

119TH CONGRESS
2D SESSION

H. R. 9645

To promote health care price transparency, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 13, 2026

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

A BILL

To promote health care price transparency, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Care Price Cer-
5 tainty for All Americans Act”.

1 **SEC. 2. REQUIRING CERTAIN FACILITIES UNDER THE MEDI-**
2 **CARE PROGRAM TO DISCLOSE CERTAIN IN-**
3 **FORMATION RELATING TO CHARGES AND**
4 **PRICES.**

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

8 **“SEC. 1899D. HEALTH CARE PROVIDER PRICE TRANS-**
9 **PARENCY.**

10 “(a) HOSPITALS.—

11 “(1) IN GENERAL.—Beginning January 1,
12 2027, each specified hospital that receives payment
13 under this title for furnishing items and services
14 shall comply with the price transparency require-
15 ment described in paragraph (2).

16 “(2) REQUIREMENT DESCRIBED.—

17 “(A) IN GENERAL.—For purposes of para-
18 graph (1), the price transparency requirement
19 described in this paragraph is, with respect to
20 a specified hospital, that such hospital—

21 “(i) in accordance with a method and
22 format established by the Secretary under
23 subparagraph (C), compile and make pub-
24 lic (without subscription and free of
25 charge), and update not less frequently
26 than annually (or at such greater fre-

1 quency as may be specified by the Sec-
2 retary)—

3 “(I) all of the hospital’s standard
4 charges (including the information de-
5 scribed in subparagraph (B)) for each
6 item and service furnished by such
7 hospital;

8 “(II) information—

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

24 “(bb) that includes, with re-
25 spect to each Centers for Medi-

1 care & Medicaid Services-speci-
2 fied shoppable service that is not
3 furnished by the hospital, an in-
4 dication that such service is not
5 so furnished;

6 “(ii) post in a publicly accessible loca-
7 tion of such hospital (in a form and man-
8 ner specified by the Secretary) the dis-
9 counted cash price, as applicable, expressed
10 as a dollar amount, for each Centers for
11 Medicare & Medicaid Services-specified
12 shoppable service that is furnished by the
13 hospital when provided in, as applicable,
14 the inpatient setting and outpatient de-
15 partment setting (or, in the case no dis-
16 counted cash price is available for such
17 service, the median cash price charged by
18 the hospital to self-pay individuals for such
19 service when provided in such settings for
20 the previous three years, expressed as a
21 dollar amount); and

22 “(iii) submit to the Secretary (in a
23 form and manner specified by the Sec-
24 retary and on an annual basis) an attesta-
25 tion, signed by the chief executive officer,

1 chief financial officer, or other comparable
2 official (as specified by the Secretary) of
3 such hospital, that all information made
4 public pursuant to this subparagraph is
5 complete and accurate.

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

12 “(i) A plain language description (as
13 specified by the Secretary) of each item or
14 service, accompanied by, as applicable,
15 commonly recognized billing code sets, in-
16 cluding the Healthcare Common Procedure
17 Coding System code, the diagnosis-related
18 group, the national drug code, or other ap-
19 plicable identifier determined appropriate
20 by the Secretary.

21 “(ii) For each such item or service
22 when provided in, as applicable, the inpa-
23 tient and outpatient department settings—

24 “(I) the gross charge, as applica-
25 ble, expressed as a dollar amount;

1 “(II) each payer-specific nego-
2 tiated charge in effect between such
3 hospital and a third party payer, ex-
4 pressed as a dollar amount;

5 “(III) the deidentified maximum
6 and minimum payer-specific nego-
7 tiated charges in effect between such
8 hospital and any third party payer;
9 and

10 “(IV) the discounted cash price,
11 as applicable, expressed as a dollar
12 amount (or, in the case no discounted
13 cash price is available for such item or
14 service, the median cash price charged
15 by the hospital (not including charity
16 care) to self-pay individuals for such
17 item or service when provided in such
18 settings for the previous three years,
19 expressed as a dollar amount).

20 “(iii) With respect to prices made
21 public pursuant to subparagraph (A)(ii), a
22 link to a consumer-friendly document that
23 clearly explains the hospital’s charity care
24 policy that includes, if applicable, any slid-

1 ing scale payment structure employed for
2 determining prices.

3 “(iv) Any other additional information
4 the Secretary may require (in consultation
5 with stakeholders) for the purpose of im-
6 proving the accuracy of, or enabling con-
7 sumers to easily understand and compare,
8 standard charges and prices for an item or
9 service (which may include, in the case
10 that charges described in clause (iii) for an
11 item or service are unable to be expressed
12 as a dollar amount, such information relat-
13 ing to past allowed charges for such item
14 or service as may be specified by the Sec-
15 retary), except information that is dupli-
16 cative of any other reporting requirement
17 under this subsection.

18 In the case of standard charges and prices for
19 an item or service included as part of a bun-
20 dled, per diem, episodic, or other similar ar-
21 rangement, the information described in this
22 subparagraph shall be made available as deter-
23 mined appropriate by the Secretary.

24 “(C) UNIFORM METHOD AND FORMAT.—

25 Not later than January 1, 2028, the Secretary

1 shall establish a standard, uniform method and
2 format for specified hospitals to use in com-
3 piling and making public standard charges pur-
4 suant to subparagraph (A)(i)(I) and a stand-
5 ard, uniform method and format for such hos-
6 pitals to use in compiling and making public
7 prices pursuant to subparagraph (A)(i)(II).
8 Such methods and formats—

9 “(i) shall, in the case of such method
10 and format for making public—

11 “(I) standard charges pursuant
12 to subparagraph (A)(i)(I), ensure that
13 such charges are made available in a
14 machine-readable format (or a suc-
15 cessor technology specified by the Sec-
16 retary); and

17 “(II) prices pursuant to subpara-
18 graph (A)(i)(II), ensure that such
19 prices are made available in a con-
20 sumer-friendly format (as specified by
21 the Secretary);

22 “(ii) may be similar to any template
23 made available by the Centers for Medicare
24 & Medicaid Services as of the date of the
25 enactment of this subparagraph;

1 “(iii) shall meet such standards as de-
2 termined appropriate by the Secretary in
3 order to ensure the accessibility and
4 usability of such charges and prices; and

5 “(iv) shall be updated as determined
6 appropriate by the Secretary, in consulta-
7 tion with stakeholders.

8 “(D) DEEMED COMPLIANCE WITH
9 SHOPPABLE SERVICES REQUIREMENT FOR HOS-
10 PITALS WITH A PRICE ESTIMATOR TOOL.—

11 “(i) IN GENERAL.—Before the effec-
12 tive date of regulations implementing the
13 provisions of sections 2799A–1(f) and
14 2799B–6 of the Public Health Service Act
15 (relating to advanced explanations of bene-
16 fits), including regulations on establishing
17 data transfer standards to effectuate such
18 provisions, a specified hospital shall be
19 deemed to have compiled and made public
20 information described in subparagraph
21 (A)(i)(II) (relating to shoppable services)
22 in accordance with a method and format
23 specified by the Secretary under subpara-
24 graph (C) if such hospital maintains a
25 price estimator tool described in clause (ii).

1 “(ii) PRICE ESTIMATOR TOOL DE-
2 SCRIBED.—For purposes of clause (i), a
3 price estimator tool described in this sub-
4 paragraph is, with respect to a specified
5 hospital, a tool that meets the following re-
6 quirements:

7 “(I) Such tool allows an indi-
8 vidual to immediately obtain a price
9 estimate (taking into account whether
10 such individual is covered under any
11 plan, coverage, or program described
12 in subclause (IV)(cc)) and the dis-
13 counted cash price charged by a speci-
14 fied hospital for each Centers for
15 Medicare & Medicaid Services-speci-
16 fied shoppable service that is fur-
17 nished by such hospital, and for each
18 additional shoppable service as such
19 hospital may select, such that price
20 estimates are available through such
21 tool for at least 300 shoppable serv-
22 ices (or for all such services, if such
23 hospital furnishes fewer than 300
24 shoppable services).

1 “(II) Such tool allows an indi-
2 vidual to obtain such an estimate by
3 billing code and by service description.

4 “(III) Such tool is prominently
5 displayed on the public internet
6 website of such hospital.

7 “(IV) Such tool does not require
8 an individual seeking such an estimate
9 to create an account or otherwise
10 input personal information, except
11 that such tool may require that such
12 individual provide information speci-
13 fied by the Secretary, which may in-
14 clude the following:

15 “(aa) The name of such in-
16 dividual.

17 “(bb) The date of birth of
18 such individual.

19 “(cc) In the case such indi-
20 vidual is covered under a group
21 health plan, group or individual
22 health insurance coverage, a Fed-
23 eral health care program, or the
24 program established under chap-
25 ter 89 of title 5, United States

1 Code, an identifying number as-
2 signed by such plan, coverage, or
3 program to such individual.

4 “(dd) In the case of an indi-
5 vidual described in item (cc), an
6 indication as to whether such in-
7 dividual is the primary insured
8 individual under such plan, cov-
9 erage, or program (and, if such
10 individual is not the primary in-
11 sured individual, a description of
12 the individual’s relationship to
13 such primary insured individual).

14 “(ee) Any other information
15 specified by the Secretary.

16 “(V) Such tool contains a state-
17 ment confirming the accuracy and
18 completeness of information presented
19 through such tool as of the date such
20 request is made.

21 “(VI) Such tool meets any other
22 requirement specified by the Sec-
23 retary.

24 “(3) MONITORING COMPLIANCE.—The Sec-
25 retary shall establish processes to monitor and as-

1 sess specified hospitals’ compliance with this sub-
2 section. Such processes shall ensure that each speci-
3 fied hospital’s compliance with this subsection is re-
4 viewed not less frequently than once every 3 years
5 and include processes relating to the following:

6 “(A) The evaluation and analysis of com-
7 plaints made by individuals or other entities re-
8 lating to such hospitals’ compliance with this
9 subsection.

10 “(B) The use of audits to ensure such hos-
11 pitals’ compliance with this subsection.

12 “(C) The obtaining of additional informa-
13 tion from such hospitals to determine such hos-
14 pitals’ compliance with this subsection (as de-
15 termined appropriate by the Secretary).

16 “(4) ENFORCEMENT.—

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

20 “(i) not later than 30 days after the
21 date on which the Secretary determines
22 such failure exists, the Secretary shall sub-
23 mit to such hospital a notification of such
24 determination (which may include, as de-
25 termined appropriate by the Secretary, a

1 request for a corrective action plan (to be
2 submitted not later than 45 days after
3 such request is made) to comply with such
4 requirements); and

5 “(ii) in the case of a hospital that
6 does not receive a request for a corrective
7 action plan as part of a notification sub-
8 mitted by the Secretary under clause (i)—

9 “(I) the Secretary shall, not later
10 than 60 days after such notification is
11 sent, determine whether such hospital
12 is in compliance with such require-
13 ments; and

14 “(II) if the Secretary determines
15 under subclause (I) that such hospital
16 is not in compliance with such re-
17 quirements, the Secretary shall ei-
18 ther—

19 “(aa) submit to such hos-
20 pital a request for a corrective
21 action plan (to be submitted not
22 later than 45 days after such re-
23 quest is made) to comply with
24 such requirements; or

1 “(bb) if the Secretary deter-
2 mines that such hospital has not
3 taken meaningful actions to come
4 into compliance since such notifi-
5 cation was sent, impose a civil
6 monetary penalty in accordance
7 with subparagraph (B).

8 “(B) CIVIL MONETARY PENALTY.—

9 “(i) IN GENERAL.—Subject to clause
10 (vii), in addition to any other enforcement
11 actions or penalties that may apply under
12 another provision of Federal law, a speci-
13 fied hospital that has received a request
14 for a corrective action plan under clause (i)
15 or (ii) of subparagraph (A) and fails to
16 comply with the requirements of this sub-
17 section by the date that is 90 days after
18 such request is made (or, if such hospital
19 has submitted such a corrective action plan
20 not later than 45 days after the date such
21 request was made, by the date that is 90
22 days after the date of the submission of
23 such corrective action plan), and a speci-
24 fied hospital with respect to which the Sec-
25 retary has made a determination described

1 in clause (ii)(II)(bb) of such subparagraph,
2 shall be subject to a civil monetary penalty
3 of an amount specified by the Secretary for
4 each day (beginning with the day on which
5 the Secretary first determined that such
6 hospital was not complying with such re-
7 quirements) during which such failure was
8 ongoing. Such amount shall not exceed—

9 “(I) in the case of a specified
10 hospital with 30 or fewer beds, \$342
11 per day;

12 “(II) in the case of a specified
13 hospital with more than 30 beds but
14 fewer than 550 beds, \$11 per bed per
15 day; and

16 “(III) in the case of a specified
17 hospital with 550 beds or more,
18 \$6,277 per day.

19 “(ii) INCREASE AUTHORITY.—In ap-
20 plying this subparagraph with respect to
21 failures to comply occurring in 2029 or a
22 subsequent year, the Secretary may
23 through notice and comment rulemaking
24 increase—

1 “(I) the limitation on the per day
2 amount of any penalty applicable to a
3 specified hospital under subclause (I)
4 or (III) of clause (i);

5 “(II) the limitations on the per
6 bed per day amount of any penalty
7 applicable under clause (i)(II); and

8 “(III) the amounts specified in
9 clause (iii)(II).

10 “(iii) PERSISTENT NONCOMPLI-
11 ANCE.—

12 “(I) IN GENERAL.—In the case
13 of a specified hospital (other than a
14 specified hospital with 30 or fewer
15 beds) that the Secretary has deter-
16 mined to be knowingly and willfully
17 noncompliant with the provisions of
18 this subsection for two or more 6-
19 month periods during any 3-year pe-
20 riod, the Secretary may increase any
21 penalty otherwise applicable under
22 this subparagraph by the amount
23 specified in subclause (II) with respect
24 to such hospital and may require such
25 hospital to complete such additional

1 corrective actions plans as the Sec-
2 retary may specify.

3 “(II) SPECIFIED AMOUNT.—For
4 purposes of subclause (I), the amount
5 specified in this subclause is, with re-
6 spect to a specified hospital—

7 “(aa) with more than 30
8 beds but fewer than 101 beds, an
9 amount that is not less than
10 \$500,000 and not more than
11 \$1,000,000;

12 “(bb) with more than 100
13 beds but fewer than 301 beds, an
14 amount that is greater than
15 \$1,000,000 and not more than
16 \$2,000,000;

17 “(cc) with more than 300
18 beds but fewer than 501 beds, an
19 amount that is greater than
20 \$2,000,000 and not more than
21 \$4,000,000; and

22 “(dd) with more than 500
23 beds, and amount that is not less
24 than \$5,000,000 and not more
25 than \$10,000,000.

1 “(iv) AUTHORITY TO WAIVE OR RE-
2 DUCE PENALTY.—

3 “(I) IN GENERAL.—Subject to
4 subclause (II), the Secretary may
5 waive any penalty, or reduce any pen-
6 alty by not more than 75 percent, oth-
7 erwise applicable under this subpara-
8 graph with respect to a specified hos-
9 pital located in a rural area (as de-
10 fined by the Federal Office of Rural
11 Health Policy for the purpose of rural
12 health grant programs administered
13 by such Office) or an underserved
14 area if the Secretary determines that
15 imposition of such penalty would re-
16 sult in an immediate threat to access
17 to care for individuals in the service
18 area of such hospital.

19 “(II) LIMITATION ON APPLICA-
20 TION.—The Secretary may not elect
21 to waive a penalty under subclause (I)
22 with respect to a specified hospital
23 more than once in a 6-year period and
24 may not elect to reduce such a penalty
25 with respect to such a hospital more

1 than once in such a period. Nothing
2 in the preceding sentence shall be con-
3 strued as prohibiting the Secretary
4 from both waiving and reducing a
5 penalty with respect to a specified
6 hospital during a 6-year period.

7 “(v) HARDSHIP EXEMPTION.—Not-
8 withstanding any limit on the waiver or re-
9 duction of a penalty under clause (iv), the
10 Secretary may waive any penalty with re-
11 spect to a specified hospital on a case-by-
12 case basis if the Secretary determines that
13 a circumstance exists interfering with such
14 hospital’s ability to comply with the provi-
15 sions of this subsection (such as a natural
16 disaster (as defined in section 602(a) of
17 the Robert T. Stafford Disaster Relief and
18 Emergency Assistance Act), a public health
19 emergency, or other unique or unexpected
20 event).

21 “(vi) PROVISION OF TECHNICAL AS-
22 SISTANCE.—The Secretary shall, to the ex-
23 tent practicable, provide technical assist-
24 ance relating to compliance with the provi-

sions of this subsection to specified hospitals requesting such assistance.

“(vii) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

“(C) PUBLICATION OF HOSPITAL PRICE TRANSPARENCY INFORMATION.—Beginning on January 1, 2028, the Secretary shall make publicly available on the website of the Centers for Medicare & Medicaid Services information with respect to compliance with the requirements of this subsection and enforcement activities undertaken by the Secretary under this subsection. Such information shall be updated in real time (if practicable) and include—

“(i) the number of reviews of compliance with this subsection undertaken by the Secretary;

1 “(ii) the number of notifications de-
2 scribed in subparagraph (A)(i) sent by the
3 Secretary;

4 “(iii) the identity of each specified
5 hospital that was sent such a notification
6 and a description of the nature of such
7 hospital’s noncompliance with this sub-
8 section;

9 “(iv) the amount of any civil monetary
10 penalty imposed on such hospital under
11 subparagraph (B);

12 “(v) whether such hospital subse-
13 quently came into compliance with this
14 subsection;

15 “(vi) any waivers or reductions of
16 penalties made pursuant to a certification
17 by the Secretary under subparagraph
18 (B)(iv), including—

19 “(I) the name of any specified
20 hospital that received such a waiver or
21 reduction;

22 “(II) the dollar amount of each
23 such penalty so waived or reduced;
24 and

1 “(III) the rationale for the grant-
2 ing of each such waiver or reduction,
3 but only to the extent that such ra-
4 tionale does not make public commer-
5 cially sensitive information; and
6 “(vii) any other information as deter-
7 mined by the Secretary.

8 “(b) CLINICAL DIAGNOSTIC LABORATORY SERV-
9 ICES.—

10 “(1) IN GENERAL.—Beginning January 1,
11 2028, any applicable laboratory that receives pay-
12 ment under this title for furnishing any specified
13 clinical diagnostic laboratory test under this title
14 shall—

15 “(A) make publicly available, in accordance
16 with a method and format established by the
17 Secretary under paragraph (3), the information
18 described in paragraph (2) with respect to each
19 such specified clinical diagnostic laboratory test
20 that such laboratory so furnishes;

21 “(B) update such information not less fre-
22 quently than annually (or at such greater fre-
23 quency as the Secretary may specify);

24 “(C) submit to the Secretary on an annual
25 basis an attestation, signed by the chief execu-

1 tive officer, chief financial officer, or other com-
2 parable official (as specified by the Secretary)
3 of such laboratory, that all such information is
4 complete and accurate; and

5 “(D) post in a publicly accessible location
6 of such laboratory (in a form and manner speci-
7 fied by the Secretary) the discounted cash price,
8 as applicable, expressed as a dollar amount, for
9 each Centers for Medicare & Medicaid Services-
10 specified shoppable service that is furnished by
11 the laboratory (or, in the case no discounted
12 cash price is available for such service, the me-
13 dian cash price charged by the laboratory to
14 self-pay individuals for such service for the pre-
15 vious three years, expressed as a dollar
16 amount).

17 “(2) INFORMATION DESCRIBED.—For purposes
18 of paragraph (1), the information described in this
19 paragraph is, with respect to an applicable labora-
20 tory and a specified clinical diagnostic laboratory
21 test, the discounted cash price for such test (or, if
22 no such price exists, the gross charge for such test).

23 “(3) UNIFORM METHOD AND FORMAT.—Not
24 later than January 1, 2028, the Secretary shall es-
25 tablish a standard, uniform method and format for

1 applicable laboratories to use in compiling and mak-
2 ing public information pursuant to paragraph (1).
3 Such method and format—

4 “(A) may be similar to any template made
5 available by the Centers for Medicare & Med-
6 icaid Services (as described in subsection
7 (a)(2)(C)(ii));

8 “(B) shall meet such standards as deter-
9 mined appropriate by the Secretary in order to
10 ensure the accessibility and usability of such in-
11 formation; and

12 “(C) shall be updated as determined ap-
13 propriate by the Secretary, in consultation with
14 stakeholders.

15 “(4) INCLUSION OF ANCILLARY SERVICES.—

16 Any price or charge for a specified clinical diagnostic
17 laboratory test furnished by an applicable laboratory
18 made publicly available in accordance with para-
19 graph (1) shall include the price or charge (as appli-
20 cable) for any ancillary item or service (such as
21 specimen collection services) that would normally be
22 furnished by such laboratory as part of such test, as
23 specified by the Secretary.

24 “(5) MONITORING COMPLIANCE.—The Sec-
25 retary shall, through notice and comment rule-

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

3 “(6) ENFORCEMENT.—

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

8 “(i) not later than 30 days after such
9 determination, the Secretary shall notify
10 such laboratory of such determination
11 (which may include, as determined appro-
12 priate by the Secretary, a request for a
13 corrective action plan (to be submitted not
14 later than 45 days after such request is
15 made)); and

16 “(ii) in the case of a laboratory that
17 does not receive a request for a corrective
18 action plan as part of a notification under
19 clause (i)—

20 “(I) the Secretary shall, not later
21 than 90 days after such notification is
22 sent, determine whether such labora-
23 tory is in compliance with such re-
24 quirements; and

1 “(II) if the Secretary determines
2 under subclause (I) that such labora-
3 tory is not in compliance with such re-
4 quirements, the Secretary shall ei-
5 ther—

6 “(aa) submit to such labora-
7 tory a request for a corrective ac-
8 tion plan (to be submitted not
9 later than 45 days after such re-
10 quest is made) to comply with
11 such requirements; or

12 “(bb) if the Secretary deter-
13 mines that such laboratory has
14 not taken meaningful actions to
15 come into compliance since such
16 notification was sent, impose a
17 civil monetary penalty in accord-
18 ance with subparagraph (B).

19 “(B) CIVIL MONETARY PENALTY.—An ap-
20 plicable laboratory that has received a request
21 for a corrective action plan under clause (i) or
22 (ii) of subparagraph (A) and fails to comply
23 with the requirements of paragraph (1) by the
24 date that is 90 days after such request is made,
25 and an applicable laboratory with respect to

1 which the Secretary has made a determination
2 described in clause (ii)(II)(bb) of such subpara-
3 graph, shall be subject to a civil monetary pen-
4 alty in an amount not to exceed \$300 for each
5 day (beginning with the day on which the Sec-
6 retary first determined that such hospital was
7 not complying with such requirements) during
8 which such failure was ongoing.

9 “(C) INCREASE AUTHORITY.—In applying
10 this paragraph with respect to failures to com-
11 ply occurring in 2029 or a subsequent year, the
12 Secretary may through notice and comment
13 rulemaking increase the per day limitation on
14 civil monetary penalties under subparagraph
15 (B).

16 “(D) APPLICATION OF CERTAIN PROVI-
17 SIONS.—The provisions of section 1128A (other
18 than subsections (a) and (b) of such section)
19 shall apply to a civil monetary penalty imposed
20 under this paragraph in the same manner as
21 such provisions apply to a civil monetary pen-
22 alty imposed under subsection (a) of such sec-
23 tion.

24 “(E) AUTHORITY TO WAIVE OR REDUCE
25 PENALTY.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), the Secretary may waive or reduce any
3 penalty otherwise applicable with respect to
4 an applicable laboratory under this para-
5 graph if the Secretary determines that im-
6 position of such penalty would result in an
7 immediate threat to access to care for indi-
8 viduals in the service area of such labora-
9 tory.

10 “(ii) LIMITATION.—The Secretary
11 may not elect to waive or reduce a penalty
12 under clause (i) with respect to an applica-
13 ble laboratory more than 3 times in a 10
14 year period.

15 “(F) HARDSHIP EXEMPTION.—Notwith-
16 standing any limit on the waiver or reduction of
17 a penalty under subparagraph (E), the Sec-
18 retary may waive any penalty with respect to an
19 applicable laboratory on a case-by-case basis if
20 the Secretary determines that a circumstance
21 exists interfering with such laboratory’s ability
22 to comply with the provisions of this subsection
23 (such as a natural disaster (as defined in sec-
24 tion 602(a) of the Robert T. Stafford Disaster
25 Relief and Emergency Assistance Act), a public

1 health emergency, or other unique or unex-
2 pected event).

3 “(7) PROVISION OF TECHNICAL ASSISTANCE.—

4 The Secretary shall, to the extent practicable, pro-
5 vide technical assistance relating to compliance with
6 the provisions of this subsection to applicable labora-
7 tories requesting such assistance.

8 “(8) 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 a successor
13 regulation), except that such term does not in-
14 clude a laboratory with respect to which stand-
15 ard charges and prices for specified clinical di-
16 agnostic laboratory tests furnished by such lab-
17 oratory are made available by—

18 “(i) a specified hospital pursuant to
19 subsection (a); or

20 “(ii) an ambulatory surgical center
21 pursuant to subsection (d).

22 “(B) SPECIFIED CLINICAL DIAGNOSTIC
23 LABORATORY TEST.—the term ‘specified clinical
24 diagnostic laboratory test’ means a clinical di-
25 agnostic laboratory test that is included on the

1 list of shoppable services specified by the Cen-
2 ters for Medicare & Medicaid Services (as de-
3 scribed in subsection (a)(2)(A)(i)(II)), other
4 than an advanced diagnostic laboratory test (as
5 defined in section 1834A(d)(5)).

6 “(c) IMAGING SERVICES.—

7 “(1) IN GENERAL.—Beginning January 1,
8 2028, each provider of services and supplier that re-
9 ceives payment under this title for furnishing a spec-
10 ified imaging service, other than such a provider or
11 supplier with respect to which standard charges and
12 prices for such services furnished by such provider
13 or supplier are made available by a specified hospital
14 pursuant to subsection (a) or an ambulatory surgical
15 center pursuant to subsection (d), shall—

16 “(A) make publicly available, in accordance
17 with a method and format established by the
18 Secretary under paragraph (3), the information
19 described in paragraph (2) with respect to each
20 such service that such provider of services or
21 supplier furnishes;

22 “(B) updated such information not less
23 frequently than annually (or at such greater
24 frequency as the Secretary may specify);

1 “(C) submit to the Secretary on an annual
2 basis an attestation, signed by the chief execu-
3 tive officer, chief financial officer, or other com-
4 parable official (as specified by the Secretary)
5 of such provider or supplier, that all such infor-
6 mation is complete and accurate; and

7 “(D) post in a publicly accessible location
8 of such provider or supplier (in a form and
9 manner specified by the Secretary) the dis-
10 counted cash price, as applicable, expressed as
11 a dollar amount, for each Centers for Medicare
12 & Medicaid Services-specified shoppable service
13 that is furnished by the provider or supplier
14 (or, in the case no discounted cash price is
15 available for such service, the median cash price
16 charged by the provider or supplier to self-pay
17 individuals for such service for the previous
18 three years, expressed as a dollar amount).

19 “(2) INFORMATION DESCRIBED.—For purposes
20 of paragraph (1), the information described in this
21 paragraph is, with respect to a provider of services
22 or supplier and a specified imaging service, the dis-
23 counted cash price for such service (or, if no such
24 price exists, the gross charge for such service).

1 “(3) UNIFORM METHOD AND FORMAT.—Not
2 later than January 1, 2028, the Secretary shall es-
3 tablish a standard, uniform method and format for
4 providers of services and suppliers to use in making
5 public information described in paragraph (2). Any
6 such method and format—

7 “(A) may be similar to any template made
8 available by the Centers for Medicare & Med-
9 icaid Services (as described in subsection
10 (a)(2)(C)(ii));

11 “(B) shall meet such standards as deter-
12 mined appropriate by the Secretary in order to
13 ensure the accessibility and usability of such in-
14 formation; and

15 “(C) shall be updated as determined ap-
16 propriate by the Secretary, in consultation with
17 stakeholders.

18 “(4) MONITORING COMPLIANCE.—The Sec-
19 retary shall, through notice and comment rule-
20 making, establish a process to monitor compliance
21 with this subsection.

22 “(5) ENFORCEMENT.—

23 “(A) IN GENERAL.—In the case that the
24 Secretary determines that a provider of services

1 or supplier is not in compliance with the re-
2 quirements of paragraph (1)—

3 “(i) not later than 30 days after such
4 determination, the Secretary shall notify
5 such provider or supplier of such deter-
6 mination (which may include, as deter-
7 mined appropriate by the Secretary, a re-
8 quest for a corrective action plan (to be
9 submitted not later than 45 days after
10 such request is made)); and

11 “(ii) in the case of a provider of serv-
12 ices or supplier that does not receive a re-
13 quest for a corrective action plan as part
14 of a notification under clause (i)—

15 “(I) the Secretary shall, not later
16 than 90 days after such notification is
17 sent, determine whether such provider
18 or supplier is in compliance with such
19 requirements; and

20 “(II) if the Secretary determines
21 under subclause (I) that such provider
22 or supplier is not in compliance with
23 such requirements, the Secretary shall
24 either—

1 “(aa) submit to such pro-
2 vider or supplier a request for a
3 corrective action plan (to be sub-
4 mitted not later than 45 days
5 after such request is made) to
6 comply with such requirements;
7 or

8 “(bb) if the Secretary deter-
9 mines that such provider or sup-
10 plier has not taken meaningful
11 actions to come into compliance
12 since such notification was sent,
13 impose a civil monetary penalty
14 in accordance with subparagraph
15 (B).

16 “(B) CIVIL MONETARY PENALTY.—A pro-
17 vider of services or supplier that has received a
18 request for a corrective action plan under clause
19 (i) or (ii) of subparagraph (A) and fails to com-
20 ply with the requirements of paragraph (1) by
21 the date that is 90 days after such request is
22 made, and a provider of services or supplier
23 with respect to which the Secretary has made
24 a determination described in clause (ii)(II)(bb)
25 of such subparagraph, shall be subject to a civil

1 monetary penalty in an amount not to exceed
2 \$300 for each day (beginning with the day on
3 which the Secretary first determined that such
4 provider or supplier was not complying with
5 such requirements) during which such failure
6 was ongoing.

7 “(C) INCREASE AUTHORITY.—In applying
8 this paragraph with respect to failures to com-
9 ply occurring in 2029 or a subsequent year, the
10 Secretary may through notice and comment
11 rulemaking increase the amount of the civil
12 monetary penalty under subparagraph (B).

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

21 “(E) AUTHORITY TO WAIVE OR REDUCE
22 PENALTY.—

23 “(i) IN GENERAL.—Subject to clause
24 (ii), the Secretary may waive or reduce any
25 penalty otherwise applicable with respect to

1 a provider of services or supplier under
2 this paragraph if the Secretary determines
3 that imposition of such penalty would re-
4 sult in an immediate threat to access to
5 care for individuals in the service area of
6 such provider or supplier.

7 “(ii) LIMITATION.—The Secretary
8 may not elect to waive or reduce a penalty
9 under clause (i) with respect to a specific
10 provider of services or supplier more than
11 3 times in a 10 year period.

12 “(F) HARDSHIP EXEMPTION.—Notwith-
13 standing any limit on the waiver or reduction of
14 a penalty under subparagraph (E), the Secretary
15 may waive any penalty with respect to a pro-
16 vider of services or supplier on a case-by-case
17 basis if the Secretary determines that a cir-
18 cumstance exists interfering with such pro-
19 vider’s or supplier’s ability to comply with the
20 provisions of this subsection (such as a natural
21 disaster (as defined in section 602(a) of the
22 Robert T. Stafford Disaster Relief and Emer-
23 gency Assistance Act), a public health emer-
24 gency, or other unique or unexpected event).

1 “(G) PROVISION OF TECHNICAL ASSIST-
 2 ANCE.—The Secretary shall, to the extent prac-
 3 ticable, provide technical assistance relating to
 4 compliance with the provisions of this sub-
 5 section to providers of services and suppliers re-
 6 questing such assistance.

7 “(6) DEFINITION.—In this subsection, the term
 8 ‘specified imaging service’ means an imaging service
 9 that is included on the list of Centers for Medicare
 10 & Medicaid Services-specified shoppable services (as
 11 described in subsection (a)(i)(II)).

12 “(d) AMBULATORY SURGICAL CENTERS.—

13 “(1) IN GENERAL.—Beginning January 1,
 14 2028, each ambulatory surgical center that receives
 15 payment under this title for furnishing items and
 16 services shall comply with the price transparency re-
 17 quirement described in paragraph (2).

18 “(2) REQUIREMENT DESCRIBED.—

19 “(A) IN GENERAL.—For purposes of para-
 20 graph (1), the price transparency requirement
 21 described in this subsection is, with respect to
 22 an ambulatory surgical center, that such cen-
 23 ter—

24 “(i) in accordance with a method and
 25 format established by the Secretary under

1 subparagraph (C), compile and make pub-
2 lic (without subscription and free of
3 charge), and update not less frequently
4 than annually (or at such greater fre-
5 quency as may be specified by the Sec-
6 retary)—

7 “(I) all of the ambulatory sur-
8 gical center’s standard charges (in-
9 cluding the information described in
10 subparagraph (B)) for each item and
11 service furnished by such surgical cen-
12 ter;

13 “(II) information on the ambula-
14 tory surgical center’s prices (including
15 the information described in subpara-
16 graph (B)) for as many of the Centers
17 for Medicare & Medicaid Services-
18 specified shoppable services (as speci-
19 fied by the Secretary) that are fur-
20 nished by such surgical center, and as
21 many additional ambulatory surgical
22 center-selected shoppable services (or
23 all such additional services, if such
24 surgical center furnishes fewer than
25 300 shoppable services) as may be

1 necessary for a combined total of at
2 least 300 shoppable services; and

3 “(III) with respect to each Cen-
4 ters for Medicare & Medicaid Serv-
5 ices-specified shoppable service that is
6 not furnished by the ambulatory sur-
7 gical center, an indication that such
8 service is not so furnished;

9 “(ii) submit to the Secretary on an
10 annual basis an attestation, signed by the
11 chief executive officer, chief financial offi-
12 cer, or other comparable official (as speci-
13 fied by the Secretary) of such center, that
14 all information made public pursuant to
15 this subparagraph is complete and accu-
16 rate; and

17 “(iii) post in a publicly accessible loca-
18 tion of such center (in a form and manner
19 specified by the Secretary) the discounted
20 cash price, as applicable, expressed as a
21 dollar amount, for each Centers for Medi-
22 care & Medicaid Services-specified
23 shoppable service that is furnished by the
24 center (or, in the case no discounted cash
25 price is available for such service, the me-

1 dian cash price charged by the center to
2 self-pay individuals for such service for the
3 previous three years, expressed as a dollar
4 amount).

5 “(B) INFORMATION DESCRIBED.—For pur-
6 poses of subparagraph (A), the information de-
7 scribed in this subparagraph is, with respect to
8 standard charges and prices, as applicable,
9 made public by an ambulatory surgical center,
10 the following:

11 “(i) A plain language description (as
12 specified by the Secretary) of each item or
13 service, accompanied by, as applicable,
14 commonly recognized billing code sets, in-
15 cluding the Healthcare Common Procedure
16 Coding System code, the national drug
17 code, or other applicable identifier deter-
18 mined appropriate by the Secretary.

19 “(ii) For each such item or service—

20 “(I) the gross charge, as applica-
21 ble, expressed as a dollar amount;

22 “(II) each payer-specific nego-
23 tiated charge in effect between such
24 center and a third party payer, ex-
25 pressed as a dollar amount;

1 “(III) the deidentified maximum
2 and minimum payer-specific nego-
3 tiated charges in effect between such
4 center and any third party payer; and

5 “(IV) the discounted cash price,
6 as applicable, expressed as a dollar
7 amount (or, in the case no discounted
8 cash price is available for an item or
9 service, the median cash price charged
10 to self-pay individuals (not including
11 charity care) for such item or service
12 for the previous three years, expressed
13 as a dollar amount).

14 “(iii) Any other additional information
15 the Secretary may require (in consultation
16 with stakeholders) for the purpose of im-
17 proving the accuracy of, or enabling con-
18 sumers to easily understand and compare,
19 standard charges and prices for an item or
20 service, except information that is dupli-
21 cative of any other reporting requirement
22 under this subsection.

23 In the case of standard charges and prices for
24 an item or service included as part of a bun-
25 dled, per diem, episodic, or other similar ar-

1 rangement, the information described in this
2 subparagraph shall be made available as deter-
3 mined appropriate by the Secretary.

4 “(C) UNIFORM METHOD AND FORMAT.—

5 Not later than January 1, 2028, the Secretary
6 shall establish a standard, uniform method and
7 format for ambulatory surgical centers to use in
8 making public standard charges pursuant to
9 subparagraph (A)(i) and a standard, uniform
10 method and format for such centers to use in
11 making public prices pursuant to subparagraph
12 (A)(ii). Any such method and format—

13 “(i) shall, in the case of—

14 “(I) standard charges made pub-
15 lic by an ambulatory surgical center
16 under subparagraph (A)(i), ensure
17 that such charges are made available
18 in a machine-readable format (or suc-
19 cessor technology); and

20 “(II) prices made public by an
21 ambulatory surgical center under sub-
22 paragraph (A)(ii), ensure that such
23 prices are made available in a con-
24 sumer-friendly format (as specified by
25 the Secretary);

1 “(ii) may be similar to any template
 2 made available by the Centers for Medicare
 3 & Medicaid Services (as described in sub-
 4 section (a)(2)(C)(ii));

5 “(iii) shall meet such standards as de-
 6 termined appropriate by the Secretary in
 7 order to ensure the accessibility and
 8 usability of such charges and prices; and

9 “(iv) shall be updated as determined
 10 appropriate by the Secretary, in consulta-
 11 tion with stakeholders.

12 “(D) DEEMED COMPLIANCE WITH
 13 SHOPPABLE SERVICES REQUIREMENT FOR CEN-
 14 TERS WITH A PRICE ESTIMATOR TOOL.—

15 “(i) IN GENERAL.—Before the effec-
 16 tive date of regulations implementing the
 17 provisions of sections 2799A–1(f) and
 18 2799B–6 of the Public Health Service Act
 19 (relating to advanced explanations of bene-
 20 fits), including regulations on establishing
 21 data transfer standards to effectuate such
 22 provisions, a specified hospital shall be
 23 deemed to have compiled and made public
 24 information described in subparagraph
 25 (A)(i)(II) (relating to shoppable services)

1 in accordance with a method and format
2 specified by the Secretary under subpara-
3 graph (C) if such hospital maintains a
4 price estimator tool described in clause (ii).

5 “(ii) PRICE ESTIMATOR TOOL DE-
6 SCRIBED.—For purposes of clause (i), a
7 price estimator tool described in this sub-
8 paragraph is, with respect to an ambula-
9 tory surgical center, a tool that meets the
10 following requirements:

11 “(I) Such tool allows an indi-
12 vidual to immediately obtain a price
13 estimate (taking into account whether
14 such individual is covered under any
15 plan, coverage, or program described
16 in subclause (IV)(cc)) and the dis-
17 counted cash price charged by an am-
18 bulatory surgical center for each Cen-
19 ters for Medicare & Medicaid Serv-
20 ices-specified shoppable service that is
21 furnished by such center, and for each
22 additional shoppable service as such
23 center may select, such that price esti-
24 mates are available through such tool
25 for at least 300 shoppable services (or

1 for all such services, if such hospital
2 furnishes fewer than 300 shoppable
3 services).

4 “(II) Such tool allows an indi-
5 vidual to obtain such an estimate by
6 billing code and by service description.

7 “(III) Such tool is prominently
8 displayed on the public internet
9 website of such center.

10 “(IV) Such tool does not require
11 an individual seeking such an estimate
12 to create an account or otherwise
13 input personal information, except
14 that such tool may require that such
15 individual provide information speci-
16 fied by the Secretary, which may in-
17 clude the following:

18 “(aa) The name of such in-
19 dividual.

20 “(bb) The date of birth of
21 such individual.

22 “(cc) In the case such indi-
23 vidual is covered under a group
24 health plan, group or individual
25 health insurance coverage, a Fed-

1 eral health care program, or the
2 program established under chap-
3 ter 89 of title 5, United States
4 Code, an identifying number as-
5 signed by such plan, coverage, or
6 program to such individual.

7 “(dd) In the case of an indi-
8 vidual described in item (cc), an
9 indication as to whether such in-
10 dividual is the primary insured
11 individual under such plan, cov-
12 erage, or program (and, if such
13 individual is not the primary in-
14 sured individual, a description of
15 the individual’s relationship to
16 such primary insured individual).

17 “(ee) Any other information
18 specified by the Secretary.

19 “(V) Such tool contains a state-
20 ment confirming the accuracy and
21 completeness of information presented
22 through such tool as of the date such
23 request is made.

1 “(VI) Such tool meets any other
2 requirement specified by the Sec-
3 retary.

4 “(3) MONITORING COMPLIANCE.—The Sec-
5 retary shall establish processes to monitor and as-
6 sess ambulatory surgical centers’ compliance with
7 this subsection. Such processes shall include proc-
8 esses relating to the following:

9 “(A) The evaluation and analysis of com-
10 plaints made by individuals or other entities re-
11 lating to such centers’ compliance with this sub-
12 section.

13 “(B) The use of audits to ensure such cen-
14 ters’ compliance with this subsection.

15 “(C) The obtaining of additional informa-
16 tion from such centers to determine such cen-
17 ters’ compliance with this subsection (as deter-
18 mined appropriate by the Secretary).

19 “(4) ENFORCEMENT.—

20 “(A) IN GENERAL.—In the case that the
21 Secretary determines that an ambulatory sur-
22 gical center is not in compliance with the re-
23 quirements of paragraph (1)—

24 “(i) not later than 30 days after such
25 determination, the Secretary shall notify

1 such center of such determination (which
2 may include, as determined appropriate by
3 the Secretary, a request for a corrective
4 action plan (to be submitted not later than
5 45 days after such request is made)); and

6 “(ii) in the case of an ambulatory sur-
7 gical center that does not receive a request
8 for a corrective action plan as part of a no-
9 tification under clause (i)—

10 “(I) the Secretary shall, not later
11 than 90 days after such notification is
12 sent, determine whether such center is
13 in compliance with such requirements;
14 and

15 “(II) if the Secretary determines
16 under subclause (I) that such center
17 is not in compliance with such re-
18 quirements, the Secretary shall ei-
19 ther—

20 “(aa) submit to such center
21 a request for a corrective action
22 plan (to be submitted not later
23 than 45 days after such request
24 is made) to comply with such re-
25 quirements; or

1 “(bb) if the Secretary deter-
2 mines that such center has not
3 taken meaningful actions to come
4 into compliance since such notifi-
5 cation was sent, impose a civil
6 monetary penalty in accordance
7 with subparagraph (B).

8 “(B) CIVIL MONETARY PENALTY.—

9 “(i) IN GENERAL.—An ambulatory
10 surgical center that has received a request
11 for a corrective action plan under clause (i)
12 or (ii) of subparagraph (A) and fails to
13 comply with the requirements of paragraph
14 (1) by the date that is 90 days after such
15 request is made, and an ambulatory sur-
16 gical center with respect to which the Sec-
17 retary has made a determination described
18 in clause (ii)(II)(bb) of such subparagraph,
19 shall be subject to a civil monetary penalty
20 in an amount not to exceed \$300 for each
21 day (beginning with the day on which the
22 Secretary first determined that such center
23 was not complying with such requirements)
24 during which such failure was ongoing.

1 “(ii) INCREASE AUTHORITY.—In ap-
2 plying this subparagraph with respect to
3 failures to comply occurring in 2029 or a
4 subsequent year, the Secretary may
5 through notice and comment rulemaking
6 increase the limitation on the per day
7 amount of any penalty under clause (i).

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

16 “(iv) AUTHORITY TO WAIVE OR RE-
17 DUCE PENALTY.—

18 “(I) IN GENERAL.—Subject to
19 subclause (II), the Secretary may
20 waive any penalty, or reduce any pen-
21 alty by not more than 75 percent, oth-
22 erwise applicable under this subpara-
23 graph with respect to an ambulatory
24 surgical center located in a rural or
25 underserved area if the Secretary cer-

1 tifies that imposition of such penalty
2 would result in an immediate threat
3 to access to care for individuals in the
4 service area of such surgical center.

5 “(II) LIMITATION ON APPLICATION.—The Secretary may not elect
6 to waive a penalty under subclause (I)
7 with respect to an ambulatory surgical
8 center more than once in a 6-year pe-
9 riod and may not elect to reduce such
10 a penalty with respect to such a sur-
11 gical center more than once in such a
12 period. Nothing in the preceding sen-
13 tence shall be construed as prohibiting
14 the Secretary from both waiving and
15 reducing a penalty with respect to an
16 ambulatory surgical center during a
17 6-year period.

18 “(v) HARDSHIP EXEMPTION.—Not-
19 withstanding any limit on the waiver or re-
20 duction of a penalty under clause (iv), the
21 Secretary may waive any penalty with re-
22 spect to an ambulatory surgical center on
23 a case-by-case basis if the Secretary deter-
24 mines that a circumstance exists inter-
25

fering with such center’s ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other unique or unexpected event).

“(5) PROVISION OF TECHNICAL ASSISTANCE.—

The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to ambulatory surgical centers requesting such assistance.

“(e) ENSURING ACCESSIBILITY THROUGH IMPLE-

MENTATION.—In implementing this section, the Secretary

shall through rulemaking ensure that a provider of serv-

ices or supplier making public charges and prices pursuant

to this section takes reasonable steps (as specified by the

Secretary) to ensure the accessibility of such charges and

information to individuals with limited English pro-

ficiency. Such steps may include the provision of interpre-

tation services or the provision of translations of charges

and information.

“(f) DEFINITIONS.—For purposes of this section:

“(1) DISCOUNTED CASH PRICE.—The term ‘dis-

counted cash price’ means the charge that applies to

1 an individual who pays cash, or cash equivalent, for
2 an item or service.

3 “(2) GROSS CHARGE.—The term ‘gross charge’
4 means the charge for an individual item or service
5 that is reflected on a specified hospital’s
6 chargemaster or provider of service or supplier’s, as
7 applicable, chargemaster (or similar list of prices),
8 absent any discounts.

9 “(3) PAYER-SPECIFIC NEGOTIATED CHARGE.—
10 The term ‘payer-specific negotiated charge’ means
11 the charge that an applicable laboratory has nego-
12 tiated with a third party payer for an item or serv-
13 ice.

14 “(4) 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 “(5) SPECIFIED HOSPITAL.—The term ‘speci-
20 fied hospital’ means a hospital (as defined in section
21 1861(e)), a critical access hospital (as defined in
22 section 1861(mmm)(1)), or a rural emergency hos-
23 pital (as defined in section 1861(kkk)).

24 “(6) THIRD PARTY PAYER.—The term ‘third
25 party payer’ means an entity that is, by statute, con-

1 tract, or agreement, legally responsible for payment
2 of a claim for an item or service.”.

3 (b) CONFORMING AMENDMENT.—Section 2718(e) of
4 the Public Health Service Act (42 U.S.C. 300gg–18(e))
5 is amended by adding at the end the following new sen-
6 tence: “The preceding provisions of this subsection shall
7 not apply beginning on January 1, 2028.”.

8 **SEC. 3. HEALTH COVERAGE PRICE TRANSPARENCY.**

9 (a) PRICE TRANSPARENCY REQUIREMENTS.—

10 (1) IRC.—

11 (A) IN GENERAL.—Section 9819 of the In-
12 ternal Revenue Code of 1986 is amended—

13 (i) in the header, by striking “**MAIN-**
14 **TENANCE OF PRICE COMPARISON**
15 **TOOL**” and inserting “**TRANSPARENCY**
16 **IN COVERAGE**”;

17 (ii) by striking “A group health plan”
18 and inserting the following:

19 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
20 FOR PLAN YEARS BEFORE 2029.—

21 “(1) IN GENERAL.—A group health plan”;

22 (iii) in subsection (a), as inserted by
23 clause (ii), by adding at the end the fol-
24 lowing new paragraph:

1 “(2) SUNSET.—Paragraph (1) shall not apply
2 with respect to plan years beginning on or after Jan-
3 uary 1, 2029.”; and

4 (iv) by adding at the end the following
5 new subsections:

6 “(b) COST-SHARING TRANSPARENCY.—

7 “(1) IN GENERAL.—For plan years beginning
8 on or after January 1, 2029, a group health plan
9 shall provide a participant or beneficiary, in a timely
10 manner upon request of the participant or bene-
11 ficiary, information on the amount of cost-sharing
12 (including deductibles, copayments, and coinsurance)
13 under the participant or beneficiary’s plan that the
14 participant or beneficiary would be responsible for
15 paying with respect to the furnishing of a specific
16 item or service by a provider. At a minimum, such
17 information shall include the information specified in
18 paragraph (2) and shall be made available to such
19 participant or beneficiary through a self-service tool
20 that meets the requirements of paragraph (3) or, at
21 the option of such participant or beneficiary,
22 through a paper disclosure or phone or other elec-
23 tronic disclosure (as selected by such participant or
24 beneficiary and provided at no cost to such partici-

1 pant or beneficiary) that meets such requirements as
2 the Secretary may specify.

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

9 “(A) If such provider is a participating
10 provider with respect to such item or service,
11 the in-network rate for such item or service.

12 “(B) If such provider is not a participating
13 provider with respect to such item or service,
14 the maximum allowed amount or other dollar
15 amount that such plan will recognize as pay-
16 ment for such item or service, along with a no-
17 tice that such participant or beneficiary may be
18 liable for additional charges.

19 “(C) The estimated amount of cost sharing
20 (including deductibles, copayments, and coin-
21 surance) that the participant or beneficiary will
22 incur for such item or service (which, in the
23 case such item or service is to be furnished by
24 a provider described in subparagraph (B), shall
25 be calculated using the maximum allowed

1 amount or other dollar amount described in
2 such subparagraph).

3 “(D) The amount the participant or bene-
4 ficiary has already accumulated with respect to
5 any deductible or out of pocket maximum under
6 the plan (broken down, in the case separate
7 deductibles or maximums apply to a participant
8 and such participant’s beneficiaries enrolled in
9 the plan, by such separate deductibles or maxi-
10 mums, in addition to any cumulative deductible
11 or maximum).

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

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

22 “(G) Any financial incentives (such as any
23 credit, payment, or other benefit provided by
24 such plan) available to the participant or bene-
25 ficiary with respect to such item or service fur-

1 nished by such provider known at the time such
2 request is made.

3 “(H) Other information determined appro-
4 priate by the Secretary.

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

9 “(A) is based on an internet website (or
10 successor technology specified by the Sec-
11 retary);

12 “(B) is made available in plain language at
13 no cost;

14 “(C) provides for real-time responses to re-
15 quests described in paragraph (1);

16 “(D) is updated in a manner such that in-
17 formation provided through such tool is timely
18 and accurate at the time such request is made;

19 “(E) allows such a request to be made
20 with respect to an item or service furnished
21 by—

22 “(i) a specific provider that is a par-
23 ticipating provider with respect to such
24 item or service;

1 “(ii) all providers that are partici-
2 pating providers with respect to such item
3 or service; or

4 “(iii) nonspecific providers located in
5 a relevant geographic region that are not
6 participating providers with respect to such
7 item or service;

8 “(F) provides that such a request may be
9 made with respect to an item or service through
10 use of the billing code for such item or service
11 or through use of a descriptive term for such
12 item or service; and

13 “(G) meets any other requirement deter-
14 mined appropriate by the Secretary, including
15 requirements to ensure the accessibility and
16 usability of information provided through such
17 tool.

18 “(c) RATE AND PAYMENT INFORMATION.—

19 “(1) IN GENERAL.—For plan years beginning
20 on or after January 1, 2029, each group health plan
21 (other than a grandfathered health plan (as defined
22 in section 1251(e) of the Patient Protection and Af-
23 fordable Care Act) or a church plan (as defined in
24 section 414(e))) shall make available to the public

1 the rate and payment information described in para-
2 graph (2) in accordance with paragraph (3).

3 “(2) RATE AND PAYMENT INFORMATION DE-
4 SCRIBED.—For purposes of paragraph (1), the rate
5 and payment information described in this para-
6 graph is, with respect to a group health plan, the
7 following:

8 “(A) With respect to each item or service
9 (other than a drug) for which benefits are avail-
10 able under such plan—

11 “(i) the in-network rate (expressed as
12 a dollar amount) in effect as of the date on
13 which such information is made public
14 with each provider that is a participating
15 provider with respect to such item or serv-
16 ice (other than, in the case that such plan
17 provides benefits for such item or service
18 only when furnished by a specific type of
19 provider, such a participating provider who
20 is not such type of provider (referred to in
21 this subparagraph as an ‘excluded pro-
22 vider’)); and

23 “(ii) with respect to each such partici-
24 pating provider (other than a provider that
25 is an excluded provider with respect to

1 such item or service), an indication of
2 whether, during the 1-year period begin-
3 ning 18 months before the date such infor-
4 mation is made public, such provider sub-
5 mitted a claim for such item or service to
6 such plan for which payment was made (in
7 whole or in part) under such plan.

8 “(B) With respect to each drug (identified
9 by national drug code) for which benefits are
10 available under such plan—

11 “(i) the in-network rate (expressed as
12 a dollar amount) in effect as of the first
13 day of the month in which such informa-
14 tion is made public with each provider that
15 is a participating provider with respect to
16 such drug;

17 “(ii) the average amount paid by such
18 plan (accounting for, in a manner deter-
19 mined appropriate by the Secretary, re-
20 bates, discounts, price concessions, and
21 any other remuneration specified by the
22 Secretary) for such drug dispensed or ad-
23 ministered during the 90-day period begin-
24 ning 180 days before such date of publica-
25 tion to each provider that was a partici-

1 pating provider with respect to such drug,
2 broken down by each such provider, unless
3 fewer than 20 claims for such drug were
4 submitted to such plan during such period;
5 and

6 “(iii) in the case such drug is an ap-
7 plicable spread price drug dispensed by a
8 pharmacy—

9 “(I) a specification that such
10 drug is such an applicable spread
11 price drug; and

12 “(II) for each pharmacy that has
13 a contractual relationship for dis-
14 pensing such drug under such plan, a
15 specification of the difference (if any)
16 between the specified payment amount
17 for such drug so dispensed by such
18 pharmacy and the specified reim-
19 bursement amount for such drug so
20 dispensed by such pharmacy.

21 “(C) With respect to each item or service
22 for which benefits are available under such
23 plan, the amount billed, and the amount al-
24 lowed by the plan, for each such item or service
25 furnished during the 6-month period beginning

1 9 months before the date such information is
2 made public by a provider that was not a par-
3 ticipating provider with respect to such item or
4 service, broken down by each such provider,
5 other than such an amount with respect to an
6 item or service for which, during such period,
7 fewer than 11 claims were made under such
8 plan. In determining the number of claims
9 made under such plan with respect to an item
10 or service during such period for purposes of
11 the preceding sentence, such number shall be
12 deemed to include all claims for such item or
13 service made during such period under all
14 group health plans offered in the same insur-
15 ance market (specified in subclause (I), (II),
16 (III), of section 9816(a)(3)(E)(iv)) by the spon-
17 sor of the plan at issue.

18 In the case that a specific dollar amount for an in-
19 network rate required to be made available pursuant
20 to this subsection with respect to an item or service
21 cannot be determined prospectively on the basis that
22 such rate is determined as a percentage of the billed
23 charges for such item or service, such percentage
24 and the median amount recognized by such plan as
25 payment for such item or service with respect to

1 claims for such item or service submitted by partici-
2 pating providers during the period described in sub-
3 paragraph (A)(ii) shall be reported by such plan in
4 lieu of such rate. Such plan shall identify that such
5 median amount represents an estimate of such in-
6 network rate for such item or service.

7 “(3) MANNER OF PUBLICATION.—

8 “(A) IN GENERAL.—Rate and payment in-
9 formation required to be made available under
10 this subsection shall be so made available in
11 dollar amounts through separate machine-read-
12 able files (and any successor technology, as ap-
13 plicable, such as application programming inter-
14 face technology, determined appropriate by the
15 Secretary) corresponding to the information de-
16 scribed in each of subparagraphs (A) through
17 (C) of paragraph (2) that meet such require-
18 ments as specified by the Secretary (which may
19 be so specified through subregulatory guid-
20 ance), including requirements relating to wheth-
21 er such information should be so made available
22 on the plan or coverage level, with respect to in-
23 dividual provider networks, or aggregated in
24 such manner as specified by the Secretary.
25 Such requirements shall ensure that such files

1 are limited to an appropriate size, do not in-
2 clude disclosure of unnecessary duplicative in-
3 formation contained in other files made avail-
4 able under this subsection, are made available
5 in a widely available format through a publicly
6 available website that allows for information
7 contained in such files to be compared across
8 group health plans and group or individual
9 health insurance coverage, and are accessible to
10 individuals at no cost and without the need to
11 establish a user account or provide other cre-
12 dentials or undertake other steps as may be
13 specified by the Secretary.

14 “(B) TIMING.—Rate and payment infor-
15 mation described in paragraph (2) shall be
16 made public on a quarterly basis.

17 “(4) USER INSTRUCTIONS.—Each group health
18 plan shall make available to the public instructions
19 written in plain language explaining how individuals
20 may search for information described in paragraph
21 (2) in files submitted in accordance with paragraph
22 (3). The Secretary shall develop and publish through
23 subregulatory guidance a template that such a plan
24 may use in developing instructions for purposes of
25 the preceding sentence.

1 “(5) SUMMARY.—For each plan year beginning
2 on or after January 1, 2029, each group health plan
3 shall make public a data file, in a manner that en-
4 sures that such file may be easily downloaded and
5 read by standard spreadsheet software and that
6 meets such requirements as established by the Sec-
7 retary, containing a summary of all rate and pay-
8 ment information made public by such plan with re-
9 spect to such plan during such plan year. Such file
10 shall include the following:

11 “(A) The mean, median, and interquartile
12 range of the in-network rate, and the amount
13 allowed for an item or service when not fur-
14 nished by a participating provider, in effect as
15 of the first day of such plan year for each item
16 or service (identified by payer identifier ap-
17 proved or used by the Centers for Medicare &
18 Medicaid Services) for which benefits are avail-
19 able under the plan, broken down by the type
20 of provider furnishing the item or service and
21 by the geographic area in which such item or
22 service is furnished.

23 “(B) Trends in payment rates for such
24 items and services over such plan year, includ-
25 ing an identification of instances in which such

1 rates have increased, decreased, or remained
2 the same.

3 “(C) The name of such plan, a description
4 of the type of network of participating providers
5 used by such plan, and a description of whether
6 such plan is self-insured or fully-insured.

7 “(D) For each item or service which is
8 paid as part of a bundled or capitated rate—

9 “(i) a description of the formulae,
10 pricing methodologies, or other information
11 used to calculate the payment rate for such
12 rate; and

13 “(ii) a list of the items and services
14 included in such rate.

15 “(E) The percentage of items and services
16 that are paid for on a fee-for-service basis and
17 the percentage of items and services that are
18 paid for as part of a bundled rate, capitated
19 payment rate, or other alternative payment
20 model.

21 “(d) ATTESTATION.— A group health plan shall an-
22 nually submit to the Secretary an attestation, signed by
23 the chief executive officer, chief financial officer, or other
24 comparable official (as specified by the Secretary) of such
25 plan, of such plan’s compliance with the provisions of this

1 section and that information made available under this
2 section is true, accurate, and complete. Such attestation
3 shall, except in the case of a grandfathered health plan
4 (as defined in section 1251(e) of the Patient Protection
5 and Affordable Care Act) or a church plan (as defined
6 in section 414(e)), include a link to the website (or other
7 successor technology) where rate and payment information
8 required to be made public under subsection (c) may be
9 accessed.

10 “(e) ACCESSIBILITY.—A group health plan shall take
11 reasonable steps (as specified by the Secretary) to ensure
12 that information provided in response to a request de-
13 scribed in subsection (b), and rate and payment informa-
14 tion made public under subsection (c), is provided in plain,
15 easily understandable language and that interpretation,
16 translations, and assistive services are provided to those
17 with limited English proficiency and those with disabili-
18 ties.

19 “(f) DEFINITIONS.—In this section:

20 “(1) APPLICABLE SPREAD PRICE DRUG.—The
21 term ‘applicable spread price drug’ means, with re-
22 spect to a group health plan, a drug for which bene-
23 fits are available under such plan and with respect
24 to which, at the time rate and payment information
25 is made public by such plan under subsection (c)—

1 “(A) a contract is in effect between an en-
2 tity providing pharmacy benefit management
3 services on behalf of such plan and a pharmacy
4 for the dispensing of such drug under such
5 plan; and

6 “(B) the specified payment amount for
7 such drug so dispensed is less than the specified
8 reimbursement amount for such drug so dis-
9 pensed.

10 “(2) IN-NETWORK RATE.—The term ‘in-net-
11 work rate’ means, with respect to a group health
12 plan and an item or service furnished by a provider
13 that is a participating provider with respect to such
14 plan and item or service, the contracted rate (re-
15 flected as a dollar amount) in effect between such
16 plan and such provider for such item or service, re-
17 gardless of whether such rate is calculated based on
18 a set amount, a fee schedule, or an amount derived
19 from another amount, or a formula, or other meth-
20 od.

21 “(3) PARTICIPATING PROVIDER.—The term
22 ‘participating provider’ means, with respect to an
23 item or service and a group health plan, a physician
24 or other health care provider (as defined in para-
25 graph (4)) who is acting within the scope of practice

1 of that provider’s license or certification under appli-
2 cable State law and who has a contractual relation-
3 ship with the plan for furnishing such item or serv-
4 ice under the plan.

5 “(4) PROVIDER.—The term ‘provider’ includes
6 a health care facility and a pharmacy.

7 “(5) SPECIFIED PAYMENT AMOUNT.—The term
8 ‘specified payment amount’ means, with respect to a
9 drug to be dispensed by a pharmacy to a participant
10 or beneficiary of a group health plan where such
11 pharmacy has in effect a contract with an entity
12 providing pharmacy benefit management services on
13 behalf of such plan for the dispensing of such drug
14 under such plan, the amount that such entity has
15 agreed to pay such pharmacy for the ingredient
16 costs and any applicable dispensing fee for such
17 drug (or the amount that such entity has agreed to
18 pay such pharmacy for such drug under any other
19 compensation structure specified by the Secretary)
20 under such contract, taking into account any cost
21 sharing requirement applicable to such drug and
22 participant or beneficiary.

23 “(6) SPECIFIED REIMBURSEMENT AMOUNT.—
24 The term ‘specified reimbursement amount’ means,
25 with respect to a drug to be dispensed by a phar-

1 macy to a participant or beneficiary of a group
 2 health plan where such pharmacy has in effect a
 3 contract with an entity providing pharmacy benefit
 4 management services on behalf of such plan for the
 5 dispensing of such drug under such plan, the
 6 amount that such plan has agreed to pay to such en-
 7 tity for the ingredient costs and any applicable dis-
 8 pensing fee for such drug (or the amount that such
 9 plan has agreed to pay such entity for such drug
 10 under any other compensation structure specified by
 11 the Secretary), taking into account any cost sharing
 12 requirement applicable to such drug and participant
 13 or beneficiary.”.

14 (B) CLERICAL AMENDMENT.—The item re-
 15 lating to section 9819 of the table of sections
 16 for subchapter B of chapter 100 of the Internal
 17 Revenue Code of 1986 is amended to read as
 18 follows:

“Sec. 9819. Transparency in coverage.”.

19 (2) PHSA.—Section 2799A–4 of the Public
 20 Health Service Act (42 U.S.C. 300gg–114) is
 21 amended—

22 (A) in the header, by striking “**MAINTENANCE OF PRICE COMPARISON TOOL**” and
 23 inserting “**TRANSPARENCY IN COVERAGE**”;
 24

1 (B) by striking “A group health plan” and
2 inserting the following:

3 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
4 FOR PLAN YEARS BEFORE 2029.—

5 “(1) IN GENERAL.—A group health plan”;

6 (C) in subsection (a), as inserted by sub-
7 paragraph (B), by adding at the end the fol-
8 lowing new paragraph:

9 “(2) SUNSET.—Paragraph (1) shall not apply
10 with respect to plan years beginning on or after Jan-
11 uary 1, 2029.”; and

12 (D) by adding at the end the following new
13 subsections:

14 “(b) COST-SHARING TRANSPARENCY.—

15 “(1) IN GENERAL.—For plan years beginning
16 on or after January 1, 2029, a group health plan
17 and a health insurance issuer offering group or indi-
18 vidual health insurance coverage shall provide a par-
19 ticipant, beneficiary, or enrollee, in a timely manner
20 upon request of the participant, beneficiary, or en-
21 rollee, information on the amount of cost-sharing
22 (including deductibles, copayments, and coinsurance)
23 under the participant, beneficiary, or enrollee’s plan
24 or coverage that the participant, beneficiary, or en-
25 rollee would be responsible for paying with respect

1 to the furnishing of a specific item or service by a
2 provider. At a minimum, such information shall in-
3 clude the information specified in paragraph (2) and
4 shall be made available to such participant, bene-
5 ficiary, or enrollee through a self-service tool that
6 meets the requirements of paragraph (3) or, at the
7 option of such participant, beneficiary, or enrollee,
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 an indi-
18 vidual enrolled under such plan or coverage, the fol-
19 lowing:

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

23 “(B) If such provider is not a participating
24 provider with respect to such item or service,
25 the maximum allowed amount or other dollar

1 amount that such plan or coverage will recog-
2 nize as payment for such item or service, along
3 with a notice that such individual may be liable
4 for additional charges.

5 “(C) The estimated amount of cost sharing
6 (including deductibles, copayments, and coin-
7 surance) that the individual will incur for such
8 item or service (which, in the case such item or
9 service is to be furnished by a provider de-
10 scribed in subparagraph (B), shall be calculated
11 using the maximum allowed amount or other
12 dollar amount described in such subparagraph).

13 “(D) The amount the individual has al-
14 ready accumulated with respect to any deduct-
15 ible or out of pocket maximum under the plan
16 or coverage (broken down, in the case separate
17 deductibles or maximums apply to individuals
18 enrolled in the plan or coverage, by such sepa-
19 rate deductibles or maximums, in addition to
20 any cumulative deductible or maximum).

21 “(E) In the case such plan imposes any
22 frequency or volume limitations with respect to
23 such item or service (excluding medical neces-
24 sity determinations), the amount that such indi-

1 vidual has accrued towards such limitation with
2 respect to 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 “(G) Any financial incentives (such as any
8 credit, payment, or other benefit provided by
9 such plan or issuer) available to the individual
10 with respect to such item or service furnished
11 by such provider known at the time such re-
12 quest is made.

13 “(H) Other information determined appro-
14 priate by the Secretary.

15 “(3) SELF-SERVICE TOOL.—For purposes of
16 paragraph (1), a self-service tool established by a
17 group health plan or health insurance issuer offering
18 group or individual health insurance coverage meets
19 the requirements of this paragraph if such tool—

20 “(A) is based on an internet website (or
21 successor technology specified by the Sec-
22 retary);

23 “(B) is made available in plain language at
24 no cost;

1 “(C) provides for real-time responses to re-
2 quests described in paragraph (1);

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

6 “(E) allows such a request to be made
7 with respect to an item or service furnished
8 by—

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

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

15 “(iii) nonspecific providers located in
16 a relevant geographic region that are not
17 participating providers with respect to such
18 item or service;

19 “(F) provides that such a request may be
20 made with respect to an item or service through
21 use of the billing code for such item or service
22 or through use of a descriptive term for such
23 item or service; and

24 “(G) meets any other requirement deter-
25 mined appropriate by the Secretary, including

1 requirements to ensure the accessibility and
2 usability of information provided through such
3 tool.

4 “(c) RATE AND PAYMENT INFORMATION.—

5 “(1) IN GENERAL.—For plan years beginning
6 on or after January 1, 2029, each group health plan
7 and health insurance issuer offering group or indi-
8 vidual health insurance coverage (other than a
9 grandfathered health plan (as defined in section
10 1251(e) of the Patient Protection and Affordable
11 Care Act) and other than such an issuer offering
12 group health insurance coverage in connection with
13 a church plan (as defined in section 414(e) of the
14 Internal Revenue Code of 1986)) shall make avail-
15 able to the public the rate and payment information
16 described in paragraph (2) in accordance with para-
17 graph (3).

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

1 “(A) With respect to each item or service
2 (other than a drug) for which benefits are avail-
3 able under such plan or coverage—

4 “(i) the in-network rate (expressed as
5 a dollar amount) in effect as of the date on
6 which such information is made public
7 with each provider that is a participating
8 provider with respect to such item or serv-
9 ice (other than, in the case that such plan
10 or coverage provides benefits for such item
11 or service only when furnished by a specific
12 type of provider, such a participating pro-
13 vider who is not such type of provider (re-
14 ferred to in this subparagraph as an ‘ex-
15 cluded provider’)); and

16 “(ii) with respect to each such partici-
17 pating provider (other than a provider that
18 is an excluded provider with respect to
19 such item or service), an indication of
20 whether, during the 1-year period begin-
21 ning 18 months before the date such infor-
22 mation is made public, such provider sub-
23 mitted a claim for such item or service to
24 such plan or coverage for which payment

1 was made (in whole or in part) under such
2 plan or coverage.

3 “(B) With respect to each drug (identified
4 by national drug code) for which benefits are
5 available under such plan or coverage—

6 “(i) the in-network rate (expressed as
7 a dollar amount) in effect as of the first
8 day of the month in which such informa-
9 tion is made public with each provider that
10 is a participating provider with respect to
11 such drug;

12 “(ii) the average amount paid by such
13 plan or coverage (accounting for, in a man-
14 ner determined appropriate by the Sec-
15 retary, rebates, discounts, price conces-
16 sions, and any other remuneration speci-
17 fied by the Secretary) for such drug dis-
18 pensed or administered during the 90-day
19 period beginning 180 days before such
20 date of publication to each provider that
21 was a participating provider with respect
22 to such drug, broken down by each such
23 provider, unless fewer than 20 claims for
24 such drug were submitted to such plan or
25 coverage during such period; and

1 “(iii) in the case such drug is an ap-
2 plicable spread price drug dispensed by a
3 pharmacy—

4 “(I) a specification that such
5 drug is such an applicable spread
6 price drug; and

7 “(II) for each pharmacy that has
8 a contractual relationship for dis-
9 pensing such drug under such plan or
10 coverage, a specification of the dif-
11 ference (if any) between the specified
12 payment amount for such drug so dis-
13 pensed by such pharmacy and the
14 specified reimbursement amount for
15 such drug so dispensed by such phar-
16 macy.

17 “(C) With respect to each item or service
18 for which benefits are available under such plan
19 or coverage, the amount billed, and the amount
20 allowed by the plan or coverage, for each such
21 item or service furnished during the 6-month
22 period beginning 9 months before the date such
23 information is made public by a provider that
24 was not a participating provider with respect to
25 such item or service, broken down by each such

1 provider, other than such an amount with re-
2 spect to an item or service for which, during
3 such period, fewer than 11 claims were made
4 under such plan or coverage. In determining the
5 number of claims made under such plan or cov-
6 erage with respect to an item or service during
7 such period for purposes of the preceding sen-
8 tence, such number shall be deemed to include
9 all claims for such item or service made during
10 such period under all group health plans and
11 health insurance coverage offered in the same
12 insurance market (specified in subclause (I),
13 (II), (III), or (IV) of section 2799A-
14 1(a)(3)(E)(iv)) by the sponsor or issuer (as ap-
15 plicable) of the plan or coverage at issue.

16 In the case that a specific dollar amount for an in-
17 network rate required to be made available pursuant
18 to this subsection with respect to an item or service
19 cannot be determined prospectively on the basis that
20 such rate is determined as a percentage of the billed
21 charges for such item or service, such percentage
22 and the median amount recognized by such plan or
23 coverage as payment for such item or service with
24 respect to claims for such item or service submitted
25 by participating providers during the period de-

1 scribed in subparagraph (A)(ii) shall be reported by
2 such plan in lieu of such rate. Such plan or coverage
3 shall identify that such median amount represents
4 an estimate of such in-network rate for such item or
5 service.

6 “(3) MANNER OF PUBLICATION.—

7 “(A) IN GENERAL.—Rate and payment in-
8 formation required to be made available under
9 this subsection shall be so made available in
10 dollar amounts through separate machine-read-
11 able files (and any successor technology, as ap-
12 plicable, such as application programming inter-
13 face technology, determined appropriate by the
14 Secretary) corresponding to the information de-
15 scribed in each of subparagraphs (A) through
16 (C) of paragraph (2) that meet such require-
17 ments as specified by the Secretary (which may
18 be so specified through subregulatory guid-
19 ance), including requirements relating to wheth-
20 er such information should be so made available
21 on the plan or coverage level, with respect to in-
22 dividual provider networks, or aggregated in
23 such manner as specified by the Secretary.
24 Such requirements shall ensure that such files
25 are limited to an appropriate size, do not in-

1 clude disclosure of unnecessary duplicative in-
2 formation contained in other files made avail-
3 able under this subsection, are made available
4 in a widely-available format through a publicly-
5 available website that allows for information
6 contained in such files to be compared across
7 group health plans and group or individual
8 health insurance coverage, and are accessible to
9 individuals at no cost and without the need to
10 establish a user account or provide other cre-
11 dentials.

12 “(B) TIMING.—Rate and payment infor-
13 mation described in paragraph (2) shall be
14 made public on a quarterly basis.

15 “(4) USER INSTRUCTIONS.—Each group health
16 plan and health insurance issuer offering group or
17 individual health insurance coverage shall make
18 available to the public instructions written in plain
19 language explaining how individuals may search for
20 information described in paragraph (2) in files sub-
21 mitted in accordance with paragraph (3). The Sec-
22 retary shall develop and publish through subregu-
23 latory guidance a template that such a plan may use
24 in developing instructions for purposes of the pre-
25 ceding sentence.

1 “(5) SUMMARY.—For each plan year beginning
2 on or after January 1, 2029, each group health plan
3 and health insurance issuer offering group or indi-
4 vidual health insurance coverage shall make public a
5 data file, in a manner that ensures that such file
6 may be easily downloaded and read by standard
7 spreadsheet software and that meets such require-
8 ments as established by the Secretary, containing a
9 summary of all rate and payment information made
10 public by such plan or issuer with respect to such
11 plan or coverage during such plan year. Such file
12 shall include the following:

13 “(A) The mean, median, and interquartile
14 range of the in-network rate, and the amount
15 allowed for an item or service when not fur-
16 nished by a participating provider, in effect as
17 of the first day of such plan year for each item
18 or service (identified by payer identifier ap-
19 proved or used by the Centers for Medicare &
20 Medicaid Services) for which benefits are avail-
21 able under the plan or coverage, broken down
22 by the type of provider furnishing the item or
23 service and by the geographic area in which
24 such item or service is furnished.

1 “(B) Trends in payment rates for such
2 items and services over such plan year, includ-
3 ing an identification of instances in which such
4 rates have increased, decreased, or remained
5 the same.

6 “(C) The name of such plan, a description
7 of the type of network of participating providers
8 used by such plan or coverage, and, in the case
9 of a group health plan, a description of whether
10 such plan is self-insured or fully-insured.

11 “(D) For each item or service which is
12 paid as part of a bundled or capitated rate—

13 “(i) a description of the formulae,
14 pricing methodologies, or other information
15 used to calculate the payment rate for such
16 rate; and

17 “(ii) a list of the items and services
18 included in such rate.

19 “(E) The percentage of items and services
20 that are paid for on a fee-for-service basis and
21 the percentage of items and services that are
22 paid for as part of a bundled rate, capitated
23 payment rate, or other alternative payment
24 model.

1 “(d) ATTESTATION.—Each group health plan and
2 health insurance issuer offering group or individual health
3 insurance coverage shall annually submit to the Secretary
4 an attestation, signed by the chief executive officer, chief
5 financial officer, or other comparable official (as specified
6 by the Secretary) of such plan or issuer, of such plan’s
7 or coverage’s compliance with the provisions of this section
8 and that information made available under this section is
9 true, accurate, and complete. Such attestation shall, ex-
10 cept in the case of a grandfathered health plan (as defined
11 in section 1251(e) of the Patient Protection and Afford-
12 able Care Act) or in the case of such an issuer offering
13 group health insurance coverage in connection with a
14 church plan (as defined in section 414(e) of the Internal
15 Revenue Code of 1986), include a link to the website (or
16 other successor technology) where rate and payment infor-
17 mation required to be made public under subsection (c)
18 may be accessed.

19 “(e) ACCESSIBILITY.—A group health plan and a
20 health insurance issuer offering group or individual health
21 insurance coverage shall take reasonable steps (as speci-
22 fied by the Secretary) to ensure that information provided
23 in response to a request described in subsection (b), and
24 rate and payment information made public under sub-
25 section (c), is provided in plain, easily understandable lan-

1 guage and that interpretation, translations, and assistive
2 services are provided to those with limited English pro-
3 ficiency and those with disabilities.

4 “(f) DEFINITIONS.—In this section:

5 “(1) APPLICABLE SPREAD PRICE DRUG.—The
6 term ‘applicable spread price drug’ means, with re-
7 spect to a group health plan or group or individual
8 health insurance coverage, a drug for which benefits
9 are available under such plan or coverage and with
10 respect to which, at the time rate and payment in-
11 formation is made public by such plan under sub-
12 section (c)—

13 “(A) a contract is in effect between an en-
14 tity providing pharmacy benefit management
15 services on behalf of such plan or coverage and
16 a pharmacy for the dispensing of such drug
17 under such plan or coverage; and

18 “(B) the specified payment amount for
19 such drug so dispensed is less than the specified
20 reimbursement amount for such drug so dis-
21 pensed.

22 “(2) IN-NETWORK RATE.—The term ‘in-net-
23 work rate’ means, with respect to a group health
24 plan or group or individual health insurance cov-
25 erage and an item or service furnished by a provider

1 that is a participating provider with respect to such
2 plan or coverage and item or service, the contracted
3 rate (reflected as a dollar amount) in effect between
4 such plan or coverage and such provider for such
5 item or service, regardless of whether such rate is
6 calculated based on a set amount, a fee schedule, or
7 an amount derived from another amount, or a for-
8 mula, or other method.

9 “(3) PARTICIPATING PROVIDER.—The term
10 ‘participating provider’ means, with respect to an
11 item or service and a group health plan or health in-
12 surance issuer offering group or individual health in-
13 surance coverage, a physician or other health care
14 provider (as defined in paragraph (4)) who is acting
15 within the scope of practice of that provider’s license
16 or certification under applicable State law and who
17 has a contractual relationship with the plan or
18 issuer, respectively, for furnishing such item or serv-
19 ice under the plan or coverage, respectively.

20 “(4) PROVIDER.—The term ‘provider’ includes
21 a health care facility and a pharmacy.

22 “(5) SPECIFIED PAYMENT AMOUNT.—The term
23 ‘specified payment amount’ means, with respect to a
24 drug to be dispensed by a pharmacy to a partici-
25 pant, beneficiary, or enrollee of a group health plan

1 or group or individual health insurance coverage
2 where such pharmacy has in effect a contract with
3 an entity providing pharmacy benefit management
4 services on behalf of such plan or coverage for the
5 dispensing of such drug under such plan or cov-
6 erage, the amount that such entity has agreed to
7 pay such pharmacy for the ingredient costs and any
8 applicable dispensing fee for such drug (or the
9 amount that such entity has agreed to pay such
10 pharmacy for such drug under any other compensa-
11 tion structure specified by the Secretary) under such
12 contract, taking into account any cost sharing re-
13 quirement applicable to such drug and participant,
14 beneficiary, or enrollee.

15 “(6) SPECIFIED REIMBURSEMENT AMOUNT.—
16 The term ‘specified reimbursement amount’ means,
17 with respect to a drug to be dispensed by a phar-
18 macy to a participant, beneficiary, or enrollee of a
19 group health plan or group or individual health in-
20 surance coverage where such pharmacy has in effect
21 a contract with an entity providing pharmacy benefit
22 management services on behalf of such plan or cov-
23 erage for the dispensing of such drug under such
24 plan or coverage, the amount that such plan or cov-
25 erage has agreed to pay to such entity for the ingre-

1 dient costs and any applicable dispensing fee for
 2 such drug (or the amount that such plan or coverage
 3 has agreed to pay such entity for such drug under
 4 any other compensation structure specified by the
 5 Secretary), taking into account any cost sharing re-
 6 quirement applicable to such drug and participant,
 7 beneficiary, or enrollee.”.

8 (3) ERISA.—

9 (A) IN GENERAL.—Section 719 of the Em-
 10 ployee Retirement Income Security Act of 1974
 11 (29 U.S.C. 1185h) is amended—

12 (i) in the header, by striking “**MAIN-**
 13 **TENANCE OF PRICE COMPARISON**
 14 **TOOL**” and inserting “**TRANSPARENCY**
 15 **IN COVERAGE**”;

16 (ii) by striking “A group health plan”
 17 and inserting the following:

18 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
 19 FOR PLAN YEARS BEFORE 2029.—

20 “(1) IN GENERAL.—A group health plan”;

21 (iii) in subsection (a), as inserted by
 22 clause (ii), by adding at the end the fol-
 23 lowing new paragraph:

1 “(2) SUNSET.—Paragraph (1) shall not apply
2 with respect to plan years beginning on or after Jan-
3 uary 1, 2029.”; and

4 (iv) by adding at the end the following
5 new subsections:

6 “(b) COST-SHARING TRANSPARENCY.—

7 “(1) IN GENERAL.—For plan years beginning
8 on or after January 1, 2029, a group health plan
9 and a health insurance issuer offering group health
10 insurance coverage shall provide a participant or
11 beneficiary, in a timely manner upon request of the
12 participant or beneficiary, information on the
13 amount of cost-sharing (including deductibles, co-
14 payments, and coinsurance) under the participant or
15 beneficiary’s plan or coverage that the participant or
16 beneficiary would be responsible for paying with re-
17 spect to the furnishing of a specific item or service
18 by a provider. At a minimum, such information shall
19 include the information specified in paragraph (2)
20 and shall be made available to such participant or
21 beneficiary through a self-service tool that meets the
22 requirements of paragraph (3) or, at the option of
23 such participant or beneficiary, through a paper dis-
24 closure or phone or other electronic disclosure (as
25 selected by such participant or beneficiary and pro-

1 vided at no cost to such participant or beneficiary)
2 that meets such requirements as the Secretary may
3 specify.

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

11 “(A) If such provider is a participating
12 provider with respect to such item or service,
13 the in-network rate for such item or service.

14 “(B) If such provider is not a participating
15 provider with respect to such item or service,
16 the maximum allowed amount or other dollar
17 amount that such plan or coverage will recog-
18 nize as payment for such item or service, along
19 with a notice that such participant or bene-
20 ficiary may be liable for additional charges.

21 “(C) The estimated amount of cost-sharing
22 (including deductibles, copayments, and coin-
23 surance) that the participant or beneficiary will
24 incur for such item or service (which, in the
25 case such item or service is to be furnished by

1 a provider described in subparagraph (B), shall
2 be calculated using the maximum allowed
3 amount or other dollar amount described in
4 such subparagraph).

5 “(D) The amount the participant or bene-
6 ficiary has already accumulated with respect to
7 any deductible or out of pocket maximum under
8 the plan or coverage (broken down, in the case
9 separate deductibles or maximums apply to a
10 participant and such participant’s beneficiaries
11 enrolled in the plan or coverage, by such sepa-
12 rate deductibles or maximums, in addition to
13 any cumulative deductible or maximum).

14 “(E) In the case such plan imposes any
15 frequency or volume limitations with respect to
16 such item or service (excluding medical neces-
17 sity determinations), the amount that such par-
18 ticipant or beneficiary has accrued towards such
19 limitation with respect to such item or service.

20 “(F) Any prior authorization, concurrent
21 review, step therapy, fail first, or similar re-
22 quirements applicable to coverage of such item
23 or service under such plan or coverage.

24 “(G) Any financial incentives (such as any
25 credit, payment, or other benefit provided by

1 such plan or issuer) available to the participant
2 or beneficiary with respect to such item or serv-
3 ice furnished by such provider known at the
4 time such request is made.

5 “(H) Other information determined appro-
6 priate by the Secretary.

7 “(3) SELF-SERVICE TOOL.—For purposes of
8 paragraph (1), a self-service tool established by a
9 group health plan or health insurance issuer offering
10 group health insurance coverage meets the require-
11 ments of this paragraph if such tool—

12 “(A) is based on an internet website (or
13 successor technology specified by the Sec-
14 retary);

15 “(B) is made available in plain language at
16 no cost;

17 “(C) provides for real-time responses to re-
18 quests described in paragraph (1);

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

22 “(E) allows such a request to be made
23 with respect to an item or service furnished
24 by—

1 “(i) a specific provider that is a par-
2 ticipating provider with respect to such
3 item or service;

4 “(ii) all providers that are partici-
5 pating providers with respect to such item
6 or service; or

7 “(iii) nonspecific providers located in
8 a relevant geographic region that are not
9 participating providers with respect to such
10 item or service;

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

16 “(G) meets any other requirement deter-
17 mined appropriate by the Secretary, including
18 requirements to ensure the accessibility and
19 usability of information provided through such
20 tool.

21 “(c) RATE AND PAYMENT INFORMATION.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after January 1, 2029, each group health plan
24 and health insurance issuer offering group health in-
25 surance coverage (other than a grandfathered health

1 plan (as defined in section 1251(e) of the Patient
 2 Protection and Affordable Care Act)) shall make
 3 available to the public the rate and payment infor-
 4 mation described in paragraph (2) in accordance
 5 with paragraph (3).

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

11 “(A) With respect to each item or service
 12 (other than a drug) for which benefits are avail-
 13 able under such plan or coverage—

14 “(i) the in-network rate (expressed as
 15 a dollar amount) in effect as of the date on
 16 which such information is made public
 17 with each provider that is a participating
 18 provider with respect to such item or serv-
 19 ice (other than, in the case that such plan
 20 or coverage provides benefits for such item
 21 or service only when furnished by a specific
 22 type of provider, such a participating pro-
 23 vider who is not such type of provider (re-
 24 ferred to in this subparagraph as an ‘ex-
 25 cluded provider’)); and

1 “(ii) with respect to each such partici-
2 pating provider (other than a provider that
3 is an excluded provider with respect to
4 such item or service), an indication of
5 whether, during the 1-year period begin-
6 ning 18 months before the date such infor-
7 mation is made public, such provider sub-
8 mitted a claim for such item or service to
9 such plan or coverage for which payment
10 was made (in whole or in part) under such
11 plan or coverage.

12 “(B) With respect to each drug (identified
13 by national drug code) for which benefits are
14 available under such plan or coverage—

15 “(i) the in-network rate (expressed as
16 a dollar amount) in effect as of the first
17 day of the month in which such informa-
18 tion is made public with each provider that
19 is a participating provider with respect to
20 such drug;

21 “(ii) the average amount paid by such
22 plan or coverage (accounting for, in a man-
23 ner determined appropriate by the Sec-
24 retary, rebates, discounts, price conces-
25 sions, and any other remuneration speci-

1 fied by the Secretary) for such drug dis-
2 pensed or administered during the 90-day
3 period beginning 180 days before such
4 date of publication to each provider that
5 was a participating provider with respect
6 to such drug, broken down by each such
7 provider, unless fewer than 20 claims for
8 such drug were submitted to such plan or
9 coverage during such period; and

10 “(iii) in the case such drug is an ap-
11 plicable spread price drug dispensed by a
12 pharmacy—

13 “(I) a specification that such
14 drug is such an applicable spread
15 price drug; and

16 “(II) for each pharmacy that has
17 a contractual relationship for dis-
18 pensing such drug under such plan or
19 coverage, a specification of the dif-
20 ference (if any) between the specified
21 payment amount for such drug so dis-
22 pensed by such pharmacy and the
23 specified reimbursement amount for
24 such drug so dispensed by such phar-
25 macy.

1 “(C) With respect to each item or service
2 for which benefits are available under such plan
3 or coverage, the amount billed, and the amount
4 allowed by the plan or coverage, for each such
5 item or service furnished during the 6-month
6 period beginning 9 months before the date such
7 information is made public by a provider that
8 was not a participating provider with respect to
9 such item or service, broken down by each such
10 provider, other than such an amount with re-
11 spect to an item or service for which, during
12 such period, fewer than 11 claims were made
13 under such plan or coverage. In determining the
14 number of claims made under such plan or cov-
15 erage with respect to an item or service during
16 such period for purposes of the preceding sen-
17 tence, such number shall be deemed to include
18 all claims for such item or service made during
19 such period under all group health plans and
20 health insurance coverage offered in the same
21 insurance market (specified in subclause (I),
22 (II), (III), or (IV) of section 716(a)(3)(E)(iv))
23 by the sponsor or issuer (as applicable) of the
24 plan or coverage at issue.

1 In the case that a specific dollar amount for an in-
2 network rate required to be made available pursuant
3 to this subsection with respect to an item or service
4 cannot be determined prospectively on the basis that
5 such rate is determined as a percentage of the billed
6 charges for such item or service, such percentage
7 and the median amount recognized by such plan or
8 coverage as payment for such item or service with
9 respect to claims for such item or service submitted
10 by participating providers during the period de-
11 scribed in subparagraph (A)(ii) shall be reported by
12 such plan or coverage in lieu of such rate. Such plan
13 or coverage shall identify that such median amount
14 represents an estimate of such in-network rate for
15 such item or service.

16 “(3) MANNER OF PUBLICATION.—

17 “(A) IN GENERAL.—Rate and payment in-
18 formation required to be made available under
19 this subsection shall be so made available in
20 dollar amounts through separate machine-read-
21 able files (and any successor technology, as ap-
22 plicable, such as application programming inter-
23 face technology, determined appropriate by the
24 Secretary) corresponding to the information de-
25 scribed in each of subparagraphs (A) through

1 (C) of paragraph (2) that meet such require-
2 ments as specified by the Secretary (which may
3 be so specified through subregulatory guid-
4 ance), including requirements relating to wheth-
5 er such information should be so made available
6 on the plan or coverage level, with respect to in-
7 dividual provider networks, or aggregated in
8 such manner as specified by the Secretary.
9 Such requirements shall ensure that such files
10 are limited to an appropriate size, do not in-
11 clude disclosure of unnecessary duplicative in-
12 formation contained in other files made avail-
13 able under this subsection, are made available
14 in a widely available format through a publicly
15 available website that allows for information
16 contained in such files to be compared across
17 group health plans and group or individual
18 health insurance coverage, and are accessible to
19 individuals at no cost and without the need to
20 establish a user account or provide other cre-
21 dentials.

22 “(B) TIMING.—Rate and payment infor-
23 mation described in paragraph (2) shall be
24 made public on a quarterly basis.

1 “(4) USER INSTRUCTIONS.—Each group health
2 plan and health insurance issuer offering group
3 health insurance coverage shall make available to the
4 public instructions written in plain language explain-
5 ing how individuals may search for information de-
6 scribed in paragraph (2) in files submitted in ac-
7 cordance with paragraph (3). The Secretary shall
8 develop and publish through subregulatory guidance
9 a template that such a plan may use in developing
10 instructions for purposes of the preceding sentence.

11 “(5) SUMMARY.—For each plan year beginning
12 on or after January 1, 2029, each group health plan
13 and health insurance issuer offering group health in-
14 surance coverage shall make public a data file, in a
15 manner that ensures that such file may be easily
16 downloaded and read by standard spreadsheet soft-
17 ware and that meets such requirements as estab-
18 lished by the Secretary, containing a summary of all
19 rate and payment information made public by such
20 plan or issuer with respect to such plan or coverage
21 during such plan year. Such file shall include the fol-
22 lowing:

23 “(A) The mean, median, and interquartile
24 range of the in-network rate, and the amount
25 allowed for an item or service when not fur-

1 nished by a participating provider, in effect as
2 of the first day of such plan year for each item
3 or service (identified by payer identifier ap-
4 proved or used by the Centers for Medicare &
5 Medicaid Services) for which benefits are avail-
6 able under the plan or coverage, broken down
7 by the type of provider furnishing the item or
8 service and by the geographic area in which
9 such item or service is furnished.

10 “(B) Trends in payment rates for such
11 items and services over such plan year, includ-
12 ing an identification of instances in which such
13 rates have increased, decreased, or remained
14 the same.

15 “(C) The name of such plan, a description
16 of the type of network of participating providers
17 used by such plan or coverage, and, in the case
18 of a group health plan, a description of whether
19 such plan is self-insured or fully-insured.

20 “(D) For each item or service which is
21 paid as part of a bundled or capitated rate—

22 “(i) a description of the formulae,
23 pricing methodologies, or other information
24 used to calculate the payment rate for such
25 rate; and

1 “(ii) a list of the items and services
2 included in such rate.

3 “(E) The percentage of items and services
4 that are paid for on a fee-for-service basis and
5 the percentage of items and services that are
6 paid for as part of a bundled rate, capitated
7 payment rate, or other alternative payment
8 model.

9 “(d) ATTESTATION.—Each group health plan and
10 health insurance issuer offering group health insurance
11 coverage shall annually submit to the Secretary an attesta-
12 tion, signed by the chief executive officer, chief financial
13 officer, or other comparable official (as specified by the
14 Secretary) of such plan or issuer, of such plan’s or cov-
15 erage’s compliance with the provisions of this section and
16 that information made available under this section is true,
17 accurate, and complete. Such attestation shall, except in
18 the case of a grandfathered health plan (as defined in sec-
19 tion 1251(e) of the Patient Protection and Affordable
20 Care Act), include a link to the website (or other successor
21 technology) where rate and payment information required
22 to be made public under subsection (c) may be accessed.

23 “(e) ACCESSIBILITY.—A group health plan and a
24 health insurance issuer offering group health insurance
25 coverage shall take reasonable steps (as specified by the

1 Secretary) to ensure that information provided in response
2 to a request described in subsection (b), and rate and pay-
3 ment information made public under subsection (c), is pro-
4 vided in plain, easily understandable language and that
5 interpretation, translations, and assistive services are pro-
6 vided to those with limited English proficiency and those
7 with disabilities.

8 “(f) DEFINITIONS.—In this section:

9 “(1) APPLICABLE SPREAD PRICE DRUG.—The
10 term ‘applicable spread price drug’ means, with re-
11 spect to a group health plan or group health insur-
12 ance coverage, a drug for which benefits are avail-
13 able under such plan or coverage and with respect
14 to which, at the time rate and payment information
15 is made public by such plan under subsection (c)—

16 “(A) a contract is in effect between an en-
17 tity providing pharmacy benefit management
18 services on behalf of such plan or coverage and
19 a pharmacy for the dispensing of such drug
20 under such plan or coverage; and

21 “(B) the specified payment amount for
22 such drug so dispensed is less than the specified
23 reimbursement amount for such drug so dis-
24 pensed.

1 “(2) IN-NETWORK RATE.—The term ‘in-net-
2 work rate’ means, with respect to a group health
3 plan or group health insurance coverage and an item
4 or service furnished by a provider that is a partici-
5 pating provider with respect to such plan or cov-
6 erage and item or service, the contracted rate (re-
7 flected as a dollar amount) in effect between such
8 plan or coverage and such provider for such item or
9 service, regardless of whether such rate is calculated
10 based on a set amount, a fee schedule, or an amount
11 derived from another amount, or a formula, or other
12 method.

13 “(3) PARTICIPATING PROVIDER.—The term
14 ‘participating provider’ means, with respect to an
15 item or service and a group health plan or health in-
16 surance issuer offering group health insurance cov-
17 erage, a physician or other health care provider (as
18 defined in paragraph (4)) who is acting within the
19 scope of practice of that provider’s license or certifi-
20 cation under applicable State law and who has a
21 contractual relationship with the plan or issuer, re-
22 spectively, for furnishing such item or service under
23 the plan or coverage, respectively.

24 “(4) PROVIDER.—The term ‘provider’ includes
25 a health care facility and a pharmacy.

1 “(5) SPECIFIED PAYMENT AMOUNT.—The term
2 ‘specified payment amount’ means, with respect to a
3 drug to be dispensed by a pharmacy to a participant
4 or beneficiary of a group health plan or group health
5 insurance coverage where such pharmacy has in ef-
6 fect a contract with an entity providing pharmacy
7 benefit management services on behalf of such plan
8 or coverage for the dispensing of such drug under
9 such plan or coverage, the amount that such entity
10 has agreed to pay such pharmacy for the ingredient
11 costs and any applicable dispensing fee for such
12 drug (or the amount that such entity has agreed to
13 pay such pharmacy for such drug under any other
14 compensation structure specified by the Secretary)
15 under such contract, taking into account any cost
16 sharing requirement applicable to such drug and
17 participant or beneficiary.

18 “(6) SPECIFIED REIMBURSEMENT AMOUNT.—
19 The term ‘specified reimbursement amount’ means,
20 with respect to a drug to be dispensed by a phar-
21 macy to a participant or beneficiary of a group
22 health plan or group health insurance coverage
23 where such pharmacy has in effect a contract with
24 an entity providing pharmacy benefit management
25 services on behalf of such plan or coverage for the

1 dispensing of such drug under such plan or cov-
2 erage, the amount that such plan or coverage has
3 agreed to pay to such entity for the ingredient costs
4 and any applicable dispensing fee for such drug (or
5 the amount that such plan or coverage has agreed
6 to pay such entity for such drug under any other
7 compensation structure specified by the Secretary),
8 taking into account any cost sharing requirement
9 applicable to such drug and participant or bene-
10 ficiary.”.

11 (B) CLERICAL AMENDMENT.—The table of
12 contents in section 1 of the Employee Retire-
13 ment Income Security Act of 1974 is amended
14 by striking the item relating to section 719 and
15 inserting the following new item:

“Sec. 719. Transparency in coverage.”.

16 (b) APPLICATION PROGRAMMING INTERFACE RE-
17 PORT.—Not later than January 1, 2029, and annually
18 thereafter, the Secretary of Health and Human Services
19 shall, in consultation with the Office of the National Coor-
20 dinator for Health Information Technology, Department
21 of Labor, the Department of the Treasury, and stake-
22 holders, submit to the House Committees on Education
23 and the Workforce, Energy and Commerce, and Ways and
24 Means, and the Senate Committees on Finance and
25 Health, Education, Labor, and Pensions a report on the

1 use of standards-based application programming inter-
2 faces (in this subsection referred to as “APIs”) to facili-
3 tate access to health care price transparency information
4 and the interoperability of other medical information.
5 Such report shall include an evaluation of the capacity of
6 the Department of Health and Human Services, the De-
7 partment of Labor, and the Department of the Treasury
8 to regulate and implement standards related to APIs and
9 recommendations for improving such capacity. Such re-
10 port shall include the following:

11 (1) A description of current use, and proposed
12 use, of APIs under Federal rules to facilitate inter-
13 operability, including information related to capacity
14 constraints within the agencies, barriers to adoption,
15 privacy and security, administrative burdens and ef-
16 ficiencies, care coordination, and levels of compli-
17 ance.

18 (2) A description of the feasibility of agency
19 participation in the development of APIs to enable
20 application access to price transparency data under
21 the amendments made by subsection (a).

22 (3) A specification of the timeline for which
23 such data standards can be required to make such
24 data accessible via an API.

1 (4) An analysis of the benefits and challenges
2 of implementing standards-based APIs for price
3 transparency data, including the ability for con-
4 sumers to access rate and payment information and
5 the amount of cost-sharing (including deductibles,
6 copayments, and coinsurance) under the consumer's
7 plan through third-party internet-based tools and
8 applications.

9 (5) An analysis of the impact that APIs which
10 provide real-time access to pricing and cost-sharing
11 information may have in increasing the amount of
12 services shoppable for individuals, such as by stand-
13 ardizing more health care spend via episode bundles.

14 (6) An analysis of which health care items and
15 services may be useful under API, such as those for
16 which prices change with the greatest frequency.

17 (7) An analysis of the cost of API standards
18 implementation on issuers, employers, and other pri-
19 vate-sector entities.

20 (8) An analysis of the ability of State regu-
21 lators to enforce API standards and the costs to the
22 Federal Government and States to regulate and en-
23 force API standards.

1 (9) An analysis of the interaction with API
2 standards and Federal health information privacy
3 standards.

4 (c) PROVIDER TOOL REPORT.—

5 (1) IN GENERAL.—Not later than 1 year after
6 the date of the enactment of this Act, The Secretary
7 of Health and Human Services, acting through the
8 Administrator of the Centers for Medicare & Med-
9 icaid Services, shall, in consultation with stake-
10 holders, conduct a study and submit to the House
11 Committees on Education and the Workforce, En-
12 ergy and Commerce, and Ways and Means, and the
13 Senate Committees on Finance and Health, Edu-
14 cation, Labor, and Pensions a report on the useful-
15 ness and feasibility of the establishment of a pro-
16 vider tool by a group health plan, or a health insur-
17 ance issuer offering group or individual health insur-
18 ance coverage, in facilitating the provision of infor-
19 mation made available pursuant to the amendments
20 made by subsection (a). Such report shall include
21 the following:

22 (A) A description of the feasibility of es-
23 tablishing a requirement for the various types
24 of plans and coverage to offer such a provider
25 tool, including any challenges to establishing a

1 provider tool using the same technology plat-
2 form as the self-service tool described in such
3 amendments.

4 (B) An evaluation on the usefulness of a
5 provider tool to aid patient-decision making and
6 how such tool would coordinate with other in-
7 formation available to a patient and their pro-
8 vider under other Federal requirements in place
9 or under consideration.

10 (C) An evaluation of whether the informa-
11 tion provided by such tool would be duplicative
12 of the advanced explanation of benefits required
13 under Federal law or any other existing require-
14 ment.

15 (D) A description of the usability and ex-
16 pected utilization of such tool among providers,
17 including among different provider types.

18 (E) An analysis of the impact of a provider
19 tool in value-based care arrangements.

20 (F) An analysis on the potential impact of
21 the provider tool on—

22 (i) patients' out-of-pocket spending;

23 (ii) plan design, including impacts on
24 cost-sharing requirements;

25 (iii) care coordination and quality;

- 1 (iv) plan premiums;
- 2 (v) overall health care spending and
- 3 utilization; and
- 4 (vi) health care access in rural areas.

5 (G) An analysis of the feasibility of a pro-
6 vider tool to include additional functionality to
7 facilitate and improve the administration of the
8 requirements on providers to submit notifica-
9 tions to such plan or coverage under section
10 2799B–6 of the Public Health Service Act and
11 the requirements on such plan or coverage to
12 provide an advanced explanation of benefits to
13 individuals under section 2799A–1(f) of such
14 Act.

15 (H) An analysis of which health care items
16 and services, would be most useful for providers
17 utilizing a provider tool.

18 (I) An analysis of rulemaking required to
19 ensure such a tool complies with federal health
20 information privacy standards.

21 (J) An analysis of the burden and cost of
22 the creation of a provider tool by plans and cov-
23 erage on providers, issuers, employers, and
24 other private-sector entities.

1 (K) An analysis of the ability of state reg-
2 ulators to enforce provider tool standards and
3 the costs to the Department and states to regu-
4 late and enforce provider tool standards.

5 (2) DEFINITION.—The term “provider tool”
6 means a tool designed to facilitate the provision of
7 information made available pursuant to the amend-
8 ments made by subsection (a) and established by a
9 group health plan or a health insurance issuer offer-
10 ing group or individual health insurance coverage
11 that allows providers to access the information such
12 plan or coverage must provide through the self-serv-
13 ice tool described in such amendments to an indi-
14 vidual with whom the provider is actively treating at
15 the time of such request, upon the request of the
16 provider, and with the consent of such individual.

17 (d) REPORTS.—

18 (1) COMPLIANCE.—Not later than January 1,
19 2029, the Comptroller General of the United States
20 shall submit to Congress a report containing—

21 (A) an analysis of compliance with the
22 amendments made by this section;

23 (B) an analysis of enforcement of such
24 amendments by the Secretaries of Health and
25 Human Services, Labor, and the Treasury;

1 (C) recommendations relating to improving
2 such enforcement; and

3 (D) recommendations relating to improving
4 public disclosure, and public awareness, of in-
5 formation required to be made available by
6 group health plans and health insurance issuers
7 pursuant to such amendments.

8 (2) PRICES.—Not later than January 1, 2029,
9 and biennially thereafter, the Secretaries of Health
10 and Human Services, Labor, and the Treasury shall
11 jointly submit to Congress a report containing an as-
12 sessment of differences in negotiated prices (and any
13 trends in such prices) in the private market be-
14 tween—

15 (A) rural and urban areas;

16 (B) the individual, small group, and large
17 group markets;

18 (C) consolidated and nonconsolidated
19 health care provider areas (as specified by the
20 Secretary of Health and Human Services);

21 (D) nonprofit and for-profit hospitals;

22 (E) nonprofit and for-profit insurers; and

23 (F) insurers serving local or regional areas
24 and insurers serving multistate or national
25 areas.

1 (e) QUALITY REPORT.—Not later than 1 year after
2 the date of enactment of this subsection, the Secretaries
3 of Health and Human Services, Labor, and the Treasury
4 shall jointly submit to Congress a report on the feasibility
5 of including data relating to the quality of health care
6 items and services with the price transparency information
7 required to be made available under the amendments
8 made by subsection (a). Such report shall include rec-
9 ommendations for legislative and regulatory actions to
10 identify appropriate metrics for assessing and comparing
11 quality of care.

12 (f) CONTINUED APPLICABILITY OF RULES FOR PRE-
13 VIOUS YEARS.—Nothing in the amendments made by sub-
14 section (a) may be construed as affecting the applicability
15 of the rule entitled “Transparency in Coverage” published
16 by the Department of the Treasury, the Department of
17 Labor, and the Department of Health and Human Serv-
18 ices on November 12, 2020 (85 Fed. Reg. 72158), for any
19 plan year beginning before January 1, 2029.

20 **SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.**

21 (a) PHSA.—

22 (1) IN GENERAL.—Part D of title XXVII of the
23 Public Health Service Act is amended by adding at
24 the end the following new section:

1 **“SEC. 2799A-12. INFORMATION ON PRESCRIPTION DRUGS.**

2 “(a) IN GENERAL.—A group health plan or a health
3 insurance issuer offering group or individual health insur-
4 ance coverage shall—

5 “(1) not restrict, directly or indirectly, any
6 pharmacy that dispenses a prescription drug to an
7 enrollee in the plan or coverage from informing (or
8 penalize such pharmacy for informing) an enrollee of
9 any differential between the enrollee’s out-of-pocket
10 cost under the plan or coverage with respect to ac-
11 quisition of the drug and the amount an individual
12 would pay for acquisition of the drug without using
13 any group health plan or health insurance coverage;
14 and

15 “(2) ensure that any entity that provides phar-
16 macy benefits management services under a contract
17 with any such health plan or health insurance cov-
18 erage does not, with respect to such plan or cov-
19 erage, restrict, directly or indirectly, a pharmacy
20 that dispenses a prescription drug from informing
21 (or penalize such pharmacy for informing) an en-
22 rollee of any differential between the enrollee’s out-
23 of-pocket cost under such plan or coverage with re-
24 spect to acquisition of the drug and the amount an
25 individual would pay for acquisition of the drug

1 without using any group health plan or health insur-
2 ance coverage.

3 “(b) DEFINITION.—For purposes of this section, the
4 term ‘out-of-pocket cost’, with respect to acquisition of a
5 drug, means the amount to be paid by the enrollee under
6 the plan or coverage, including any cost-sharing (including
7 any deductible, copayment, or coinsurance) and, as deter-
8 mined by the Secretary, any other expenditure.”.

9 (2) CONFORMING AMENDMENT.—Section 2729
10 of the Public Health Service Act (42 U.S.C. 300gg–
11 29) is amended by adding at the end the following
12 new subsection:

13 “(c) SUNSET.—The preceding provisions of this sec-
14 tion shall not apply beginning on the date of the enact-
15 ment of this subsection.”.

16 (b) ERISA.—

17 (1) IN GENERAL.—Subpart B of part 7 of Sub-
18 title B of title I of the Employee Retirement Income
19 Security Act of 1974 (29 U.S.C. 1185 et seq.) is
20 amended by adding at the end the following new sec-
21 tion:

22 **“SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.**

23 “(a) IN GENERAL.—A group health plan or a health
24 insurance issuer offering group health insurance coverage
25 shall—

1 “(1) not restrict, directly or indirectly, any
2 pharmacy that dispenses a prescription drug to a
3 participant or beneficiary in the plan or coverage
4 from informing (or penalize such pharmacy for in-
5 forming) a participant or beneficiary of any differen-
6 tial between the participant’s or beneficiary’s out-of-
7 pocket cost under the plan or coverage with respect
8 to acquisition of the drug and the amount an indi-
9 vidual would pay for acquisition of the drug without
10 using any group health plan or health insurance cov-
11 erage; and

12 “(2) ensure that any entity that provides phar-
13 macy benefits management services under a contract
14 with any such health plan or health insurance cov-
15 erage does not, with respect to such plan or cov-
16 erage, restrict, directly or indirectly, a pharmacy
17 that dispenses a prescription drug from informing
18 (or penalize such pharmacy for informing) a partici-
19 pant or beneficiary of any differential between the
20 participant’s or beneficiary’s out-of-pocket cost
21 under such plan or coverage with respect to acquisi-
22 tion of the drug and the amount an individual would
23 pay for acquisition of the drug without using any
24 group health plan or health insurance coverage.

1 “(b) DEFINITION.—For purposes of this section, the
 2 term ‘out-of-pocket cost’, with respect to acquisition of a
 3 drug, means the amount to be paid by the participant or
 4 beneficiary under the plan or coverage, including any cost-
 5 sharing (including any deductible, copayment, or coinsur-
 6 ance) and, as determined by the Secretary, any other ex-
 7 penditure.”.

8 (2) CLERICAL AMENDMENT.—The table of con-
 9 tents in section 1 of the Employee Retirement In-
 10 come Security Act of 1974 (29 U.S.C. 1001 et seq.)
 11 is amended by inserting after the item relating to
 12 section 726 the following new item:

“Sec. 727. Information on prescription drugs.”.

13 (c) IRC.—

14 (1) IN GENERAL.—Subchapter B of chapter
 15 100 of the Internal Revenue Code of 1986 is amend-
 16 ed by adding at the end the following:

17 **“SEC. 9827. INFORMATION ON PRESCRIPTION DRUGS.**

18 “(a) IN GENERAL.—A group health plan shall—

19 “(1) not restrict, directly or indirectly, any
 20 pharmacy that dispenses a prescription drug to a
 21 participant or beneficiary in the plan from informing
 22 (or penalize such pharmacy for informing) a partici-
 23 pant or beneficiary of any differential between the
 24 participant’s or beneficiary’s out-of-pocket cost
 25 under the plan with respect to acquisition of the

1 drug and the amount an individual would pay for ac-
 2 quisition of the drug without using any group health
 3 plan or health insurance coverage; and

4 “(2) ensure that any entity that provides phar-
 5 macy benefits management services under a contract
 6 with any such plan does not, with respect to such
 7 plan or coverage, restrict, directly or indirectly, a
 8 pharmacy that dispenses a prescription drug from
 9 informing (or penalize such pharmacy for informing)
 10 a participant or beneficiary of any differential be-
 11 tween the participant’s or beneficiary’s out-of-pocket
 12 cost under the plan with respect to acquisition of the
 13 drug and the amount an individual would pay for ac-
 14 quisition of the drug without using any group health
 15 plan or health insurance coverage.

16 “(b) DEFINITION.—For purposes of this section, the
 17 term ‘out-of-pocket cost’, with respect to acquisition of a
 18 drug, means the amount to be paid by the participant or
 19 beneficiary under the plan, including any cost-sharing (in-
 20 cluding any deductible, copayment, or coinsurance) and,
 21 as determined by the Secretary, any other expenditure.”.

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

“Sec. 9827. Information on prescription drugs.”.

1 **SEC. 5. VERTICAL INTEGRATION ACCOUNTABILITY.**

2 (a) REQUIRED MA AND PDP REPORTING.—

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

6 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-
7 FORMATION RELATING TO HEALTH CARE PROVIDER
8 OWNERSHIP.—

9 “(A) IN GENERAL.—For plan year 2028
10 and for every third plan year thereafter, each
11 applicable MA organization offering an MA
12 plan under this part during such plan year shall
13 submit to the Secretary, at a time and in a
14 manner specified by the Secretary—

15 “(i) the taxpayer identification num-
16 ber for each health care provider that was
17 a specified health care provider with re-
18 spect to such organization during such
19 year;

20 “(ii) the total amount of incentive-
21 based payments made with respect to such
22 plan year to such specified health care pro-
23 viders that have in effect a financial risk
24 arrangement with respect to such plan
25 year;

1 “(iii) the total amount of recoupments
2 collected with respect to such plan year
3 from such specified health care providers
4 that have in effect a financial risk arrange-
5 ment with respect to such plan year;

6 “(iv) the total amount of incentive-
7 based payments made with respect to such
8 plan year to providers of services and sup-
9 pliers not that are not specified health care
10 providers and that have in effect a finan-
11 cial risk arrangement with respect to such
12 plan year; and

13 “(v) the total amount of recoupments
14 collected with respect to such plan year
15 from such providers of services and sup-
16 pliers that have in effect a financial risk
17 arrangement with respect to such plan
18 year.

19 “(B) DEFINITIONS.—For purposes of this
20 paragraph:

21 “(i) APPLICABLE MA ORGANIZA-
22 TION.—The term ‘applicable MA organiza-
23 tion’ means, with respect to a plan year,
24 an MA organization with at least 25,000
25 individuals enrolled across all Medicare Ad-

1 vantage plans offered by such organization
2 during such plan year.

3 “(ii) SPECIFIED HEALTH CARE PRO-
4 VIDER.—The term ‘specified health care
5 provider’ means, with respect to an appli-
6 cable MA organization and a plan year, a
7 provider of services or supplier that—

8 “(I) is owned by, controlled by,
9 or related under a common ownership
10 structure with such MA organization;

11 “(II) has in effect a contract
12 solely with such organization (or with
13 an entity owned by, controlled by, or
14 related under a common ownership
15 structure with such organization (or
16 that has in effect any comparable ar-
17 rangement with such organization))
18 for furnishing items and services;

19 “(III) is a partner under a part-
20 nership (as defined in section
21 7701(a)(2) of the Internal Revenue
22 Code of 1986) with such organization
23 (or with any an entity owned by, con-
24 trolled by, or related under a common

1 ownership structure with such organi-
2 zation); or

3 “(IV) through contract, owner-
4 ship, or otherwise—

5 “(aa) directly or indirectly
6 controls, is controlled by, or is
7 under common ownership with
8 such organization (or with an en-
9 tity owned by, controlled by, or
10 related under a common owner-
11 ship structure with such organi-
12 zation);

13 “(bb) is part of a controlled
14 group of corporations under sec-
15 tion 1563 of the Internal Rev-
16 enue Code of 1986 with such or-
17 ganization (or with any such en-
18 tity);

19 “(cc) is a participant in a
20 lawful combination under which
21 such provider or supplier shares
22 substantial financial risk in con-
23 nection with such organization’s
24 operations (or with the oper-
25 ations of any such entity); or

1 “(dd) part of an affiliated
2 service group under section 414
3 of such Code with such organiza-
4 tion (or with any such entity).”.

5 (2) PRESCRIPTION DRUG PLANS.—Section
6 1860D–12(b) of the Social Security Act (42 U.S.C.
7 1395w–112(b)) is amended by adding at the end the
8 following new paragraph:

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

11 “(A) IN GENERAL.—For plan year 2028
12 and for every third plan year thereafter, each
13 PDP sponsor offering a prescription drug plan
14 under this part during such plan year shall sub-
15 mit to the Secretary, at a time and in a manner
16 specified by the Secretary, the taxpayer identi-
17 fication number and National Provider Identi-
18 fier for each pharmacy that was a specified
19 pharmacy with respect to such plan during such
20 year.

21 “(B) DEFINITION.—For purposes of this
22 paragraph, the term ‘specified pharmacy’
23 means, with respect to a prescription drug plan
24 offered by a PDP sponsor and a plan year, a
25 pharmacy that—

1 “(i) is owned by, controlled by, or re-
2 lated under a common ownership structure
3 with such sponsor;

4 “(ii) has in effect a contract solely
5 with such sponsor (or with an entity owned
6 by, controlled by, or related under a com-
7 mon ownership structure with such spon-
8 sor (or that has in effect any comparable
9 arrangement with such sponsor)) for dis-
10 pensing covered part D drugs;

11 “(iii) is a partner under a partnership
12 (as defined in section 7701(a)(2) of the In-
13 ternal Revenue Code of 1986) with such
14 sponsor (or with any an entity owned by,
15 controlled by, or related under a common
16 ownership structure with such sponsor); or

17 “(iv) through contract, ownership, or
18 otherwise—

19 “(I) directly or indirectly con-
20 trols, is controlled by, or is under
21 common ownership with such sponsor
22 (or with an entity owned by, con-
23 trolled by, or related under a common
24 ownership structure with such spon-
25 sor);

1 “(II) is part of a controlled
2 group of corporations under section
3 1563 of the Internal Revenue Code of
4 1986 with such sponsor (or with any
5 such entity);

6 “(III) is a participant in a lawful
7 combination under which such pro-
8 vider or supplier shares substantial fi-
9 nancial risk in connection with such
10 sponsor’s operations (or with the op-
11 erations of any such sponsor); or

12 “(IV) part of an affiliated service
13 group under section 414 of such Code
14 with such sponsor (or with any such
15 entity).”.

16 (b) REPORTS ON VERTICAL INTEGRATION UNDER
17 MEDICARE.—

18 (1) IN GENERAL.—Not later than the first June
19 15 occurring on or after the date that is 2 years
20 after the Secretary of Health and Human Services
21 first makes available information submitted under
22 sections 1857(e)(6) and 1860D–12(b)(9) of the So-
23 cial Security Act (as added by paragraphs (1) and
24 (2), respectively, of subsection (a)) to the Medicare
25 Payment Advisory Commission, and again not later

1 than 4 years after the first report is submitted
2 under this paragraph, the Medicare Payment Advi-
3 sory Commission shall submit to Congress a report
4 on the state of vertical integration in the health care
5 sector during the applicable year with respect to en-
6 tities participating in the Medicare program under
7 part C of title XVIII of the Social Security Act (42
8 U.S.C. 1395w–21 et seq.) or part D of such title (42
9 U.S.C. 1395w–101 et seq.), including health care
10 providers, pharmacies, prescription drug plan spon-
11 sors, Medicare Advantage organizations, and phar-
12 macy benefit managers. Such report shall include, to
13 the extent practicable—

14 (A) with respect to Medicare Advantage
15 organizations, the evaluation described in para-
16 graph (2);

17 (B) with respect to prescription drug
18 plans, pharmacy benefit managers, and phar-
19 macies, the comparisons and summary de-
20 scribed in paragraph (3);

21 (C) an assessment of the Medicare Advan-
22 tage organization and PDP sponsor integration
23 information described in paragraph (4); and

1 (D) an analysis of the impact of such inte-
2 gration on health care access, price, quality,
3 and outcomes.

4 (2) MEDICARE ADVANTAGE ORGANIZATIONS.—
5 For purposes of paragraph (1)(A), the evaluation
6 described in this paragraph is, with respect to Medi-
7 care Advantage organizations and an applicable
8 year, an evaluation, taking into account patient acu-
9 ity and the types of areas serviced by such organiza-
10 tion, of—

11 (A) the average number of qualifying diag-
12 noses made during such year with respect to
13 enrollees of a Medicare Advantage plan offered
14 by such organization who, during such year, re-
15 ceived a health risk assessment from a specified
16 health care provider, compared to the average
17 number of such diagnoses made during such
18 year with respect to enrollees of such plan who,
19 during such year, did not receive such an as-
20 sessment from such a provider;

21 (B) the average risk score for enrollees of
22 a Medicare Advantage plan who received such
23 an assessment from a specified health care pro-
24 vider during such year compared to the average
25 risk score for enrollees of such plan who did not

1 receive such an assessment from such a pro-
2 vider during such year;

3 (C) any relationship between risk scores
4 for such enrollees receiving such an assessment
5 from such a provider during such year and in-
6 centive-based payments made to such providers;

7 (D) the average risk score for enrollees of
8 such plan who received any item or service from
9 a specified health care provider during such
10 year compared to the average risk score for en-
11 rollees of such plan who did not receive any
12 item or service from such a provider during
13 such year;

14 (E) any relationship between the risk
15 scores of enrollees under such plan and whether
16 the enrollees have received any item or service
17 from a specified provider; and

18 (F) any relationship between the risk
19 scores of enrollees under such plan that have
20 received any item or service from a specified
21 provider and incentive-based payments made
22 under the plan to specified providers.

23 (3) PRESCRIPTION DRUG PLANS.—For purposes
24 of paragraph (1)(B), the comparisons and summary
25 described in this paragraph are, with respect to pre-

1 scription drug plans and an applicable year, the fol-
2 lowing:

3 (A) For each covered part D drug for
4 which benefits are available under such a plan,
5 a comparison of information about payments
6 submitted with respect to such plan under sec-
7 tion 1860D–12(h)(1)(C)(i)(I) of the Social Se-
8 curity Act (42 U.S.C. 1395w–
9 112(h)(1)(C)(i)(I)) with respect to specified
10 pharmacies with the same such information
11 about payments submitted by such plan with
12 respect to in-network pharmacies that are not
13 specified pharmacies.

14 (B) Comparisons of the following:

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

21 (ii) The total amount paid by such
22 sponsors to specified pharmacy benefit
23 managers as reimbursement for covered
24 part D drugs and the total amount so paid
25 to pharmacy benefit managers that are not

1 specified pharmacy benefit managers as
 2 such reimbursement.

3 (C) A summary of the total manufacturer-
 4 derived revenue retained by pharmacy benefit
 5 managers and any affiliates of such pharmacy
 6 benefit managers (as reported under section
 7 1860D–12(h)(1)(C)(i)(I)(kk) of the Social Se-
 8 curity Act (42 U.S.C. 1395w–
 9 112(h)(1)(C)(i)(I)(kk)).

10 (4) MEDICARE ADVANTAGE ORGANIZATION AND
 11 PDP SPONSOR INTEGRATION INFORMATION.—For
 12 purposes of paragraph (1)(C), the Medicare Advan-
 13 tage organization and PDP sponsor integration in-
 14 formation described in this paragraph is information
 15 submitted under sections 1857(e)(6) and 1860D–
 16 12(b)(9) of the Social Security Act (as added by
 17 paragraphs (1) and (2), respectively, of subsection
 18 (a)) and section 1860D–12(h) of such Act (42 U.S.C.
 19 1395w–112(h)).

20 (5) DEFINITIONS.—In this subsection:

21 (A) APPLICABLE YEAR.—The term “appli-
 22 cable year” means—

23 (i) with respect to the first report sub-
 24 mitted under paragraph (1), plan year
 25 2028; and

1 (ii) with respect to the second report
2 submitted under paragraph (1), plan year
3 2031.

4 (B) COVERED PART D DRUG.—The term
5 “covered part D drug” has the meaning given
6 such term in section 1860D–2(e) of the Social
7 Security Act (42 U.S.C. 1395w–102(e)).

8 (C) QUALIFYING DIAGNOSIS.—The term
9 “qualifying diagnosis” means, with respect to
10 an enrollee of a Medicare Advantage plan, a di-
11 agnosis that is taken into account in calculating
12 a risk score for such enrollee under the risk ad-
13 justment methodology established by the Sec-
14 retary pursuant to section 1853(a)(3) of the
15 Social Security Act (42 U.S.C. 1305w–
16 23(a)(3)).

17 (D) RISK SCORE.—The term “risk score”
18 means, with respect to an enrollee of a Medi-
19 care Advantage plan, the score calculated for
20 such individual using the methodology described
21 in subparagraph (E).

22 (E) SPECIFIED HEALTH CARE PRO-
23 VIDER.—The term “specified health care pro-
24 vider” means, with respect to a Medicare Ad-

1 vantage plan offered by a Medicare Advantage
2 organization, a health care provider that—

3 (i) is owned by, controlled by, or re-
4 lated under a common ownership structure
5 with such organization;

6 (ii) has in effect a contract solely with
7 such organization (or with an entity owned
8 by, controlled by, or related under a com-
9 mon ownership structure with such organi-
10 zation (or that has in effect any com-
11 parable arrangement with such organiza-
12 tion)) for furnishing items and services;

13 (iii) is a partner under a partnership
14 (as defined in section 7701(a)(2) of the In-
15 ternal Revenue Code of 1986) with such
16 organization (or with any an entity owned
17 by, controlled by, or related under a com-
18 mon ownership structure with such organi-
19 zation); or

20 (iv) through contract, ownership, or
21 otherwise—

22 (I) directly or indirectly controls,
23 is controlled by, or is under common
24 ownership with such organization (or
25 with an entity owned by, controlled

1 by, or related under a common owner-
2 ship structure with such organiza-
3 tion);

4 (II) is part of a controlled group
5 of corporations under section 1563 of
6 the Internal Revenue Code of 1986
7 with such organization (or with any
8 such entity);

9 (III) is a participant in a lawful
10 combination under which such pro-
11 vider or supplier shares substantial fi-
12 nancial risk in connection with such
13 organization's operations (or with the
14 operations of any such entity); or

15 (IV) part of an affiliated service
16 group under section 414 of such Code
17 with such organization (or with any
18 such entity).

19 (F) SPECIFIED PHARMACY.—The term
20 “specified pharmacy” means, with respect to a
21 prescription drug plan offered by a prescription
22 drug plan sponsor, a pharmacy that—

23 (i) is owned by, controlled by, or re-
24 lated under a common ownership structure
25 with such sponsor;

1 (ii) has in effect a contract solely with
2 such sponsor (or with an entity owned by,
3 controlled by, or related under a common
4 ownership structure with such sponsor (or
5 that has in effect any comparable arrange-
6 ment with such sponsor)) for dispensing
7 covered part D drugs;

8 (iii) is a partner under a partnership
9 (as defined in section 7701(a)(2) of the In-
10 ternal Revenue Code of 1986) with such
11 sponsor (or with any an entity owned by,
12 controlled by, or related under a common
13 ownership structure with such sponsor); or

14 (iv) through contract, ownership, or
15 otherwise—

16 (I) directly or indirectly controls,
17 is controlled by, or is under common
18 ownership with such sponsor (or with
19 an entity owned by, controlled by, or
20 related under a common ownership
21 structure with such sponsor);

22 (II) is part of a controlled group
23 of corporations under section 1563 of
24 the Internal Revenue Code of 1986

1 with such sponsor (or with any such
2 entity);

3 (III) is a participant in a lawful
4 combination under which such pro-
5 vider or supplier shares substantial fi-
6 nancial risk in connection with such
7 sponsor's operations (or with the op-
8 erations of any such entity); or

9 (IV) part of an affiliated service
10 group under section 414 of such Code
11 with such sponsor (or with any such
12 entity).

13 (G) SPECIFIED PHARMACY BENEFIT MAN-
14 AGER.—The term “specified pharmacy benefit
15 manager” means, with respect to a prescription
16 drug plan offered by a prescription drug plan
17 sponsor, a pharmacy benefit manager that—

18 (i) is owned by, controlled by, or re-
19 lated under a common ownership structure
20 with such sponsor;

21 (ii) has in effect a contract solely with
22 such sponsor (or with an entity owned by,
23 controlled by, or related under a common
24 ownership structure with such sponsor (or
25 that has in effect any comparable arrange-

1 ment with such sponsor)) for furnishing
2 pharmacy benefit management services;

3 (iii) is a partner under a partnership
4 (as defined in section 7701(a)(2) of the In-
5 ternal Revenue Code of 1986) with such
6 sponsor (or with any an entity owned by,
7 controlled by, or related under a common
8 ownership structure with such sponsor); or

9 (iv) through contract, ownership, or
10 otherwise—

11 (I) directly or indirectly controls,
12 is controlled by, or is under common
13 ownership with such sponsor (or with
14 an entity owned by, controlled by, or
15 related under a common ownership
16 structure with such sponsor);

17 (II) is part of a controlled group
18 of corporations under section 1563 of
19 the Internal Revenue Code of 1986
20 with such sponsor (or with any such
21 entity);

22 (III) is a participant in a lawful
23 combination under which such pro-
24 vider or supplier shares substantial fi-
25 nancial risk in connection with such

1 sponsor's operations (or with the op-
2 erations of any such entity); or
3 (IV) part of an affiliated service
4 group under section 414 of such Code
5 with such sponsor (or with any such
6 entity).

7 **SEC. 6. IMPLEMENTATION FUNDING.**

8 (a) IN GENERAL.—For the purposes described in
9 subsection (b), there are appropriated, in addition to
10 amounts otherwise available, out of amounts in the Treas-
11 ury not otherwise appropriated—

12 (1) to the Secretary of Health and Human
13 Services and the Secretary of the Treasury,
14 \$65,000,000 for fiscal year 2027, to remain avail-
15 able through fiscal year 2032; and

16 (2) to the Secretary of Labor, \$35,000,000 for
17 fiscal year 2027, to remain available through fiscal
18 year 2032.

19 (b) PERMITTED PURPOSES.—The purposes described
20 in this subsection are the following purposes, insofar as
21 such purposes are to carry out the provisions of, including
22 the amendments made by, this title:

23 (1) Preparing, drafting, and issuing proposed
24 and final regulations or interim regulations.

1 (2) Preparing, drafting, and issuing guidance
2 and public information.

3 (3) Preparing, drafting, and publishing reports.

4 (4) Enforcement of such provisions.

5 (5) Reporting, collection, and analysis of data.

6 (6) Other administrative duties necessary for
7 implementation of such provisions.

8 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—

9 Each Secretary described in subsection (a) shall annually
10 submit, not later than September 1st of each year, to the
11 Committees on Energy and Commerce, on Ways and
12 Means, on Education and the Workforce, and on Appro-
13 priations of the House of Representatives and the Com-
14 mittees on Health, Education, Labor, and Pensions, on
15 Finance, and on Appropriations of the Senate a report on
16 funds expended pursuant to funds appropriated under this
17 section.

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