          quirements applicable to coverage of such item  
11          or service under such plan or coverage.

12          The Secretary may provide that information de-  
13          scribed in any of subparagraphs (A) through (F) not  
14          be treated as information specified in this para-  
15          graph, and specify additional information that shall  
16          be treated as information specified in this para-  
17          graph, if determined appropriate by the Secretary.

18          “(3) SELF-SERVICE TOOL.—For purposes of  
19          paragraph (1), a self-service tool established by a  
20          group health plan or group or individual health in-  
21          surance coverage meets the requirements of this  
22          paragraph if such tool—

23                 “(A) is based on an Internet website;

24                 “(B) provides for real-time responses to re-  
25          quests described in paragraph (1);

1           “(C) is updated in a manner such that in-  
2           formation provided through such tool is timely  
3           and accurate at the time such request is made;

4           “(D) allows such a request to be made  
5           with respect to an item or service furnished  
6           by—

7                   “(i) a specific provider that is a par-  
8                   ticipating provider with respect to such  
9                   item or service;

10                   “(ii) all providers that are partici-  
11                   pating providers with respect to such item  
12                   or service; or

13                   “(iii) a provider that is not described  
14                   in clause (ii);

15           “(E) provides that such a request may be  
16           made with respect to an item or service through  
17           use of the billing code for such item or service  
18           or through use of a descriptive term for such  
19           item or service; and

20           “(F) meets any other requirement deter-  
21           mined appropriate by the Secretary.

22           The Secretary may require such tool, as a condition  
23           of complying with subparagraph (E), to link multiple  
24           billing codes to a single descriptive term if the Sec-

1       retary determines that the billing codes to be so  
2       linked correspond to similar items and services.

3       “(b) RATE AND PAYMENT INFORMATION.—

4               “(1) IN GENERAL.—For plan years beginning  
5       on or after the date that is 2 years after the date  
6       of the enactment of the Health Care Price Trans-  
7       parency Act of 2023, each group health plan or  
8       group or individual health insurance coverage (other  
9       than a grandfathered health plan (as defined in sec-  
10      tion 1251(e) of the Patient Protection and Afford-  
11      able Care Act)) shall, not less frequently than once  
12      every 3 months (or, in the case of information de-  
13      scribed in paragraph (2)(B), not less frequently than  
14      monthly), make available to the public the rate and  
15      payment information described in paragraph (2) in  
16      accordance with paragraph (3).

17              “(2) RATE AND PAYMENT INFORMATION DE-  
18      SCRIBED.—For purposes of paragraph (1), the rate  
19      and payment information described in this para-  
20      graph is, with respect to a group health plan or  
21      group or individual health insurance coverage, the  
22      following:

23                      “(A) With respect to each item or service  
24                      (other than a drug) for which benefits are avail-  
25                      able under such plan or coverage, the in-net-



1 work rate in effect with each provider that is a  
2 participating provider with respect to such item  
3 or service, other than such a rate in effect with  
4 a provider that, during the 1-year period ending  
5 10 business days before the date of the publica-  
6 tion of such information, did not submit any  
7 claim for such item or service to such plan or  
8 coverage.

9 “(B) With respect to each drug (identified  
10 by national drug code) for which benefits are  
11 available under such plan, the average amount  
12 paid by such plan or coverage (net of rebates,  
13 discounts, and price concessions) for such drug  
14 dispensed or administered during the 90-day  
15 period beginning 180 days before such date of  
16 publication to each provider that was a partici-  
17 pating provider with respect to such drug, bro-  
18 ken down by each such provider, other than  
19 such an amount paid to a provider that, during  
20 such period, submitted fewer than 20 claims for  
21 such drug to such plan or coverage.

22 “(C) With respect to each item or service  
23 for which benefits are available under such plan  
24 or coverage, the amount billed, and the amount  
25 allowed by the plan or coverage, for each such

1 item or service furnished during the 90-day pe-  
2 riod specified in subparagraph (B) by a pro-  
3 vider that was not a participating provider with  
4 respect to such item or service, broken down by  
5 each such provider, other than items and serv-  
6 ices with respect to which fewer than 20 claims  
7 for such item or service were submitted to such  
8 plan or coverage during such period.

9 “(3) MANNER OF PUBLICATION.—Rate and  
10 payment information required to be made available  
11 under this subsection shall be so made available in  
12 dollar amounts through 3 separate machine-readable  
13 files (or any successor technology, such as applica-  
14 tion program interface technology, determined ap-  
15 propriate by the Secretary) corresponding to the in-  
16 formation described in each of subparagraphs (A)  
17 through (C) of paragraph (2) that meet such re-  
18 quirements as specified by the Secretary. Such re-  
19 quirements shall ensure that such files are limited to  
20 an appropriate size, do not include disclosure of un-  
21 necessary duplicative information contained in other  
22 files made available under this subsection, are made  
23 available in a widely-available format through a pub-  
24 licly-available website that allows for information  
25 contained in such files to be compared across group

1 health plans and group and individual health insur-  
2 ance coverage, and are accessible to individuals at no  
3 cost and without the need to establish a user ac-  
4 count or provide other credentials.

5 “(4) USER INSTRUCTIONS.—Each group health  
6 plan and group or individual health insurance cov-  
7 erage shall make available to the public instructions  
8 written in plain language explaining how individuals  
9 may search for information described in paragraph  
10 (2) in files submitted in accordance with paragraph  
11 (3). The Secretary shall develop and publish a tem-  
12 plate that such a plan or coverage may use in devel-  
13 oping instructions for purposes of the preceding sen-  
14 tence.

15 “(5) ATTESTATION.—Each group health plan  
16 and group or individual health insurance coverage  
17 shall post, along with rate and payment information  
18 made public by such plan or coverage, an attestation  
19 that such information is complete and accurate.

20 “(c) DEFINITIONS.—In this section:

21 “(1) PARTICIPATING PROVIDER.—The term  
22 ‘participating provider’ has the meaning given such  
23 term in section 2791A–1(a)(3)(G)(ii).

24 “(2) IN-NETWORK RATE.—The term ‘in-net-  
25 work rate’ means, with respect to a health plan or

1 coverage and an item or service furnished by a pro-  
2 vider that is a participating provider with respect to  
3 such plan and item or service, the contracted rate in  
4 effect between such plan or coverage and such pro-  
5 vider for such item or service.”.

6 (3) ERISA.—

7 (A) IN GENERAL.—Section 719 of the Em-  
8 ployee Retirement Income Security Act of 1974  
9 (29 U.S.C. 1185h) is amended to read as fol-  
10 lows:

11 **“SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.**

12 **“(a) COST SHARING TRANSPARENCY.—**

13 **“(1) IN GENERAL.—**For plan years beginning  
14 on or after the date that is 2 years after the date  
15 of the enactment of the Health Care Price Trans-  
16 parency Act of 2023, a group health plan or a  
17 health insurance issuer offering group health insur-  
18 ance coverage shall permit individuals to learn the  
19 amount of cost-sharing (including deductibles, co-  
20 payments, and coinsurance) under the individual’s  
21 plan or coverage that the individual would be re-  
22 sponsible for paying with respect to the furnishing  
23 of a specific item or service by a provider in a timely  
24 manner upon the request of the individual. At a  
25 minimum, such information shall include the infor-

1       mation specified in paragraph (2) and shall be made  
2       available to such individual through a self-service  
3       tool that meets the requirements of paragraph (3)  
4       or, at the option of such individual, through a paper  
5       disclosure or phone or other electronic disclosure (as  
6       selected by such individual and provided at no cost  
7       to such individual) that meets such requirements as  
8       the Secretary may specify.

9           “(2) SPECIFIED INFORMATION.—For purposes  
10       of paragraph (1), the information specified in this  
11       paragraph is, with respect to an item or service for  
12       which benefits are available under a group health  
13       plan or group health insurance coverage furnished  
14       by a health care provider to a participant or bene-  
15       ficiary of such plan, or enrollee in such coverage, the  
16       following:

17           “(A) If such provider is a participating  
18       provider with respect to such item or service,  
19       the in-network rate (as defined in subsection  
20       (c)) for such item or service.

21           “(B) If such provider is not described in  
22       subparagraph (A), the maximum allowed  
23       amount for such item or service.

24           “(C) The estimated amount of cost sharing  
25       (including deductibles, copayments, and coin-

1           surance) that the participant, beneficiary, or  
2           enrollee will incur for such item or service  
3           (which, in the case such item or service is to be  
4           furnished by a provider described in subpara-  
5           graph (B), shall be calculated using the max-  
6           imum amount described in such subparagraph).

7           “(D) The amount the participant, bene-  
8           ficiary, or enrollee has already accumulated  
9           with respect to any deductible or out of pocket  
10          maximum, whether for items and services fur-  
11          nished by a participating provider or for items  
12          and services furnished by a provider that is not  
13          a participating provider, under the plan or cov-  
14          erage (broken down, in the case separate  
15          deductibles or maximums apply to separate par-  
16          ticipants, beneficiaries or enrollees enrolled in  
17          the plan or coverage, by such separate  
18          deductibles or maximums, in addition to any  
19          cumulative deductible or maximum).

20          “(E) In the case such plan or coverage im-  
21          poses any frequency or volume limitations with  
22          respect to such item or service (excluding med-  
23          ical necessity determinations), the amount that  
24          such participant, beneficiary, or enrollee has ac-

1           crued towards such limitation with respect to  
2           such item or service.

3           “(F) Any prior authorization, concurrent  
4           review, step therapy, fail first, or similar re-  
5           quirements applicable to coverage of such item  
6           or service under such plan or coverage.

7           The Secretary may provide that information de-  
8           scribed in any of subparagraphs (A) through (F) not  
9           be treated as information specified in this para-  
10          graph, and specify additional information that shall  
11          be treated as information specified in this para-  
12          graph, if determined appropriate by the Secretary.

13          “(3) SELF-SERVICE TOOL.—For purposes of  
14          paragraph (1), a self-service tool established by a  
15          group health plan or group health insurance cov-  
16          erage meets the requirements of this paragraph if  
17          such tool—

18                 “(A) is based on an Internet website;

19                 “(B) provides for real-time responses to re-  
20                 quests described in paragraph (1);

21                 “(C) is updated in a manner such that in-  
22                 formation provided through such tool is timely  
23                 and accurate at the time such request is made;

1           “(D) allows such a request to be made  
2           with respect to an item or service furnished  
3           by—

4                   “(i) a specific provider that is a par-  
5                   ticipating provider with respect to such  
6                   item or service;

7                   “(ii) all providers that are partici-  
8                   pating providers with respect to such item  
9                   or service; or

10                   “(iii) a provider that is not described  
11                   in clause (ii);

12           “(E) provides that such a request may be  
13           made with respect to an item or service through  
14           use of the billing code for such item or service  
15           or through use of a descriptive term for such  
16           item or service; and

17           “(F) meets any other requirement deter-  
18           mined appropriate by the Secretary.

19           The Secretary may require such tool, as a condition  
20           of complying with subparagraph (E), to link multiple  
21           billing codes to a single descriptive term if the Sec-  
22           retary determines that the billing codes to be so  
23           linked correspond to similar items and services.

24           “(b) RATE AND PAYMENT INFORMATION.—



1           “(1) IN GENERAL.—For plan years beginning  
2           on or after the date that is 2 years after the date  
3           of the enactment of the Health Care Price Trans-  
4           parency Act of 2023, each group health plan or  
5           group health insurance coverage (other than a  
6           grandfathered health plan (as defined in section  
7           1251(e) of the Patient Protection and Affordable  
8           Care Act)) shall, not less frequently than once every  
9           3 months (or, in the case of information described  
10          in paragraph (2)(B), not less frequently than month-  
11          ly), make available to the public the rate and pay-  
12          ment information described in paragraph (2) in ac-  
13          cordance with paragraph (3).

14           “(2) RATE AND PAYMENT INFORMATION DE-  
15          SCRIBED.—For purposes of paragraph (1), the rate  
16          and payment information described in this para-  
17          graph is, with respect to a group health plan or  
18          group health insurance coverage, the following:

19                   “(A) With respect to each item or service  
20                   (other than a drug) for which benefits are avail-  
21                   able under such plan or coverage, the in-net-  
22                   work rate in effect with each provider that is a  
23                   participating provider with respect to such item  
24                   or service, other than such a rate in effect with  
25                   a provider that, during the 1-year period ending

1           10 business days before the date of the publica-  
2           tion of such information, did not submit any  
3           claim for such item or service to such plan or  
4           coverage.

5           “(B) With respect to each drug (identified  
6           by national drug code) for which benefits are  
7           available under such plan, the average amount  
8           paid by such plan or coverage (net of rebates,  
9           discounts, and price concessions) for such drug  
10          dispensed or administered during the 90-day  
11          period beginning 180 days before such date of  
12          publication to each provider that was a partici-  
13          pating provider with respect to such drug, bro-  
14          ken down by each such provider, other than  
15          such an amount paid to a provider that, during  
16          such period, submitted fewer than 20 claims for  
17          such drug to such plan or coverage.

18          “(C) With respect to each item or service  
19          for which benefits are available under such plan  
20          or coverage, the amount billed, and the amount  
21          allowed by the plan or coverage, for each such  
22          item or service furnished during the 90-day pe-  
23          riod specified in subparagraph (B) by a pro-  
24          vider that was not a participating provider with  
25          respect to such item or service, broken down by

1           each such provider, other than items and serv-  
2           ices with respect to which fewer than 20 claims  
3           for such item or service were submitted to such  
4           plan or coverage during such period.

5           “(3) MANNER OF PUBLICATION.—Rate and  
6           payment information required to be made available  
7           under this subsection shall be so made available in  
8           dollar amounts through 3 separate machine-readable  
9           files (or any successor technology, such as applica-  
10          tion program interface technology, determined ap-  
11          propriate by the Secretary) corresponding to the in-  
12          formation described in each of subparagraphs (A)  
13          through (C) of paragraph (2) that meet such re-  
14          quirements as specified by the Secretary. Such re-  
15          quirements shall ensure that such files are limited to  
16          an appropriate size, do not include disclosure of un-  
17          necessary duplicative information contained in other  
18          files made available under this subsection, are made  
19          available in a widely-available format through a pub-  
20          licly-available website that allows for information  
21          contained in such files to be compared across group  
22          health plans and group and individual health insur-  
23          ance coverage, and are accessible to individuals at no  
24          cost and without the need to establish a user ac-  
25          count or provide other credentials.

1           “(4) USER INSTRUCTIONS.—Each group health  
2           plan and group health insurance coverage shall make  
3           available to the public instructions written in plain  
4           language explaining how individuals may search for  
5           information described in paragraph (2) in files sub-  
6           mitted in accordance with paragraph (3). The Sec-  
7           retary shall develop and publish a template that  
8           such a plan or coverage may use in developing in-  
9           structions for purposes of the preceding sentence.

10           “(5) ATTESTATION.—Each group health plan  
11           and group health insurance coverage shall post,  
12           along with rate and payment information made pub-  
13           lic by such plan or coverage, an attestation that such  
14           information is complete and accurate.

15           “(c) DEFINITIONS.—In this section:

16           “(1) PARTICIPATING PROVIDER.—The term  
17           ‘participating provider’ has the meaning given such  
18           term in section 716(a)(3)(G)(ii).

19           “(2) IN-NETWORK RATE.—The term ‘in-net-  
20           work rate’ means, with respect to a health plan or  
21           coverage and an item or service furnished by a pro-  
22           vider that is a participating provider with respect to  
23           such plan and item or service, the contracted rate in  
24           effect between such plan or coverage and such pro-  
25           vider for such item or service.”.

1 (B) CLERICAL AMENDMENT.—The table of  
2 contents in section 1 of the Employee Retirement  
3 Income Security Act of 1974 is amended  
4 by striking the item relating to section 719 and  
5 inserting the following new item:

“Sec. 719. Price transparency requirements.”.

6 (b) ACCESSIBILITY THROUGH IMPLEMENTATION.—  
7 In implementing the amendments made by subsection (a),  
8 the Secretary of the Treasury, the Secretary of Health and  
9 Human Services, and the Secretary of Labor shall take  
10 reasonable steps to ensure the accessibility of information  
11 made available pursuant to such amendments, including  
12 reasonable steps to ensure that such information is pro-  
13 vided in plain, easily understandable language and that  
14 interpretation, translations, and assistive services are pro-  
15 vided by group health plans and health insurance issuers  
16 offering group or individual health insurance coverage to  
17 make such information accessible to those with limited  
18 English proficiency and those with disabilities.

19 (c) CONTINUED APPLICABILITY OF RULES FOR PRE-  
20 VIOUS YEARS.—Nothing in the amendments made by sub-  
21 section (a) may be construed as affecting the applicability  
22 of the rule entitled “Transparency in Coverage” published  
23 by the Department of the Treasury, the Department of  
24 Labor, and the Department of Health and Human Serv-  
25 ices on November 12, 2020 (85 Fed. Reg. 72158) for any

1 plan year beginning before the date that is 2 years after  
2 the date of the enactment of this Act.

3 **SEC. 103. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
4 **SERVICES.**

5 (a) IRC.—

6 (1) IN GENERAL.—Subchapter B of chapter  
7 100 of the Internal Revenue Code of 1986 is amend-  
8 ed by adding at the end the following:

9 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-**  
10 **AGER SERVICES.**

11 “(a) IN GENERAL.—For plan years beginning on or  
12 after the date that is 3 years after the date of enactment  
13 of this section, a group health plan, or an entity or sub-  
14 sidiary providing pharmacy benefits management services  
15 on behalf of such a plan, shall not enter into a contract  
16 with a drug manufacturer, distributor, wholesaler, subcon-  
17 tractor, rebate aggregator, or any associated third party  
18 that limits the disclosure of information to plan sponsors  
19 in such a manner that prevents the plan, or an entity or  
20 subsidiary providing pharmacy benefits management serv-  
21 ices on behalf of a plan, from making the report described  
22 in subsection (b).

23 “(b) ANNUAL REPORT.—

24 “(1) IN GENERAL.—With respect to plan years  
25 beginning on or after the date that is 3 years after

1 the date of enactment of this section, for each such  
2 plan year, a group health plan, or an entity pro-  
3 viding pharmacy benefits management services on  
4 behalf of such a plan, shall submit to the plan spon-  
5 sor (as defined in section 3(16)(B) of the Employee  
6 Retirement Income Security Act of 1974) of such  
7 plan a report in a machine-readable format. Each  
8 such report shall include, with respect to such plan  
9 provided for such plan year—

10 “(A) to the extent feasible, information col-  
11 lected from drug manufacturers (or an entity  
12 administering copay assistance on behalf of  
13 such manufacturers) by such plan (or entity or  
14 subsidiary providing pharmacy benefits manage-  
15 ment services on behalf of such plan) on the  
16 total amount of copayment assistance dollars  
17 paid, or copayment cards applied, that were  
18 funded by the drug manufacturer with respect  
19 to the participants and beneficiaries in such  
20 plan;

21 “(B) a list of each drug covered by such  
22 plan that was dispensed during the plan year,  
23 including, with respect to each such drug dur-  
24 ing such plan year—

1                   “(i) the brand name, chemical entity,  
2                   and National Drug Code;

3                   “(ii) the number of participants and  
4                   beneficiaries for whom the drug was dis-  
5                   pensed during the plan year, the total  
6                   number of prescription claims for the drug  
7                   (including original prescriptions and re-  
8                   fills), and the total number of dosage units  
9                   of the drug dispensed across the plan year,  
10                  disaggregated by dispensing channel (such  
11                  as retail, mail order, or specialty phar-  
12                  macy);

13                  “(iii) the wholesale acquisition cost,  
14                  listed as cost per days supply and cost per  
15                  pill, or in the case of a drug in another  
16                  form, per dosage unit;

17                  “(iv) the total out-of-pocket spending  
18                  by participants and beneficiaries on such  
19                  drug, including participant and beneficiary  
20                  spending through copayments, coinsurance,  
21                  and deductibles;

22                  “(v) for any drug for which gross  
23                  spending of the group health plan exceeded  
24                  \$10,000 during the plan year—



1                   “(I) a list of all other drugs in  
2                   the same therapeutic category or  
3                   class, including brand name drugs  
4                   and biological products and generic  
5                   drugs or biosimilar biological products  
6                   that are in the same therapeutic cat-  
7                   egory or class as such drug; and

8                   “(II) the rationale for the for-  
9                   mulary placement of such drug in that  
10                  therapeutic category or class, if appli-  
11                  cable;

12                  “(vi) the amount received, or expected  
13                  to be received, from drug manufacturers in  
14                  rebates, fees, alternative discounts, or  
15                  other remuneration for claims incurred for  
16                  such drug during the plan year;

17                  “(vii) the total net spending, after de-  
18                  ducting rebates, price concessions, alter-  
19                  native discounts or other remuneration  
20                  from drug manufacturers, by the health  
21                  plan on such drug; and

22                  “(viii) the net price per course of  
23                  treatment or single fill, such as a 30-day  
24                  supply or 90-day supply, incurred by the  
25                  health plan and its participants and bene-

1                   ficiaries after manufacturer rebates, fees,  
2                   and other remuneration for such drug dis-  
3                   pensed during the plan year;

4                   “(C) a list of each therapeutic category or  
5                   class of drugs that were dispensed under the  
6                   health plan during the plan year, and, with re-  
7                   spect to each such therapeutic category or class  
8                   of drugs, during the plan year—

9                   “(i) total gross spending by the plan,  
10                  before manufacturer rebates, fees, or other  
11                  manufacturer remuneration;

12                  “(ii) the number of participants and  
13                  beneficiaries who were dispensed a drug  
14                  covered by such plan in that category or  
15                  class, broken down by each such drug  
16                  (identified by National Drug Code);

17                  “(iii) if applicable to that category or  
18                  class, a description of the formulary tiers  
19                  and utilization management (such as prior  
20                  authorization or step therapy) employed  
21                  for drugs in that category or class; and

22                  “(iv) the total out-of-pocket spending  
23                  by participants and beneficiaries, including  
24                  participant and beneficiary spending

1 through copayments, coinsurance, and  
2 deductibles;

3 “(D) total gross spending on prescription  
4 drugs by the plan during the plan year, before  
5 rebates and other manufacturer fees or remun-  
6 eration;

7 “(E) total amount received, or expected to  
8 be received, by the health plan in drug manu-  
9 facturer rebates, fees, alternative discounts, and  
10 all other remuneration received from the manu-  
11 facturer or any third party, other than the plan  
12 sponsor, related to utilization of drug or drug  
13 spending under that health plan during the  
14 plan year;

15 “(F) the total net spending on prescription  
16 drugs by the health plan during the plan year;  
17 and

18 “(G) amounts paid directly or indirectly in  
19 rebates, fees, or any other type of remuneration  
20 to brokers, consultants, advisors, or any other  
21 individual or firm for the referral of the group  
22 health plan’s business to the pharmacy benefits  
23 manager.

24 “(2) PRIVACY REQUIREMENTS.—Entities pro-  
25 viding pharmacy benefits management services on

1       behalf of a group health plan shall provide informa-  
2       tion under paragraph (1) in a manner consistent  
3       with the privacy, security, and breach notification  
4       regulations promulgated under section 264(c) of the  
5       Health Insurance Portability and Accountability Act  
6       of 1996, and shall restrict the use and disclosure of  
7       such information according to such privacy regula-  
8       tions.

9               “(3) DISCLOSURE AND REDISCLOSURE.—

10               “(A) LIMITATION TO BUSINESS ASSOCI-  
11               ATES.—A group health plan receiving a report  
12               under paragraph (1) may disclose such informa-  
13               tion only to business associates of such plan as  
14               defined in section 160.103 of title 45, Code of  
15               Federal Regulations (or successor regulations).

16               “(B) CLARIFICATION REGARDING PUBLIC  
17               DISCLOSURE OF INFORMATION.—Nothing in  
18               this section prevents an entity providing phar-  
19               macy benefits management services on behalf of  
20               a group health plan from placing reasonable re-  
21               strictions on the public disclosure of the infor-  
22               mation contained in a report described in para-  
23               graph (1), except that such entity may not re-  
24               strict disclosure of such report to the Depart-  
25               ment of Health and Human Services, the De-

1           partment of Labor, the Department of the  
2           Treasury, the Comptroller General of the  
3           United States, or applicable State agencies.

4           “(C) LIMITED FORM OF REPORT.—The  
5           Secretary shall define through rulemaking a  
6           limited form of the report under paragraph (1)  
7           required of plan sponsors who are drug manu-  
8           facturers, drug wholesalers, or other direct par-  
9           ticipants in the drug supply chain, in order to  
10          prevent anti-competitive behavior.

11          “(4) REPORT TO GAO.—A group health plan, or  
12          an entity providing pharmacy benefits management  
13          services on behalf of a group health plan, shall sub-  
14          mit to the Comptroller General of the United States  
15          each of the first 4 reports submitted to a plan spon-  
16          sor under paragraph (1) with respect to such plan,  
17          and other such reports as requested, in accordance  
18          with the privacy requirements under paragraph (2),  
19          the disclosure and redisclosure standards under  
20          paragraph (3), the standards specified pursuant to  
21          paragraph (5), and such other information that the  
22          Comptroller General determines necessary to carry  
23          out the study under section 103(d) of the Health  
24          Care Price Transparency Act of 2023.

1           “(5) STANDARD FORMAT.—Not later than 18  
2           months after the date of enactment of this section,  
3           the Secretary shall specify through rulemaking  
4           standards for entities required to submit reports  
5           under paragraph (4) to submit such reports in a  
6           standard format.

7           “(c) RULE OF CONSTRUCTION.—Nothing in this sec-  
8           tion shall be construed to permit a group health plan or  
9           other entity to restrict disclosure to, or otherwise limit the  
10          access of, the Secretary of the Treasury to a report de-  
11          scribed in subsection (b)(1) or information related to com-  
12          pliance with subsection (a) or (b) by such plan or other  
13          entity subject to such subsections.

14          “(d) DEFINITION.—In this section, the term ‘whole-  
15          sale acquisition cost’ has the meaning given such term in  
16          section 1847A(c)(6)(B) of the Social Security Act.”.

17           (2) CLERICAL AMENDMENT.—The table of sec-  
18          tions for subchapter B of chapter 100 of the Inter-  
19          nal Revenue Code of 1986 is amended by adding at  
20          the end the following new item:

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

21          (b) PHSA.—Title XXVII of the Public Health Serv-  
22          ice Act (42 U.S.C. 300gg et seq.) is amended—

23           (1) in part D (42 U.S.C. 300gg–111 et seq.),  
24          by adding at the end the following new section:

1 **“SEC. 2799A-11. OVERSIGHT OF PHARMACY BENEFITS MAN-**  
2 **AGER SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or  
4 after the date that is 3 years after the date of enactment  
5 of this section, a group health plan or health insurance  
6 issuer offering group health insurance coverage, or an en-  
7 tity or subsidiary providing pharmacy benefits manage-  
8 ment services on behalf of such a plan or issuer, shall not  
9 enter into a contract with a drug manufacturer, dis-  
10 tributor, wholesaler, subcontractor, rebate aggregator, or  
11 any associated third party that limits the disclosure of in-  
12 formation to plan sponsors in such a manner that prevents  
13 the plan or issuer, or an entity or subsidiary providing  
14 pharmacy benefits management services on behalf of a  
15 plan or issuer, from making the report described in sub-  
16 section (b).

17 “(b) ANNUAL REPORT.—

18 “(1) IN GENERAL.—With respect to plan years  
19 beginning on or after the date that is 3 years after  
20 the date of enactment of this section, for each such  
21 plan year, a group health plan or health insurance  
22 issuer offering group health insurance coverage, or  
23 an entity providing pharmacy benefits management  
24 services on behalf of such a plan or an issuer, shall  
25 submit to the plan sponsor (as defined in section  
26 3(16)(B) of the Employee Retirement Income Secu-

1 rity Act of 1974) of such plan or coverage a report  
2 in a machine-readable format. Each such report  
3 shall include, with respect to such plan or coverage  
4 provided for such plan year—

5 “(A) to the extent feasible, information col-  
6 lected from drug manufacturers (or an entity  
7 administering copay assistance on behalf of  
8 such manufacturers) by such plan or issuer (or  
9 entity or subsidiary providing pharmacy bene-  
10 fits management services on behalf of such plan  
11 or issuer) on the total amount of copayment as-  
12 sistance dollars paid, or copayment cards ap-  
13 plied, that were funded by the drug manufac-  
14 turer with respect to the participants, bene-  
15 ficiaries, and enrollees in such plan or coverage;

16 “(B) a list of each drug covered by such  
17 plan or coverage that was dispensed during the  
18 plan year, including, with respect to each such  
19 drug during such plan year—

20 “(i) the brand name, chemical entity,  
21 and National Drug Code;

22 “(ii) the number of participants, bene-  
23 ficiaries, and enrollees for whom the drug  
24 was dispensed during the plan year, the  
25 total number of prescription claims for the



1 drug (including original prescriptions and  
2 refills), and the total number of dosage  
3 units of the drug dispensed across the plan  
4 year, disaggregated by dispensing channel  
5 (such as retail, mail order, or specialty  
6 pharmacy);

7 “(iii) the wholesale acquisition cost,  
8 listed as cost per days supply and cost per  
9 pill, or in the case of a drug in another  
10 form, per dosage unit;

11 “(iv) the total out-of-pocket spending  
12 by participants, beneficiaries, and enrollees  
13 on such drug, including participant, bene-  
14 ficiary, and enrollee spending through co-  
15 payments, coinsurance, and deductibles;

16 “(v) for any drug for which gross  
17 spending of the group health plan or  
18 health insurance coverage exceeded  
19 \$10,000 during the plan year—

20 “(I) a list of all other drugs in  
21 the same therapeutic category or  
22 class, including brand name drugs  
23 and biological products and generic  
24 drugs or biosimilar biological products

1 that are in the same therapeutic cat-  
2 egory or class as such drug; and

3 “(II) the rationale for the for-  
4 mulary placement of such drug in that  
5 therapeutic category or class, if appli-  
6 cable;

7 “(vi) the amount received, or expected  
8 to be received, from drug manufacturers in  
9 rebates, fees, alternative discounts, or  
10 other remuneration for claims incurred for  
11 such drug during the plan year;

12 “(vii) the total net spending, after de-  
13 ducting rebates, price concessions, alter-  
14 native discounts or other remuneration  
15 from drug manufacturers, by the health  
16 plan or health insurance coverage on such  
17 drug; and

18 “(viii) the net price per course of  
19 treatment or single fill, such as a 30-day  
20 supply or 90-day supply, incurred by the  
21 health plan or health insurance coverage  
22 and its participants, beneficiaries, and en-  
23 rollees, after manufacturer rebates, fees,  
24 and other remuneration for such drug dis-  
25 pensed during the plan year;

1           “(C) a list of each therapeutic category or  
2           class of drugs that were dispensed under the  
3           health plan or health insurance coverage during  
4           the plan year, and, with respect to each such  
5           therapeutic category or class of drugs, during  
6           the plan year—

7                   “(i) total gross spending by the plan  
8                   or coverage, before manufacturer rebates,  
9                   fees, or other manufacturer remuneration;

10                   “(ii) the number of participants, bene-  
11                   ficiaries, and enrollees who were dispensed  
12                   a drug covered by such plan or coverage in  
13                   that category or class, broken down by  
14                   each such drug (identified by National  
15                   Drug Code);

16                   “(iii) if applicable to that category or  
17                   class, a description of the formulary tiers  
18                   and utilization management (such as prior  
19                   authorization or step therapy) employed  
20                   for drugs in that category or class; and

21                   “(iv) the total out-of-pocket spending  
22                   by participants, beneficiaries, and enroll-  
23                   ees, including participant, beneficiary, and  
24                   enrollee spending through copayments, co-  
25                   insurance, and deductibles;

1           “(D) total gross spending on prescription  
2           drugs by the plan or coverage during the plan  
3           year, before rebates and other manufacturer  
4           fees or remuneration;

5           “(E) total amount received, or expected to  
6           be received, by the health plan or health insur-  
7           ance coverage in drug manufacturer rebates,  
8           fees, alternative discounts, and all other remu-  
9           neration received from the manufacturer or any  
10          third party, other than the plan sponsor, re-  
11          lated to utilization of drug or drug spending  
12          under that health plan or health insurance cov-  
13          erage during the plan year;

14          “(F) the total net spending on prescription  
15          drugs by the health plan or health insurance  
16          coverage during the plan year; and

17          “(G) amounts paid directly or indirectly in  
18          rebates, fees, or any other type of remuneration  
19          to brokers, consultants, advisors, or any other  
20          individual or firm for the referral of the group  
21          health plan’s or health insurance issuer’s busi-  
22          ness to the pharmacy benefits manager.

23          “(2) PRIVACY REQUIREMENTS.—Health insur-  
24          ance issuers offering group health insurance cov-  
25          erage and entities providing pharmacy benefits man-

1       agement services on behalf of a group health plan  
2       shall provide information under paragraph (1) in a  
3       manner consistent with the privacy, security, and  
4       breach notification regulations promulgated under  
5       section 264(c) of the Health Insurance Portability  
6       and Accountability Act of 1996, and shall restrict  
7       the use and disclosure of such information according  
8       to such privacy regulations.

9               “(3) DISCLOSURE AND REDISCLOSURE.—

10               “(A) LIMITATION TO BUSINESS ASSOCI-  
11               ATES.—A group health plan receiving a report  
12               under paragraph (1) may disclose such informa-  
13               tion only to business associates of such plan as  
14               defined in section 160.103 of title 45, Code of  
15               Federal Regulations (or successor regulations).

16               “(B) CLARIFICATION REGARDING PUBLIC  
17               DISCLOSURE OF INFORMATION.—Nothing in  
18               this section prevents a health insurance issuer  
19               offering group health insurance coverage or an  
20               entity providing pharmacy benefits management  
21               services on behalf of a group health plan from  
22               placing reasonable restrictions on the public dis-  
23               closure of the information contained in a report  
24               described in paragraph (1), except that such  
25               issuer or entity may not restrict disclosure of

1           such report to the Department of Health and  
2           Human Services, the Department of Labor, the  
3           Department of the Treasury, the Comptroller  
4           General of the United States, or applicable  
5           State agencies.

6           “(C) LIMITED FORM OF REPORT.—The  
7           Secretary shall define through rulemaking a  
8           limited form of the report under paragraph (1)  
9           required of plan sponsors who are drug manu-  
10          facturers, drug wholesalers, or other direct par-  
11          ticipants in the drug supply chain, in order to  
12          prevent anti-competitive behavior.

13          “(4) REPORT TO GAO.—A group health plan or  
14          health insurance issuer offering group health insur-  
15          ance coverage, or an entity providing pharmacy ben-  
16          efits management services on behalf of a group  
17          health plan shall submit to the Comptroller General  
18          of the United States each of the first 4 reports sub-  
19          mitted to a plan sponsor under paragraph (1) with  
20          respect to such coverage or plan, and other such re-  
21          ports as requested, in accordance with the privacy  
22          requirements under paragraph (2), the disclosure  
23          and redisclosure standards under paragraph (3), the  
24          standards specified pursuant to paragraph (5), and  
25          such other information that the Comptroller General

1 determines necessary to carry out the study under  
2 section 103(d) of the Health Care Price Trans-  
3 parency Act of 2023.

4 “(5) STANDARD FORMAT.—Not later than 18  
5 months after the date of enactment of this section,  
6 the Secretary shall specify through rulemaking  
7 standards for health insurance issuers and entities  
8 required to submit reports under paragraph (4) to  
9 submit such reports in a standard format.

10 “(c) ENFORCEMENT.—

11 “(1) IN GENERAL.—Notwithstanding section  
12 2723, the Secretary, in consultation with the Sec-  
13 retary of Labor and the Secretary of the Treasury,  
14 shall enforce this section.

15 “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
16 TION.—A health insurance issuer or an entity pro-  
17 viding pharmacy benefits management services that  
18 violates subsection (a) or fails to provide information  
19 required under subsection (b) shall be subject to a  
20 civil monetary penalty in the amount of \$10,000 for  
21 each day during which such violation continues or  
22 such information is not disclosed or reported.

23 “(3) FALSE INFORMATION.—A health insurance  
24 issuer or entity providing pharmacy benefits man-  
25 agement services that knowingly provides false infor-

1       mation under this section shall be subject to a civil  
2       money penalty in an amount not to exceed \$100,000  
3       for each item of false information. Such civil money  
4       penalty shall be in addition to other penalties as  
5       may be prescribed by law.

6               “(4) PROCEDURE.—The provisions of section  
7       1128A of the Social Security Act, other than sub-  
8       section (a) and (b) and the first sentence of sub-  
9       section (c)(1) of such section shall apply to civil  
10      monetary penalties under this subsection in the  
11      same manner as such provisions apply to a penalty  
12      or proceeding under section 1128A of the Social Se-  
13      curity Act.

14              “(5) WAIVERS.—The Secretary may waive pen-  
15      alties under paragraph (2), or extend the period of  
16      time for compliance with a requirement of this sec-  
17      tion, for an entity in violation of this section that  
18      has made a good-faith effort to comply with this sec-  
19      tion.

20              “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
21      tion shall be construed to permit a health insurance issuer,  
22      group health plan, or other entity to restrict disclosure to,  
23      or otherwise limit the access of, the Secretary of Health  
24      and Human Services to a report described in subsection  
25      (b)(1) or information related to compliance with sub-



1 section (a) or (b) by such issuer, plan, or other entity sub-  
2 ject to such subsections.

3 “(e) DEFINITION.—In this section, the term ‘whole-  
4 sale acquisition cost’ has the meaning given such term in  
5 section 1847A(c)(6)(B) of the Social Security Act.”; and

6 (2) in section 2723 of such Act (42 U.S.C.  
7 300gg-22)—

8 (A) in subsection (a)—

9 (i) in paragraph (1), by inserting  
10 “(other than subsections (a) and (b) of  
11 section 2799A-11)” after “part D”; and

12 (ii) in paragraph (2), by inserting  
13 “(other than subsections (a) and (b) of  
14 section 2799A-11)” after “part D”; and

15 (B) in subsection (b)—

16 (i) in paragraph (1), by inserting  
17 “(other than subsections (a) and (b) of  
18 section 2799A-11)” after “part D”;

19 (ii) in paragraph (2)(A), by inserting  
20 “(other than subsections (a) and (b) of  
21 section 2799A-11)” after “part D”; and

22 (iii) in paragraph (2)(C)(ii), by insert-  
23 ing “(other than subsections (a) and (b) of  
24 section 2799A-11)” after “part D”.

25 (c) ERISA.—

1           (1) IN GENERAL.—Subtitle B of title I of the  
2           Employee Retirement Income Security Act of 1974  
3           (29 U.S.C. 1021 et seq.) is amended—

4                   (A) in subpart B of part 7 (29 U.S.C.  
5           1185 et seq.), by adding at the end the fol-  
6           lowing:

7   **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
8                   **SERVICES.**

9           “(a) IN GENERAL.—For plan years beginning on or  
10          after the date that is 3 years after the date of enactment  
11          of this section, a group health plan or health insurance  
12          issuer offering group health insurance coverage, or an en-  
13          tity or subsidiary providing pharmacy benefits manage-  
14          ment services on behalf of such a plan or issuer, shall not  
15          enter into a contract with a drug manufacturer, dis-  
16          tributor, wholesaler, subcontractor, rebate aggregator, or  
17          any associated third party that limits the disclosure of in-  
18          formation to plan sponsors in such a manner that prevents  
19          the plan or issuer, or an entity or subsidiary providing  
20          pharmacy benefits management services on behalf of a  
21          plan or issuer, from making the report described in sub-  
22          section (b).

23          “(b) ANNUAL REPORT.—

24                   “(1) IN GENERAL.—With respect to plan years  
25          beginning on or after the date that is 3 years after

1 the date of enactment of this section, for each such  
2 plan year, a group health plan or health insurance  
3 issuer offering group health insurance coverage, or  
4 an entity providing pharmacy benefits management  
5 services on behalf of such a plan or an issuer, shall  
6 submit to the plan sponsor (as defined in section  
7 3(16)(B)) of such plan or coverage a report in a ma-  
8 chine-readable format. Each such report shall in-  
9 clude, with respect to such plan or coverage provided  
10 for such plan year—

11 “(A) to the extent feasible, information col-  
12 lected from drug manufacturers (or an entity  
13 administering copay assistance on behalf of  
14 such manufacturers) by such plan or issuer (or  
15 entity or subsidiary providing pharmacy bene-  
16 fits management services on behalf of such plan  
17 or issuer) on the total amount of copayment as-  
18 sistance dollars paid, or copayment cards ap-  
19 plied, that were funded by the drug manufac-  
20 turer with respect to the participants, bene-  
21 ficiaries, and enrollees in such plan or coverage;

22 “(B) a list of each drug covered by such  
23 plan or coverage that was dispensed during the  
24 plan year, including, with respect to each such  
25 drug during such plan year—

1                   “(i) the brand name, chemical entity,  
2                   and National Drug Code;

3                   “(ii) the number of participants, bene-  
4                   ficiaries, and enrollees for whom the drug  
5                   was dispensed during the plan year, the  
6                   total number of prescription claims for the  
7                   drug (including original prescriptions and  
8                   refills), and the total number of dosage  
9                   units of the drug dispensed across the plan  
10                  year, disaggregated by dispensing channel  
11                  (such as retail, mail order, or specialty  
12                  pharmacy);

13                  “(iii) the wholesale acquisition cost,  
14                  listed as cost per days supply and cost per  
15                  pill, or in the case of a drug in another  
16                  form, per dosage unit;

17                  “(iv) the total out-of-pocket spending  
18                  by participants, beneficiaries, and enrollees  
19                  on such drug, including participant, bene-  
20                  ficiary, and enrollee spending through co-  
21                  payments, coinsurance, and deductibles;

22                  “(v) for any drug for which gross  
23                  spending of the group health plan or  
24                  health insurance coverage exceeded  
25                  \$10,000 during the plan year—

1                   “(I) a list of all other drugs in  
2                   the same therapeutic category or  
3                   class, including brand name drugs  
4                   and biological products and generic  
5                   drugs or biosimilar biological products  
6                   that are in the same therapeutic cat-  
7                   egory or class as such drug; and

8                   “(II) the rationale for the for-  
9                   mulary placement of such drug in that  
10                  therapeutic category or class, if appli-  
11                  cable;

12                  “(vi) the amount received, or expected  
13                  to be received, from drug manufacturers in  
14                  rebates, fees, alternative discounts, or  
15                  other remuneration for claims incurred for  
16                  such drug during the plan year;

17                  “(vii) the total net spending, after de-  
18                  ducting rebates, price concessions, alter-  
19                  native discounts or other remuneration  
20                  from drug manufacturers, by the health  
21                  plan or health insurance coverage on such  
22                  drug; and

23                  “(viii) the net price per course of  
24                  treatment or single fill, such as a 30-day  
25                  supply or 90-day supply, incurred by the

1 health plan or health insurance coverage  
2 and its participants, beneficiaries, and en-  
3 rollees, after manufacturer rebates, fees,  
4 and other remuneration for such drug dis-  
5 pensed during the plan year;

6 “(C) a list of each therapeutic category or  
7 class of drugs that were dispensed under the  
8 health plan or health insurance coverage during  
9 the plan year, and, with respect to each such  
10 therapeutic category or class of drugs, during  
11 the plan year—

12 “(i) total gross spending by the plan  
13 or coverage, before manufacturer rebates,  
14 fees, or other manufacturer remuneration;

15 “(ii) the number of participants, bene-  
16 ficiaries, and enrollees who were dispensed  
17 a drug covered by such plan or coverage in  
18 that category or class, broken down by  
19 each such drug (identified by National  
20 Drug Code);

21 “(iii) if applicable to that category or  
22 class, a description of the formulary tiers  
23 and utilization management (such as prior  
24 authorization or step therapy) employed  
25 for drugs in that category or class; and

1                   “(iv) the total out-of-pocket spending  
2                   by participants, beneficiaries, and enroll-  
3                   ees, including participant, beneficiary, and  
4                   enrollee spending through copayments, co-  
5                   insurance, and deductibles;

6                   “(D) total gross spending on prescription  
7                   drugs by the plan or coverage during the plan  
8                   year, before rebates and other manufacturer  
9                   fees or remuneration;

10                  “(E) total amount received, or expected to  
11                  be received, by the health plan or health insur-  
12                  ance coverage in drug manufacturer rebates,  
13                  fees, alternative discounts, and all other remu-  
14                  neration received from the manufacturer or any  
15                  third party, other than the plan sponsor, re-  
16                  lated to utilization of drug or drug spending  
17                  under that health plan or health insurance cov-  
18                  erage during the plan year;

19                  “(F) the total net spending on prescription  
20                  drugs by the health plan or health insurance  
21                  coverage during the plan year; and

22                  “(G) amounts paid directly or indirectly in  
23                  rebates, fees, or any other type of remuneration  
24                  to brokers, consultants, advisors, or any other  
25                  individual or firm for the referral of the group

1 health plan's or health insurance issuer's busi-  
2 ness to the pharmacy benefits manager.

3 “(2) PRIVACY REQUIREMENTS.—Health insur-  
4 ance issuers offering group health insurance cov-  
5 erage and entities providing pharmacy benefits man-  
6 agement services on behalf of a group health plan  
7 shall provide information under paragraph (1) in a  
8 manner consistent with the privacy, security, and  
9 breach notification regulations promulgated under  
10 section 264(c) of the Health Insurance Portability  
11 and Accountability Act of 1996, and shall restrict  
12 the use and disclosure of such information according  
13 to such privacy regulations.

14 “(3) DISCLOSURE AND REDISCLOSURE.—

15 “(A) LIMITATION TO BUSINESS ASSOCI-  
16 ATES.—A group health plan receiving a report  
17 under paragraph (1) may disclose such informa-  
18 tion only to business associates of such plan as  
19 defined in section 160.103 of title 45, Code of  
20 Federal Regulations (or successor regulations).

21 “(B) CLARIFICATION REGARDING PUBLIC  
22 DISCLOSURE OF INFORMATION.—Nothing in  
23 this section prevents a health insurance issuer  
24 offering group health insurance coverage or an  
25 entity providing pharmacy benefits management



1 services on behalf of a group health plan from  
2 placing reasonable restrictions on the public dis-  
3 closure of the information contained in a report  
4 described in paragraph (1), except that such  
5 issuer or entity may not restrict disclosure of  
6 such report to the Department of Health and  
7 Human Services, the Department of Labor, the  
8 Department of the Treasury, the Comptroller  
9 General of the United States, or applicable  
10 State agencies.

11 “(C) LIMITED FORM OF REPORT.—The  
12 Secretary shall define through rulemaking a  
13 limited form of the report under paragraph (1)  
14 required of plan sponsors who are drug manu-  
15 facturers, drug wholesalers, or other direct par-  
16 ticipants in the drug supply chain, in order to  
17 prevent anti-competitive behavior.

18 “(4) REPORT TO GAO.—A group health plan or  
19 health insurance issuer offering group health insur-  
20 ance coverage, or an entity providing pharmacy ben-  
21 efits management services on behalf of a group  
22 health plan shall submit to the Comptroller General  
23 of the United States each of the first 4 reports sub-  
24 mitted to a plan sponsor under paragraph (1) with  
25 respect to such coverage or plan, and other such re-

1 ports as requested, in accordance with the privacy  
2 requirements under paragraph (2), the disclosure  
3 and redisclosure standards under paragraph (3), the  
4 standards specified pursuant to paragraph (5), and  
5 such other information that the Comptroller General  
6 determines necessary to carry out the study under  
7 section 103(d) of the Health Care Price Trans-  
8 parency Act of 2023.

9 “(5) STANDARD FORMAT.—Not later than 18  
10 months after the date of enactment of this section,  
11 the Secretary shall specify through rulemaking  
12 standards for health insurance issuers and entities  
13 required to submit reports under paragraph (4) to  
14 submit such reports in a standard format.

15 “(c) ENFORCEMENT.—

16 “(1) IN GENERAL.—Notwithstanding section  
17 502, the Secretary, in consultation with the Sec-  
18 retary of Health and Human Services and the Sec-  
19 retary of the Treasury, shall enforce this section.

20 “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
21 TION.—A health insurance issuer or an entity pro-  
22 viding pharmacy benefits management services that  
23 violates subsection (a) or fails to provide information  
24 required under subsection (b) shall be subject to a  
25 civil monetary penalty in the amount of \$10,000 for

1 each day during which such violation continues or  
2 such information is not disclosed or reported.

3 “(3) FALSE INFORMATION.—A health insurance  
4 issuer or entity providing pharmacy benefits man-  
5 agement services that knowingly provides false infor-  
6 mation under this section shall be subject to a civil  
7 money penalty in an amount not to exceed \$100,000  
8 for each item of false information. Such civil money  
9 penalty shall be in addition to other penalties as  
10 may be prescribed by law.

11 “(4) PROCEDURE.—The provisions of section  
12 1128A of the Social Security Act, other than sub-  
13 section (a) and (b) and the first sentence of sub-  
14 section (c)(1) of such section shall apply to civil  
15 monetary penalties under this subsection in the  
16 same manner as such provisions apply to a penalty  
17 or proceeding under section 1128A of the Social Se-  
18 curity Act.

19 “(5) WAIVERS.—The Secretary may waive pen-  
20 alties under paragraph (2), or extend the period of  
21 time for compliance with a requirement of this sec-  
22 tion, for an entity in violation of this section that  
23 has made a good-faith effort to comply with this sec-  
24 tion.

1           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
2 tion shall be construed to permit a health insurance issuer,  
3 group health plan, or other entity to restrict disclosure to,  
4 or otherwise limit the access of, the Secretary of Labor  
5 to a report described in subsection (b)(1) or information  
6 related to compliance with subsection (a) or (b) by such  
7 issuer, plan, or other entity subject to such subsections.

8           “(e) DEFINITION.—In this section, the term ‘whole-  
9 sale acquisition cost’ has the meaning given such term in  
10 section 1847A(c)(6)(B) of the Social Security Act.”; and

11                                 (B) in section 502 (29 U.S.C. 1132)—

12   (i) in subsection (a)—

13   (I) in paragraph (6), by striking  
14   “or (9)” and inserting “(9), or (13)”;

15   (II) in paragraph (10), by strik-  
16   ing at the end “or”;

17   (III) in paragraph (11), at the  
18   end by striking the period and insert-  
19   ing “; or”; and

20   (IV) by adding at the end the fol-  
21   lowing new paragraph:

22   “(12) by the Secretary, in consultation with the  
23   Secretary of Health and Human Services, and the  
24   Secretary of the Treasury, to enforce section 726.”;

1 (ii) in subsection (b)(3), by inserting  
2 “and subsections (a)(12) and (c)(13)” be-  
3 fore “, the Secretary is not”; and

4 (iii) in subsection (c), by adding at  
5 the end the following new paragraph:

6 “(13) SECRETARIAL ENFORCEMENT AUTHORITY  
7 RELATING TO OVERSIGHT OF PHARMACY BENEFITS  
8 MANAGER SERVICES.—

9 “(A) FAILURE TO PROVIDE TIMELY INFOR-  
10 MATION.—The Secretary, in consultation with  
11 the Secretary of Health and Human Services  
12 and the Secretary of the Treasury, may impose  
13 a penalty against any group health plan or  
14 health insurance issuer offering group health  
15 insurance coverage, or entity providing phar-  
16 macy benefits management services on behalf of  
17 such plan or coverage, that violates section  
18 726(a) or fails to provide information required  
19 under section 726(b), in the amount of \$10,000  
20 for each day during which such violation con-  
21 tinues or such information is not disclosed or  
22 reported.

23 “(B) FALSE INFORMATION.—The Sec-  
24 retary, in consultation with the Secretary of  
25 Health and Human Services and the Secretary

1 of the Treasury, may impose a penalty against  
2 a group health plan or health insurance issuer  
3 offering group health coverage, or an entity  
4 providing pharmacy benefits management serv-  
5 ices on behalf of such plan or coverage, that  
6 knowingly provides false information under sec-  
7 tion 726 in an amount not to exceed \$100,000  
8 for each item of false information. Such penalty  
9 shall be in addition to other penalties as may  
10 be prescribed by law.

11 “(C) WAIVERS.—The Secretary may waive  
12 penalties under subparagraph (A), or extend  
13 the period of time for compliance with a re-  
14 quirement of section 726, for an entity in viola-  
15 tion of such section that has made a good-faith  
16 effort to comply with such section.”.

17 (2) CLERICAL AMENDMENT.—The table of con-  
18 tents in section 1 of the Employee Retirement In-  
19 come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
20 is amended by inserting after the item relating to  
21 section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefits manager services.”.

22 (d) GAO STUDY.—

23 (1) IN GENERAL.—Not later than 3 years after  
24 the date of enactment of this Act, the Comptroller

1       General of the United States shall submit to Con-  
2       gress a report on—

3               (A) pharmacy networks of group health  
4               plans, health insurance issuers, and entities  
5               providing pharmacy benefits management serv-  
6               ices under such group health plan or group or  
7               individual health insurance coverage, including  
8               networks that have pharmacies that are under  
9               common ownership (in whole or part) with  
10              group health plans, health insurance issuers, or  
11              entities providing pharmacy benefits manage-  
12              ment services or pharmacy benefits administra-  
13              tive services under group health plan or group  
14              or individual health insurance coverage;

15              (B) as it relates to pharmacy networks  
16              that include pharmacies under common owner-  
17              ship described in subparagraph (A)—

18                      (i) whether such networks are de-  
19                      signed to encourage enrollees of a plan or  
20                      coverage to use such pharmacies over other  
21                      network pharmacies for specific services or  
22                      drugs, and if so, the reasons the networks  
23                      give for encouraging use of such phar-  
24                      macies; and

1 (ii) whether such pharmacies are used  
2 by enrollees disproportionately more in the  
3 aggregate or for specific services or drugs  
4 compared to other network pharmacies;

5 (C) whether group health plans and health  
6 insurance issuers offering group or individual  
7 health insurance coverage have options to elect  
8 different network pricing arrangements in the  
9 marketplace with entities that provide phar-  
10 macy benefits management services, the preva-  
11 lence of electing such different network pricing  
12 arrangements;

13 (D) pharmacy network design parameters  
14 that encourage enrollees in the plan or coverage  
15 to fill prescriptions at mail order, specialty, or  
16 retail pharmacies that are wholly or partially-  
17 owned by that issuer or entity; and

18 (E) the degree to which mail order, spe-  
19 cialty, or retail pharmacies that dispense pre-  
20 scription drugs to an enrollee in a group health  
21 plan or health insurance coverage that are  
22 under common ownership (in whole or part)  
23 with group health plans, health insurance  
24 issuers, or entities providing pharmacy benefits  
25 management services or pharmacy benefits ad-



1           ministrative services under group health plan or  
2           group or individual health insurance coverage  
3           receive reimbursement that is greater than the  
4           median price charged to the group health plan  
5           or health insurance issuer when the same drug  
6           is dispensed to enrollees in the plan or coverage  
7           by other pharmacies included in the pharmacy  
8           network of that plan, issuer, or entity that are  
9           not wholly or partially owned by the health in-  
10          surance issuer or entity providing pharmacy  
11          benefits management services.

12           (2) REQUIREMENT.—The Comptroller General  
13          of the United States shall ensure that the report  
14          under paragraph (1) does not contain information  
15          that would allow a reader to identify a specific plan  
16          or entity providing pharmacy benefits management  
17          services or otherwise contain commercial or financial  
18          information that is privileged or confidential.

19           (3) DEFINITIONS.—In this subsection, the  
20          terms “group health plan”, “health insurance cov-  
21          erage”, and “health insurance issuer” have the  
22          meanings given such terms in section 2791 of the  
23          Public Health Service Act (42 U.S.C. 300gg–91).

1 **SEC. 104. REPORTS ON HEALTH CARE TRANSPARENCY**  
2 **TOOLS AND DATA REQUIREMENTS.**

3 (a) INITIAL REPORT.—Not later than December 31,  
4 2024, the Comptroller General of the United States shall  
5 submit to the Committees (as defined in subsection (d))  
6 an initial report that—

7 (1) identifies and describes health care trans-  
8 parency tools and Federal health care reporting re-  
9 quirements (as described in subsection (d)) that are  
10 in effect as of the date of the submission of such ini-  
11 tial report, including the frequency of reports with  
12 respect to each such requirement and whether any  
13 such requirements are duplicative;

14 (2) reviews how such reporting requirements  
15 are enforced;

16 (3) analyzes whether the public availability of  
17 health care transparency tools, and the publication  
18 of data pursuant to such reporting requirements,  
19 has—

20 (A) been utilized and valued by consumers,  
21 including reasons for such utilization (or lack  
22 thereof); and

23 (B) assisted health insurance plan spon-  
24 sors and fiduciaries improve benefits, lower  
25 health care costs for plan participants, and  
26 meet fiduciary requirements;

1           (4) includes recommendations to the Commit-  
2           tees, the Secretary of Health and Human Services,  
3           the Secretary of Labor, and the Secretary of the  
4           Treasury to—

5                   (A) improve the efficiency, accuracy, and  
6                   usability of health care transparency tools;

7                   (B) streamline Federal health care report-  
8                   ing requirements to eliminate duplicative re-  
9                   quirements and reduce the burden on entities  
10                  required to submit reports pursuant to such  
11                  provisions;

12                  (C) improve the accuracy and efficiency of  
13                  such reports while maintaining the integrity  
14                  and usability of the data provided by such re-  
15                  ports;

16                  (D) address any gaps in data provided by  
17                  such reports; and

18                  (E) ensure that the data and information  
19                  reported is comparable and usable to con-  
20                  sumers, including patients, plan sponsors, and  
21                  policy makers.

22           (b) FINAL REPORT.—Not later than December 31,  
23           2028, the Comptroller General of the United States shall  
24           submit to the Committees a report that includes—

1           (1) the information provided in the initial re-  
2           port, along with any updates to such information;  
3           and

4           (2) any new information with respect to health  
5           care transparency tools that have been released fol-  
6           lowing the submission of such initial report, or new  
7           reporting requirements in effect as of the date of the  
8           submission of the final report.

9           (c) REPORT ON EXPANDING PRICE TRANSPARENCY  
10          REQUIREMENTS.—Not later than December 31, 2025, the  
11          Comptroller General of the United States, in consultation  
12          with the Secretary of Health and Human Services, health  
13          care provider groups, and patient advocacy groups, shall  
14          submit to the Committees a report that includes rec-  
15          ommendations to expand price transparency reporting re-  
16          quirements to additional care settings, with an emphasis  
17          on settings where shoppable services (as defined in sub-  
18          section (d)) are furnished.

19          (d) DEFINITIONS.—In this section:

20                 (1) COMMITTEES.—The term “Committees”  
21                 means the Committee on Ways and Means, the  
22                 Committee on Energy and Commerce, and the Com-  
23                 mittee on Education and the Workforce of the  
24                 House of Representatives, and the Committee on Fi-

1 nance and the Committee on Health, Education,  
2 Labor, and Pensions of the Senate.

3 (2) FEDERAL HEALTH CARE REPORTING RE-  
4 QUIREMENTS.—The term “Federal health care re-  
5 porting requirements” includes regulatory and statu-  
6 tory requirements with respect to the reporting and  
7 publication of health care price, cost access, and  
8 quality data, including requirements established by  
9 the Consolidated Appropriations Act of 2021 (Public  
10 Law 116–260), this Act, and other reporting and  
11 publication requirements with respect to trans-  
12 parency in health care as identified by the Comp-  
13 troller General of the United States.

14 (3) SHOPPABLE SERVICE.—The term  
15 “shoppable service” means a service that can be  
16 scheduled by a health care consumer in advance and  
17 includes all ancillary items and services customarily  
18 furnished as part of such service.

19 **SEC. 105. REPORT ON INTEGRATION IN MEDICARE.**

20 (a) REQUIRED MA AND PDP REPORTING.—

21 (1) MA PLANS.—Section 1857(e) of the Social  
22 Security Act (42 U.S.C. 1395w–27(e)) is amended  
23 by adding at the end the following new paragraph:

1           “(6) REQUIRED DISCLOSURE OF CERTAIN IN-  
2           FORMATION RELATING TO HEALTH CARE PROVIDER  
3           OWNERSHIP.—

4           “(A) IN GENERAL.—For plan year 2025  
5           and for every third plan year thereafter, each  
6           MA organization offering an MA plan under  
7           this part during such plan year shall submit to  
8           the Secretary, at a time and in a manner speci-  
9           fied by the Secretary—

10           “(i) the taxpayer identification num-  
11           ber for each health care provider that was  
12           a specified health care provider with re-  
13           spect to such organization during such  
14           year;

15           “(ii) the total amount of incentive-  
16           based payments made to, and the total  
17           amount of shared losses recoupments col-  
18           lected from, such specified health care pro-  
19           viders during such plan year; and

20           “(iii) the total amount of incentive-  
21           based payments made to, and the total  
22           amount of shared losses recoupments col-  
23           lected from, providers of services and sup-  
24           pliers not described in clause (ii) during  
25           such plan year.

1           “(B) DEFINITION.—For purposes of this  
2           paragraph, the term ‘specified health care pro-  
3           vider’ means, with respect to an MA organiza-  
4           tion and a plan year, a provider of services or  
5           supplier with respect to which such organization  
6           (or any person with an ownership or control in-  
7           terest (as defined in section 1124(a)(3)) in such  
8           organization) is a person with an ownership or  
9           control interest (as so defined).”.

10           (2) PRESCRIPTION DRUG PLANS.—Section  
11           1860D–12(b) of the Social Security Act (42 U.S.C.  
12           1395w–112(b)) is amended by adding at the end the  
13           following new paragraph:

14           “(9) PROVISION OF INFORMATION RELATING TO  
15           PHARMACY OWNERSHIP.—

16           “(A) IN GENERAL.—For plan year 2025  
17           and for every third plan year thereafter, each  
18           PDP sponsor offering a prescription drug plan  
19           under this part during such plan year shall sub-  
20           mit to the Secretary, at a time and in a manner  
21           specified by the Secretary, the taxpayer identi-  
22           fication number and National Provider Identifi-  
23           fier for each pharmacy that was a specified  
24           pharmacy with respect to such sponsor during  
25           such year.





1 state of vertical integration in the health care sector dur-  
2 ing the applicable year with respect to entities partici-  
3 pating in the Medicare program, including health care pro-  
4 viders, pharmacies, prescription drug plan sponsors, Medi-  
5 care Advantage organizations, and pharmacy benefit man-  
6 agers. Such report shall include—

7           “(1) with respect to Medicare Advantage orga-  
8           nizations, the evaluation described in subsection (b);

9           “(2) with respect to prescription drug plans,  
10          pharmacy benefit managers, and pharmacies, the  
11          comparisons and evaluations described in subsection  
12          (c);

13          “(3) with respect to Medicare Advantage plans  
14          under which benefits are available for physician-ad-  
15          ministered drugs, the information described in sub-  
16          section (d); and

17          “(4) the identifications described in subsection  
18          (e); and

19          “(5) an analysis of the impact of such integra-  
20          tion on health care access, price, quality, and out-  
21          comes.

22          “(b) **MEDICARE ADVANTAGE ORGANIZATIONS.**—For  
23          purposes of subsection (a)(1), the evaluation described in  
24          this subsection is, with respect to Medicare Advantage or-  
25          ganizations and an applicable year, an evaluation, taking

1 into account patient acuity and the types of areas serviced  
2 by such organization, of—

3 “(1) the average number of qualifying diag-  
4 noses made during such year with respect to enroll-  
5 ees of a Medicare Advantage plan offered by such  
6 organization who, during such year, received a  
7 health risk assessment from a specified health care  
8 provider;

9 “(2) the average risk score for such enrollees  
10 who received such an assessment during such year;

11 “(3) any relationship between such risk scores  
12 for such enrollees receiving such an assessment from  
13 such a provider during such year and incentive pay-  
14 ments made to such providers;

15 “(4) the average risk score for enrollees of such  
16 plan who received any item or service from a speci-  
17 fied health care provider during such year;

18 “(5) any relationship between the risk scores of  
19 enrollees under such plan and whether the enrollees  
20 have received any item or service from a specified  
21 provider; and

22 “(6) any relationship between the risk scores of  
23 enrollees under such plan that have received any  
24 item or service from a specified provider and incen-

1           tive payments made under the plan to specified pro-  
2           viders.

3           “(c) PRESCRIPTION DRUG PLANS.—For purposes of  
4 subsection (a)(2), the comparisons and evaluations de-  
5 scribed in this subsection are, with respect to prescription  
6 drug plans and an applicable year, the following:

7                   “(1) For each covered part D drug for which  
8 benefits are available under such a plan, a compari-  
9 son of the average negotiated rate in effect with  
10 specified pharmacies with such rates in effect for in-  
11 network pharmacies that are not specified phar-  
12 macies.

13                   “(2) Comparisons of the following:

14                           “(A) The total amount paid by pharmacy  
15 benefit managers to specified pharmacies for  
16 covered part D drugs and the total amount so  
17 paid to pharmacies that are not specified phar-  
18 macies for such drugs.

19                           “(B) The total amount paid by such spon-  
20 sors to specified pharmacy benefit managers as  
21 reimbursement for covered part D drugs and  
22 the total amount so paid to pharmacy benefit  
23 managers that are not specified pharmacy ben-  
24 efit managers as such reimbursement.

1           “(C) Fees paid under by plan to specified  
2           pharmacy benefit managers compared to such  
3           fees paid to pharmacy benefit managers that  
4           are not specified pharmacy benefit managers.

5           “(3) An evaluation of the total amount of direct  
6           and indirect remuneration for covered part D drugs  
7           passed through to prescription drug plan sponsors  
8           and the total amount retained by pharmacy benefit  
9           managers (including entities under contract with  
10          such a manager).

11          “(4) To the extent that the available data per-  
12          mits, an evaluation of fees charged by rebate  
13          aggregators that are affiliated with plan sponsors.

14          “(d) PHYSICIAN-ADMINISTERED DRUGS.—For pur-  
15          poses of subsection (a)(3), the information described in  
16          this subsection is, with respect to physician-administered  
17          drugs for which benefits are available under a Medicare  
18          Advantage plan during an applicable year, the following:

19                 “(1) With respect to each such plan, an identi-  
20                 fication of each drug for which benefits were avail-  
21                 able under such plan only when administered by a  
22                 health care provider that acquired such drug from  
23                 an affiliated pharmacy.

24                 “(2) An evaluation of the difference between  
25                 the total number of drugs administered by a health

1 care provider that were acquired from affiliated  
2 pharmacies compared to the number of such drugs  
3 so administered that were acquired from pharmacies  
4 other than affiliated pharmacies, and an evaluation  
5 of the difference in payments for such drugs so ad-  
6 ministered when acquired from a specified pharmacy  
7 and when acquired from a pharmacy that is not a  
8 specified pharmacy.

9 “(3) An evaluation of the dollar value of all  
10 such drugs that were not so administered because of  
11 a delay attributable to an affiliated pharmacy com-  
12 pared to the dollar value of all such drugs that were  
13 not so administered because of a delay attributable  
14 to pharmacy that is not an affiliated pharmacy.

15 “(4) The number of enrollees administered such  
16 a drug that was acquired from an affiliated phar-  
17 macy.

18 “(5) The number of enrollees furnished such a  
19 drug that was acquired from a pharmacy that is not  
20 an affiliated pharmacy.

21 “(e) IDENTIFICATIONS.—For purposes of subsection  
22 (a)(4), the identifications described in this subsection are,  
23 with respect to an applicable year, identifications of each  
24 health care entity participating under the Medicare pro-  
25 gram with respect to which another health care entity so

1 participating is a person with an ownership or control in-  
2 terest (as defined in section 1124(a)(3)).

3 “(f) DEFINITIONS.—In this section:

4 “(1) AFFILIATED PHARMACY.—The term ‘affili-  
5 ated pharmacy’ means, with respect to a Medicare  
6 Advantage plan offered by a Medicare Advantage or-  
7 ganization, a pharmacy with respect to which such  
8 organization (or any person with an ownership or  
9 control interest (as defined in section 1124(a)(3)) in  
10 such organization) is a person with an ownership or  
11 control interest (as so defined).

12 “(2) APPLICABLE YEAR.—The term ‘applicable  
13 year’ means, with respect to a report submitted  
14 under subsection (a), the first calendar year begin-  
15 ning at least 4 years prior to the date of the submis-  
16 sion of such report.

17 “(3) COVERED PART D DRUG.—The term ‘cov-  
18 ered part D drug’ has the meaning given such term  
19 in section 1860D–2(e).

20 “(4) DIRECT AND INDIRECT REMUNERATION.—  
21 The term ‘direct and indirect remuneration’ has the  
22 meaning given such term in section 423.308 of title  
23 42, Code of Federal Regulations (or any successor  
24 regulation).

1           “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-  
2           fying diagnosis’ means, with respect to an enrollee of  
3           a Medicare Advantage plan, a diagnosis that is  
4           taken into account in calculating a risk score for  
5           such enrollee under the risk adjustment methodology  
6           established by the Secretary pursuant to section  
7           1853(a)(3).

8           “(6) RISK SCORE.—The term ‘risk score’  
9           means, with respect to an enrollee of a Medicare Ad-  
10          vantage plan, the score calculated for such individual  
11          using the methodology described in paragraph (5).

12          “(7) PHYSICIAN-ADMINISTERED DRUG.—The  
13          term ‘physician-administered drug’ means a drug  
14          furnished to an individual that, had such individual  
15          been enrolled under part B and not enrolled under  
16          part C, would have been payable under section  
17          1842(o).

18          “(8) SPECIFIED HEALTH CARE PROVIDER.—  
19          The term ‘specified health care provider’ means,  
20          with respect to a Medicare Advantage plan offered  
21          by a Medicare Advantage organization, a health care  
22          provider with respect to which such organization (or  
23          any person with an ownership or control interest (as  
24          defined in section 1124(a)(3)) in such organization)

1 is a person with an ownership or control interest (as  
2 so defined).

3 “(9) SPECIFIED PHARMACY.—The term ‘speci-  
4 fied pharmacy’ means, with respect to a prescription  
5 drug plan offered by a prescription drug plan spon-  
6 sor, a pharmacy with respect to which—

7 “(A) such sponsor (or any person with an  
8 ownership or control interest (as defined in sec-  
9 tion 1124(a)(3)) in such sponsor) is a person  
10 with an ownership or control interest (as so de-  
11 fined); or

12 “(B) a pharmacy benefit manager offering  
13 services under such plan (or any person with an  
14 ownership or control interest (as so defined) in  
15 such sponsor) is a person with an ownership or  
16 control interest (as so defined).

17 “(10) SPECIFIED PHARMACY BENEFIT MAN-  
18 AGER.—The term ‘specified pharmacy benefit man-  
19 ager’ means, with respect to a prescription drug  
20 plan offered by a prescription drug plan sponsor, a  
21 pharmacy benefit manager with respect to which  
22 such sponsor (or any person with an ownership or  
23 control interest (as defined in section 1124(a)(3)) in  
24 such sponsor) is a person with an ownership or con-  
25 trol interest (as so defined).”.



1           **TITLE II—FAIR PRICES FOR**  
2                                   **PATIENTS**

3   **SEC. 201. LIMITATION ON COST SHARING TO NET PRICE**  
4                                   **AMOUNT UNDER MEDICARE PART D.**

5           (a) IN GENERAL.—Section 1860D–2 of the Social  
6 Security Act (42 U.S.C. 1395w–102) is amended—

7                   (1) in subsection (b)—

8                           (A) in paragraph (2)(A), by striking “(8)  
9                           and (9)” and inserting “(8), (9), and (10)”;

10                          (B) in paragraph (9)(B)(ii), by striking  
11                          “For a plan year” and inserting “Subject to  
12                          paragraph (10), for a plan year”; and

13                          (C) by adding at the end the following new  
14                          paragraph:

15                          “(10) LIMITATION ON COST SHARING TO NET  
16                          PRICE AMOUNT.—

17                               “(A) IN GENERAL.—For a plan year begin-  
18                               ning on or after January 1, 2027, the coverage  
19                               provides benefits for a supply of a covered part  
20                               D drug dispensed by a pharmacy, for costs in  
21                               excess of the deductible specified in paragraph  
22                               (1) and prior to an individual reaching the out-  
23                               of-pocket threshold under paragraph (4), with  
24                               cost-sharing for a month’s supply that does not  
25                               exceed the average net price for such a supply

1 of such drug during such plan year (or, if  
2 lower, the applicable cash price for such a sup-  
3 ply of such drug so dispensed by such phar-  
4 macy).

5 “(B) DEFINITIONS.—In this paragraph:

6 “(i) APPLICABLE CASH PRICE.—The  
7 term ‘applicable cash price’ means, with  
8 respect to a supply of a covered part D  
9 drug dispensed by a pharmacy, the price  
10 that such pharmacy would charge for such  
11 supply of such drug dispensed to an indi-  
12 vidual without benefits for such drug  
13 under any Federal health care program (as  
14 defined in section 1128B), a group health  
15 plan or group or individual health insur-  
16 ance coverage (as such terms are defined  
17 in section 2791 of the Public Health Serv-  
18 ice Act), or the program established under  
19 chapter 89 of title 5, United States Code.

20 “(ii) AVERAGE NET PRICE.—The term  
21 ‘average net price’ means, with respect to  
22 a supply of a covered part D drug, a pre-  
23 scription drug plan, and a plan year, the  
24 average amount paid under such plan (in-  
25 cluding any amounts paid by an individual

1 enrolled under such plan as cost sharing  
2 for such drug) as payment for such a sup-  
3 ply of such drug dispensed during such  
4 year, less any rebates or other forms of re-  
5 munerations received under such plan with  
6 respect to such drug.”; and

7 (2) in subsection (c), by adding at the end the  
8 following new paragraph:

9 “(7) COST SHARING LIMITED TO NET PRICE.—  
10 The coverage is provided in accordance with sub-  
11 section (b)(10).”.

12 (b) CONFORMING AMENDMENT TO COST-SHARING  
13 FOR LOW-INCOME INDIVIDUALS.—Section 1860D-  
14 14(a)(1)(D)(iii) of the Social Security Act (42 U.S.C.  
15 1395w-114(a)(1)(D)(iii)) is amended by adding at the  
16 end the following new sentence: “For plan year 2027 and  
17 subsequent plan years, the copayment amount applicable  
18 under this clause to a supply of a covered part D drug  
19 dispensed to the individual may not exceed the amount  
20 provided under section 1860D-2(b)(10).”.

21 (c) GAO REPORT.—Not later than January 1, 2029,  
22 the Comptroller General of the United States shall submit  
23 to Congress a report containing—

24 (1) an analysis of compliance with the amend-  
25 ments made by this section;

1           (2) an analysis of enforcement of such amend-  
2           ments;

3           (3) recommendations with respect to improving  
4           such enforcement; and

5           (4) recommendations relating to improving pub-  
6           lic disclosure, and public awareness of, the require-  
7           ments of such amendments.

8 **SEC. 202. REQUIRING A SEPARATE IDENTIFICATION NUM-**  
9           **BER AND AN ATTESTATION FOR EACH OFF-**  
10           **CAMPUS OUTPATIENT DEPARTMENT OF A**  
11           **PROVIDER.**

12           (a) IN GENERAL.—Section 1833(t) of the Social Se-  
13           curity Act (42 U.S.C. 1395l(t)) is amended by adding at  
14           the end the following new paragraph:

15           “(23) USE OF UNIQUE HEALTH IDENTIFIERS;  
16           ATTESTATION.—

17           “(A) IN GENERAL.—No payment may be  
18           made under this subsection (or under an appli-  
19           cable payment system pursuant to paragraph  
20           (21)) for items and services furnished on or  
21           after January 1, 2026, by an off-campus out-  
22           patient department of a provider (as defined in  
23           subparagraph (C)) unless—

24           “(i) such department has obtained,  
25           and such items and services are billed

1 under, a standard unique health identifier  
2 for health care providers (as described in  
3 section 1173(b)) that is separate from  
4 such identifier for such provider; and

5 “(ii) such provider has submitted to  
6 the Secretary, during the 2-year period  
7 ending on the date such items and services  
8 are so furnished, an attestation that such  
9 department is compliant with the require-  
10 ments described in section 413.65 of title  
11 42, Code of Federal Regulations (or a suc-  
12 cessor regulation).

13 “(B) PROCESS FOR SUBMISSION AND RE-  
14 VIEW.—Not later than 1 year after the date of  
15 enactment of this paragraph, the Secretary  
16 shall, through notice and comment rulemaking,  
17 establish a process for each provider with an  
18 off-campus outpatient department of a provider  
19 to submit an attestation pursuant to subpara-  
20 graph (A)(ii), and for the Secretary to review  
21 each such attestation and determine, through  
22 site visits, remote audits, or other means (as  
23 determined appropriate by the Secretary),  
24 whether such department is compliant with the  
25 requirements described in such subparagraph.

1                   “(C) OFF-CAMPUS OUTPATIENT DEPART-  
2                   MENT OF A PROVIDER DEFINED.—For purposes  
3                   of this paragraph, the term ‘off-campus out-  
4                   patient department of a provider’ means a de-  
5                   partment of a provider (as defined in section  
6                   413.65 of title 42, Code of Federal Regulations,  
7                   or any successor regulation) that is not lo-  
8                   cated—

9                   “(i) on the campus (as defined in such  
10                  section) of such provider; or

11                  “(ii) within the distance (described in  
12                  such definition of campus) from a remote  
13                  location of a hospital facility (as defined in  
14                  such section).”.

15                  (b) HHS OIG ANALYSIS.—Not later than January  
16 1, 2030, the Inspector General of the Department of  
17 Health and Human Services shall submit to Congress—

18                  (1) an analysis of the process established by the  
19                  Secretary of Health and Human Services to conduct  
20                  the reviews and determinations described in section  
21                  1833(t)(23)(B) of the Social Security Act, as added  
22                  by subsection (a) of this section; and

23                  (2) recommendations based on such analysis, as  
24                  the Inspector General determines appropriate.

1 **SEC. 203. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**  
2 **OUTPATIENT DEPARTMENT SERVICES FUR-**  
3 **NISHED OFF-CAMPUS.**

4 (a) IN GENERAL.—Section 1833(t)(16) of the Social  
5 Security Act (42 U.S.C. 1395l(t)(16)) is amended by add-  
6 ing at the end the following new subparagraph:

7 “(H) PARITY IN FEE SCHEDULE AMOUNT  
8 FOR CERTAIN SERVICES FURNISHED BY AN  
9 OFF-CAMPUS OUTPATIENT DEPARTMENT OF A  
10 PROVIDER.—

11 “(i) IN GENERAL.—Subject to clause  
12 (iii), in the case of specified OPD services  
13 (as defined in clause (v)) that are fur-  
14 nished during 2025 or a subsequent year  
15 by an off-campus outpatient department of  
16 a provider (as defined in clause (iv)) (or,  
17 in the case of an off-campus outpatient de-  
18 partment of a provider that is a hospital  
19 described in section 1886(d)(1)(B)(v), or is  
20 located in a rural area or a health profes-  
21 sional shortage area, such services that are  
22 furnished during 2026 or a subsequent  
23 year), there shall be substituted for the  
24 amount otherwise determined under this  
25 subsection for such service and year an  
26 amount equal to the payment amount that

1 would have been payable under the applica-  
2 ble payment system under this part (other  
3 than under this subsection) had such serv-  
4 ices been furnished by such a department  
5 subject to such payment system pursuant  
6 to paragraph (21)(C).

7 “(ii) NOT BUDGET NEUTRAL IMPLE-  
8 MENTATION.—In making any budget neu-  
9 trality adjustments under this subsection  
10 for 2025 or a subsequent year, the Sec-  
11 retary shall not take into account the re-  
12 duced expenditures that result from the  
13 application of this subparagraph.

14 “(iii) TRANSITION.—The Secretary  
15 shall provide for a 4-year phase-in of the  
16 application of clause (i), with clause (i)  
17 being fully applicable for specified OPD  
18 services beginning with 2028 (or in the  
19 case of an off-campus outpatient depart-  
20 ment of a provider that is a hospital de-  
21 scribed in section 1886(d)(1)(B)(v), or is  
22 located in a rural area or a health profes-  
23 sional shortage area, beginning with 2029).

24 “(iv) OFF-CAMPUS DEPARTMENT OF A  
25 PROVIDER.—For purposes of this subpara-



1 graph, the term ‘off-campus outpatient de-  
2 partment of a provider’ means a depart-  
3 ment of a provider (as defined in section  
4 413.65(a)(2) of title 42, Code of Federal  
5 Regulations) that is not located—

6 “(I) on the campus (as such term  
7 is defined in such section) of such  
8 provider; or

9 “(II) within the distance (de-  
10 scribed in such definition of campus)  
11 from a remote location of a hospital  
12 facility (as defined in such section).

13 “(v) OTHER DEFINITIONS.—For pur-  
14 poses of this subparagraph:

15 “(I) DESIGNATED AMBULATORY  
16 PAYMENT CLASSIFICATION GROUP.—  
17 The term ‘designated ambulatory pay-  
18 ment classification group’ means an  
19 ambulatory payment classification  
20 group for drug administration serv-  
21 ices.

22 “(II) HEALTH PROFESSIONAL  
23 SHORTAGE AREA.—The term ‘health  
24 professional shortage area’ has the  
25 meaning given such term in section

1                   332(a)(1)(A) of the Public Health  
2                   Service Act.

3                   “(III) RURAL AREA.—The term  
4                   ‘rural area’ has the meaning given  
5                   such term in section 1886(d)(2)(D).

6                   “(IV) SPECIFIED OPD SERV-  
7                   ICES.—The term ‘specified OPD serv-  
8                   ices’ means covered OPD services as-  
9                   signed to a designated ambulatory  
10                  payment classification group.”.

11               (b) IMPLEMENTATION.—Section 1833(t)(12) of the  
12 Social Security Act (42 U.S.C. 1395l(t)(12)) is amend-  
13 ed—

14               (1) in subparagraph (D), by striking “and” at  
15               the end;

16               (2) in subparagraph (E), by striking the period  
17               at the end and inserting “; and”; and

18               (3) by adding at the end the following new sub-  
19               paragraph:

20               “(F) the determination of any payment  
21               amount under paragraph (16)(H), including the  
22               transition under clause (iii) of such para-  
23               graph.”.

1       **TITLE III—PATIENT-FOCUSED**  
2                               **INVESTMENTS**

3       **SEC. 301. ESTABLISHING REQUIREMENTS WITH RESPECT**  
4                               **TO THE USE OF PRIOR AUTHORIZATION**  
5                               **UNDER MEDICARE ADVANTAGE PLANS.**

6           (a) IN GENERAL.—Section 1852 of the Social Secu-  
7 rity Act (42 U.S.C. 1395w–22) is amended by adding at  
8 the end the following new subsection:

9           “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

10                   “(1) IN GENERAL.—In the case of a Medicare  
11 Advantage plan that imposes any prior authorization  
12 requirement with respect to any applicable item or  
13 service (as defined in paragraph (5)) during a plan  
14 year, such plan shall—

15                               “(A) beginning with the third plan year be-  
16 ginning after the date of the enactment of this  
17 subsection—

18                                       “(i) establish the electronic prior au-  
19 thorization program described in para-  
20 graph (2); and

21                                       “(ii) meet the enrollee protection  
22 standards specified pursuant to paragraph  
23 (4); and

24                               “(B) beginning with the fourth plan year  
25 beginning after the date of the enactment of

1           this subsection, meet the transparency require-  
2           ments specified in paragraph (3).

3           “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-  
4           GRAM.—

5                   “(A) IN GENERAL.—For purposes of para-  
6           graph (1)(A), the electronic prior authorization  
7           program described in this paragraph is a pro-  
8           gram that provides for the secure electronic  
9           transmission of—

10                           “(i) a prior authorization request  
11                           from a provider of services or supplier to  
12                           a Medicare Advantage plan with respect to  
13                           an applicable item or service to be fur-  
14                           nished to an individual and a response, in  
15                           accordance with this paragraph, from such  
16                           plan to such provider or supplier; and

17                                   “(ii) any attachment relating to such  
18                           request or response.

19           “(B) ELECTRONIC TRANSMISSION.—

20                   “(i) EXCLUSIONS.—For purposes of  
21           this paragraph, a facsimile, a proprietary  
22           payer portal that does not meet standards  
23           specified by the Secretary, or an electronic  
24           form shall not be treated as an electronic

1 transmission described in subparagraph  
2 (A).

3 “(ii) STANDARDS.—An electronic  
4 transmission described in subparagraph  
5 (A) shall comply with—

6 “(I) applicable technical stand-  
7 ards adopted by the Secretary pursu-  
8 ant to section 1173; and

9 “(II) other requirements to pro-  
10 mote the standardization and stream-  
11 lining of electronic transactions under  
12 this part specified by the Secretary.

13 “(iii) DEADLINE FOR SPECIFICATION  
14 OF ADDITIONAL REQUIREMENTS.—Not  
15 later than July 1, 2024, the Secretary  
16 shall finalize requirements described in  
17 clause (ii)(II).

18 “(C) REAL-TIME DECISIONS.—

19 “(i) IN GENERAL.—Subject to clause  
20 (iv), the program described in subpara-  
21 graph (A) shall provide for real-time deci-  
22 sions (as defined by the Secretary in ac-  
23 cordance with clause (v)) by a Medicare  
24 Advantage plan with respect to prior au-  
25 thorization requests for applicable items

1 and services identified by the Secretary  
2 pursuant to clause (ii) if such requests are  
3 submitted with all medical or other docu-  
4 mentation required by such plan.

5 “(ii) IDENTIFICATION OF ITEMS AND  
6 SERVICES.—

7 “(I) IN GENERAL.—For purposes  
8 of clause (i), the Secretary shall iden-  
9 tify, not later than the date on which  
10 the initial announcement described in  
11 section 1853(b)(1)(B)(i) for the third  
12 plan year beginning after the date of  
13 the enactment of this subsection is re-  
14 quired to be announced, applicable  
15 items and services for which prior au-  
16 thorization requests are routinely ap-  
17 proved.

18 “(II) UPDATES.—The Secretary  
19 shall consider updating the applicable  
20 items and services identified under  
21 subclause (I) based on the information  
22 described in paragraph (3)(A)(i) (if  
23 available and determined practicable  
24 to utilize by the Secretary) and any  
25 other information determined appro-

1                   prorate by the Secretary not less fre-  
2                   quently than biennially. The Secretary  
3                   shall announce any such update that  
4                   is to apply with respect to a plan year  
5                   not later than the date on which the  
6                   initial announcement described in sec-  
7                   tion 1853(b)(1)(B)(i) for such plan  
8                   year is required to be announced.

9                   “(iii) REQUEST FOR INFORMATION.—  
10                  The Secretary shall issue a request for in-  
11                  formation for purposes of initially identi-  
12                  fying applicable items and services under  
13                  clause (ii)(I).

14                  “(iv) EXCEPTION FOR EXTENUATING  
15                  CIRCUMSTANCES.—In the case of a prior  
16                  authorization request submitted to a Medi-  
17                  care Advantage plan for an individual en-  
18                  rolled in such plan during a plan year with  
19                  respect to an item or service identified by  
20                  the Secretary pursuant to clause (ii) for  
21                  such plan year, such plan may, in lieu of  
22                  providing a real-time decision with respect  
23                  to such request in accordance with clause  
24                  (i), delay such decision under extenuating  
25                  circumstances (as specified by the Sec-

1           retary), provided that such decision is pro-  
2           vided no later than 72 hours after receipt  
3           of such request (or, in the case that the  
4           provider of services or supplier submitting  
5           such request has indicated that such delay  
6           may seriously jeopardize such individual's  
7           life, health, or ability to regain maximum  
8           function, no later than 24 hours after re-  
9           ceipt of such request).

10           “(v) DEFINITION OF REAL-TIME DECI-  
11           SION.—In establishing the definition of a  
12           real-time decision for purposes of clause  
13           (i), the Secretary shall take into account  
14           current medical practice, technology,  
15           health care industry standards, and other  
16           relevant information relating to how quick-  
17           ly a Medicare Advantage plan may provide  
18           responses with respect to prior authoriza-  
19           tion requests.

20           “(vi) IMPLEMENTATION.—The Sec-  
21           retary shall use notice and comment rule-  
22           making for each of the following:

23                   “(I) Establishing the definition  
24                   of a ‘real-time decision’ for purposes  
25                   of clause (i).



1 “(II) Updating such definition.

2 “(III) Initially identifying appli-  
3 cable items or services pursuant to  
4 clause (ii)(I).

5 “(IV) Updating applicable items  
6 and services so identified as described  
7 in clause (ii)(II).

8 “(3) TRANSPARENCY REQUIREMENTS.—

9 “(A) IN GENERAL.—For purposes of para-  
10 graph (1)(B), the transparency requirements  
11 specified in this paragraph are, with respect to  
12 a Medicare Advantage plan, the following:

13 “(i) The plan, annually and in a man-  
14 ner specified by the Secretary, shall submit  
15 to the Secretary the following information:

16 “(I) A list of all applicable items  
17 and services that were subject to a  
18 prior authorization requirement under  
19 the plan during the previous plan  
20 year.

21 “(II) The percentage and number  
22 of specified requests (as defined in  
23 subparagraph (F)) approved during  
24 the previous plan year by the plan in  
25 an initial determination and the per-

1 centage and number of specified re-  
2 quests denied during such plan year  
3 by such plan in an initial determina-  
4 tion (both in the aggregate and cat-  
5 egorized by each item and service).

6 “(III) The percentage and num-  
7 ber of specified requests submitted  
8 during the previous plan year that  
9 were made with respect to an item or  
10 service identified by the Secretary  
11 pursuant to paragraph (2)(C)(ii) for  
12 such plan year, and the percentage  
13 and number of such requests that  
14 were subject to an exception under  
15 paragraph (2)(C)(iv) (categorized by  
16 each item and service).

17 “(IV) The percentage and num-  
18 ber of specified requests submitted  
19 during the previous plan year that  
20 were made with respect to an item or  
21 service identified by the Secretary  
22 pursuant to paragraph (2)(C)(ii) for  
23 such plan year that were approved  
24 (categorized by each item and serv-  
25 ice).

1           “(V) The percentage and number  
2 of specified requests that were denied  
3 during the previous plan year by the  
4 plan in an initial determination and  
5 that were subsequently appealed.

6           “(VI) The number of appeals of  
7 specified requests resolved during the  
8 preceding plan year, and the percent-  
9 age and number of such resolved ap-  
10 peals that resulted in approval of the  
11 furnishing of the item or service that  
12 was the subject of such request, cat-  
13 egorized by each applicable item and  
14 service and categorized by each level  
15 of appeal (including judicial review).

16           “(VII) The percentage and num-  
17 ber of specified requests that were de-  
18 nied, and the percentage and number  
19 of specified requests that were ap-  
20 proved, by the plan during the pre-  
21 vious plan year through the utilization  
22 of decision support technology, artifi-  
23 cial intelligence technology, machine-  
24 learning technology, clinical decision-

1 making technology, or any other tech-  
2 nology specified by the Secretary.

3 “(VIII) The average and the me-  
4 dian amount of time (in hours) that  
5 elapsed during the previous plan year  
6 between the submission of a specified  
7 request to the plan and a determina-  
8 tion by the plan with respect to such  
9 request for each such item and serv-  
10 ice, excluding any such requests that  
11 were not submitted with the medical  
12 or other documentation required to be  
13 submitted by the plan.

14 “(IX) The percentage and num-  
15 ber of specified requests that were ex-  
16 cluded from the calculation described  
17 in subclause (VIII) based on the  
18 plan’s determination that such re-  
19 quests were not submitted with the  
20 medical or other documentation re-  
21 quired to be submitted by the plan.

22 “(X) Information on each occur-  
23 rence during the previous plan year in  
24 which, during a surgical or medical  
25 procedure involving the furnishing of

1 an applicable item or service with re-  
2 spect to which such plan had ap-  
3 proved a prior authorization request,  
4 the provider of services or supplier  
5 furnishing such item or service deter-  
6 mined that a different or additional  
7 item or service was medically nec-  
8 essary, including a specification of  
9 whether such plan subsequently ap-  
10 proved the furnishing of such dif-  
11 ferent or additional item or service.

12 “(XI) A disclosure and descrip-  
13 tion of any technology described in  
14 subclause (VII) that the plan utilized  
15 during the previous plan year in mak-  
16 ing determinations with respect to  
17 specified requests.

18 “(XII) The number of grievances  
19 (as described in subsection (f)) re-  
20 ceived by such plan during the pre-  
21 vious plan year that were related to a  
22 prior authorization requirement.

23 “(XIII) Such other information  
24 as the Secretary determines appro-  
25 priate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier  
3 who seeks to enter into a contract  
4 with such plan to furnish applicable  
5 items and services under such plan,  
6 the list described in clause (i)(I) and  
7 any policies or procedures used by the  
8 plan for making determinations with  
9 respect to prior authorization re-  
10 quests;

11 “(II) to each such provider and  
12 supplier that enters into such a con-  
13 tract, access to the criteria used by  
14 the plan for making such determina-  
15 tions and an itemization of the med-  
16 ical or other documentation required  
17 to be submitted by a provider or sup-  
18 plier with respect to such a request;  
19 and

20 “(III) to an enrollee of the plan,  
21 upon request, access to the criteria  
22 used by the plan for making deter-  
23 minations with respect to prior au-  
24 thorization requests for an item or  
25 service.

1           “(B) OPTION FOR PLAN TO PROVIDE CER-  
2           TAIN ADDITIONAL INFORMATION.—As part of  
3           the information described in subparagraph  
4           (A)(i) provided to the Secretary during a plan  
5           year, a Medicare Advantage plan may elect to  
6           include information regarding the percentage  
7           and number of specified requests made with re-  
8           spect to an individual and an item or service  
9           that were denied by the plan during the pre-  
10          ceding plan year in an initial determination  
11          based on such requests failing to demonstrate  
12          that such individuals met the clinical criteria  
13          established by such plan to receive such items  
14          or services.

15          “(C) REGULATIONS.—The Secretary shall,  
16          through notice and comment rulemaking, estab-  
17          lish requirements for Medicare Advantage plans  
18          regarding the provision of—

19                 “(i) access to criteria described in  
20                 subparagraph (A)(ii)(II) to providers of  
21                 services and suppliers in accordance with  
22                 such subparagraph; and

23                 “(ii) access to such criteria to enroll-  
24                 ees in accordance with subparagraph  
25                 (A)(ii)(III).

1           “(D) PUBLICATION OF INFORMATION.—  
2           The Secretary shall publish information de-  
3           scribed in subparagraph (A)(i) and subpara-  
4           graph (B) on a public website of the Centers  
5           for Medicare & Medicaid Services. Such infor-  
6           mation shall be so published on an individual  
7           plan level and may in addition be aggregated in  
8           such manner as determined appropriate by the  
9           Secretary.

10           “(E) MEDPAC REPORT.—Not later than 3  
11           years after the date information is first sub-  
12           mitted under subparagraph (A)(i), the Medicare  
13           Payment Advisory Commission shall submit to  
14           Congress a report on such information that in-  
15           cludes a descriptive analysis of the use of prior  
16           authorization. As appropriate, the Commission  
17           should report on statistics including the fre-  
18           quency of appeals and overturned decisions.  
19           The Commission shall provide recommenda-  
20           tions, as appropriate, on any improvement that  
21           should be made to the electronic prior author-  
22           ization programs of Medicare Advantage plans.

23           “(F) SPECIFIED REQUEST DEFINED.—For  
24           purposes of this paragraph, the term ‘specified  
25           request’ means a prior authorization request



1           made with respect to an applicable item or serv-  
2           ice.

3           “(4) ENROLLEE PROTECTION STANDARDS.—

4           For purposes of paragraph (1)(A)(ii), with respect  
5           to the use of prior authorization by Medicare Advan-  
6           tage plans for applicable items and services, the en-  
7           rollee protection standards specified in this para-  
8           graph are—

9                   “(A) the adoption of transparent prior au-  
10                   thorization programs developed in consultation  
11                   with enrollees and with providers and suppliers  
12                   with contracts in effect with such plans for fur-  
13                   nishing such items and services under such  
14                   plans;

15                   “(B) allowing for the waiver or modifica-  
16                   tion of prior authorization requirements based  
17                   on the performance of such providers and sup-  
18                   pliers in demonstrating compliance with such  
19                   requirements, such as adherence to evidence-  
20                   based medical guidelines and other quality cri-  
21                   teria; and

22                   “(C) conducting annual reviews of such  
23                   items and services for which prior authorization  
24                   requirements are imposed under such plans  
25                   through a process that takes into account input

1 from enrollees and from providers and suppliers  
2 with such contracts in effect and is based on  
3 consideration of prior authorization data from  
4 previous plan years and analyses of current cov-  
5 erage criteria.

6 “(5) APPLICABLE ITEM OR SERVICE DE-  
7 FINED.—For purposes of this subsection, the term  
8 ‘applicable item or service’ means, with respect to a  
9 Medicare Advantage plan, any item or service for  
10 which benefits are available under such plan, other  
11 than a covered part D drug.

12 “(6) REPORTS TO CONGRESS.—

13 “(A) GAO.—Not later than the end of the  
14 fourth plan year beginning on or after the date  
15 of the enactment of this subsection, the Comp-  
16 troller General of the United States shall sub-  
17 mit to Congress a report containing an evalua-  
18 tion of the implementation of the requirements  
19 of this subsection and an analysis of issues in  
20 implementing such requirements faced by Medi-  
21 care Advantage plans.

22 “(B) HHS.—Not later than the end of the  
23 fifth plan year beginning after the date of the  
24 enactment of this subsection, and biennially  
25 thereafter through the date that is 10 years

1 after such date of enactment, the Secretary  
2 shall submit to Congress a report containing a  
3 description of the information submitted under  
4 paragraph (3)(A)(i) during—

5 “(i) in the case of the first such re-  
6 port, the fourth plan year beginning after  
7 the date of the enactment of this sub-  
8 section; and

9 “(ii) in the case of a subsequent re-  
10 port, the 2 plan years preceding the year  
11 of the submission of such report.”.

12 (b) ENSURING TIMELY RESPONSES FOR ALL PRIOR  
13 AUTHORIZATION REQUESTS SUBMITTED UNDER PART  
14 C.—Section 1852(g) of the Social Security Act (42 U.S.C.  
15 1395w–22(g)) is amended—

16 (1) in paragraph (1)(A), by inserting “and in  
17 accordance with paragraph (6)” after “paragraph  
18 (3)”;

19 (2) in paragraph (3)(B)(iii), by inserting “(or,  
20 subject to subsection (o), with respect to prior au-  
21 thorization requests submitted on or after the first  
22 day of the third plan year beginning after the date  
23 of the enactment of the Health Care Price Trans-  
24 parency Act of 2023, not later than 24 hours)” after  
25 “72 hours”.

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

3           “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-  
4 THORIZATION REQUESTS.—Subject to paragraph (3)  
5 and subsection (o), in the case of an organization  
6 determination made with respect to a prior author-  
7 ization request for an item or service to be furnished  
8 to an individual submitted on or after the first day  
9 of the third plan year beginning after the date of the  
10 enactment of this paragraph, the organization shall  
11 notify the enrollee (and the physician involved, as  
12 appropriate) of such determination no later than 7  
13 days (or such shorter timeframe as the Secretary  
14 may specify through notice and comment rule-  
15 making, taking into account enrollee and stakeholder  
16 feedback) after receipt of such request.”.

17       (c) RULE OF CONSTRUCTION.—None of the amend-  
18 ments made by this section may be construed to affect  
19 the finalization of the proposed rule entitled “Medicare  
20 and Medicaid Programs; Patient Protection and Afford-  
21 able Care Act; Advancing Interoperability and Improving  
22 Prior Authorization Processes for Medicare Advantage Or-  
23 ganizations, Medicaid Managed Care Plans, State Med-  
24 icaid Agencies, Children’s Health Insurance Program  
25 (CHIP) Agencies and CHIP Managed Care Entities,

1 Issuers of Qualified Health Plans on the Federally Facili-  
2 tated Exchanges, Merit-Based Incentive Payment System  
3 (MIPS) Eligible Clinicians, and Eligible Hospitals and  
4 Critical Access Hospitals in the Medicare Promoting  
5 Interoperability Program” published on December 13,  
6 2022 (87 Fed. Reg. 76238), or application of such rule  
7 so finalized, for plan years before the third plan year be-  
8 ginning on or after the date of the enactment of this Act.

9 (d) FUNDING.—The Secretary of Health and Human  
10 Services shall provide for the transfer, from the Federal  
11 Hospital Insurance Trust Fund established under section  
12 1817 of the Social Security Act (42 U.S.C. 1395i) and  
13 the Federal Supplementary Medical Insurance Trust  
14 Fund established under section 1841 of such Act (42  
15 U.S.C. 1395t) (in such proportion as determined appro-  
16 priate by the Secretary) to the Centers for Medicare &  
17 Medicaid Services Program Management Account, of  
18 \$25,000,000 for fiscal year 2024, to remain available until  
19 expended, for purposes of carrying out the amendments  
20 made by this section.

21 **SEC. 302. EXTENSION OF CERTAIN DIRECT SPENDING RE-**  
22 **DUCTIONS.**

23 Section 251A(6)(D) of the Balanced Budget and  
24 Emergency Deficit Control Act of 1985 (2 U.S.C.  
25 901a(6)(D)) is amended—

1           (1) in clause (i), by striking “; and” and insert-  
2           ing a semicolon;

3           (2) in clause (ii), by striking “second 6 months  
4           in which such order is effective for such fiscal year,  
5           the payment reduction shall be 0 percent.” and in-  
6           serting “2 month period beginning on the day after  
7           the last day of the period described in clause (i) in  
8           which such order is effective for such fiscal year, the  
9           payment reduction shall be 1.5 percent; and”;

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

12                       “(iii) with respect to the last 4  
13                       months in which such order is effective for  
14                       such fiscal year, the payment reduction  
15                       shall be 0 percent.”.

