

Suspend the Rules and Pass the Bill, H.R. 5378, with An Amendment

(The amendment strikes all after the enacting clause and inserts a new text)

118TH CONGRESS
1ST SESSION

H. R. 5378

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 8, 2023

Mrs. RODGERS of Washington (for herself, Mr. PALLONE, Mr. SMITH of Missouri, and Ms. FOXX) 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 the 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 price transparency in the health care sector,
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 “Lower Costs, More
5 Transparency Act”.

1 SEC. 2. TABLE OF CONTENTS.

2 The table of contents of this Act is as follows:

- Sec. 1. Short title.
- Sec. 2. Table of contents.

TITLE I—IMPROVING HEALTH CARE TRANSPARENCY

- Sec. 101. Hospital price transparency.
- Sec. 102. Clinical diagnostic laboratory test price transparency.
- Sec. 103. Imaging price transparency.
- Sec. 104. Ambulatory surgical center price transparency.
- Sec. 105. Health coverage price transparency.
- Sec. 106. Pharmacy benefits price transparency.
- Sec. 107. Reports on health care transparency tools and data.
- Sec. 108. Report on integration in Medicare.
- Sec. 109. Advisory Committee.
- Sec. 110. Report on impact of Medicare regulations on provider and payer consolidation.
- Sec. 111. Implementation funding.

TITLE II—REDUCING HEALTH CARE COSTS FOR PATIENTS

- Sec. 201. Increasing transparency in generic drug applications.
- Sec. 202. Improving transparency and preventing the use of abusive spread pricing and related practices in Medicaid.
- Sec. 203. Parity in Medicare payments for hospital outpatient department services furnished off-campus.
- Sec. 204. Requiring a separate identification number and an attestation for each off-campus outpatient department of a provider.

TITLE III—SUPPORTING PATIENTS, HEALTH CARE WORKERS, COMMUNITY HEALTH CENTERS, AND HOSPITALS

- Sec. 301. Extension for community health centers, the national health service corps, and teaching health centers that operate GME programs.
- Sec. 302. Extension of special diabetes programs.
- Sec. 303. Delaying certain disproportionate share hospital payment reductions under the Medicaid program.
- Sec. 304. Medicaid improvement fund.

TITLE IV—INCREASING ACCESS TO QUALITY HEALTH DATA AND LOWERING HIDDEN FEES

- Sec. 401. Increasing Plan Fiduciaries' Access to Health Data.
- Sec. 402. Hidden Fees Disclosure Requirements.
- Sec. 403. Prescription drug price information requirement.
- Sec. 404. Implementation funding.

1 **TITLE I—IMPROVING HEALTH**
2 **CARE TRANSPARENCY**

3 **SEC. 101. HOSPITAL PRICE TRANSPARENCY.**

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

7 **“SEC. 1899C. HOSPITAL PRICE TRANSPARENCY.**

8 “(a) **TRANSPARENCY REQUIREMENT.**—

9 “(1) **IN GENERAL.**—Beginning January 1,
10 2026, each specified hospital that receives payment
11 under this title for furnishing items and services
12 shall comply with the price transparency require-
13 ment described in paragraph (2).

14 “(2) **REQUIREMENT DESCRIBED.**—

15 “(A) **IN GENERAL.**—For purposes of para-
16 graph (1), the price transparency requirement
17 described in this paragraph is, with respect to
18 a specified hospital, that such hospital, in ac-
19 cordance with a method and format established
20 by the Secretary under subparagraph (C), com-
21 pile and make public (without subscription and
22 free of charge) for each year—

23 “(i) all of the hospital’s standard
24 charges (including the information de-

1 scribed in subparagraph (B)) for each item
2 and service furnished by such hospital;

3 “(ii) information in a consumer-
4 friendly format (as specified by the Sec-
5 retary)—

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

19 “(II) that includes, with respect
20 to each Centers for Medicare & Med-
21 icaid Services-specified shoppable
22 service that is not furnished by the
23 hospital, an indication that such serv-
24 ice is not so furnished; and

1 “(iii) an attestation that all informa-
2 tion made public pursuant to this subpara-
3 graph is complete and accurate.

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

10 “(i) A plain language description of
11 each item or service, accompanied by, as
12 applicable, the Healthcare Common Proce-
13 dure Coding System code, the diagnosis-re-
14 lated group, the national drug code, or
15 other identifier used or approved by the
16 Centers for Medicare & Medicaid Services.

17 “(ii) The gross charge, as applicable,
18 expressed as a dollar amount, for each
19 such item or service, when provided in, as
20 applicable, the inpatient setting and out-
21 patient department setting.

22 “(iii) The discounted cash price, as
23 applicable, expressed as a dollar amount,
24 for each such item or service when pro-
25 vided in, as applicable, the inpatient set-

1 ting and outpatient department setting (or,
2 in the case no discounted cash price is
3 available for an item or service, the median
4 cash price charged by the hospital to self-
5 pay individuals for such item or service
6 when provided in such settings for the pre-
7 vious three years, expressed as a dollar
8 amount, as well as, with respect to prices
9 made public pursuant to subparagraph
10 (A)(ii), a link to a consumer-friendly docu-
11 ment that clearly explains the hospital’s
12 charity care policy that includes, if applica-
13 ble, any sliding scale payment structure
14 employed for determining charges for a
15 self-pay individual).

16 “(iv) The payer-specific negotiated
17 charges, as applicable, clearly associated
18 with the name of the third party payer and
19 plan and expressed as a dollar amount,
20 that apply to each such item or service
21 when provided in, as applicable, the inpa-
22 tient setting and outpatient department
23 setting.

1 “(v) The de-identified maximum and
2 minimum negotiated charges, as applica-
3 ble, for each such item or service.

4 “(vi) Any other additional information
5 the Secretary may require for the purpose
6 of improving the accuracy of, or enabling
7 consumers to easily understand and com-
8 pare, standard charges and prices for an
9 item or service, except information that is
10 duplicative of any other reporting require-
11 ment under this subsection.

12 In the case of standard charges and prices for
13 an item or service included as part of a bun-
14 dled, per diem, episodic, or other similar ar-
15 rangement, the information described in this
16 subparagraph shall be made available as deter-
17 mined appropriate by the Secretary.

18 “(C) UNIFORM METHOD AND FORMAT.—
19 Not later than January 1, 2026, the Secretary
20 shall establish a standard, uniform method and
21 format for specified hospitals to use in com-
22 piling and making public standard charges pur-
23 suant to subparagraph (A)(i) and a standard,
24 uniform method and format for such hospitals
25 to use in compiling and making public prices

1 pursuant to subparagraph (A)(ii). Such meth-
2 ods and formats—

3 “(i) shall, in the case of such method
4 and format for making public standard
5 charges pursuant to subparagraph (A)(i),
6 ensure that such charges are made avail-
7 able in a machine-readable format (or a
8 successor technology specified by the Sec-
9 retary);

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

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

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

21 “(3) MONITORING COMPLIANCE.—The Sec-
22 retary shall, through notice and comment rule-
23 making and in consultation with the Inspector Gen-
24 eral of the Department of Health and Human Serv-
25 ices, establish a process to monitor compliance with

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

5 “(4) ENFORCEMENT.—

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

9 “(i) not later than 30 days after the
10 date on which the Secretary determines
11 such failure exists, the Secretary shall sub-
12 mit to such hospital a notification of such
13 determination (which may include, as de-
14 termined appropriate by the Secretary, a
15 request for a corrective action plan to com-
16 ply with such requirements); and

17 “(ii) in the case of a hospital that
18 does not receive a request for a corrective
19 action plan as part of a notification sub-
20 mitted by the Secretary under clause (i)—

21 “(I) the Secretary shall, not later
22 than 45 days after such notification is
23 sent, determine whether such hospital
24 is in compliance with such require-
25 ments; and

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

6 “(aa) submit to such hos-
7 pital a request for a corrective
8 action plan to comply with such
9 requirements; or

10 “(bb) if the Secretary deter-
11 mines that such hospital has not
12 taken meaningful actions to come
13 into compliance since such notifi-
14 cation was sent, impose a civil
15 monetary penalty in accordance
16 with subparagraph (B).

17 “(B) CIVIL MONETARY PENALTY.—

18 “(i) IN GENERAL.—Subject to clause
19 (vii), in addition to any other enforcement
20 actions or penalties that may apply under
21 another provision of law, a specified hos-
22 pital that has received a request for a cor-
23 rective action plan under clause (i) or (ii)
24 of subparagraph (A) and fails to comply
25 with the requirements of this subsection by

1 the date that is 45 days after such request
2 is made, and a specified hospital with re-
3 spect to which the Secretary has made a
4 determination described in clause
5 (ii)(II)(bb) of such subparagraph, shall be
6 subject to a civil monetary penalty of an
7 amount specified by the Secretary for each
8 day (beginning with the day on which the
9 Secretary first determined that such hos-
10 pital was not complying with such require-
11 ments) during which such failure was on-
12 going. Such amount shall not exceed—

13 “(I) in the case of a specified
14 hospital with 30 or fewer beds, \$300
15 per day (or, in the case of such a hos-
16 pital that has been noncompliant with
17 such requirements for a 1-year period
18 or longer, beginning with the first day
19 following such 1-year period, \$400 per
20 day);

21 “(II) in the case of a specified
22 hospital with more than 30 beds but
23 fewer than 101 beds, \$12.50 per bed
24 per day (or, in the case of such a hos-
25 pital that has been noncompliant with

1 such requirements for a 1-year period
2 or longer, beginning with the first day
3 following such 1-year period, \$15 per
4 bed per day);

5 “(III) in the case of a specified
6 hospital with more than 100 beds but
7 fewer than 201 beds, \$17.50 per bed
8 per day (or, in the case of such a hos-
9 pital that has been noncompliant with
10 such requirements for a 1-year period
11 or longer, beginning with the first day
12 following such 1-year period, \$20 per
13 bed per day);

14 “(IV) in the case of a specified
15 hospital with more than 200 beds but
16 fewer than 501 beds, \$20 per bed per
17 day (or, in the case of such a hospital
18 that has been noncompliant with such
19 requirements for a 1-year period or
20 longer, beginning with the first day
21 following such 1-year period, \$25 per
22 bed per day); and

23 “(V) in the case of a specified
24 hospital with more than 500 beds,
25 \$25 per bed per day (or, in the case

1 of such a hospital that has been non-
2 compliant with such requirements for
3 a 1-year period or longer, beginning
4 with the first day following such 1-
5 year period, \$35 per bed per day).

6 “(ii) INCREASE AUTHORITY.—In ap-
7 plying this subparagraph with respect to
8 violations occurring in 2027 or a subse-
9 quent year, the Secretary may through no-
10 tice and comment rulemaking increase—

11 “(I) the limitation on the per day
12 amount of any penalty applicable to a
13 specified hospital under clause (i)(I);

14 “(II) the limitations on the per
15 bed per day amount of any penalty
16 applicable under any of subclauses
17 (II) through (V) of clause (i); and

18 “(III) the amounts specified in
19 clause (iii)(II).

20 “(iii) PERSISTENT NONCOMPLI-
21 ANCE.—

22 “(I) IN GENERAL.—In the case
23 of a specified hospital (other than a
24 specified hospital with 30 or fewer
25 beds) that the Secretary has deter-

1 mined to be knowingly and willfully
2 noncompliant with the provisions of
3 this subsection two or more times dur-
4 ing a 1-year period, the Secretary may
5 increase any penalty otherwise appli-
6 cable under this subparagraph by the
7 amount specified in subclause (II)
8 with respect to such hospital and may
9 require such hospital to complete such
10 additional corrective actions plans as
11 the Secretary may specify.

12 “(II) SPECIFIED AMOUNT.—For
13 purposes of subclause (I), the amount
14 specified in this subclause is, with re-
15 spect to a specified hospital—

16 “(aa) with more than 30
17 beds but fewer than 101 beds, an
18 amount that is not less than
19 \$500,000 and not more than
20 \$1,000,000;

21 “(bb) with more than 100
22 beds but fewer than 301 beds, an
23 amount that is greater than
24 \$1,000,000 and not more than
25 \$2,000,000;

1 “(cc) with more than 300
2 beds but fewer than 501 beds, an
3 amount that is greater than
4 \$2,000,000 and not more than
5 \$4,000,000; and

6 “(dd) with more than 500
7 beds, and amount that is not less
8 than \$5,000,000 and not more
9 than \$10,000,000.

10 “(iv) AUTHORITY TO WAIVE OR RE-
11 DUCE PENALTY.—

12 “(I) IN GENERAL.—Subject to
13 subclause (II), the Secretary may
14 waive any penalty, or reduce any pen-
15 alty by not more than 75 percent, oth-
16 erwise applicable under this subpara-
17 graph with respect to a specified hos-
18 pital located in a rural or underserved
19 area if the Secretary certifies that im-
20 position of such penalty would result
21 in an immediate threat to access to
22 care for individuals in the service area
23 of such hospital.

24 “(II) LIMITATION ON APPLICA-
25 TION.—The Secretary may not elect

1 to waive a penalty under subclause (I)
2 with respect to a specified hospital
3 more than once in a 6-year period and
4 may not elect to reduce such a penalty
5 with respect to such a hospital more
6 than once in such a period. Nothing
7 in the preceding sentence shall be con-
8 strued as prohibiting the Secretary
9 from both waiving and reducing a
10 penalty with respect to a specified
11 hospital during a 6-year period.

12 “(v) PROVISION OF TECHNICAL AS-
13 SISTANCE.—The Secretary shall, to the ex-
14 tent practicable, provide technical assist-
15 ance relating to compliance with the provi-
16 sions of this subsection to specified hos-
17 pitals requesting such assistance.

18 “(vi) APPLICATION OF CERTAIN PRO-
19 VISIONS.—The provisions of section 1128A
20 (other than subsections (a) and (b) of such
21 section) shall apply to a civil monetary
22 penalty imposed under this subparagraph
23 in the same manner as such provisions
24 apply to a civil monetary penalty imposed
25 under subsection (a) of such section.

1 “(vii) NONDUPLICATION OF CERTAIN
2 PENALTIES.—The Secretary may not sub-
3 ject a specified hospital to a civil monetary
4 penalty under this subparagraph with re-
5 spect to noncompliance with the provisions
6 of this section for a period if the Secretary
7 has imposed a civil monetary penalty on
8 such hospital under section 2718(f) of the
9 Public Health Service Act for failure to
10 comply with the provisions of such section
11 for such period.

12 “(C) PUBLICATION OF HOSPITAL PRICE
13 TRANSPARENCY INFORMATION.—Beginning on
14 January 1, 2026, the Secretary shall make pub-
15 licly available on the public website of the Cen-
16 ters for Medicare & Medicaid Services informa-
17 tion with respect to compliance with the re-
18 quirements of this subsection and enforcement
19 activities undertaken by the Secretary under
20 this subsection. Such information shall be up-
21 dated in real time and include—

22 “(i) the number of reviews of compli-
23 ance with this subsection undertaken by
24 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 and

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

6 “(b) ENSURING ACCESSIBILITY THROUGH IMPLE-
7 MENTATION.—In implementing the amendments made by
8 this section, the Secretary of Health and Human Services
9 shall through rulemaking ensure that a hospital submit-
10 ting charges and information pursuant to such amend-
11 ments takes reasonable steps (as specified by the Sec-
12 retary) to ensure the accessibility of such charges and in-
13 formation to individuals with limited English proficiency.
14 Such steps may include the hospital’s provision of inter-
15 pretation services or the hospital’s provision of trans-
16 lations of charges and information.

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

18 “(1) DISCOUNTED CASH PRICE.—The term ‘dis-
19 counted cash price’ means the charge that applies to
20 an individual who pays cash, or cash equivalent, for
21 an item or service.

22 “(2) FEDERAL HEALTH CARE PROGRAM.—The
23 term ‘Federal health care program’ has the meaning
24 given such term in section 1128B.

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

6 “(4) GROUP HEALTH PLAN; GROUP HEALTH IN-
7 SURANCE COVERAGE; INDIVIDUAL HEALTH INSUR-
8 ANCE COVERAGE.—The terms ‘group health plan’,
9 ‘group health insurance coverage’, and ‘individual
10 health insurance coverage’ have the meaning given
11 such terms in section 2791 of the Public Health
12 Service Act.

13 “(5) PAYER-SPECIFIC NEGOTIATED CHARGE.—
14 The term ‘payer-specific negotiated charge’ means
15 the charge that a specified hospital or provider of
16 services or supplier, as applicable, has negotiated
17 with a third party payer for an item or service.

18 “(6) SHOPPABLE SERVICE.—The term
19 ‘shoppable service’ means a service that can be
20 scheduled by a health care consumer in advance and
21 includes all ancillary items and services customarily
22 furnished as part of such service.

23 “(7) SPECIFIED HOSPITAL.—The term ‘speci-
24 fied hospital’ means a hospital (as defined in section
25 1861(e)), a critical access hospital (as defined in

1 section 1861(mmm)(1)), or a rural emergency hos-
2 pital (as defined in section 1861(kkk)).

3 “(8) THIRD PARTY PAYER.—The term ‘third
4 party payer’ means an entity that is, by statute, con-
5 tract, or agreement, legally responsible for payment
6 of a claim for a health care item or service.”.

7 (b) PHSA.—

8 (1) IN GENERAL.—Section 2718 of the Public
9 Health Service Act (42 U.S.C. 300gg–18) is amend-
10 ed by adding at the end the following new sub-
11 section:

12 “(f) HOSPITAL TRANSPARENCY REQUIREMENT.—

13 “(1) IN GENERAL.—Beginning January 1,
14 2026, each hospital shall comply with the price
15 transparency requirement described in paragraph
16 (2).

17 “(2) REQUIREMENT DESCRIBED.—

18 “(A) IN GENERAL.—For purposes of para-
19 graph (1), the price transparency requirement
20 described in this paragraph is, with respect to
21 a hospital, that such hospital, in accordance
22 with a method and format established by the
23 Secretary under subparagraph (C), compile and
24 make public (without subscription and free of
25 charge) for each year—

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

5 “(ii) information in a consumer-
6 friendly format (as specified by the Sec-
7 retary)—

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

21 “(II) that includes, with respect
22 to each Centers for Medicare & Med-
23 icaid Services-specified shoppable
24 service that is not furnished by the

1 hospital, an indication that such serv-
2 ice is not so furnished; and

3 “(iii) an attestation that all informa-
4 tion made public pursuant to this subpara-
5 graph is 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 hospital, the following:

11 “(i) A plain language description of
12 each item or service, accompanied by, as
13 applicable, the Healthcare Common Proce-
14 dure Coding System code, the diagnosis-re-
15 lated group, the national drug code, cur-
16 rent procedure terminology codes, or other
17 identifier used or approved by the Centers
18 for Medicare & Medicaid Services.

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

24 “(iii) The discounted cash price, as
25 applicable, expressed as a dollar amount,

1 for each such item or service when pro-
2 vided in, as applicable, the inpatient set-
3 ting and outpatient department setting (or,
4 in the case no discounted cash price is
5 available for an item or service, the median
6 cash price charged by the hospital to self-
7 pay individuals for such item or service
8 when provided in such settings for the pre-
9 vious three years, expressed as a dollar
10 amount, as well as, with respect to prices
11 made public pursuant to subparagraph
12 (A)(ii), a link to a consumer-friendly docu-
13 ment that clearly explains the hospital's
14 charity care policy that includes, if applica-
15 ble, any sliding scale payment structure
16 employed for determining charges for a
17 self-pay individual).

18 “(iv) The payer-specific negotiated
19 charges, as applicable, clearly associated
20 with the name of the third party payer and
21 plan and expressed as a dollar amount,
22 that apply to each such item or service
23 when provided in, as applicable, the inpa-
24 tient setting and outpatient department
25 setting.

1 “(v) The de-identified maximum and
2 minimum negotiated charges, as applica-
3 ble, for each such item or service.

4 “(vi) Any other additional information
5 the Secretary may require for the purpose
6 of improving the accuracy of, or enabling
7 consumers to easily understand and com-
8 pare, standard charges and prices for an
9 item or service, except information that is
10 duplicative of any other reporting require-
11 ment under this subsection.

12 In the case of standard charges and prices for
13 an item or service included as part of a bun-
14 dled, per diem, episodic, or other similar ar-
15 rangement, the information described in this
16 subparagraph shall be made available as deter-
17 mined appropriate by the Secretary.

18 “(C) UNIFORM METHOD AND FORMAT.—
19 Not later than January 1, 2026, the Secretary
20 shall establish a standard, uniform method and
21 format for hospitals to use in compiling and
22 making public standard charges pursuant to
23 subparagraph (A)(i) and a standard, uniform
24 method and format for such hospitals to use in
25 compiling and making public prices pursuant to

1 subparagraph (A)(ii). Such methods and for-
2 mats—

3 “(i) shall, in the case of such method
4 and format for making public standard
5 charges pursuant to subparagraph (A)(i),
6 ensure that such charges are made avail-
7 able in a machine-readable format (or a
8 successor technology specified by the Sec-
9 retary);

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

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

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

21 “(3) MONITORING COMPLIANCE.—The Sec-
22 retary shall, through notice and comment rule-
23 making and in consultation with the Inspector Gen-
24 eral of the Department of Health and Human Serv-
25 ices, establish a process to monitor compliance with

1 this subsection. Such process shall ensure that each
2 hospital’s compliance with this subsection is re-
3 viewed not less frequently than once every 3 years.

4 “(4) ENFORCEMENT.—

5 “(A) IN GENERAL.—In the case of a hos-
6 pital that fails to comply with the requirements
7 of this subsection—

8 “(i) not later than 30 days after the
9 date on which the Secretary determines
10 such failure exists, the Secretary shall sub-
11 mit to such hospital a notification of such
12 determination (which may include, as de-
13 termined appropriate by the Secretary, a
14 request for a corrective action plan to com-
15 ply with such requirements); and

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

20 “(I) the Secretary shall, not later
21 than 45 days after such notification is
22 sent, determine whether such hospital
23 is in compliance with such require-
24 ments; and

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

6 “(aa) submit to such hos-
7 pital a request for a corrective
8 action plan to comply with such
9 requirements; or

10 “(bb) if the Secretary deter-
11 mines that such hospital has not
12 taken meaningful actions to come
13 into compliance since such notifi-
14 cation was sent, impose a civil
15 monetary penalty in accordance
16 with subparagraph (B).

17 “(B) CIVIL MONETARY PENALTY.—

18 “(i) IN GENERAL.—In addition to any
19 other enforcement actions or penalties that
20 may apply under another provision of law,
21 a hospital that has received a request for
22 a corrective action plan under clause (i) or
23 (ii) of subparagraph (A) and fails to com-
24 ply with the requirements of this sub-
25 section by the date that is 45 days after

1 such request is made, and a hospital with
2 respect to which the Secretary has made a
3 determination described in clause
4 (ii)(II)(bb) of such subparagraph, shall be
5 subject to a civil monetary penalty of an
6 amount specified by the Secretary for each
7 day (beginning with the day on which the
8 Secretary first determined that such hos-
9 pital was not complying with such require-
10 ments) during which such failure was on-
11 going. Such amount shall not exceed—

12 “(I) in the case of a hospital with
13 30 or fewer beds, \$300 per day (or, in
14 the case of such a hospital that has
15 been noncompliant with such require-
16 ments for a 1-year period or longer,
17 beginning with the first day following
18 such 1-year period, \$400 per bed per
19 day);

20 “(II) in the case of a hospital
21 with more than 30 beds but fewer
22 than 101 beds, \$12.50 per bed per
23 day (or, in the case of such a hospital
24 that has been noncompliant with such
25 requirements for a 1-year period or

1 longer, beginning with the first day
2 following such 1-year period, \$15 per
3 bed per day);

4 “(III) in the case of a hospital
5 with more than 100 beds but fewer
6 than 201 beds, \$17.50 per bed per
7 day (or, in the case of such a hospital
8 that has been noncompliant with such
9 requirements for a 1-year period or
10 longer, beginning with the first day
11 following such 1-year period, \$20 per
12 bed per day);

13 “(IV) in the case of a hospital
14 with more than 200 beds but fewer
15 than 501 beds, \$20 per bed per day
16 (or, in the case of such a hospital that
17 has been noncompliant with such re-
18 quirements for a 1-year period or
19 longer, beginning with the first day
20 following such 1-year period, \$25 per
21 bed per day); and

22 “(V) in the case of a hospital
23 with more than 500 beds, \$25 per bed
24 per day (or, in the case of such a hos-
25 pital that has been noncompliant with

1 such requirements for a 1-year period
2 or longer, beginning with the first day
3 following such 1-year period, \$35 per
4 bed per day).

5 “(ii) INCREASE AUTHORITY.—In ap-
6 plying this subparagraph with respect to
7 violations occurring in 2027 or a subse-
8 quent year, the Secretary may through no-
9 tice and comment rulemaking increase—

10 “(I) the limitation on the per day
11 amount of any penalty applicable to a
12 hospital under clause (i)(I);

13 “(II) the limitations on the per
14 bed per day amount of any penalty
15 applicable under any of subclauses
16 (II) through (V) of clause (i); and

17 “(III) the amounts specified in
18 clause (iii)(II).

19 “(iii) PERSISTENT NONCOMPLI-
20 ANCE.—

21 “(I) IN GENERAL.—In the case
22 of a hospital (other than a hospital
23 with 30 or fewer beds) that the Sec-
24 retary has determined to be knowingly
25 and willfully noncompliant with the

1 provisions of this subsection two or
2 more times during a 1-year period,
3 the Secretary may increase any pen-
4 alty otherwise applicable under this
5 subparagraph by the amount specified
6 in subclause (II) with respect to such
7 hospital and may require such hos-
8 pital to complete such additional cor-
9 rective actions plans as the Secretary
10 may specify.

11 “(II) SPECIFIED AMOUNT.—For
12 purposes of subclause (I), the amount
13 specified in this subclause is, with re-
14 spect to a hospital—

15 “(aa) with more than 30
16 beds but fewer than 101 beds, an
17 amount that is not less than
18 \$500,000 and not more than
19 \$1,000,000;

20 “(bb) with more than 100
21 beds but fewer than 301 beds, an
22 amount that is greater than
23 \$1,000,000 and not more than
24 \$2,000,000;

1 “(cc) with more than 300
2 beds but fewer than 501 beds, an
3 amount that is greater than
4 \$2,000,000 and not more than
5 \$4,000,000; and

6 “(dd) with more than 500
7 beds, and amount that is not less
8 than \$5,000,000 and not more
9 than \$10,000,000.

10 “(iv) AUTHORITY TO WAIVE OR RE-
11 DUCE PENALTY.—

12 “(I) IN GENERAL.—Subject to
13 subclause (II), the Secretary may
14 waive any penalty, or reduce any pen-
15 alty by not more than 75 percent, oth-
16 erwise applicable under this subpara-
17 graph with respect to a hospital lo-
18 cated in a rural or underserved area if
19 the Secretary certifies that imposition
20 of such penalty would result in an im-
21 mediate threat to access to care for
22 individuals in the service area of such
23 hospital.

24 “(II) LIMITATION ON APPLICA-
25 TION.—The Secretary may not elect

1 to waive a penalty under subclause (I)
2 with respect to a hospital more than
3 once in a 6-year period and may not
4 elect to reduce such a penalty with re-
5 spect to such a hospital more than
6 once in such a period. Nothing in the
7 preceding sentence shall be construed
8 as prohibiting the Secretary from both
9 waiving and reducing a penalty with
10 respect to a hospital during a 6-year
11 period.

12 “(v) PROVISION OF TECHNICAL AS-
13 SISTANCE.—The Secretary shall, to the ex-
14 tent practicable, provide technical assist-
15 ance relating to compliance with the provi-
16 sions of this section to hospitals requesting
17 such assistance.

18 “(vi) APPLICATION OF CERTAIN PRO-
19 VISIONS.—The provisions of section 1128A
20 (other than subsections (a) and (b) of such
21 section) shall apply to a civil monetary
22 penalty imposed under this subparagraph
23 in the same manner as such provisions
24 apply to a civil monetary penalty imposed
25 under subsection (a) of such section.

1 “(vii) NONDUPLICATION OF PEN-
2 ALTIES.—The Secretary may not subject a
3 hospital to a civil monetary penalty under
4 this subparagraph with respect to non-
5 compliance with the provisions of this sub-
6 section for a period if the Secretary has
7 imposed a civil monetary penalty on such
8 hospital under section 1899C of the Social
9 Security Act for failure to comply with the
10 provisions of such section for such period.

11 “(C) PUBLICATION OF HOSPITAL PRICE
12 TRANSPARENCY INFORMATION.—Beginning on
13 January 1, 2026, the Secretary shall make pub-
14 licly available on the public website of the Cen-
15 ters for Medicare & Medicaid Services informa-
16 tion with respect to compliance with the re-
17 quirements of this subsection and enforcement
18 activities undertaken by the Secretary under
19 this subsection. Such information shall be up-
20 dated in real time and include—

21 “(i) the number of reviews of compli-
22 ance with this subsection undertaken by
23 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 hospital that
5 was sent such a notification and a descrip-
6 tion of the nature of such hospital’s non-
7 compliance with this subsection;

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

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

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

18 “(I) the name of any hospital
19 that received such a waiver or reduc-
20 tion;

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

1 “(III) the rationale for the grant-
2 ing of each such waiver or reduction;
3 and

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

6 “(5) ENSURING ACCESSIBILITY THROUGH IM-
7 PLEMENTATION.—In implementing the amendments
8 made by this section, the Secretary of Health and
9 Human Services shall through rulemaking ensure
10 that a hospital submitting charges and information
11 pursuant to such amendments takes reasonable
12 steps (as specified by the Secretary) to ensure the
13 accessibility of such charges and information to indi-
14 viduals with limited English proficiency. Such steps
15 may include the hospital’s provision of interpretation
16 services or the hospital’s provision of translations of
17 charges and information.

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

20 “(A) DISCOUNTED CASH PRICE.—The
21 term ‘discounted cash price’ means the charge
22 that applies to an individual who pays cash, or
23 cash equivalent, for a hospital-furnished item or
24 service.

1 “(B) FEDERAL HEALTH CARE PROGRAM.—
2 The term ‘Federal health care program’ has the
3 meaning given such term in section 1128B of
4 the Social Security Act.

5 “(C) GROSS CHARGE.—The term ‘gross
6 charge’ means the charge for an individual item
7 or service that is reflected on a hospital’s
8 chargemaster, absent any discounts.

9 “(D) PAYER-SPECIFIC NEGOTIATED
10 CHARGE.—The term ‘payer-specific negotiated
11 charge’ means the charge that a hospital has
12 negotiated with a third party payer for an item
13 or service.

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

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

1 (2) CONFORMING AMENDMENTS.—Section 2718
2 of the Public Health Service Act (42 U.S.C. 300gg–
3 18) is amended—

4 (A) in subsection (b)(3), by inserting
5 “(other than the provisions of subsection (f))”
6 after “this section”; and

7 (B) in subsection (e), by adding at the end
8 the following new sentence: “The preceding pro-
9 visions of this subsection shall not apply begin-
10 ning on January 1, 2026.”.

11 (3) EFFECTIVE DATE.—The amendments made
12 by this subsection shall apply beginning January 1,
13 2026.

14 (c) ACCESSIBILITY THROUGH IMPLEMENTATION.—
15 In implementing the amendments made by this section,
16 the Secretary of Health and Human Services shall
17 through rulemaking ensure that a hospital submitting
18 charges and information pursuant to such amendments
19 takes reasonable steps (as specified by the Secretary) to
20 ensure the accessibility of such charges and information
21 to individuals with limited English proficiency. Such steps
22 may include the hospital’s provision of interpretation serv-
23 ices or the hospital’s provision of translations of charges
24 and information.

1 **SEC. 102. CLINICAL DIAGNOSTIC LABORATORY TEST PRICE**
2 **TRANSPARENCY.**

3 Section 1846 of the Social Security Act (42 U.S.C.
4 1395w-2) is amended—

5 (1) in the header, by inserting “**AND ADDI-**
6 **TIONAL REQUIREMENTS**” after “**SANCTIONS**”;
7 and

8 (2) by adding at the end the following new sub-
9 section:

10 “(c) **PRICE TRANSPARENCY REQUIREMENT.**—

11 “(1) **IN GENERAL.**—Beginning January 1,
12 2026, any applicable laboratory that receives pay-
13 ment under this title for furnishing any specified
14 clinical diagnostic laboratory test under this title
15 shall—

16 “(A) make publicly available on an internet
17 website the information described in paragraph
18 (2) with respect to each such specified clinical
19 diagnostic laboratory test that such laboratory
20 so furnishes; and

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

23 “(2) **INFORMATION DESCRIBED.**—For purposes
24 of paragraph (1), the information described in this
25 paragraph is, with respect to an applicable labora-

1 tory and a specified clinical diagnostic laboratory
2 test, the following:

3 “(A) The discounted cash price for such
4 test (or, if no such price exists, the gross
5 charge for such test).

6 “(B) The deidentified minimum payer-spe-
7 cific negotiated charge between such laboratory
8 and any third party payer for such test.

9 “(C) The deidentified maximum payer-spe-
10 cific negotiated charge between such laboratory
11 and any third party payer for such test.

12 “(3) UNIFORM METHOD AND FORMAT.—Not
13 later than January 1, 2026, the Secretary shall es-
14 tablish a standard, uniform method and format for
15 applicable laboratories to use in compiling and mak-
16 ing public information pursuant to paragraph (1).
17 Such method and format—

18 “(A) may be similar to any template made
19 available by the Centers for Medicare & Med-
20 icaid Services (as described in section
21 1899C(a)(2)(C)(ii));

22 “(B) shall meet such standards as deter-
23 mined appropriate by the Secretary in order to
24 ensure the accessibility and usability of such in-
25 formation; and

1 “(C) shall be updated as determined ap-
2 propriate by the Secretary, in consultation with
3 stakeholders.

4 “(4) INCLUSION OF ANCILLARY SERVICES.—
5 Any price or rate for a specified clinical diagnostic
6 laboratory test available to be furnished by an appli-
7 cable laboratory made publicly available in accord-
8 ance with paragraph (1) shall include the price or
9 rate (as applicable) for any ancillary item or service
10 (such as specimen collection services) that would
11 normally be furnished by such laboratory as part of
12 such test, as specified by the Secretary.

13 “(5) ENFORCEMENT.—

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

17 “(i) not later than 30 days after such
18 determination, the Secretary shall notify
19 such laboratory of such determination; and

20 “(ii) if such laboratory continues to
21 fail to comply with such paragraph after
22 the date that is 90 days after such notifi-
23 cation is sent, the Secretary may impose a
24 civil monetary penalty in an amount not to
25 exceed \$300 for each (beginning with the

1 day on which the Secretary first deter-
2 mined that such laboratory was failing to
3 comply with such paragraph) during which
4 such failure is ongoing.

5 “(B) INCREASE AUTHORITY.—In applying
6 this paragraph with respect to violations occur-
7 ring in 2027 or a subsequent year, the Sec-
8 retary may through notice and comment rule-
9 making increase the per day limitation on civil
10 monetary penalties under subparagraph (A)(ii).

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

19 “(6) PROVISION OF TECHNICAL ASSISTANCE.—
20 The Secretary shall, to the extent practicable, pro-
21 vide technical assistance relating to compliance with
22 the provisions of this subsection to applicable labora-
23 tories requesting such assistance.

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

1 “(A) APPLICABLE LABORATORY.—The
2 term ‘applicable laboratory’ has the meaning
3 given such term in section 414.502, of title 42,
4 Code of Federal Regulations (or a successor
5 regulation), except that such term does not in-
6 clude a laboratory with respect to which stand-
7 ard charges and prices for specified clinical di-
8 agnostic laboratory tests furnished by such lab-
9 oratory are made available by a hospital pursu-
10 ant to section 1899C or section 2718(f) of the
11 Public Health Service Act.

12 “(B) DISCOUNTED CASH PRICE.—The
13 term ‘discounted cash price’ means the charge
14 that applies to an individual who pays cash, or
15 cash equivalent, for an item or service.

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

20 “(D) PAYER-SPECIFIC NEGOTIATED
21 CHARGE.—The term ‘payer-specific negotiated
22 charge’ means the charge that an applicable
23 laboratory has negotiated with a third party
24 payer for an item or service.

1 “(E) SPECIFIED CLINICAL DIAGNOSTIC
2 LABORATORY TEST.—the term ‘specified clinical
3 diagnostic laboratory test’ means a clinical di-
4 agnostic laboratory test that is included on the
5 list of shoppable services specified by the Cen-
6 ters for Medicare & Medicaid Services (as de-
7 scribed in section 1899C(a)(2)(A)(ii)(I)), other
8 than such a test that is only available to be fur-
9 nished by a single provider of services or sup-
10 plier.

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

16 **SEC. 103. IMAGING PRICE TRANSPARENCY.**

17 Section 1899C of the Social Security Act, as added
18 by section 101, is amended—

19 (1) by redesignating subsection (b) as sub-
20 section (c);

21 (2) by inserting after subsection (a) the fol-
22 lowing new subsection:

23 “(b) IMAGING SERVICES PRICE TRANSPARENCY.—

24 “(1) IN GENERAL.—Beginning January 1,
25 2028, each provider of services and supplier that re-

1 ceives payment under this title for furnishing a spec-
2 ified imaging service, other than such a provider or
3 supplier with respect to which standard charges and
4 prices for such services furnished by such provider
5 or supplier are made available by a hospital pursu-
6 ant to section 1899C or section 2718(f) of the Pub-
7 lic Health Service Act, shall—

8 “(A) make publicly available (in accord-
9 ance with paragraph (3)) on an internet website
10 the information described in paragraph (2) with
11 respect to each such service that such provider
12 of services or supplier furnishes; and

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

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

20 “(A) The discounted cash price for such
21 service (or, if no such price exists, the gross
22 charge for such service).

23 “(B) If required by the Secretary, the
24 deidentified minimum payer-specific negotiated
25 charge for such service and the deidentified

1 maximum payer-specific negotiated charge for
2 such service.

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

9 “(A) may be similar to any template made
10 available by the Centers for Medicare & Med-
11 icaid Services (as described in section
12 1899C(a)(2)(C)(ii));

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

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

20 “(4) MONITORING COMPLIANCE.—The Sec-
21 retary shall, through notice and comment rule-
22 making and in consultation with the Inspector Gen-
23 eral of the Department of Health and Human Serv-
24 ices, establish a process to monitor compliance with
25 this subsection.

1 “(5) ENFORCEMENT.—

2 “(A) IN GENERAL.—In the case that the
3 Secretary determines that a provider of services
4 or supplier is not in compliance with paragraph
5 (1)—

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

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

16 “(iii) if such provider or supplier con-
17 tinues to fail to comply with such para-
18 graph after the date that is 90 days after
19 such notification is sent (or, in the case of
20 such a provider or supplier that has sub-
21 mitted a corrective action plan described in
22 clause (ii) in response to a request so de-
23 scribed, after the date that is 90 days after
24 such submission), the Secretary may im-
25 pose a civil monetary penalty in an amount

1 not to exceed \$300 for each day (beginning
2 with the day on which the Secretary first
3 determined that such provider or supplier
4 was failing to comply with such paragraph)
5 during which such failure to comply or fail-
6 ure to submit is ongoing.

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

13 “(C) 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 “(D) 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 subparagraph if the Secretary certifies
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.

12 “(E) PROVISION OF TECHNICAL ASSIST-
13 ANCE.—The Secretary shall, to the extent prac-
14 ticable, provide technical assistance relating to
15 compliance with the provisions of this sub-
16 section to providers of services and suppliers re-
17 questing such assistance.

18 “(F) CLARIFICATION OF NONAPPLICA-
19 BILITY OF OTHER ENFORCEMENT PROVI-
20 SIONS.—Notwithstanding any other provision of
21 this title, this paragraph shall be the sole
22 means of enforcing the provisions of this sub-
23 section.”; and

24 (3) in subsection (c), as so redesignated by
25 paragraph (1)—

1 (A) by redesignating paragraph (8) as
2 paragraph (9); and

3 (B) by inserting after paragraph (7) the
4 following new paragraph:

5 “(8) SPECIFIED IMAGING SERVICE.—the term
6 ‘specified imaging service’ means an imaging service
7 that is a Centers for Medicare & Medicaid Services-
8 specified shoppable service (as described in sub-
9 section (a)(2)(A)(ii)(I)).”.

1 **SEC. 104. AMBULATORY SURGICAL CENTER PRICE TRANS-**
2 **PARENCY.**

3 Section 1834 of the Social Security Act (42 U.S.C.
4 1395m) is amended by adding at the end the following
5 new subsection:

6 “(aa) AMBULATORY SURGICAL CENTER PRICE
7 TRANSPARENCY.—

8 “(1) IN GENERAL.—Beginning January 1,
9 2026, each ambulatory surgical center that receives
10 payment under this title for furnishing items and
11 services shall comply with the price transparency re-
12 quirement described in paragraph (2).

13 “(2) REQUIREMENT DESCRIBED.—

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

23 “(i) all of the ambulatory surgical
24 center’s standard charges (including the
25 information described in subparagraph

1 (B)) for each item and service furnished by
2 such surgical center;

3 “(ii) information on the ambulatory
4 surgical center’s prices (including the in-
5 formation described in subparagraph (B))
6 for as many of the Centers for Medicare &
7 Medicaid Services-specified shoppable serv-
8 ices that are furnished by such surgical
9 center, and as many additional ambulatory
10 surgical center-selected shoppable services
11 (or all such additional services, if such sur-
12 gical center furnishes fewer than 300
13 shoppable services) as may be necessary
14 for a combined total of at least 300
15 shoppable services; and

16 “(iii) with respect to each Centers for
17 Medicare & Medicaid Services-specified
18 shoppable service that is not furnished by
19 the ambulatory surgical center, an indica-
20 tion that such service is not so furnished.

21 “(B) INFORMATION DESCRIBED.—For pur-
22 poses of subparagraph (A), the information de-
23 scribed in this subparagraph is, with respect to
24 standard charges and prices (as applicable)

1 made public by an ambulatory surgical center,
2 the following:

3 “(i) A plain language description of
4 each item or service, accompanied by, as
5 applicable, the Healthcare Common Proce-
6 dure Coding System code, the diagnosis-re-
7 lated group, the national drug code, or
8 other identifier used or approved by the
9 Centers for Medicare & Medicaid Services.

10 “(ii) The gross charge, as applicable,
11 expressed as a dollar amount, for each
12 such item or service.

13 “(iii) The discounted cash price, as
14 applicable, expressed as a dollar amount,
15 for each such item or service (or, in the
16 case no discounted cash price is available
17 for an item or service, the median cash
18 price charged to self-pay individuals for
19 such item or service for the previous three
20 years, expressed as a dollar amount).

21 “(iv) The current payer-specific nego-
22 tiated charges, clearly associated with the
23 name of the third party payer and plan
24 and expressed as a dollar amount, that ap-
25 plies to each such item or service.

1 “(v) The de-identified maximum and
2 minimum negotiated charges, as applica-
3 ble, for each such item or service.

4 “(vi) Any other additional information
5 the Secretary may require for the purpose
6 of improving the accuracy of, or enabling
7 consumers to easily understand and com-
8 pare, standard charges and prices for an
9 item or service, except information that is
10 duplicative of any other reporting require-
11 ment under this subsection.

12 “(C) UNIFORM METHOD AND FORMAT.—
13 Not later than January 1, 2026, the Secretary
14 shall establish a standard, uniform method and
15 format for ambulatory surgical centers to use in
16 making public standard charges and a stand-
17 ard, uniform method and format for such cen-
18 ters to use in making public prices pursuant to
19 subparagraph (A). Any such method and for-
20 mat—

21 “(i) shall, in the case of such charges
22 made public by an ambulatory surgical
23 center, ensure that such charges are made
24 available in a machine-readable format (or
25 successor technology);

1 “(ii) may be similar to any template
2 made available by the Centers for Medicare
3 & Medicaid Services as of the date of the
4 enactment of this paragraph;

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 “(3) MONITORING COMPLIANCE.—The Sec-
13 retary shall, through notice and comment rule-
14 making and in consultation with the Inspector Gen-
15 eral of the Department of Health and Human Serv-
16 ices, establish a process to monitor compliance with
17 this subsection. Such process shall ensure that each
18 ambulatory surgical center’s compliance with this
19 subsection is reviewed not less frequently than once
20 every 3 years.

21 “(4) ENFORCEMENT.—

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

1 “(i) the Secretary shall notify such
2 ambulatory surgical center of such failure
3 not later than 30 days after the date on
4 which the Secretary determines such fail-
5 ure exists; and

6 “(ii) upon request of the Secretary,
7 the ambulatory surgical center shall submit
8 to the Secretary, not later than 45 days
9 after the date of such request, a corrective
10 action plan to comply with such require-
11 ments.

12 “(B) CIVIL MONETARY PENALTY.—

13 “(i) IN GENERAL.—In addition to any
14 other enforcement actions or penalties that
15 may apply under another provision of law,
16 an ambulatory surgical center that has re-
17 ceived a notification under subparagraph
18 (A)(i) and fails to comply with the require-
19 ments of this subsection by the date that
20 is 90 days after such notification (or, in
21 the case of an ambulatory surgical center
22 that has submitted a corrective action plan
23 described in subparagraph (A)(ii) in re-
24 sponse to a request so described, by the
25 date that is 90 days after such submission)

1 shall be subject to a civil monetary penalty
2 of an amount specified by the Secretary for
3 each subsequent day during which such
4 failure is ongoing (not to exceed \$300 per
5 day).

6 “(ii) INCREASE AUTHORITY.—In ap-
7 plying this subparagraph with respect to
8 violations occurring in 2027 or a subse-
9 quent year, the Secretary may through no-
10 tice and comment rulemaking increase the
11 limitation on the per day amount of any
12 penalty applicable to an ambulatory sur-
13 gical center under clause (i).

14 “(iii) APPLICATION OF CERTAIN PRO-
15 VISIONS.—The provisions of section 1128A
16 (other than subsections (a) and (b) of such
17 section) shall apply to a civil monetary
18 penalty imposed under this subparagraph
19 in the same manner as such provisions
20 apply to a civil monetary penalty imposed
21 under subsection (a) of such section.

22 “(iv) AUTHORITY TO WAIVE OR RE-
23 DUCE PENALTY.—

24 “(I) IN GENERAL.—Subject to
25 subclause (II), the Secretary may

1 waive any penalty, or reduce any pen-
2 alty by not more than 75 percent, oth-
3 erwise applicable under this subpara-
4 graph with respect to an ambulatory
5 surgical center located in a rural or
6 underserved area if the Secretary cer-
7 tifies that imposition of such penalty
8 would result in an immediate threat
9 to access to care for individuals in the
10 service area of such surgical center.

11 “(II) LIMITATION ON APPLICA-
12 TION.—The Secretary may not elect
13 to waive a penalty under subclause (I)
14 with respect to an ambulatory surgical
15 center more than once in a 6-year pe-
16 riod and may not elect to reduce such
17 a penalty with respect to such a sur-
18 gical center more than once in such a
19 period. Nothing in the preceding sen-
20 tence shall be construed as prohibiting
21 the Secretary from both waiving and
22 reducing a penalty with respect to an
23 ambulatory surgical center during a
24 6-year period.

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

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

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

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

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

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

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

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

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

13 **SEC. 105. HEALTH COVERAGE PRICE TRANSPARENCY.**

14 (a) PRICE TRANSPARENCY REQUIREMENTS.—

15 (1) IRC.—

16 (A) IN GENERAL.—Section 9819 of the In-
17 ternal Revenue Code of 1986 is amended to
18 read as follows:

19 **“SEC. 9819. TRANSPARENCY IN COVERAGE.**

20 “(a) COST-SHARING TRANSPARENCY.—

21 “(1) IN GENERAL.—For plan years beginning
22 on or after January 1, 2026, a group health plan
23 shall permit a participant or beneficiary to learn the
24 amount of cost-sharing (including deductibles, co-
25 payments, and coinsurance) under the participant or

1 beneficiary’s plan that the participant or beneficiary
2 would be responsible for paying with respect to the
3 furnishing of a specific item or service by a provider
4 in a timely manner upon the request of the partici-
5 pant or beneficiary. At a minimum, such information
6 shall include the information specified in paragraph
7 (2) and shall be made available to such participant
8 or beneficiary through a self-service tool that meets
9 the requirements of paragraph (3) or, at the option
10 of such participant or beneficiary, through a paper
11 disclosure or phone or other electronic disclosure (as
12 selected by such participant or beneficiary and pro-
13 vided at no cost to such participant or beneficiary)
14 that meets such requirements as the Secretary may
15 specify.

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

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

1 “(B) If such provider is not a participating
2 provider with respect to such item or service,
3 the maximum allowed amount or other dollar
4 amount that such plan or coverage will recog-
5 nize as payment for such item or service, along
6 with a notice that such participant or bene-
7 ficiary may be liable for additional charges.

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

17 “(D) The amount the participant or bene-
18 ficiary has already accumulated with respect to
19 any deductible or out of pocket maximum under
20 the plan (broken down, in the case separate
21 deductibles or maximums apply to separate par-
22 ticipants and beneficiaries enrolled in the plan,
23 by such separate deductibles or maximums, in
24 addition to any cumulative deductible or max-
25 imum).

1 “(E) In the case such plan imposes any
2 frequency or volume limitations with respect to
3 such item or service (excluding medical neces-
4 sity determinations), the amount that such par-
5 ticipant or beneficiary has accrued towards such
6 limitation with respect to such item or service.

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

11 “(G) Any shared savings (such as any
12 credit, payment, or other benefit provided by
13 such plan) available to the participant or bene-
14 ficiary with respect to such item or service fur-
15 nished by such provider known at the time such
16 request is made.

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

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

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

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

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

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

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

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

18 “(F) meets any other requirement deter-
19 mined appropriate by the Secretary to ensure
20 the accessibility and usability of information
21 provided through such tool.

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

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

3 “(b) RATE AND PAYMENT INFORMATION.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2026, each group health plan
6 (other than a grandfathered health plan (as defined
7 in section 1251(e) of the Patient Protection and Af-
8 fordable Care Act)) shall, for each month, not later
9 than the tenth day of such month, make available to
10 the public the rate and payment information de-
11 scribed in paragraph (2) in accordance with para-
12 graph (3).

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

18 “(A) With respect to each item or service
19 (other than a drug) for which benefits are avail-
20 able under such plan, the in-network rate (ex-
21 pressed as a dollar amount) in effect as of the
22 date on which such information is made public
23 with each provider that is a participating pro-
24 vider with respect to such item or service.

1 “(B) With respect to each drug (identified
2 by national drug code) for which benefits are
3 available under such plan—

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

10 “(ii) the average amount paid by such
11 plan (net of rebates, discounts, and price
12 concessions) for such drug dispensed or
13 administered during the 90-day period be-
14 ginning 180 days before such date of pub-
15 lication to each provider that was a partici-
16 pating provider with respect to such drug,
17 broken down by each such provider, other
18 than such an amount paid to a provider
19 that, during such period, submitted fewer
20 than 20 claims for such drug to such plan.

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 90-day period specified in

1 subparagraph (B) by a provider that was not a
2 participating provider with respect to such item
3 or service, broken down by each such provider.

4 “(3) MANNER OF PUBLICATION.—Rate and
5 payment information required to be made available
6 under this subsection shall be so made available in
7 dollar amounts through separate machine-readable
8 files (and any successor technology, such as applica-
9 tion program interface technology, determined ap-
10 propriate by the Secretary) corresponding to the in-
11 formation described in each of subparagraphs (A)
12 through (C) of paragraph (2) that meet such re-
13 quirements as specified by the Secretary through
14 subregulatory guidance. Such requirements shall en-
15 sure that such files are limited to an appropriate
16 size, do not include disclosure of unnecessary dupli-
17 cative information contained in other files made
18 available under this subsection, are made available
19 in a widely available format through a publicly avail-
20 able website that allows for information contained in
21 such files to be compared across group health plans
22 and group or individual health insurance coverage,
23 and are accessible to individuals at no cost and with-
24 out the need to establish a user account or provide
25 other credentials.

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

10 “(5) SUMMARY.—For each plan year beginning
11 on or after January 1, 2026, each group health plan
12 shall make public a data file, in a manner that en-
13 sures that such file may be easily downloaded and
14 read by standard spreadsheet software and that
15 meets such requirements as established by the Sec-
16 retary, containing a summary of all rate and pay-
17 ment information made public by such plan with re-
18 spect to such plan during such plan year. Such file
19 shall include the following:

20 “(A) The mean, median, and interquartile
21 range of the in-network rate, and the amount
22 allowed for an item or service when not fur-
23 nished by a participating provider, in effect as
24 of the first day of such plan year for each item
25 or service (identified by payer identifier ap-

1 proved or used by the Centers for Medicare &
2 Medicaid Services) for which benefits are avail-
3 able under the plan, broken down by the type
4 of provider furnishing the item or service and
5 by the geographic area in which such item or
6 service is furnished.

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

12 “(C) The name of such plan, a description
13 of the type of network of participating providers
14 used by such plan, and a description of whether
15 such plan is self-insured or fully-insured.

16 “(D) For each item or service which is
17 paid as part of a bundled rate—

18 “(i) a description of the formulae,
19 pricing methodologies, or other information
20 used to calculate the payment rate for such
21 bundle; and

22 “(ii) a list of the items and services
23 included in such bundle.

24 “(E) The percentage of items and services
25 that are paid for on a fee-for-service basis and

1 the percentage of items and services that are
2 paid for as part of a bundled rate, capitated
3 payment rate, or other alternative payment
4 model.

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

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

18 “(d) DEFINITIONS.—In this section:

19 “(1) PARTICIPATING PROVIDER.—The term
20 ‘participating provider’ means, with respect to an
21 item or service and a group health plan, a physician
22 or other health care provider who is acting within
23 the scope of practice of that provider’s license or cer-
24 tification under applicable State law and who has a
25 contractual relationship with the plan, respectively,

1 for furnishing such item or service under the plan,
2 and includes facilities, respectively.

3 “(2) PROVIDER.—The term ‘provider’ includes
4 a health care facility.

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

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

“Sec. 9819. Transparency in coverage.”.

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

24 **“SEC. 2799A–4. TRANSPARENCY IN COVERAGE.**

25 “(a) COST-SHARING TRANSPARENCY.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2026, a group health plan
3 and a health insurance issuer offering group or indi-
4 vidual health insurance coverage shall permit an in-
5 dividual enrolled under such plan or coverage to
6 learn the amount of cost-sharing (including
7 deductibles, copayments, and coinsurance) under the
8 individual’s plan or coverage that the individual
9 would be responsible for paying with respect to the
10 furnishing of a specific item or service by a provider
11 in a timely manner upon the request of the indi-
12 vidual. At a minimum, such information shall in-
13 clude the information specified in paragraph (2) and
14 shall be made available to such individual through a
15 self-service tool that meets the requirements of para-
16 graph (3) or, at the option of such individual,
17 through a paper disclosure or phone or other elec-
18 tronic disclosure (as selected by such individual and
19 provided at no cost to such individual) that meets
20 such requirements as the Secretary may specify.

21 “(2) SPECIFIED INFORMATION.—For purposes
22 of paragraph (1), the information specified in this
23 paragraph is, with respect to an item or service for
24 which benefits are available under a group health
25 plan or group or individual health insurance cov-

1 erage furnished by a health care provider to an indi-
2 vidual enrolled under such plan or coverage, the fol-
3 lowing:

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

8 “(B) If such provider is not a participating
9 provider with respect to such item or service,
10 the maximum allowed amount or other dollar
11 amount that such plan or coverage will recog-
12 nize as payment for such item or service, along
13 with a notice that such individual may be liable
14 for additional charges.

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

23 “(D) The amount the individual has al-
24 ready accumulated with respect to any deduct-
25 ible or out of pocket maximum under the plan

1 or coverage (broken down, in the case separate
2 deductibles or maximums apply to separate in-
3 dividuals enrolled in the plan or coverage, by
4 such separate deductibles or maximums, in ad-
5 dition to any cumulative deductible or max-
6 imum).

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

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

17 “(G) Any shared savings (such as any
18 credit, payment, or other benefit provided by
19 such plan or issuer) available to the individual
20 with respect to such item or service furnished
21 by such provider known at the time such re-
22 quest is made.

23 “(3) SELF-SERVICE TOOL.—For purposes of
24 paragraph (1), a self-service tool established by a
25 group health plan or health insurance issuer offering

1 group or individual health insurance coverage meets
2 the requirements of this paragraph if such tool—

3 “(A) is based on an internet website (or
4 successor technology specified by the Sec-
5 retary);

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

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

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

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

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

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

1 “(F) meets any other requirement deter-
2 mined appropriate by the Secretary to ensure
3 the accessibility and usability of information
4 provided through such tool.

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

10 “(b) RATE AND PAYMENT INFORMATION.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after January 1, 2026, each group health plan
13 and health insurance issuer offering group or indi-
14 vidual health insurance coverage (other than a
15 grandfathered health plan (as defined in section
16 1251(e) of the Patient Protection and Affordable
17 Care Act)) shall, for each month, not later than the
18 tenth day of such month, make available to the pub-
19 lic the rate and payment information described in
20 paragraph (2) in accordance with paragraph (3).

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

1 group or individual health insurance coverage, the
2 following:

3 “(A) With respect to each item or service
4 (other than a drug) for which benefits are avail-
5 able under such plan or coverage, the in-net-
6 work rate (expressed as a dollar amount) in ef-
7 fect as of the date on which such information
8 is made public with each provider that is a par-
9 ticipating provider with respect to such item or
10 service.

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

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

20 “(ii) the average amount paid by such
21 plan (net of rebates, discounts, and price
22 concessions) for such drug dispensed or
23 administered during the 90-day period be-
24 ginning 180 days before such date of pub-
25 lication to each provider that was a partici-

1 pating provider with respect to such drug,
2 broken down by each such provider, other
3 than such an amount paid to a provider
4 that, during such period, submitted fewer
5 than 20 claims for such drug to such plan
6 or coverage.

7 “(C) With respect to each item or service
8 for which benefits are available under such plan
9 or coverage, the amount billed, and the amount
10 allowed by the plan, for each such item or serv-
11 ice furnished during the 90-day period specified
12 in subparagraph (B) by a provider that was not
13 a participating provider with respect to such
14 item or service, broken down by each such pro-
15 vider.

16 “(3) MANNER OF PUBLICATION.—Rate and
17 payment information required to be made available
18 under this subsection shall be so made available in
19 dollar amounts through separate machine-readable
20 files (and any successor technology, such as applica-
21 tion program interface technology, determined ap-
22 propriate by the Secretary) corresponding to the in-
23 formation described in each of subparagraphs (A)
24 through (C) of paragraph (2) that meet such re-
25 quirements as specified by the Secretary through

1 subregulatory guidance. Such requirements shall en-
2 sure that such files are limited to an appropriate
3 size, do not include disclosure of unnecessary dupli-
4 cative information contained in other files made
5 available under this subsection, are made available
6 in a widely-available format through a publicly-avail-
7 able website that allows for information contained in
8 such files to be compared across group health plans
9 and group or individual health insurance coverage,
10 and are accessible to individuals at no cost and with-
11 out the need to establish a user account or provide
12 other credentials.

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

24 “(5) SUMMARY.—For each plan year beginning
25 on or after January 1, 2026, each group health plan

1 and health insurance issuer offering group or indi-
2 vidual health insurance coverage shall make public a
3 data file, in a manner that ensures that such file
4 may be easily downloaded and read by standard
5 spreadsheet software and that meets such require-
6 ments as established by the Secretary, containing a
7 summary of all rate and payment information made
8 public by such plan or issuer with respect to such
9 plan or coverage 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 or coverage, broken down
20 by the type of provider furnishing the item or
21 service and by the geographic area in which
22 such item or 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 or coverage, and, in the case
6 of a group health plan, a description of whether
7 such plan is self-insured or fully-insured.

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

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

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

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

22 “(6) ATTESTATION.—Each group health plan
23 and health insurance issuer offering group or indi-
24 vidual health insurance coverage shall post, along
25 with rate and payment information made public by

1 such plan or issuer, an attestation that such infor-
2 mation is complete and accurate.

3 “(c) ACCESSIBILITY.—A group health plan and a
4 health insurance issuer offering group or individual health
5 insurance coverage shall take reasonable steps (as speci-
6 fied by the Secretary) to ensure that information provided
7 in response to a request described in subsection (a), and
8 rate and payment information made public under sub-
9 section (b), is provided in plain, easily understandable lan-
10 guage and that interpretation, translations, and assistive
11 services are provided to those with limited English pro-
12 ficiency and those with disabilities.

13 “(d) DEFINITIONS.—In this section:

14 “(1) PARTICIPATING PROVIDER.—The term
15 ‘participating provider’ means, with respect to an
16 item or service and a group health plan or health in-
17 surance issuer offering group or individual health in-
18 surance coverage, a physician or other health care
19 provider who is acting within the scope of practice
20 of that provider’s license or certification under appli-
21 cable State law and who has a contractual relation-
22 ship with the plan or issuer, respectively, for fur-
23 nishing such item or service under the plan or cov-
24 erage, and includes facilities, respectively.

1 “(2) PROVIDER.—The term ‘provider’ includes
2 a health care facility.

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

15 (3) ERISA.—

16 (A) IN GENERAL.—Section 719 of the Em-
17 ployee Retirement Income Security Act of 1974
18 (29 U.S.C. 1185h) is amended to read as fol-
19 lows:

20 **“SEC. 719. TRANSPARENCY IN COVERAGE.**

21 “(a) COST-SHARING TRANSPARENCY.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after January 1, 2026, a group health plan
24 and a health insurance issuer offering group health
25 insurance coverage shall permit a participant or ben-

1 efficiary to learn the amount of cost-sharing (includ-
2 ing deductibles, copayments, and coinsurance) under
3 the participant or beneficiary’s plan or coverage that
4 the participant or beneficiary would be responsible
5 for paying with respect to the furnishing of a spe-
6 cific item or service by a provider in a timely man-
7 ner upon the request of the participant or bene-
8 ficiary. At a minimum, such information shall in-
9 clude the information specified in paragraph (2) and
10 shall be made available to such participant or bene-
11 ficiary through a self-service tool that meets the re-
12 quirements of paragraph (3) or, at the option of
13 such participant or beneficiary, through a paper dis-
14 closure or phone or other electronic disclosure (as
15 selected by such participant or beneficiary and pro-
16 vided at no cost to such participant or beneficiary)
17 that meets such requirements as the Secretary may
18 specify.

19 “(2) SPECIFIED INFORMATION.—For purposes
20 of paragraph (1), the information specified in this
21 paragraph is, with respect to an item or service for
22 which benefits are available under a group health
23 plan or group health insurance coverage furnished
24 by a health care provider to a participant or bene-
25 ficiary of such plan or coverage, the following:

1 “(A) If such provider is a participating
2 provider with respect to such item or service,
3 the in-network rate (as defined in subsection
4 (c)) for such item or service.

5 “(B) If such provider is not a participating
6 provider with respect to such item or service,
7 the maximum allowed amount or other dollar
8 amount that such plan or coverage will recog-
9 nize as payment for such item or service, along
10 with a notice that such participant or bene-
11 ficiary may be liable for additional charges.

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

21 “(D) The amount the participant or bene-
22 ficiary has already accumulated with respect to
23 any deductible or out of pocket maximum under
24 the plan or coverage (broken down, in the case
25 separate deductibles or maximums apply to sep-

1 arate participants and beneficiaries enrolled in
2 the plan or coverage, by such separate
3 deductibles or maximums, in addition to any
4 cumulative deductible or maximum).

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

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

15 “(G) Any shared savings (such as any
16 credit, payment, or other benefit provided by
17 such plan or issuer) available to the participant
18 or beneficiary with respect to such item or serv-
19 ice furnished by such provider known at the
20 time such request is made.

21 “(3) SELF-SERVICE TOOL.—For purposes of
22 paragraph (1), a self-service tool established by a
23 group health plan or health insurance issuer offering
24 group health insurance coverage meets the require-
25 ments of this paragraph if such tool—

1 “(A) is based on an internet website (or
2 successor technology specified by the Sec-
3 retary);

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

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

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

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

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

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

23 “(F) meets any other requirement deter-
24 mined appropriate by the Secretary to ensure

1 the accessibility and usability of information
2 provided through such tool.

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

8 “(b) RATE AND PAYMENT INFORMATION.—

9 “(1) IN GENERAL.—For plan years beginning
10 on or after January 1, 2026, each group health plan
11 and health insurance issuer offering group health in-
12 surance coverage (other than a grandfathered health
13 plan (as defined in section 1251(e) of the Patient
14 Protection and Affordable Care Act)) shall, for each
15 month, not later than the tenth day of such month,
16 make available to the public the rate and payment
17 information described in paragraph (2) in accord-
18 ance with paragraph (3).

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

24 “(A) With respect to each item or service
25 (other than a drug) for which benefits are avail-

1 able under such plan or coverage, the in-net-
2 work rate (expressed as a dollar amount) in ef-
3 fect as of the date on which such information
4 is made public with each provider that is a par-
5 ticipating provider with respect to such item or
6 service.

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

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

16 “(ii) the average amount paid by such
17 plan (net of rebates, discounts, and price
18 concessions) for such drug dispensed or
19 administered during the 90-day period be-
20 ginning 180 days before such date of pub-
21 lication to each provider that was a partici-
22 pating provider with respect to such drug,
23 broken down by each such provider, other
24 than such an amount paid to a provider
25 that, during such period, submitted fewer

1 than 20 claims for such drug to such plan
2 or coverage.

3 “(C) With respect to each item or service
4 for which benefits are available under such plan
5 or coverage, the amount billed, and the amount
6 allowed by the plan, for each such item or serv-
7 ice furnished during the 90-day period specified
8 in subparagraph (B) by a provider that was not
9 a participating provider with respect to such
10 item or service, broken down by each such pro-
11 vider.

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

1 available under this subsection, are made available
2 in a widely available format through a publicly avail-
3 able website that allows for information contained in
4 such files to be compared across group health plans
5 and group or individual health insurance coverage,
6 and are accessible to individuals at no cost and with-
7 out the need to establish a user account or provide
8 other credentials.

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

19 “(5) SUMMARY.—For each plan year beginning
20 on or after January 1, 2026, each group health plan
21 and health insurance issuer offering group health in-
22 surance coverage shall make public a data file, in a
23 manner that ensures that such file may be easily
24 downloaded and read by standard spreadsheet soft-
25 ware and that meets such requirements as estab-

1 lished by the Secretary, containing a summary of all
2 rate and payment information made public by such
3 plan or issuer with respect to such plan or coverage
4 during such plan year. Such file shall include the fol-
5 lowing:

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

18 “(B) Trends in payment rates for such
19 items and services over such plan year, includ-
20 ing an identification of instances in which such
21 rates have increased, decreased, or remained
22 the same.

23 “(C) The name of such plan, a description
24 of the type of network of participating providers
25 used by such plan or coverage, and, in the case

1 of a group health plan, a description of whether
2 such plan is self-insured or fully-insured.

3 “(D) For each item or service which is
4 paid as part of a bundled rate—

5 “(i) a description of the formulae,
6 pricing methodologies, or other information
7 used to calculate the payment rate for such
8 bundle; and

9 “(ii) a list of the items and services
10 included in such bundle.

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

17 “(6) ATTESTATION.—Each group health plan
18 and health insurance issuer offering group health in-
19 surance coverage shall post, along with rate and
20 payment information made public by such plan or
21 issuer, an attestation that such information is com-
22 plete and accurate.

23 “(c) 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 (a), and rate and pay-
3 ment information made public under subsection (b), is
4 provided 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 “(d) DEFINITIONS.—In this section:

9 “(1) 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 who is acting within the scope of practice
15 of that provider’s license or certification under appli-
16 cable State law and who has a contractual relation-
17 ship with the plan or issuer, respectively, for fur-
18 nishing such item or service under the plan or cov-
19 erage, and includes facilities, respectively.

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

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

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

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

“Sec. 719. Transparency in coverage.”.

14 (b) APPLICATION PROGRAMMING INTERFACE RE-
15 PORT.—Not later than January 1, 2025, and annually
16 thereafter, the Secretary of Health and Human Services
17 shall, in consultation with the Office of the National Coor-
18 dinator for Health Information Technology, Department
19 of Labor, the Department of the Treasury, and stake-
20 holders, submit to the House Committees on Education
21 and the Workforce, Energy and Commerce, and Ways and
22 Means, and the Senate Committees on Finance and
23 Health, Education, Labor, and Pensions a report on the
24 use of standards-based application programming inter-
25 faces (in this subsection referred to as “APIs”) to facili-

1 tate access to health care price transparency information
2 and the interoperability of other medical information.
3 Such report shall include an evaluation of the capacity of
4 the Department of Health and Human Services, the De-
5 partment of Labor, and the Department of the Treasury
6 to regulate and implement standards related to APIs and
7 recommendations for improving such capacity. Such re-
8 port shall include the following:

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

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

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

23 (4) An analysis of the benefits and challenges
24 of implementing standards-based APIs for price
25 transparency data, including the ability for con-

1 sumers to access rate and payment information and
2 the amount of cost-sharing (including deductibles,
3 copayments, and coinsurance) under the consumer's
4 plan through third-party internet-based tools and
5 applications.

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

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

14 (7) An analysis of the cost of API standards
15 implementation on issuers, employers, and other pri-
16 vate-sector entities.

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

21 (9) An analysis of the interaction with API
22 standards and Federal health information privacy
23 standards.

24 (c) PROVIDER TOOL REPORT.—

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

18 (A) A description of the feasibility of es-
19 tablishing a requirement for the various types
20 of plans and coverage to offer such a provider
21 tool, including any challenges to establishing a
22 provider tool using the same technology plat-
23 form as the self-service tool described in such
24 amendments.

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

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

12 (D) A description of the usability and ex-
13 pected utilization of such tool among providers,
14 including among different provider types.

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

17 (F) An analysis on the potential impact of
18 the provider tool on—

- 19 (i) patients' out-of-pocket spending;
20 (ii) plan design, including impacts on
21 cost-sharing requirements;
22 (iii) care coordination and quality;
23 (iv) plan premiums;
24 (v) overall health care spending and
25 utilization; and

1 (vi) health care access in rural areas.

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

12 (H) An analysis of which health care items
13 and services, would be most useful for patients
14 utilizing a provider tool.

15 (I) An analysis of rulemaking required to
16 ensure such a tool complies with federal health
17 information privacy standards.

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

22 (K) An analysis of the ability of state reg-
23 ulators to enforce provider tool standards and
24 the costs to the Department and states to regu-
25 late and enforce provider tool standards.

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

13 (d) REPORTS.—

14 (1) COMPLIANCE.—Not later than January 1,
15 2027, the Comptroller General of the United States
16 shall submit to Congress a report containing—

17 (A) an analysis of compliance with the
18 amendments made by this section;

19 (B) an analysis of enforcement of such
20 amendments by the Secretaries of Health and
21 Human Services, Labor, and the Treasury;

22 (C) recommendations relating to improving
23 such enforcement; and

24 (D) recommendations relating to improving
25 public disclosure, and public awareness, of in-

1 formation required to be made available by
2 group health plans and health insurance issuers
3 pursuant to such amendments.

4 (2) PRICES.—Not later than January 1, 2028,
5 and biennially thereafter, the Secretaries of Health
6 and Human Services, Labor, and the Treasury shall
7 jointly submit to Congress a report containing an as-
8 sessment of differences in negotiated prices (and any
9 trends in such prices) in the private market be-
10 tween—

11 (A) rural and urban areas;

12 (B) the individual, small group, and large
13 group markets;

14 (C) consolidated and nonconsolidated
15 health care provider areas (as specified by the
16 Secretary of Health and Human Services);

17 (D) nonprofit and for-profit hospitals;

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

19 (F) insurers serving local or regional areas
20 and insurers serving multistate or national
21 areas.

22 (e) QUALITY REPORT.—Not later than 1 year after
23 the date of enactment of this subsection, the Secretaries
24 of Health and Human Services, Labor, and the Treasury
25 shall jointly submit to Congress a report on the feasibility

1 of including data relating to the quality of health care
2 items and services with the price transparency information
3 required to be made available under the amendments
4 made by subsection (a). Such report shall include rec-
5 ommendations for legislative and regulatory actions to
6 identify appropriate metrics for assessing and comparing
7 quality of care.

8 (f) CONTINUED APPLICABILITY OF RULES FOR PRE-
9 VIOUS YEARS.—Nothing in the amendments made by sub-
10 section (a) may be construed as affecting the applicability
11 of the rule entitled “Transparency in Coverage” published
12 by the Department of the Treasury, the Department of
13 Labor, and the Department of Health and Human Serv-
14 ices on November 12, 2020 (85 Fed. Reg. 72158), for any
15 plan year beginning before January 1, 2026.

16 **SEC. 106. PHARMACY BENEFITS PRICE TRANSPARENCY.**

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

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

21 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-
22 AGER SERVICES.**

23 “(a) IN GENERAL.—For plan years beginning on or
24 after the date that is 2 years after the date of enactment
25 of this section, a group health plan or a health insurance

1 issuer offering group health insurance coverage, or an en-
2 tity or subsidiary providing pharmacy benefits manage-
3 ment services on behalf of such a plan or issuer, shall not
4 enter into a contract with a drug manufacturer, dis-
5 tributor, wholesaler, subcontractor, rebate aggregator, or
6 any other third party that limits (or delays beyond the
7 applicable reporting period described in subsection (b)(1))
8 the disclosure of information to plan sponsors in such a
9 manner that prevents such plan, issuer, or entity from
10 making the reports described in subsection (b).

11 “(b) REPORTS.—

12 “(1) IN GENERAL.—With respect to plan years
13 beginning on or after the date that is 2 years after
14 the date of enactment of this section, not less fre-
15 quently than every 6 months (or at the request of
16 a plan sponsor, not less frequently than quarterly,
17 but under the same conditions, terms, and cost of
18 the semiannual report under this subsection), a
19 group health plan or health insurance issuer offering
20 group health insurance coverage, or an entity pro-
21 viding pharmacy benefits management services on
22 behalf of such a plan or issuer, shall submit to the
23 plan sponsor (as defined in section 3(16)(B) of the
24 Employee Retirement Income Security Act of 1974)
25 of such plan or coverage a report in accordance with

1 this section. Each such report shall be made avail-
2 able to such plan sponsor in a machine-readable for-
3 mat and shall include the information described in
4 paragraph (2).

5 “(2) INFORMATION DESCRIBED.—For purposes
6 of paragraph (1), the information described in this
7 paragraph is, with respect to drugs covered by a
8 group health plan or health insurance issuer offering
9 group health insurance coverage during each report-
10 ing period—

11 “(A) a list of drugs for which a claim was
12 filed and, with respect to each such drug on
13 such list—

14 “(i) the brand name, chemical entity,
15 and National Drug Code;

16 “(ii) the type of dispensing channel
17 used to furnish such drug, including retail,
18 mail order, or specialty pharmacy;

19 “(iii) with respect to each drug dis-
20 pensed under each type of dispensing chan-
21 nel (including retail, mail order, or spe-
22 cialty pharmacy)—

23 “(I) whether such drug is a
24 brand name drug or a generic drug,
25 and—

1 “(aa) in the case of a brand
2 name drug, the wholesale acquisi-
3 tion cost, listed as cost per days
4 supply and cost per dosage unit,
5 on the date such drug was dis-
6 pensed; and

7 “(bb) in the case of a ge-
8 neric drug, the average wholesale
9 price, listed as cost per days sup-
10 ply and cost per dosage unit, on
11 the date such drug was dis-
12 pensed; and

13 “(II) the total number of—

14 “(aa) prescription claims
15 (including original prescriptions
16 and refills);

17 “(bb) participants, bene-
18 ficiaries, and enrollees for whom
19 a claim for such drug was filed;

20 “(cc) dosage units per fill of
21 such drug; and

22 “(dd) days supply of such
23 drug per fill;

24 “(iv) the net price per course of treat-
25 ment or single fill, such as a 30-day supply

1 or 90-day supply to the plan or coverage
2 after manufacturer rebates, fees, and other
3 remuneration or adjustments;

4 “(v) the total amount of out-of-pocket
5 spending by participants, beneficiaries, and
6 enrollees on such drug, including spending
7 through copayments, coinsurance, and
8 deductibles;

9 “(vi) the total net spending by the
10 plan or coverage;

11 “(vii) total amount received, or ex-
12 pected to be received, by the plan or cov-
13 erage from any entity in drug manufac-
14 turer rebates, fees, alternative discounts,
15 and all other remuneration received from
16 an entity or any third party (including
17 group purchasing organizations) other
18 than the plan sponsor;

19 “(viii) the total amount received, or
20 expected to be received by the plan or
21 issuer, from drug manufacturers in re-
22 bates, fees, alternative discounts, or other
23 remuneration—

24 “(I) that has been paid, or is to
25 be paid, by drug manufacturers for

1 claims incurred during the reporting
2 period; and

3 “(II) that is related to utilization
4 rebates for such drug; and

5 “(ix) to the extent feasible, informa-
6 tion on the total amount of remuneration,
7 including copayment assistance dollars
8 paid, copayment cards applied, or other
9 discounts provided by each drug manufac-
10 turer (or entity administering copay assist-
11 ance on behalf of such drug manufacturer)
12 to the participants, beneficiaries, and en-
13 rollees enrolled in such plan or coverage;

14 “(B) for each category or class of drugs
15 for which a claim was filed, a breakdown of the
16 total gross spending on drugs in such category
17 or class before rebates, price concessions, alter-
18 native discounts, or other remuneration from
19 drug manufacturers, and the net spending after
20 such rebates, price concessions, alternative dis-
21 counts, or other remuneration from drug manu-
22 facturers, including—

23 “(i) the number of participants, bene-
24 ficiaries, and enrollees who filled a pre-
25 scription for a drug in such category or

1 class, including the National Drug Code
2 for each such drug;

3 “(ii) if applicable, a description of the
4 formulary tiers and utilization mechanisms
5 (such as prior authorization or step ther-
6 apy) employed for drugs in that category
7 or class; and

8 “(iii) the total out-of-pocket spending
9 under the plan or coverage by participants,
10 beneficiaries, and enrollees, including
11 spending through copayments, coinsurance,
12 and deductibles;

13 “(C) in the case of a drug for which gross
14 spending by such plan, coverage, or entity ex-
15 ceeded \$10,000 during the reporting period—

16 “(i) a list of all other drugs in the
17 same therapeutic category or class; and

18 “(ii) the rationale for the formulary
19 placement of such drug in that therapeutic
20 category or class, if applicable;

21 “(D) amounts paid directly or indirectly in
22 rebates, fees, or any other type of compensation
23 (as defined in section 408(b)(2)(B)(ii)(dd)(AA)
24 of the Employee Retirement Income Security
25 Act) to brokers, consultants, advisors, or any

1 other individual or firm, for the referral of the
2 group health plan's or health insurance issuer's
3 business to an entity providing pharmacy bene-
4 fits management services, including the identity
5 of the recipient of such amounts;

6 “(E) an explanation of any benefit design
7 parameters that encourage or require partici-
8 pants, beneficiaries, and enrollees in such plan
9 or coverage to fill prescriptions at mail order,
10 specialty, or retail pharmacies that are affili-
11 ated with or under common ownership with the
12 entity providing pharmacy benefit management
13 services under such plan or coverage, including
14 mandatory mail and specialty home delivery
15 programs, retail and mail auto-refill programs,
16 and cost-sharing assistance incentives directly
17 or indirectly funded by such entity; and

18 “(F) in the case of a plan or coverage (or
19 an entity providing pharmacy benefits manage-
20 ment services on behalf of such plan or cov-
21 erage) that has an affiliated pharmacy or phar-
22 macy under common ownership—

23 “(i) the percentage of total prescrip-
24 tions dispensed by such pharmacies to in-
25 dividuals enrolled in such plan or coverage;

1 “(ii) a list of all drugs dispensed by
2 such pharmacies to individuals enrolled in
3 such plan or coverage, and, with respect to
4 each drug dispensed—

5 “(I) the amount charged, per
6 dosage unit, per 30-day supply, or per
7 90-day supply (as applicable) to the
8 plan or issuer, and to participants,
9 beneficiaries, and enrollees enrolled in
10 such plan or coverage;

11 “(II) the median amount charged
12 to such plan or issuer, and the inter-
13 quartile range of the costs, per dosage
14 unit, per 30-day supply, and per 90-
15 day supply, including amounts paid by
16 the participants, beneficiaries, and en-
17 rollees, when the same drug is dis-
18 pensed by other pharmacies that are
19 not affiliated with or under common
20 ownership with the entity and that are
21 included in the pharmacy network of
22 such plan or coverage;

23 “(III) the lowest cost per dosage
24 unit, per 30-day supply and per 90-
25 day supply, for each such drug, in-

1 including amounts charged to the plan
2 and participants, beneficiaries, and
3 enrollees, that is available from any
4 pharmacy included in the network of
5 such plan or coverage; and

6 “(IV) the net acquisition cost per
7 dosage unit, per 30-day supply, and
8 per 90-day supply, if such drug is
9 subject to a maximum price discount.

10 “(3) PRIVACY REQUIREMENTS.—Health insur-
11 ance issuers offering group health insurance cov-
12 erage and entities providing pharmacy benefits man-
13 agement services on behalf of a group health plan
14 shall provide information under paragraph (1) in a
15 manner consistent with the privacy, security, and
16 breach notification regulations promulgated under
17 section 13402(a) of the Health Information Tech-
18 nology for Clinical Health Act, and shall restrict the
19 use and disclosure of such information according to
20 such privacy regulations.

21 “(4) DISCLOSURE AND REDISCLOSURE.—

22 “(A) LIMITATION TO BUSINESS ASSOCI-
23 ATES.—A plan sponsor receiving a report under
24 paragraph (1) may disclose such information
25 only to the entity from which the report was re-

1 received, the group health plan for which the re-
2 port pertains, or to that entity's business asso-
3 ciates as defined in section 160.103 of title 45,
4 Code of Federal Regulations (or successor regu-
5 lations) or as permitted by the HIPAA Privacy
6 Rule (45 CFR parts 160 and 164, subparts A
7 and E).

8 “(B) CLARIFICATION REGARDING PUBLIC
9 DISCLOSURE OF INFORMATION.—Nothing in
10 this section shall prevent a group health plan or
11 health insurance issuer offering group health
12 insurance coverage, or an entity providing phar-
13 macy benefits management services on behalf of
14 such a plan or coverage, from placing reason-
15 able restrictions on the public disclosure of the
16 information contained in a report described in
17 paragraph (1), except that such plan, issuer, or
18 entity may not restrict disclosure of such report
19 to the Department of Health and Human Serv-
20 ices, the Department of Labor, the Department
21 of the Treasury, or the Comptroller General of
22 the United States.

23 “(C) LIMITED FORM OF REPORT.—The
24 Secretary shall define through rulemaking a
25 limited form of the report under paragraph (1)

1 required of plan sponsors who are drug manu-
2 facturers, drug wholesalers, or other direct par-
3 ticipants in the drug supply chain, in order to
4 prevent anti-competitive behavior.

5 “(5) REPORT TO GAO.—A group health plan or
6 health insurance issuer offering group health insur-
7 ance coverage, or an entity providing pharmacy ben-
8 efits management services on behalf of such plan or
9 coverage, shall submit to the Comptroller General of
10 the United States each of the first 4 reports sub-
11 mitted to a plan sponsor under paragraph (1) and
12 other such reports as requested, in accordance with
13 the privacy requirements under paragraph (3), the
14 disclosure and redisclosure standards under para-
15 graph (4), the standards specified pursuant to para-
16 graph (6), and such other information that the
17 Comptroller General determines necessary to carry
18 out the study under section 106(d) of the Lower
19 Costs, More Transparency Act.

20 “(6) STANDARD FORMAT.—Not later than 1
21 year after the date of enactment of this section, the
22 Secretary shall specify through rulemaking stand-
23 ards for group health plans, health insurance issuers
24 offering group health insurance coverage, and enti-
25 ties providing pharmacy benefits management serv-

1 ices on behalf of such plans or coverage, required to
2 submit reports under paragraph (1) to submit such
3 reports in a standard format.

4 “(c) ENFORCEMENT.—

5 “(1) IN GENERAL.—The Secretary shall enforce
6 this section.

7 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
8 TION.—A health insurance issuer or an entity pro-
9 viding pharmacy benefits management services on
10 behalf of such plan or coverage that violates sub-sec-
11 tion (a) or fails to provide the information required
12 under subsection (b) shall be subject to a civil mone-
13 etary penalty in the amount of \$10,000 for each day
14 during which such violation continues or such infor-
15 mation is not disclosed or reported.

16 “(3) FALSE INFORMATION.—A health insurance
17 issuer or an entity providing pharmacy benefits
18 management services on behalf of such a plan or
19 coverage that knowingly provides false information
20 under this section shall be subject to a civil money
21 penalty in an amount not to exceed \$100,000 for
22 each item of false information. Such civil money
23 penalty shall be in addition to other penalties as
24 may be prescribed by law.

1 “(4) PROCEDURE.—The provisions of section
2 1128A of the Social Security Act, other than sub-
3 sections (a) and (b) and the first sentence of sub-
4 section (c)(1) of such section shall apply to civil
5 monetary penalties under this subsection in the
6 same manner as such provisions apply to a penalty
7 or proceeding under such section.

8 “(5) WAIVERS.—The Secretary may waive pen-
9 alties under paragraph (2), or extend the period of
10 time for compliance with a requirement of this sec-
11 tion, for an entity in violation of this section that
12 has made a good-faith effort to comply with the re-
13 quirements in this section.

14 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed to permit a group health plan,
16 health insurance issuer, or entity providing pharmacy ben-
17 efits management services on behalf of such plan or cov-
18 erage, to restrict disclosure to, or otherwise limit the ac-
19 cess of, the Department of Health and Human Services
20 to a report described in subsection (b)(1) or information
21 related to compliance with subsection (a) or (b) by entities
22 subject to such subsection.

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

1 (2) in section 2723 (42 U.S.C. 300gg-22)—

2 (A) in subsection (a)—

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

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

9 (B) in subsection (b)—

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

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

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

19 (b) ERISA.—

20 (1) IN GENERAL.—Subtitle B of title I of the
21 Employee Retirement Income Security Act of 1974
22 (29 U.S.C. 1021 et seq.) is amended—

23 (A) in subpart B of part 7 (29 U.S.C.
24 1185 et seq.), by adding at the end the fol-
25 lowing:

1 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
2 **SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or
4 after the date that is 2 years after the date of enactment
5 of this section, a group health plan or a health insurance
6 issuer offering group health insurance coverage, or an en-
7 tity or subsidiary providing pharmacy benefits manage-
8 ment services on behalf of such a plan or issuer, shall not
9 enter into a contract with a drug manufacturer, dis-
10 tributor, wholesaler, subcontractor, rebate aggregator, or
11 any other third party that limits (or delays beyond the
12 applicable reporting period described in subsection (b)(1))
13 the disclosure of information to plan sponsors in such a
14 manner that prevents such plan, issuer, or entity from
15 making the reports described in subsection (b).

16 “(b) REPORTS.—

17 “(1) IN GENERAL.—With respect to plan years
18 beginning on or after the date that is 2 years after
19 the date of enactment of this section, not less fre-
20 quently than every 6 months (or at the request of
21 a plan sponsor, not less frequently than quarterly,
22 but under the same conditions, terms, and cost of
23 the semiannual report under this subsection), a
24 group health plan or health insurance issuer offering
25 group health insurance coverage, or an entity pro-
26 viding pharmacy benefits management services on

1 behalf of such a plan or issuer, shall submit to the
2 plan sponsor (as defined in section 3(16)(B)) of
3 such plan or coverage a report in accordance with
4 this section. Each such report shall be made avail-
5 able to such plan sponsor in a machine-readable for-
6 mat and shall include the information described in
7 paragraph (2).

8 “(2) INFORMATION DESCRIBED.—For purposes
9 of paragraph (1), the information described in this
10 paragraph is, with respect to drugs covered by a
11 group health plan or health insurance issuer offering
12 group health insurance coverage during each report-
13 ing period—

14 “(A) a list of drugs for which a claim was
15 filed and, with respect to each such drug on
16 such list—

17 “(i) the brand name, chemical entity,
18 and National Drug Code;

19 “(ii) the type of dispensing channel
20 used to furnish such drug, including retail,
21 mail order, or specialty pharmacy;

22 “(iii) with respect to each drug dis-
23 pensed under each type of dispensing chan-
24 nel (including retail, mail order, or spe-
25 cialty pharmacy)—

1 “(I) whether such drug is a
2 brand name drug or a generic drug,
3 and—

4 “(aa) in the case of a brand
5 name drug, the wholesale acquisi-
6 tion cost, listed as cost per days
7 supply and cost per dosage unit,
8 on the date such drug was dis-
9 pensed; and

10 “(bb) in the case of a ge-
11 neric drug, the average wholesale
12 price, listed as cost per days sup-
13 ply and cost per dosage unit, on
14 the date such drug was dis-
15 pensed; and

16 “(II) the total number of—

17 “(aa) prescription claims
18 (including original prescriptions
19 and refills);

20 “(bb) participants, bene-
21 ficiaries, and enrollees for whom
22 a claim for such drug was filed;

23 “(cc) dosage units per fill of
24 such drug; and

1 “(dd) days supply of such
2 drug per fill;

3 “(iv) the net price per course of treat-
4 ment or single fill, such as a 30-day supply
5 or 90-day supply to the plan or coverage
6 after manufacturer rebates, fees, and other
7 remuneration or adjustments;

8 “(v) the total amount of out-of-pocket
9 spending by participants, beneficiaries, and
10 enrollees on such drug, including spending
11 through copayments, coinsurance, and
12 deductibles;

13 “(vi) the total net spending by the
14 plan or coverage;

15 “(vii) total amount received, or ex-
16 pected to be received, by the plan or cov-
17 erage from any entity in drug manufac-
18 turer rebates, fees, alternative discounts,
19 and all other remuneration received from
20 an entity or any third party (including
21 group purchasing organizations) other
22 than the plan sponsor;

23 “(viii) the total amount received, or
24 expected to be received by the plan or
25 issuer, from drug manufacturers in re-

1 bates, fees, alternative discounts, or other
2 remuneration—

3 “(I) that has been paid, or is to
4 be paid, by drug manufacturers for
5 claims incurred during the reporting
6 period; and

7 “(II) that is related to utilization
8 rebates for such drug; and

9 “(ix) to the extent feasible, informa-
10 tion on the total amount of remuneration,
11 including copayment assistance dollars
12 paid, copayment cards applied, or other
13 discounts provided by each drug manufac-
14 turer (or entity administering copay assist-
15 ance on behalf of such drug manufacturer)
16 to the participants, beneficiaries, and en-
17 rollees enrolled in such plan or coverage;

18 “(B) for each category or class of drugs
19 for which a claim was filed, a breakdown of the
20 total gross spending on drugs in such category
21 or class before rebates, price concessions, alter-
22 native discounts, or other remuneration from
23 drug manufacturers, and the net spending after
24 such rebates, price concessions, alternative dis-

1 counts, or other remuneration from drug manu-
2 facturers, including—

3 “(i) the number of participants, bene-
4 ficiaries, and enrollees who filled a pre-
5 scription for a drug in such category or
6 class, including the National Drug Code
7 for each such drug;

8 “(ii) if applicable, a description of the
9 formulary tiers and utilization mechanisms
10 (such as prior authorization or step ther-
11 apy) employed for drugs in that category
12 or class; and

13 “(iii) the total out-of-pocket spending
14 under the plan or coverage by participants,
15 beneficiaries, and enrollees, including
16 spending through copayments, coinsurance,
17 and deductibles;

18 “(C) in the case of a drug for which gross
19 spending by such plan, coverage, or entity ex-
20 ceeded \$10,000 during the reporting period—

21 “(i) a list of all other drugs in the
22 same therapeutic category or class; and

23 “(ii) the rationale for the formulary
24 placement of such drug in that therapeutic
25 category or class, if applicable;

1 “(D) amounts paid directly or indirectly in
2 rebates, fees, or any other type of compensation
3 (as defined in section 408(b)(2)(B)(ii)(dd)(AA))
4 to brokers, consultants, advisors, or any other
5 individual or firm, for the referral of the group
6 health plan’s or health insurance issuer’s busi-
7 ness to an entity providing pharmacy benefits
8 management services, including the identity of
9 the recipient of such amounts;

10 “(E) an explanation of any benefit design
11 parameters that encourage or require partici-
12 pants, beneficiaries, and enrollees in such plan
13 or coverage to fill prescriptions at mail order,
14 specialty, or retail pharmacies that are affili-
15 ated with or under common ownership with the
16 entity providing pharmacy benefit management
17 services under such plan or coverage, including
18 mandatory mail and specialty home delivery
19 programs, retail and mail auto-refill programs,
20 and cost-sharing assistance incentives directly
21 or indirectly funded by such entity; and

22 “(F) in the case of a plan or coverage (or
23 an entity providing pharmacy benefits manage-
24 ment services on behalf of such plan or cov-

1 erage) that has an affiliated pharmacy or phar-
2 macy under common ownership—

3 “(i) the percentage of total prescrip-
4 tions dispensed by such pharmacies to in-
5 dividuals enrolled in such plan or coverage;

6 “(ii) a list of all drugs dispensed by
7 such pharmacies to individuals enrolled in
8 such plan or coverage, and, with respect to
9 each drug dispensed—

10 “(I) the amount charged, per
11 dosage unit, per 30-day supply, or per
12 90-day supply (as applicable) to the
13 plan or issuer, and to participants,
14 beneficiaries, and enrollees enrolled in
15 such plan or coverage;

16 “(II) the median amount charged
17 to such plan or issuer, and the inter-
18 quartile range of the costs, per dosage
19 unit, per 30-day supply, and per 90-
20 day supply, including amounts paid by
21 the participants, beneficiaries, and en-
22 rollees, when the same drug is dis-
23 pensed by other pharmacies that are
24 not affiliated with or under common
25 ownership with the entity and that are

1 included in the pharmacy network of
2 such plan or coverage;

3 “(III) the lowest cost per dosage
4 unit, per 30-day supply and per 90-
5 day supply, for each such drug, in-
6 cluding amounts charged to the plan
7 and participants, beneficiaries, and
8 enrollees, that is available from any
9 pharmacy included in the network of
10 such plan or coverage; and

11 “(IV) the net acquisition cost per
12 dosage unit, per 30-day supply, and
13 per 90-day supply, if such drug is
14 subject to a maximum price discount.

15 “(3) PRIVACY REQUIREMENTS.—Health insur-
16 ance issuers offering group health insurance cov-
17 erage and entities providing pharmacy benefits man-
18 agement services on behalf of a group health plan
19 shall provide information under paragraph (1) in a
20 manner consistent with the privacy, security, and
21 breach notification regulations promulgated under
22 section 13402(a) of the Health Information Tech-
23 nology for Clinical Health Act, and shall restrict the
24 use and disclosure of such information according to
25 such privacy regulations.

1 “(4) DISCLOSURE AND REDISCLOSURE.—

2 “(A) LIMITATION TO BUSINESS ASSOCI-
3 ATES.—A plan sponsor receiving a report under
4 paragraph (1) may disclose such information
5 only to the entity from which the report was re-
6 ceived, the group health plan for which the re-
7 port pertains, or to that entity’s business asso-
8 ciates as defined in section 160.103 of title 45,
9 Code of Federal Regulations (or successor regu-
10 lations) or as permitted by the HIPAA Privacy
11 Rule (45 CFR parts 160 and 164, subparts A
12 and E).

13 “(B) CLARIFICATION REGARDING PUBLIC
14 DISCLOSURE OF INFORMATION.—Nothing in
15 this section shall prevent a group health plan or
16 health insurance issuer offering group health
17 insurance coverage, or an entity providing phar-
18 macy benefits management services on behalf of
19 such a plan or coverage, from placing reason-
20 able restrictions on the public disclosure of the
21 information contained in a report described in
22 paragraph (1), except that such plan, issuer, or
23 entity may not restrict disclosure of such report
24 to the Department of Health and Human Serv-
25 ices, the Department of Labor, the Department

1 of the Treasury, or the Comptroller General of
2 the United States.

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

10 “(5) REPORT TO GAO.—A group health plan or
11 health insurance issuer offering group health insur-
12 ance coverage, or an entity providing pharmacy ben-
13 efits management services on behalf of such plan or
14 coverage, shall submit to the Comptroller General of
15 the United States each of the first 4 reports sub-
16 mitted to a plan sponsor under paragraph (1) and
17 other such reports as requested, in accordance with
18 the privacy requirements under paragraph (3), the
19 disclosure and redisclosure standards under para-
20 graph (4), the standards specified pursuant to para-
21 graph (6), and such other information that the
22 Comptroller General determines necessary to carry
23 out the study under section 106(d) of the Lower
24 Costs, More Transparency Act.

1 “(6) STANDARD FORMAT.—Not later than 1
2 year after the date of enactment of this section, the
3 Secretary shall specify through rulemaking stand-
4 ards for group health plans, health insurance issuers
5 offering group health insurance coverage, and enti-
6 ties providing pharmacy benefits management serv-
7 ices on behalf of such plans or coverage, required to
8 submit reports under paragraph (1) to submit such
9 reports in a standard format.

10 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
11 tion shall be construed to permit a group health plan,
12 health insurance issuer, or entity providing pharmacy ben-
13 efits management services on behalf of such plan or cov-
14 erage, to restrict disclosure to, or otherwise limit the ac-
15 cess of, the Secretary of Labor to a report described in
16 subsection (b)(1) or information related to compliance
17 with subsection (a) or (b) by entities subject to such sub-
18 section.

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

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

23 (i) in subsection (b)(3), by striking
24 “under subsection (c)(9))” and inserting

1 “under paragraphs (9) and (13) of sub-
2 section (c))”; and

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

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

8 “(A) FAILURE TO PROVIDE TIMELY INFOR-
9 MATION.—The Secretary may impose a penalty
10 against any health insurance issuer or entity
11 providing pharmacy benefits management serv-
12 ices that violates section 726(a) or fails to pro-
13 vide information required under section 726(b)
14 in the amount of \$10,000 for each day during
15 which such violation continues or such informa-
16 tion is not disclosed or reported.

17 “(B) FALSE INFORMATION.—The Sec-
18 retary may impose a penalty against a health
19 insurance issuer or entity providing pharmacy
20 benefits management services that knowingly
21 provides false information under section 726 in
22 an amount not to exceed \$100,000 for each
23 item of false information. Such penalty shall be
24 in addition to other penalties as may be pre-
25 scribed by law.

1 “(C) WAIVERS.—The Secretary may waive
2 penalties under subparagraph (A), or extend
3 the period of time for compliance with a re-
4 quirement of section 726, for an entity in viola-
5 tion of such section that has made a good-faith
6 effort to comply with such section.”.

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

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

12 (e) IRC.—

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

16 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
17 **SERVICES.**

18 “(a) IN GENERAL.—For plan years beginning on or
19 after the date that is 2 years after the date of enactment
20 of this section, a group health plan, or an entity or sub-
21 sidiary providing pharmacy benefits management services
22 on behalf of such a plan, shall not enter into a contract
23 with a drug manufacturer, distributor, wholesaler, subcon-
24 tractor, rebate aggregator, or any other third party that
25 limits (or delays beyond the applicable reporting period de-

1 scribed in subsection (b)(1)) the disclosure of information
2 to plan sponsors in such a manner that prevents such plan
3 or entity from making the reports described in subsection
4 (b).

5 “(b) REPORTS.—

6 “(1) IN GENERAL.—With respect to plan years
7 beginning on or after the date that is 2 years after
8 the date of enactment of this section, not less fre-
9 quently than every 6 months (or at the request of
10 a plan sponsor, not less frequently than quarterly,
11 but under the same conditions, terms, and cost of
12 the semiannual report under this subsection), a
13 group health plan, or an entity providing pharmacy
14 benefits management services on behalf of such a
15 plan, shall submit to the plan sponsor (as defined in
16 section 3(16)(B) of the Employee Retirement In-
17 come Security Act of 1974) of such plan a report in
18 accordance with this section. Each such report shall
19 be made available to such plan sponsor in a ma-
20 chine-readable format and shall include the informa-
21 tion described in paragraph (2).

22 “(2) INFORMATION DESCRIBED.—For purposes
23 of paragraph (1), the information described in this
24 paragraph is, with respect to drugs covered by a
25 group health plan during each reporting period—

1 “(A) a list of drugs for which a claim was
2 filed and, with respect to each such drug on
3 such list—

4 “(i) the brand name, chemical entity,
5 and National Drug Code;

6 “(ii) the type of dispensing channel
7 used to furnish such drug, including retail,
8 mail order, or specialty pharmacy;

9 “(iii) with respect to each drug dis-
10 pensed under each type of dispensing chan-
11 nel (including retail, mail order, or spe-
12 cialty pharmacy)—

13 “(I) whether such drug is a
14 brand name drug or a generic drug,
15 and—

16 “(aa) in the case of a brand
17 name drug, the wholesale acquisi-
18 tion cost, listed as cost per days
19 supply and cost per dosage unit,
20 on the date such drug was dis-
21 pensed; and

22 “(bb) in the case of a ge-
23 neric drug, the average wholesale
24 price, listed as cost per days sup-
25 ply and cost per dosage unit, on

1 the date such drug was dis-
2 pensed; and

3 “(II) the total number of—

4 “(aa) prescription claims
5 (including original prescriptions
6 and refills);

7 “(bb) participants and bene-
8 ficiaries for whom a claim for
9 such drug was filed;

10 “(cc) dosage units per fill of
11 such drug; and

12 “(dd) days supply of such
13 drug per fill;

14 “(iv) the net price per course of treat-
15 ment or single fill, such as a 30-day supply
16 or 90-day supply to the plan after manu-
17 facturer rebates, fees, and other remunera-
18 tion or adjustments;

19 “(v) the total amount of out-of-pocket
20 spending by participants and beneficiaries
21 on such drug, including spending through
22 copayments, coinsurance, and deductibles;

23 “(vi) the total net spending by the
24 plan;

1 “(vii) total amount received, or ex-
2 pected to be received, by the plan from any
3 entity in drug manufacturer rebates, fees,
4 alternative discounts, and all other remu-
5 neration received from an entity or any
6 third party (including group purchasing or-
7 ganizations) other than the plan sponsor;

8 “(viii) the total amount received, or
9 expected to be received, by the plan from
10 drug manufacturers in rebates, fees, alter-
11 native discounts, or other remuneration—

12 “(I) that has been paid, or is to
13 be paid, by drug manufacturers for
14 claims incurred during the reporting
15 period; and

16 “(II) that is related to utilization
17 rebates for such drug; and

18 “(ix) to the extent feasible, informa-
19 tion on the total amount of remuneration,
20 including copayment assistance dollars
21 paid, copayment cards applied, or other
22 discounts provided by each drug manufac-
23 turer (or entity administering copay assist-
24 ance on behalf of such drug manufacturer)

1 to the participants and beneficiaries en-
2 rolled in such plan;

3 “(B) for each category or class of drugs
4 for which a claim was filed, a breakdown of the
5 total gross spending on drugs in such category
6 or class before rebates, price concessions, alter-
7 native discounts, or other remuneration from
8 drug manufacturers, and the net spending after
9 such rebates, price concessions, alternative dis-
10 counts, or other remuneration from drug manu-
11 facturers, including—

12 “(i) the number of participants and
13 beneficiaries who filled a prescription for a
14 drug in such category or class, including
15 the National Drug Code for each such
16 drug;

17 “(ii) if applicable, a description of the
18 formulary tiers and utilization mechanisms
19 (such as prior authorization or step ther-
20 apy) employed for drugs in that category
21 or class; and

22 “(iii) the total out-of-pocket spending
23 under the plan by participants and bene-
24 ficiaries, including spending through co-
25 payments, coinsurance, and deductibles;

1 “(C) in the case of a drug for which gross
2 spending by such plan or entity exceeded
3 \$10,000 during the reporting period—

4 “(i) a list of all other drugs in the
5 same therapeutic category or class; and

6 “(ii) the rationale for the formulary
7 placement of such drug in that therapeutic
8 category or class, if applicable;

9 “(D) amounts paid directly or indirectly in
10 rebates, fees, or any other type of compensation
11 (as defined in section 408(b)(2)(B)(ii)(dd)(AA)
12 of the Employee Retirement Income Security
13 Act) to brokers, consultants, advisors, or any
14 other individual or firm, for the referral of the
15 group health plan’s business to an entity pro-
16 viding pharmacy benefits management services,
17 including the identity of the recipient of such
18 amounts;

19 “(E) an explanation of any benefit design
20 parameters that encourage or require partici-
21 pants, beneficiaries, and enrollees in such plan
22 to fill prescriptions at mail order, specialty, or
23 retail pharmacies that are affiliated with or
24 under common ownership with the entity pro-
25 viding pharmacy benefit management services

1 under such plan, including mandatory mail and
2 specialty home delivery programs, retail and
3 mail auto-refill programs, and cost-sharing as-
4 sistance incentives directly or indirectly funded
5 by such entity; and

6 “(F) in the case of a plan (or an entity
7 providing pharmacy benefits management serv-
8 ices on behalf of such plan) that has an affili-
9 ated pharmacy or pharmacy under common
10 ownership—

11 “(i) the percentage of total prescrip-
12 tions dispensed by such pharmacies to in-
13 dividuals enrolled in such plan;

14 “(ii) a list of all drugs dispensed by
15 such pharmacies to individuals enrolled in
16 such plan and, with respect to each drug
17 dispensed—

18 “(I) the amount charged, per
19 dosage unit, per 30-day supply, or per
20 90-day supply (as applicable) to the
21 plan and to participants and bene-
22 ficiaries enrolled in such plan;

23 “(II) the median amount charged
24 to such plan, and the interquartile
25 range of the costs, per dosage unit,

1 per 30-day supply, and per 90-day
2 supply, including amounts paid by the
3 participants and beneficiaries, when
4 the same drug is dispensed by other
5 pharmacies that are not affiliated with
6 or under common ownership with the
7 entity and that are included in the
8 pharmacy network of such plan;

9 “(III) the lowest cost per dosage
10 unit, per 30-day supply and per 90-
11 day supply, for each such drug, in-
12 cluding amounts charged to the plan
13 and to participants and beneficiaries,
14 that is available from any pharmacy
15 included in the network of such plan;
16 and

17 “(IV) the net acquisition cost per
18 dosage unit, per 30-day supply, and
19 per 90-day supply, if such drug is
20 subject to a maximum price discount.

21 “(3) PRIVACY REQUIREMENTS.—Health insur-
22 ance issuers offering group health insurance cov-
23 erage and entities providing pharmacy benefits man-
24 agement services on behalf of a group health plan
25 shall provide information under paragraph (1) in a

1 manner consistent with the privacy, security, and
2 breach notification regulations promulgated under
3 section 13402(a) of the Health Information Tech-
4 nology for Clinical Health Act, and shall restrict the
5 use and disclosure of such information according to
6 such privacy regulations.

7 “(4) DISCLOSURE AND REDISCLOSURE.—

8 “(A) LIMITATION TO BUSINESS ASSOCI-
9 ATES.—A plan sponsor receiving a report under
10 paragraph (1) may disclose such information
11 only to the entity from which the report was re-
12 ceived, the group health plan for which the re-
13 port pertains, or to that entity’s business asso-
14 ciates as defined in section 160.103 of title 45,
15 Code of Federal Regulations (or successor regu-
16 lations) or as permitted by the HIPAA Privacy
17 Rule (45 CFR parts 160 and 164, subparts A
18 and E).

19 “(B) CLARIFICATION REGARDING PUBLIC
20 DISCLOSURE OF INFORMATION.—Nothing in
21 this section shall prevent a group health plan or
22 health insurance issuer offering group health
23 insurance coverage, or an entity providing phar-
24 macy benefits management services on behalf of
25 such a plan or coverage, from placing reason-

1 able restrictions on the public disclosure of the
2 information contained in a report described in
3 paragraph (1), except that such plan, issuer, or
4 entity may not restrict disclosure of such report
5 to the Department of Health and Human Serv-
6 ices, the Department of Labor, the Department
7 of the Treasury, or the Comptroller General of
8 the United States.

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

16 “(5) REPORT TO GAO.—A group health plan, or
17 an entity providing pharmacy benefits management
18 services on behalf of such plan, shall submit to the
19 Comptroller General of the United States each of
20 the first 4 reports submitted to a plan sponsor under
21 paragraph (1) and other such reports as requested,
22 in accordance with the privacy requirements under
23 paragraph (3), the disclosure and redisclosure stand-
24 ards under paragraph (4), the standards specified
25 pursuant to paragraph (6), and such other informa-

1 tion that the Comptroller General determines nec-
2 essary to carry out the study under section 106(d)
3 of the Lower Costs, More Transparency Act.

4 “(6) STANDARD FORMAT.—Not later than 1
5 year after the date of enactment of this section, the
6 Secretary shall specify through rulemaking stand-
7 ards for group health plans, and entities providing
8 pharmacy benefits management services on behalf of
9 such plans, required to submit reports under para-
10 graph (1) to submit such reports in a standard for-
11 mat.

12 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
13 tion shall be construed to permit a group health plan or
14 entity providing pharmacy benefits management services
15 on behalf of such plan, to restrict disclosure to, or other-
16 wise limit the access of, the Secretary of Health and
17 Human Services to a report described in subsection (b)(1)
18 or information related to compliance with subsections (a)
19 or (b) by entities subject to such subsection.

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

23 (2) CLERICAL AMENDMENT.—The table of sec-
24 tions for subchapter B of chapter 100 of the Inter-

1 nal Revenue Code of 1986 is amended by adding at
2 the end the following new item:

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

3 (d) GAO REPORTS.—

4 (1) REPORT ON PHARMACY NETWORK DE-
5 SIGN.—

6 (A) IN GENERAL.—Not later than 3 years
7 after the date of enactment of this Act, the
8 Comptroller General of the United States shall
9 submit to Congress a report on—

10 (i) pharmacy networks that have con-
11 tracted with group health plans, health in-
12 surance issuers offering group health in-
13 surance coverage, or entities providing
14 pharmacy benefits management services on
15 behalf of such plans or issuers, including
16 networks with pharmacies that are under
17 common ownership (in whole or part) with
18 such plans, issuers, or entities (including
19 entities that provide pharmacy benefits ad-
20 ministrative services on behalf of such
21 plans or issuers);

22 (ii) pharmacy network design param-
23 eters that encourage individuals enrolled in
24 such plans or coverage to fill prescriptions
25 at mail order, specialty, or retail phar-

1 macies that are wholly or partially owned
2 by a plan, issuer, or entity;

3 (iii) whether such plans and issuers
4 have options to elect different network
5 pricing arrangements in the marketplace
6 with entities that provide pharmacy bene-
7 fits management services and the preva-
8 lence of electing such different network
9 pricing arrangements;

10 (iv) with respect to pharmacy net-
11 works that include pharmacies under com-
12 mon ownership described in clause (i)—

13 (I) whether such networks are
14 designed to encourage individuals en-
15 rolled in a group health plan or health
16 insurance coverage to use such phar-
17 macies over other network pharmacies
18 for specific services or drugs, and if
19 so, the reasons the networks give for
20 encouraging use of such pharmacies;
21 and

22 (II) whether such pharmacies are
23 used by enrollees disproportionately
24 more in the aggregate or for specific

1 services or drugs compared to other
2 network pharmacies;

3 (v) the degree to which mail order,
4 specialty, or retail pharmacies that dis-
5 pense prescription drugs to an enrollee in
6 a plan or coverage that are under common
7 ownership (in whole or part) with plans,
8 issuers, or entities providing pharmacy
9 benefits management services or pharmacy
10 benefits administrative services on behalf
11 of such plan or coverage receive reimburse-
12 ment that is greater than the median price
13 charged to the plan or issuer when the
14 same drug is dispensed to enrollees in the
15 plan or coverage by other pharmacies in-
16 cluded in the pharmacy network of that
17 plan, issuer, or entity that are not wholly
18 or partially owned by the plan or issuer, or
19 entity providing pharmacy benefits man-
20 agement services on behalf of such plan or
21 issuer.

22 (B) REQUIREMENT.—The Comptroller
23 General of the United States shall ensure that
24 the report under subparagraph (A) does not
25 contain information that would identify a spe-

1 cific group health plan or health insurance
2 issuer (or an entity providing pharmacy benefits
3 management services on behalf of such plan or
4 issuer), or otherwise contain commercial or fi-
5 nancial information that is privileged or con-
6 fidential.

7 (C) DEFINITIONS.—In this paragraph, the
8 terms “group health plan”, “health insurance
9 coverage”, and “health insurance issuer” have
10 the meanings given such terms in section 2791
11 of the Public Health Service Act (42 U.S.C.
12 300gg–91).

13 (2) REPORT ON COPAY ASSISTANCE PRO-
14 GRAMS.—Not later than 18 months after the date of
15 the enactment of this Act, the Comptroller General
16 of the United States shall submit to Congress a re-
17 port on what is known about the role of copay as-
18 sistance programs and the impact of such programs
19 on commercial health insurance, stop loss, and drug
20 prices. Such report shall include to the extent fea-
21 sible—

22 (A) a description of copay assistance pro-
23 grams, including—

24 (i) the types of programs available
25 and the methods of providing copay assist-

- 1 ance through such programs, including
2 cash discounts, copay cards, or drugs pro-
3 vided to an individual at no cost;
- 4 (ii) how such programs are funded;
- 5 (iii) the types of entities that own, op-
6 erate, or otherwise conduct such programs,
7 the types of information such entities col-
8 lect, and the direct and indirect contrac-
9 tual relationships between the entities in
10 the drug supply chain that interact with
11 such programs, such as a drug manufac-
12 turer, pharmacy, wholesaler, switch, rebate
13 aggregator, pharmacy benefit manager,
14 and other entities in the drug supply chain;
- 15 (iv) the effect of such programs on
16 patient out-of-pocket spending, including
17 for stop-loss insurance, and drug utiliza-
18 tion, including drug adherence; and
- 19 (v) patient eligibility criteria for such
20 programs; and
- 21 (B) an analysis of—
- 22 (i) the sources of funding for such
23 programs; and
- 24 (ii) the effects of such programs on
25 Federal health care programs and the indi-

1 viduals enrolled in such Federal health
2 care programs.

3 **SEC. 107. REPORTS ON HEALTH CARE TRANSPARENCY**
4 **TOOLS AND DATA.**

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

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

16 (2) reviews how such reporting requirements
17 are enforced;

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

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

1 (B) assisted health insurance plan spon-
2 sors and fiduciaries improve benefits, lower
3 health care costs for plan participants, and
4 meet fiduciary requirements;

5 (4) includes recommendations to the Commit-
6 tees, the Secretary of Health and Human Services,
7 the Secretary of Labor, and the Secretary of the
8 Treasury to—

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

11 (B) streamline Federal health care report-
12 ing requirements to eliminate duplicative re-
13 quirements and reduce the burden on entities
14 required to submit reports pursuant to such
15 provisions;

16 (C) improve the accuracy and efficiency of
17 such reports while maintaining the integrity
18 and usability of the data provided by such re-
19 ports;

20 (D) address any gaps in data provided by
21 such reports; and

22 (E) ensure that the data and information
23 reported is comparable and usable to con-
24 sumers, including patients, plan sponsors, and
25 policy makers.

1 (b) FINAL REPORT.—Not later than December 31,
2 2028, the Comptroller General of the United States shall
3 submit to the Committees a report that includes—

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

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

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

22 (d) DEFINITIONS.—In this section:

23 (1) COMMITTEES.—The term “Committees”
24 means the Committee on Ways and Means, the
25 Committee on Energy and Commerce, and the Com-

1 mittee on Education and the Workforce of the
2 House of Representatives, and the Committee on Fi-
3 nance and the Committee on Health, Education,
4 Labor, and Pensions of the Senate.

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

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

21 **SEC. 108. REPORT ON INTEGRATION IN MEDICARE.**

22 (a) REQUIRED MA AND PDP REPORTING.—

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

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

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

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

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

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

1 “(B) DEFINITIONS.—For purposes of this
2 paragraph:

3 “(i) APPLICABLE MA ORGANIZA-
4 TION.—The term ‘applicable MA organiza-
5 tion’ means, with respect to a plan year,
6 an MA organization with at least 25,000
7 individuals enrolled under Medicare Advan-
8 tage plans offered by such organization
9 during such plan year.

10 “(ii) SPECIFIED HEALTH CARE PRO-
11 VIDER.—The term ‘specified health care
12 provider’ means, with respect to an appli-
13 cable MA organization and a plan year, a
14 provider of services or supplier with re-
15 spect to which such organization (or any
16 person with an ownership or control inter-
17 est (as defined in section 1124(a)(3)) in
18 such organization) is a person with an
19 ownership or control interest (as so de-
20 fined).”.

21 (2) PRESCRIPTION DRUG PLANS.—Section
22 1860D–12(b) of the Social Security Act (42 U.S.C.
23 1395w–112(b)) is amended by adding at the end the
24 following new paragraph:

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

3 “(A) IN GENERAL.—For plan year 2025
4 and for every third plan year thereafter, each
5 PDP sponsor offering a prescription drug plan
6 under this part during such plan year shall sub-
7 mit to the Secretary, at a time and in a manner
8 specified by the Secretary, the taxpayer identi-
9 fication number and National Provider Identifi-
10 fier for each pharmacy that was a specified
11 pharmacy with respect to such sponsor during
12 such year.

13 “(B) DEFINITION.—For purposes of this
14 paragraph, the term ‘specified pharmacy’
15 means, with respect to an PDP sponsor offering
16 a prescription drug plan and a plan year, a
17 pharmacy with respect to which—

18 “(i) such sponsor (or any person with
19 an ownership or control interest (as de-
20 fined in section 1124(a)(3)) in such spon-
21 sor) is a person with an ownership or con-
22 trol interest (as so defined); or

23 “(ii) a pharmacy benefit manager of-
24 fering services under such plan (or any
25 person with an ownership or control inter-

1 est (as so defined) in such sponsor) is a
2 person with an ownership or control inter-
3 est (as so defined).”.

4 (b) MEDPAC REPORTS.—Part E of title XVIII of the
5 Social Security Act (42 U.S.C. 1395x et seq.), as amended
6 by section 101, is further amended by adding at the end
7 the following new section:

8 **“SEC. 1899D. REPORTS ON VERTICAL INTEGRATION UNDER**
9 **MEDICARE.**

10 “(a) IN GENERAL.—Not later than June 15, 2029,
11 and every 3 years thereafter, the Medicare Payment Advi-
12 sory Commission shall submit to Congress a report on the
13 state of vertical integration in the health care sector dur-
14 ing the applicable year with respect to entities partici-
15 pating in the Medicare program, including health care pro-
16 viders, pharmacies, prescription drug plan sponsors, Medi-
17 care Advantage organizations, and pharmacy benefit man-
18 agers. Such report shall include—

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

21 “(2) with respect to prescription drug plans,
22 pharmacy benefit managers, and pharmacies, the
23 comparisons and evaluations described in subsection
24 (c);

1 “(3) with respect to Medicare Advantage plans
2 under which benefits are available for physician-ad-
3 ministered drugs, the information described in sub-
4 section (d);

5 “(4) the identifications described in subsection
6 (e); and

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

10 “(b) MEDICARE ADVANTAGE ORGANIZATIONS.—For
11 purposes of subsection (a)(1), the evaluation described in
12 this subsection is, with respect to Medicare Advantage or-
13 ganizations and an applicable year, an evaluation, taking
14 into account patient acuity and the types of areas serviced
15 by such organization, of—

16 “(1) the average number of qualifying diag-
17 noses made during such year with respect to enroll-
18 ees of a Medicare Advantage plan offered by such
19 organization who, during such year, received a
20 health risk assessment from a specified health care
21 provider;

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

24 “(3) any relationship between such risk scores
25 for such enrollees receiving such an assessment from

1 such a provider during such year and incentive pay-
2 ments made to such providers;

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

6 “(5) any relationship between the risk scores of
7 enrollees under such plan and whether the enrollees
8 have received any item or service from a specified
9 provider; and

10 “(6) any relationship between the risk scores of
11 enrollees under such plan that have received any
12 item or service from a specified provider and incen-
13 tive payments made under the plan to specified pro-
14 viders.

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

19 “(1) For each covered part D drug for which
20 benefits are available under such a plan, a compari-
21 son of the average negotiated rate in effect with
22 specified pharmacies with such rates in effect for in-
23 network pharmacies that are not specified phar-
24 macies.

25 “(2) Comparisons of the following:

1 “(A) The total amount paid by pharmacy
2 benefit managers to specified pharmacies for
3 covered part D drugs and the total amount so
4 paid to pharmacies that are not specified phar-
5 macies for such drugs.

6 “(B) The total amount paid by such spon-
7 sors to specified pharmacy benefit managers as
8 reimbursement for covered part D drugs and
9 the total amount so paid to pharmacy benefit
10 managers that are not specified pharmacy ben-
11 efit managers as such reimbursement.

12 “(C) Fees paid under by plan to specified
13 pharmacy benefit managers compared to such
14 fees paid to pharmacy benefit managers that
15 are not specified pharmacy benefit managers.

16 “(3) An evaluation of the total amount of direct
17 and indirect remuneration for covered part D drugs
18 passed through to prescription drug plan sponsors
19 and the total amount retained by pharmacy benefit
20 managers (including entities under contract with
21 such a manager).

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

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

6 “(1) With respect to each such plan, an identi-
7 fication of each drug for which benefits were avail-
8 able under such plan only when administered by a
9 health care provider that acquired such drug from
10 an affiliated pharmacy.

11 “(2) An evaluation of the difference between
12 the total number of drugs administered by a health
13 care provider that were acquired from affiliated
14 pharmacies compared to the number of such drugs
15 so administered that were acquired from pharmacies
16 other than affiliated pharmacies, and an evaluation
17 of the difference in payments for such drugs so ad-
18 ministered when acquired from a specified pharmacy
19 and when acquired from a pharmacy that is not a
20 specified pharmacy.

21 “(3) An evaluation of the dollar value of all
22 such drugs that were not so administered because of
23 a delay attributable to an affiliated pharmacy com-
24 pared to the dollar value of all such drugs that were

1 not so administered because of a delay attributable
2 to pharmacy that is not an affiliated pharmacy.

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

6 “(5) The number of enrollees furnished such a
7 drug that was acquired from a pharmacy that is not
8 an affiliated pharmacy.

9 “(e) IDENTIFICATIONS.—For purposes of subsection
10 (a)(4), the identifications described in this subsection are,
11 with respect to an applicable year, identifications of each
12 health care entity participating under the Medicare pro-
13 gram with respect to which another health care entity so
14 participating is a person with an ownership or control in-
15 terest (as defined in section 1124(a)(3)).

16 “(f) DEFINITIONS.—In this section:

17 “(1) AFFILIATED PHARMACY.—The term ‘affili-
18 ated pharmacy’ means, with respect to a Medicare
19 Advantage plan offered by a Medicare Advantage or-
20 ganization, a pharmacy with respect to which such
21 organization (or any person with an ownership or
22 control interest (as defined in section 1124(a)(3)) in
23 such organization) is a person with an ownership or
24 control interest (as so defined).

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

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

9 “(4) DIRECT AND INDIRECT REMUNERATION.—
10 The term ‘direct and indirect remuneration’ has the
11 meaning given such term in section 423.308 of title
12 42, Code of Federal Regulations (or any successor
13 regulation).

14 “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-
15 fying diagnosis’ means, with respect to an enrollee of
16 a Medicare Advantage plan, a diagnosis that is
17 taken into account in calculating a risk score for
18 such enrollee under the risk adjustment methodology
19 established by the Secretary pursuant to section
20 1853(a)(3).

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

1 “(7) PHYSICIAN-ADMINISTERED DRUG.—The
2 term ‘physician-administered drug’ means a drug
3 furnished to an individual that, had such individual
4 been enrolled under part B and not enrolled under
5 part C, would have been payable under section
6 1842(o).

7 “(8) SPECIFIED HEALTH CARE PROVIDER.—
8 The term ‘specified health care provider’ means,
9 with respect to a Medicare Advantage plan offered
10 by a Medicare Advantage organization, a health care
11 provider with respect to which such organization (or
12 any person with an ownership or control interest (as
13 defined in section 1124(a)(3)) in such organization)
14 is a person with an ownership or control interest (as
15 so defined).

16 “(9) SPECIFIED PHARMACY.—The term ‘speci-
17 fied pharmacy’ means, with respect to a prescription
18 drug plan offered by a prescription drug plan spon-
19 sor, a pharmacy with respect to which—

20 “(A) such sponsor (or any person with an
21 ownership or control interest (as defined in sec-
22 tion 1124(a)(3)) in such sponsor) is a person
23 with an ownership or control interest (as so de-
24 fined); or

1 “(B) a pharmacy benefit manager offering
2 services under such plan (or any person with an
3 ownership or control interest (as so defined) in
4 such sponsor) is a person with an ownership or
5 control interest (as so defined).

6 “(10) SPECIFIED PHARMACY BENEFIT MAN-
7 AGER.—The term ‘specified pharmacy benefit man-
8 ager’ means, with respect to a prescription drug
9 plan offered by a prescription drug plan sponsor, a
10 pharmacy benefit manager with respect to which
11 such sponsor (or any person with an ownership or
12 control interest (as defined in section 1124(a)(3)) in
13 such sponsor) is a person with an ownership or con-
14 trol interest (as so defined).”.

15 **SEC. 109. ADVISORY COMMITTEE.**

16 (a) IN GENERAL.—Not later than January 1, 2025,
17 the Secretary of Labor, the Secretary of Health and
18 Human Services, and the Secretary of the Treasury shall
19 jointly convene an advisory committee (in this section re-
20 ferred to as the “committee”) consisting of 9 members to
21 advise the Secretaries on how to improve the usefulness,
22 accessibility, and usability of information made available
23 in accordance the amendments made by sections 105 and
24 106, and by section 204 of division BB of the Consolidated

1 Appropriation Act, 2021 (Public Law 116–260), stream-
2 line the reporting of such information, and ensure that—

3 (1) such information is accurate, accessible, and
4 is delivered in a form and manner consistent with
5 the requirements of such section;

6 (2) the form and manner in which such infor-
7 mation is delivered is routinely updated in accord-
8 ance with widely-used practices in order to ensure
9 accessibility; and

10 (3) such information is available for audit (in-
11 cluding by making recommendations relating to how
12 Federal and State actors may conduct such audits).

13 (b) MEMBERSHIP.—The Secretaries shall jointly ap-
14 point members representing end-users of the information
15 described in subsection (a). Vacancies on the committee
16 shall be filled by appointment consistent with this sub-
17 section not later than 3 months after the vacancy arises.

18 (c) TERMINATION.—The committee shall terminate
19 on January 1, 2028.

20 (d) NONAPPLICATION OF FACA.—The Federal Advi-
21 sory Committee Act (5 U.S.C. App.) shall not apply to
22 the committee.

1 **SEC. 110. REPORT ON IMPACT OF MEDICARE REGULATIONS**
2 **ON PROVIDER AND PAYER CONSOLIDATION.**

3 (a) ANNUAL REPORT ON THE IMPACT OF CERTAIN
4 MEDICARE REGULATIONS ON PROVIDER AND PAYER
5 CONSOLIDATION; PUBLIC COMMENT ON PROVIDER AND
6 PAYER CONSOLIDATION FOR CERTAIN PROPOSED
7 RULES.—

8 (1) ANNUAL REPORT.—Not later than Decem-
9 ber 30, 2026, and annually thereafter, the Secretary
10 of Health and Human Services (in this section re-
11 ferred to as the “Secretary”) shall submit to Con-
12 gress a report on the impact in the aggregate on
13 provider and payer consolidation with respect to reg-
14 ulations for parts A, B, C, and D of title XVIII of
15 the Social Security Act (42 U.S.C. 1395 et seq.) im-
16 plemented in the calendar year immediately prior to
17 such report. Such report shall include regulations
18 that—

19 (A) implement a change to an applicable
20 payment system, a rate schedule, or another
21 payment system under part A, B, C, or D of
22 such title; or

23 (B) result in a significant rule effecting
24 provider or payer consolidation.

25 (2) PUBLIC COMMENT ON IMPACT TO PROVIDER
26 AND PAYER CONSOLIDATION.—Beginning for 2025,

1 as part of any notice and comment rulemaking pro-
2 cess that will result in a significant rule effecting pro-
3 vider or payer consolidation with respect to a pro-
4 posed rule for parts A, B, C, and D of title XVIII
5 of the Social Security Act (42 U.S.C. 1395j et seq.),
6 the Secretary shall seek public comment on the pro-
7 jected impact of such proposed rule on provider and
8 payer consolidation in the aggregate.

9 (3) DEFINITIONS.—In this section:

10 (A) PROVIDER AND PAYER CONSOLIDA-
11 TION.—The term “provider and payer consoli-
12 dation” includes the vertical or horizontal inte-
13 gration among providers of services (as defined
14 in subsection (u) of section 1861 of the Social
15 Security Act (42 U.S.C. 1395x)), suppliers (as
16 defined in subsection (d) of such section), ac-
17 countable care organizations under section 1899
18 of the Social Security Act (42 U.S.C. 1395jjj),
19 Medicare Advantage organizations, PDP spon-
20 sors, pharmacy benefit managers, pharmacies,
21 and integrated delivery systems.

22 (B) APPLICABLE PAYMENT SYSTEM.—The
23 term “applicable payment system” includes—

24 (i) with respect to outpatient hospital
25 services, the prospective payment system

1 for covered OPD services established under
2 section 1833(t) of such Act (42 U.S.C.
3 1395(l)); and

4 (ii) with respect to physicians' serv-
5 ices, the physician fee schedules established
6 under section 1848 of such Act (42 U.S.C.
7 1395w-4).

8 (b) CONSIDERATION OF EFFECTS ON PROVIDER AND
9 PAYER CONSOLIDATION WITH RESPECT TO CMI MOD-
10 ELS.—

11 (1) IN GENERAL.—Section 1115A(b)(4)(A) of
12 the Social Security Act (42 U.S.C. 1315a(b)(4)(A))
13 is amended—

14 (A) in clause (i), by striking at the end
15 “and”;

16 (B) in clause (ii), by striking the period at
17 the end and inserting “; and”; and

18 (C) by adding at the end the following new
19 clause:

20 “(iii) the extent to which, and how,
21 the model has effected and could effect
22 provider and payer consolidation, which in-
23 cludes the vertical or horizontal integration
24 among providers of services (as defined in
25 subsection (u) of section 1861), suppliers

1 (as defined in subsection (d) of such sec-
2 tion), and accountable care organizations
3 under section 1899.”.

4 (2) EFFECTIVE DATE.—The amendments made
5 by paragraph (1) shall apply with respect to models
6 tested on or after January 1, 2025.

7 **SEC. 111. IMPLEMENTATION FUNDING.**

8 (a) IN GENERAL.—For the purposes described in
9 subsection (b), there are appropriated, out of amounts in
10 the Treasury not otherwise appropriated, to the Secretary
11 of Health and Human Services and the Secretary of the
12 Treasury, \$25,000,000 for fiscal year 2024, to remain
13 available through fiscal year 2029.

14 (b) PERMITTED PURPOSES.—The purposes described
15 in this subsection are the following purposes, insofar as
16 such purposes are to carry out the provisions of, including
17 the amendments made by, this title:

18 (1) Preparing, drafting, and issuing proposed
19 and final regulations or interim regulations.

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

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

23 (4) Enforcement of such provisions.

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

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

3 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—
4 Each Secretary described in subsection (a) shall annually
5 submit, no later than September 1st of each year, to the
6 Committees on Energy and Commerce, on Ways and
7 Means, on Education and Workforce, and on Appropria-
8 tions of the House of Representatives and on the Commit-
9 tees on Health, Education, Labor, and Pensions and on
10 Appropriations of the Senate a report on funds expended
11 pursuant to funds appropriated under this section.

12 **TITLE II—REDUCING HEALTH**
13 **CARE COSTS FOR PATIENTS**

14 **SEC. 201. INCREASING TRANSPARENCY IN GENERIC DRUG**
15 **APPLICATIONS.**

16 (a) IN GENERAL.—Section 505(j)(3) of the Federal
17 Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(3)) is
18 amended by adding at the end the following:

19 “(H)(i) Upon request (in controlled correspondence
20 or an analogous process) by a person that has submitted
21 or intends to submit an abbreviated application under this
22 subsection for a drug that is required by regulation to con-
23 tain one or more of the same inactive ingredients in the
24 same concentrations as the listed drug referred to, or for
25 which the Secretary determines there is a scientific jus-

1 tification for an approach that is in vitro in whole or in
2 part to be used to demonstrate bioequivalence for a drug
3 if such a drug contains one or more of the same inactive
4 ingredients in the same concentrations as the listed drug,
5 the Secretary shall inform the person whether such drug
6 is qualitatively and quantitatively the same as the listed
7 drug. The Secretary may also provide such information
8 to such a person on the Secretary's own initiative during
9 the review of an abbreviated application under this sub-
10 section for such drug.

11 “(ii) Notwithstanding section 301(j), if the Secretary
12 determines that such drug is not qualitatively or quan-
13 titatively the same as the listed drug, the Secretary shall
14 identify and disclose to the person—

15 “(I) the ingredient or ingredients that cause
16 such drug not to be qualitatively or quantitatively
17 the same as the listed drug; and

18 “(II) for any ingredient for which there is an
19 identified quantitative deviation, the amount of such
20 deviation.

21 “(iii) If the Secretary determines that such drug is
22 qualitatively and quantitatively the same as the listed
23 drug, the Secretary shall not change or rescind such deter-
24 mination after the submission of an abbreviated applica-
25 tion for such drug under this subsection unless—

1 “(I) the formulation of the listed drug has been
2 changed and the Secretary has determined that the
3 prior listed drug formulation was withdrawn for rea-
4 sons of safety or effectiveness; or

5 “(II) the Secretary makes a written determina-
6 tion that the prior determination must be changed
7 because an error has been identified.

8 “(iv) If the Secretary makes a written determination
9 described in clause (iii)(II), the Secretary shall provide no-
10 tice and a copy of the written determination to the person
11 making the request under clause (i).

12 “(v) The disclosures required by this subparagraph
13 are disclosures authorized by law, including for purposes
14 of section 1905 of title 18, United States Code.”.

15 (b) GUIDANCE.—

16 (1) IN GENERAL.—Not later than one year
17 after the date of enactment of this Act, the Sec-
18 retary of Health and Human Services shall issue
19 draft guidance, or update guidance, describing how
20 the Secretary will determine whether a drug is quali-
21 tatively and quantitatively the same as the listed
22 drug (as such terms are used in section
23 505(j)(3)(H) of the Federal Food, Drug, and Cos-
24 metic Act, as added by subsection (a)), including
25 with respect to assessing pH adjusters.

1 (2) PROCESS.—In issuing guidance under this
2 subsection, the Secretary of Health and Human
3 Services shall—

4 (A) publish draft guidance;

5 (B) provide a period of at least 60 days for
6 comment on the draft guidance; and

7 (C) after considering any comments re-
8 ceived and not later than one year after the
9 close of the comment period on the draft guid-
10 ance, publish final guidance.

11 (c) APPLICABILITY.—Section 505(j)(3)(H) of the
12 Federal Food, Drug, and Cosmetic Act, as added by sub-
13 section (a), applies beginning on the date of enactment
14 of this Act, irrespective of the date on which the guidance
15 required by subsection (b) is finalized.

16 **SEC. 202. IMPROVING TRANSPARENCY AND PREVENTING**
17 **THE USE OF ABUSIVE SPREAD PRICING AND**
18 **RELATED PRACTICES IN MEDICAID.**

19 (a) PHARMACY PRICE REIMBURSEMENT REQUIRE-
20 MENTS.—

21 (1) IN GENERAL.—Section 1927(e) of the So-
22 cial Security Act (42 U.S.C. 1396r–8(e)) is amended
23 by adding at the end the following:

24 “(6) PHARMACY PRICE REIMBURSEMENT RE-
25 QUIRED.—

1 “(A) IN GENERAL.—A contract between
2 the State and a pharmacy benefit manager (in
3 this paragraph referred to as a ‘PBM’), or a
4 contract between the State and a designated en-
5 tity (as defined in subparagraph (C)) that in-
6 cludes provisions making the designated entity
7 responsible for the administration of medical
8 assistance consisting of covered outpatient
9 drugs for individuals enrolled with the des-
10 ignated entity, shall require that payment for
11 such drugs and related administrative services
12 (as applicable), including payments made by a
13 PBM on behalf of the State or designated enti-
14 ty, is based on pharmacy price reimbursement
15 model under which—

16 “(i) any payment made by the des-
17 ignated entity or the PBM (as applicable)
18 for such a drug—

19 “(I) is limited to—

20 “(aa) ingredient cost; and

21 “(bb) a professional dis-
22 pensing fee that is not less than
23 the professional dispensing fee
24 that the State plan or waiver

1 would pay if the plan or waiver
2 was making the payment directly;
3 “(II) is passed through in its en-
4 tirety by the designated entity or
5 PBM to the pharmacy or provider
6 that dispenses the drug and is not
7 retroactively denied or reduced except
8 as the result of an audit performed
9 pursuant to a contract between such
10 designated entity or PBM and such
11 pharmacy or provider, or as otherwise
12 permitted or required by law (includ-
13 ing in response to instances of fraud,
14 waste, or abuse); and
15 “(III) is made in a manner that
16 is consistent with sections 447.502,
17 447.512, 447.514, and 447.518 of
18 title 42, Code of Federal Regulations
19 (or any successor regulation) as if
20 such requirements applied directly to
21 the designated entity or the PBM, ex-
22 cept that any payment by the des-
23 ignated entity or the PBM for the in-
24 gredient cost of such a drug pur-
25 chased by a covered entity (as defined

1 in subsection (a)(5)(B)) may exceed
2 the actual acquisition cost (as defined
3 in section 447.502 of title 42, Code of
4 Federal Regulations (or any successor
5 regulation)) for such drug if—

6 “(aa) such drug was subject
7 to an agreement under section
8 340B of the Public Health Serv-
9 ice Act;

10 “(bb) such payment for such
11 cost of such drug does not exceed
12 the maximum payment that
13 would have been made by the
14 designated entity or the PBM for
15 the ingredient cost of such drug
16 had such drug not been pur-
17 chased by such a covered entity;
18 and

19 “(cc) such covered entity re-
20 ports to the Secretary, on an an-
21 nual basis (in a form and manner
22 specified by the Secretary) and
23 with respect to payments for
24 such costs of such drugs so pur-
25 chased by such covered entity

1 that are in excess of the actual
2 acquisition costs for such drugs,
3 the aggregate amount of such ex-
4 cess;

5 “(ii) payment to the designated entity
6 or the PBM (as applicable) for administra-
7 tive services performed by the designated
8 entity or PBM is limited to an administra-
9 tive fee that reflects the fair market value
10 of providing such services;

11 “(iii) the designated entity or the
12 PBM (as applicable) makes available to
13 the State, and the Secretary upon request,
14 all costs and payments related to covered
15 outpatient drugs and accompanying admin-
16 istrative services incurred, received, or
17 made by the designated entity or the PBM,
18 including ingredient costs, professional dis-
19 pensing fees, administrative fees, post-sale
20 and post-invoice fees, discounts, or related
21 adjustments such as direct and indirect re-
22 munerations fees, and any and all other re-
23 munerations; and

24 “(iv) any form of spread pricing
25 whereby any amount charged or claimed by

1 the designated entity or the PBM (as ap-
2 plicable) is in excess of the amount paid to
3 the pharmacies by the designated entity or
4 the PBM, including any post-sale or post-
5 invoice fees, discounts, or related adjust-
6 ments such as direct and indirect remu-
7 neration fees or assessments (after allow-
8 ing for a fair market administrative fee as
9 described in clause (ii)), is not allowable
10 for purposes of claiming Federal matching
11 payments under this title.

12 “(B) MAKING CERTAIN INFORMATION
13 AVAILABLE.—The Secretary shall publish, not
14 less frequently than on an annual basis, infor-
15 mation received by the Secretary pursuant to
16 subparagraph (A)(i)(III)(cc). Such information
17 shall be so published in an electronic and
18 searchable format, such as through the 340B
19 Office of Pharmacy Affairs Information System
20 (or a successor system).

21 “(C) DEFINITIONS.—In this paragraph:

22 “(i) DESIGNATED ENTITY.—The term
23 ‘designated entity’ means a managed care
24 entity or other specified entity.

1 “(ii) MANAGED CARE ENTITY; OTHER
2 SPECIFIED ENTITY.—The terms ‘managed
3 care entity’ and ‘other specified entity’
4 have the meaning given such terms in sec-
5 tion 1903(m)(9)(D).”.

6 (2) CONFORMING AMENDMENTS.—Section
7 1903(m)(2)(A) of such Act (42 U.S.C.
8 1396b(m)(2)(A)) is amended—

9 (A) in clause (i), by inserting before the
10 semicolon at the end the following: “(or, in the
11 case of a contract described in section
12 1927(e)(6), is an other specified entity (as de-
13 fined in paragraph (9)(D))”; and

14 (B) in clause (xiii)—

15 (i) by striking “and (III)” and insert-
16 ing “(III)”;

17 (ii) by inserting before the period at
18 the end the following: “, and (IV) the
19 pharmacy benefit provided by the entity
20 (or pharmacy benefit manager on behalf of
21 the entity under a contract), the other
22 specified entity (as defined in paragraph
23 (9)(D)) (or pharmacy benefit manager on
24 behalf of the other specified entity under a
25 contract), or by another arrangement be-

1 tween the entity or other specified entity
2 and the pharmacy benefit manager, shall
3 comply with the requirements of section
4 1927(e)(6)”; and

5 (iii) by moving the margin 2 ems to
6 the left.

7 (3) EFFECTIVE DATE.—The amendments made
8 by this subsection apply to contracts between States
9 and pharmacy benefit managers and designated enti-
10 ties (as defined in section 1927(e)(6) of the Social
11 Security Act, as added by paragraph (1)) that have
12 an effective date beginning on or after the date that
13 is 18 months after the date of enactment of this Act.

14 (b) ENSURING ACCURATE PAYMENTS TO PHAR-
15 MACIES UNDER MEDICAID.—

16 (1) IN GENERAL.—Section 1927(f) of the Social
17 Security Act (42 U.S.C. 1396r–8(f)) is amended—

18 (A) by striking “and” after the semicolon
19 at the end of paragraph (1)(A)(i) and all that
20 precedes it through “(1)” and inserting the fol-
21 lowing:

22 “(1) DETERMINING PHARMACY ACTUAL ACQUI-
23 SITION COSTS.—The Secretary shall conduct a sur-
24 vey of retail community pharmacy drug prices to de-

1 terminate the national average drug acquisition cost as
2 follows:

3 “(A) USE OF VENDOR.—The Secretary
4 may contract services for—

5 “(i) with respect to retail community
6 pharmacies, the determination of retail
7 survey prices of the national average drug
8 acquisition cost for covered outpatient
9 drugs based on a monthly survey of such
10 pharmacies; and”;

11 (B) by adding at the end of paragraph (1)
12 the following:

13 “(F) SURVEY REPORTING.—A State shall
14 require that any retail community pharmacy in
15 the State that receives any payment, reimburse-
16 ment, administrative fee, discount, or rebate re-
17 lated to the dispensing of covered outpatient
18 drugs to individuals receiving benefits under
19 this title, regardless of whether such payment,
20 reimbursement, administrative fee, discount, or
21 rebate is received from the State or a des-
22 ignated entity (as defined in subsection
23 (e)(6)(C)) directly or from a pharmacy benefit
24 manager that has a contract with the State or

1 a designated entity, shall respond to surveys of
2 retail prices conducted under this subsection.

3 “(G) SURVEY INFORMATION.—Information
4 on national drug acquisition prices obtained
5 under this paragraph shall be made publicly
6 available in a timely manner following the col-
7 lection of such information and shall include at
8 least the following:

9 “(i) The monthly response rate to the
10 survey including a list of pharmacies not in
11 compliance with subparagraph (F).

12 “(ii) The sampling frame and number
13 of pharmacies sampled monthly.

14 “(iii) Information on price concessions
15 to the pharmacy, including discounts, re-
16 bates, and other price concessions, to the
17 extent that such information may be pub-
18 licly released and is available during the
19 survey period.

20 “(H) REPORT ON SPECIALTY PHAR-
21 MACIES.—Not later than 1 year after the date
22 that this subparagraph takes effect, the Sec-
23 retary shall submit to Congress a report exam-
24 ining specialty drug coverage and reimburse-
25 ment under this title, including—

1 “(i) a description of how State Med-
2 icaid programs define specialty drugs and
3 specialty pharmacies;

4 “(ii) the amount State Medicaid pro-
5 grams pay for specialty drugs;

6 “(iii) how States and designated enti-
7 ties (as defined in subsection (e)(6)(C)) de-
8 termine payment for specialty drugs;

9 “(iv) the settings in which specialty
10 drugs are dispensed to individuals receiv-
11 ing benefits under this title (such as retail
12 community pharmacies or specialty phar-
13 macies);

14 “(v) the extent to which specialty
15 drugs (as defined by the respective States)
16 are captured in the national average drug
17 acquisition cost survey (or through another
18 process);

19 “(vi) examples of specialty drug dis-
20 pensing fees to support the services associ-
21 ated with dispensing such specialty drugs;
22 and

23 “(vii) recommendations as to whether
24 specialty pharmacies should be included in
25 the survey of retail prices to ensure na-

1 tional average drug acquisition costs cap-
2 ture drugs sold at specialty pharmacies,
3 and how such specialty pharmacies should
4 be defined.

5 “(I) ENFORCEMENT.—At the discretion of
6 the Secretary, the Secretary (acting through the
7 Inspector General and in collaboration with the
8 Administrator of the Centers for Medicare &
9 Medicaid Services) may enforce non-compliance
10 with this paragraph by a pharmacy through the
11 establishment of penalties until compliance with
12 this paragraph has been completed.”; and

13 (C) in paragraph (2)—

14 (i) in subparagraph (A), by inserting
15 “(including payment rates under managed
16 care organization as defined in section
17 1932(a)(1)(B)(i) and PIHPs and PAHPs
18 as defined in section 1903(m)(9)(D)(iii)(I)
19 and (II), respectively)” after “under this
20 title”; and

21 (ii) in subparagraph (B), by inserting
22 “, and the basis for such dispensing fees”
23 before the semicolon at the end.

24 (2) EFFECTIVE DATE.—The amendments made
25 by this subsection shall take effect on the first day

1 of the first quarter that begins on or after the date
2 that is 18 months after the date of enactment of
3 this Act.

4 **SEC. 203. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**
5 **OUTPATIENT DEPARTMENT SERVICES FUR-**
6 **NISHED OFF-CAMPUS.**

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

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

14 “(i) IN GENERAL.—Subject to clause
15 (iii), in the case of specified OPD services
16 (as defined in clause (v)) that are fur-
17 nished during 2025 or a subsequent year
18 by an off-campus outpatient department of
19 a provider (as defined in clause (iv)) (or,
20 in the case of an off-campus outpatient de-
21 partment of a provider that is a hospital
22 described in section 1886(d)(1)(B)(v), or is
23 located in a rural area or a health profes-
24 sional shortage area, such services that are
25 furnished during 2026 or a subsequent

1 year), there shall be substituted for the
2 amount otherwise determined under this
3 subsection for such service and year an
4 amount equal to the payment amount that
5 would have been payable under the applica-
6 ble payment system under this part (other
7 than under this subsection) had such serv-
8 ices been furnished by such a department
9 subject to such payment system pursuant
10 to paragraph (21)(C).

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

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

1 located in a rural area or a health profes-
2 sional shortage area, beginning with 2029).

3 “(iv) OFF-CAMPUS DEPARTMENT OF A
4 PROVIDER.—For purposes of this subpara-
5 graph, the term ‘off-campus outpatient de-
6 partment of a provider’ means a depart-
7 ment of a provider (as defined in section
8 413.65(a)(2) of title 42, Code of Federal
9 Regulations) that is not located—

10 “(I) on the campus (as such term
11 is defined in such section) of such
12 provider; or

13 “(II) within the distance (de-
14 scribed in such definition of campus)
15 from a remote location of a hospital
16 facility (as defined in such section).

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

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

1 “(II) HEALTH PROFESSIONAL
2 SHORTAGE AREA.—The term ‘health
3 professional shortage area’ has the
4 meaning given such term in section
5 332(a)(1)(A) of the Public Health
6 Service Act.

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

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

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

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

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

22 (3) by adding at the end the following new sub-
23 paragraph:

24 “(F) the determination of any payment
25 amount under paragraph (16)(H), including the

1 transition under clause (iii) of such para-
2 graph.”.

3 **SEC. 204. REQUIRING A SEPARATE IDENTIFICATION NUM-**
4 **BER AND AN ATTESTATION FOR EACH OFF-**
5 **CAMPUS OUTPATIENT DEPARTMENT OF A**
6 **PROVIDER.**

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

10 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;
11 ATTESTATION.—

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

19 “(i) such department has obtained,
20 and such items and services are billed
21 under, a standard unique health identifier
22 for health care providers (as described in
23 section 1173(b)) that is separate from
24 such identifier for such provider; and

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

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

22 “(C) OFF-CAMPUS OUTPATIENT DEPART-
23 MENT OF A PROVIDER DEFINED.—For purposes
24 of this paragraph, the term ‘off-campus out-
25 patient department of a provider’ means a de-

1 partment of a provider (as defined in section
2 413.65 of title 42, Code of Federal Regulations,
3 or any successor regulation) that is not lo-
4 cated—

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

7 “(ii) within the distance (described in
8 such definition of campus) from a remote
9 location of a hospital facility (as defined in
10 such section).”.

11 (b) HHS OIG ANALYSIS.—Not later than January
12 1, 2030, the Inspector General of the Department of
13 Health and Human Services shall submit to Congress—

14 (1) an analysis of the process established by the
15 Secretary of Health and Human Services to conduct
16 the reviews and determinations described in section
17 1833(t)(23)(B) of the Social Security Act, as added
18 by subsection (a) of this section; and

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

1 **TITLE III—SUPPORTING PA-**
2 **TIENTS, HEALTH CARE WORK-**
3 **ERS, COMMUNITY HEALTH**
4 **CENTERS, AND HOSPITALS**

5 **SEC. 301. EXTENSION FOR COMMUNITY HEALTH CENTERS,**
6 **THE NATIONAL HEALTH SERVICE CORPS,**
7 **AND TEACHING HEALTH CENTERS THAT OP-**
8 **ERATE GME PROGRAMS.**

9 (a) TEACHING HEALTH CENTERS THAT OPERATE
10 GRADUATE MEDICAL EDUCATION PROGRAMS.—

11 (1) ADDITION TO CAPPED AMOUNTS FOR FIS-
12 CAL YEARS 2024 AND 2025.—Paragraph (2) of section
13 340H(b) of the Public Health Service Act (42
14 U.S.C. 256h(b)) is amended by adding at the end
15 the following:

16 “(C) ADDITION.—Notwithstanding any
17 provision of this section, for each of fiscal years
18 2024 and 2025, the Secretary may use any
19 amounts made available in any fiscal year to
20 carry out this section (including amounts re-
21 couped under subsection (f)) to make payments
22 described in paragraphs (1)(A) and (1)(B), in
23 addition to the total amount of funds appro-
24 priated under subsection (g).”.

1 (2) RECONCILIATION.—Section 340H(f) of the
2 Public Health Service Act (42 U.S.C. 256h(f)) is
3 amended—

4 (A) by striking “The Secretary shall deter-
5 mine” and inserting the following:

6 “(1) DETERMINATION.—The Secretary shall de-
7 termine”; and

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

9 “(2) ANNUAL REPORT TO CONGRESS.—For
10 each fiscal year, the Secretary shall submit to the
11 Committee on Energy and Commerce of the House
12 of Representatives and the Committee on Health,
13 Education, Labor, and Pensions of the Senate a re-
14 port specifying—

15 “(A) the total amount of funds recouped
16 under paragraph (1);

17 “(B) the rationale for the funds being re-
18 couped; and

19 “(C) in the case of the reports for each of
20 fiscal years 2024 and 2025, the total amount of
21 funds recouped under paragraph (1) that were
22 used pursuant to subsection (b)(2)(C) to adjust
23 total payment amounts above the total amounts
24 appropriated under subsection (g).”.

1 (3) FUNDING.—Section 340H(g) of the Public
2 Health Service Act (42 U.S.C. 256h(g)) is amend-
3 ed—

4 (A) by amending paragraph (1) to read as
5 follows:

6 “(1) IN GENERAL.—To carry out this section,
7 there are appropriated such sums as may be nec-
8 essary, not to exceed—

9 “(A) \$230,000,000, for the period of fiscal
10 years 2011 through 2015;

11 “(B) \$60,000,000 for each of fiscal years
12 2016 and 2017;

13 “(C) \$126,500,000 for each of fiscal years
14 2018 through 2023;

15 “(D) \$175,000,000 for each of fiscal years
16 2024 and 2025;

17 “(E) \$225,000,000 for each of fiscal years
18 2026 and 2027; and

19 “(F) \$300,000,000 for each of fiscal years
20 2028, 2029, and 2030.”; and

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

22 “(3) AVAILABILITY.—The amounts made avail-
23 able under paragraph (1) shall remain available until
24 expended.”.

1 (b) EXTENSION FOR COMMUNITY HEALTH CEN-
2 TERS.—Section 10503(b)(1)(F) of the Patient Protection
3 and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is
4 amended—

5 (1) by striking “and” before “\$4,000,000,000”
6 and inserting a comma; and

7 (2) by inserting “, \$4,400,000,000 for each of
8 fiscal years 2024 and 2025, and \$1,109,000,000 for
9 the period beginning October 1, 2025, and ending
10 December 31, 2025” before the semicolon.

11 (c) EXTENSION FOR THE NATIONAL HEALTH SERV-
12 ICE CORPS.—Section 10503(b)(2) of the Patient Protec-
13 tion and Affordable Care Act (42 U.S.C. 254b–2(b)(2))
14 is amended—

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

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

19 (3) by adding at the end the following:

20 “(I) \$350,000,000 for each of fiscal years
21 2024 and 2025, and \$88,219,178 for the period
22 beginning October 1, 2025, and ending Decem-
23 ber 31, 2025.”.

24 (d) GOVERNMENT ACCOUNTABILITY OFFICE RE-
25 PORT.—

1 (1) IN GENERAL.—Not later than one year
2 after the date of enactment of this Act, the Comp-
3 troller General of the United States shall submit to
4 the Committee on Energy and Commerce of the
5 House of Representatives and the Committee on
6 Health, Education, Labor, and Pensions of the Sen-
7 ate a report assessing the effectiveness of the Na-
8 tional Health Service Corps at attracting health care
9 professionals to HPSAs, including by—

10 (A) assessing the metrics used by the
11 Health Resources and Services Administration
12 in evaluating the program;

13 (B) comparing the retention rates of
14 NHSC participants in the HPSAs where they
15 completed their period of obligated service to
16 the retention rate of non-NHSC participants in
17 the corresponding HPSAs;

18 (C) comparing the retention rates of
19 NHSC participants in the HPSAs where they
20 completed their period of obligated service to
21 the retention rates of NHSC participants in
22 HPSAs other than those where they completed
23 their period of obligated service;

24 (D) identifying factors that influence a
25 NHSC participant's decision to practice in a

1 HPSA other than the HPSA where they com-
2 pleted their period of obligated service;

3 (E) identifying factors other than partici-
4 pation in the National Health Service Corps
5 Scholarship and Loan Repayment Programs
6 that attract health care professionals to a
7 HPSA;

8 (F) assessing the impact the National
9 Health Service Corps has on wages for health
10 care professionals in a HPSA; and

11 (G) comparing the distribution of NHSC
12 participants across HPSAs, including a com-
13 parison of rural versus non-rural HPSAs.

14 (2) DEFINITION.—In this section:

15 (A) The term “HPSA” means a health
16 professional shortage area designated under
17 section 332 of the Public Health Service Act
18 (42 U.S.C. 254e).

19 (B) The term “NHSC participant” means
20 a National Health Service Corps member par-
21 ticipating in the National Health Service Corps
22 Scholarship or Loan Repayment Program.

23 (e) APPLICATION OF PROVISIONS.—Amounts appro-
24 priated pursuant to the amendments made by this section
25 shall be subject to the requirements contained in Public

1 Law 117–328 for funds for programs authorized under
2 sections 330 through 340 of the Public Health Service
3 Act.

4 (f) CONFORMING AMENDMENT.—Paragraph (4) of
5 section 3014(h) of title 18, United States Code, is amend-
6 ed by striking “and section 301(d) of division BB of the
7 Consolidated Appropriations Act, 2021.” and inserting
8 “section 301(d) of division BB of the Consolidated Appro-
9 priations Act, 2021, and section 301(e) of the Lower
10 Costs, More Transparency Act.”.

11 **SEC. 302. EXTENSION OF SPECIAL DIABETES PROGRAMS.**

12 (a) EXTENSION OF SPECIAL DIABETES PROGRAMS
13 FOR TYPE I DIABETES.—Section 330B(b)(2) of the Pub-
14 lic Health Service Act (42 U.S.C. 254c–2(b)(2)) is amend-
15 ed—

16 (1) in subparagraph (C), by striking “and” at
17 the end;

18 (2) in subparagraph (D), by striking the period
19 at the end and inserting a semicolon; and

20 (3) by adding at the end the following:

21 “(E) \$170,000,000 for each of fiscal years
22 2024 and 2025, to remain available until ex-
23 pended; and

1 “(F) \$42,849,315 for the period beginning
2 October 1, 2025, and ending December 31,
3 2025, to remain available until expended.”.

4 (b) **EXTENDING FUNDING FOR SPECIAL DIABETES**
5 **PROGRAMS FOR INDIANS.**—Section 330C(e)(2) of the
6 Public Health Service Act (42 U.S.C. 254e–3(e)(2)) is
7 amended—

8 (1) in subparagraph (C), by striking “and” at
9 the end;

10 (2) in subparagraph (D), by striking the period
11 at the end and inserting a semicolon; and

12 (3) by adding at the end the following:

13 “(E) \$170,000,000 for each of fiscal years
14 2024 and 2025, to remain available until ex-
15 pended; and

16 “(F) \$42,849,315 for the period beginning
17 October 1, 2025, and ending December 31,
18 2025, to remain available until expended.”.

19 **SEC. 303. DELAYING CERTAIN DISPROPORTIONATE SHARE**
20 **HOSPITAL PAYMENT REDUCTIONS UNDER**
21 **THE MEDICAID PROGRAM.**

22 Section 1923(f)(7)(A) of the Social Security Act (42
23 U.S.C.1396r–4(f)(7)(A)) is amended—

1 (1) in clause (i), in the matter preceding sub-
2 clause (I), by striking “2024” and inserting “2026”;
3 and

4 (2) in clause (ii), by striking “2024” and in-
5 serting “2026”.

6 **SEC. 304. MEDICAID IMPROVEMENT FUND.**

7 Section 1941(b)(3)(A) of the Social Security Act (42
8 U.S.C. 1396w-1(b)(3)(A)) is amended by striking
9 “\$7,000,000,000” and inserting “\$0”.

10 **TITLE IV—INCREASING ACCESS**
11 **TO QUALITY HEALTH DATA**
12 **AND LOWERING HIDDEN**
13 **FEEES**

14 **SEC. 401. INCREASING PLAN FIDUCIARIES’ ACCESS TO**
15 **HEALTH DATA.**

16 (a) PLAN FIDUCIARY ACCESS TO INFORMATION.—

17 (1) IN GENERAL.—Paragraph (2) of section
18 408(b) of the Employee Retirement Income Security
19 Act of 1974 (29 U.S.C. 1108(b)) is amended by
20 adding at the end the following new subparagraph:

21 “(C) No contract or arrangement for services
22 between a group health plan and any other entity,
23 including a health care provider (including a health
24 care facility), network or association of providers,
25 service provider offering access to a network of pro-

1 viders, third-party administrator, or pharmacy ben-
2 efit manager, is reasonable within the meaning of
3 this paragraph unless such contract or arrange-
4 ment—

5 “(i) allows the responsible plan fiduciary to
6 audit or review all de-identified claims and en-
7 counter information or data described in section
8 724(a)(1)(B) to—

9 “(I) ensure that such entity complies
10 with the terms of the plan and any appli-
11 cable law; and

12 “(II) determine the reasonableness of
13 compensation received by such entity; and

14 “(ii) does not—

15 “(I) unreasonably limit the number of
16 audits permitted during a given period of
17 time;

18 “(II) limit the number of de-identified
19 claims and encounter information or data
20 that the responsible plan fiduciary may ac-
21 cess during an audit;

22 “(III) limit the disclosure of pricing
23 terms for value-based payment arrange-
24 ments or capitated payment arrangements,
25 including—

1 “(aa) payment calculations and
2 formulas;
3 “(bb) quality measures;
4 “(cc) contract terms;
5 “(dd) payment amounts;
6 “(ee) measurement periods for all
7 incentives; and
8 “(ff) other payment methodolo-
9 gies used by an entity, including a
10 health care provider (including a
11 health care facility), network or asso-
12 ciation of providers, service provider
13 offering access to a network of pro-
14 viders, third-party administrator, or
15 pharmacy benefit manager;
16 “(IV) limit the disclosure of overpay-
17 ments and overpayment recovery terms;
18 “(V) limit the right of the responsible
19 plan fiduciary to select an auditor;
20 “(VI) otherwise limit or unduly delay
21 by greater than 60 calendar days after the
22 date of request the responsible plan fidu-
23 ciary from auditing all de-identified claims
24 and encounter information or data; or

1 “(VII) permit the entity to charge a
2 fee beyond the reasonable direct costs to
3 provide the required information and oth-
4 erwise comply and assist with an audit re-
5 quest.

6 “(D) PRIVACY REQUIREMENTS.—Covered
7 service providers shall provide information
8 under this subparagraph in a manner consistent
9 with the privacy, security, and breach notifica-
10 tion regulations promulgated under section
11 13402(a) of the Health Information Technology
12 for Clinical Health Act, and shall restrict the
13 use and disclosure of such information accord-
14 ing to such privacy regulations.

15 “(E) DISCLOSURE AND REDISCLOSURE.—

16 “(i) LIMITATION TO BUSINESS ASSO-
17 CIATES.—A responsible plan fiduciary re-
18 ceiving a report under this subparagraph
19 may disclose such information only to the
20 entity from which the report was received,
21 the group health plan for which the report
22 pertains, or to that entity’s business asso-
23 ciates as defined in section 160.103 of title
24 45, Code of Federal Regulations (or suc-
25 cessor regulations) or as permitted by the

1 HIPAA Privacy Rule (45 C.F.R. parts 160
2 and 164, subparts A and E).

3 “(ii) CLARIFICATION REGARDING PUB-
4 LIC DISCLOSURE OF INFORMATION.—Noth-
5 ing in this section shall prevent a group
6 health plan or health insurance issuer of-
7 fering group health insurance coverage, or
8 a covered service provider, from placing
9 reasonable restrictions on the public dislo-
10 sure of the information contained in a re-
11 port described in this subparagraph, except
12 that such plan, issuer, or entity may not
13 restrict disclosure of such report to the De-
14 partment of Labor.”.

15 (2) CIVIL ENFORCEMENT.—

16 (A) IN GENERAL.—Subsection (c) of sec-
17 tion 502 of such Act (29 U.S.C. 1132) is
18 amended by adding at the end the following
19 new paragraph:

20 “(13) In the case of an agreement between a group
21 health plan and a health care provider (including a health
22 care facility), network or association of providers, service
23 provider offering access to a network of providers, third-
24 party administrator, or pharmacy benefit manager, that
25 violates the provisions of section 724, the Secretary may

1 assess a civil penalty against such provider, network or
2 association, service provider offering access to a network
3 of providers, third-party administrator, pharmacy benefit
4 manager, or other service provider in the amount of
5 \$10,000 for each day during which such violation con-
6 tinues. Such penalty shall be in addition to other penalties
7 as may be prescribed by law.”.

8 (B) CONFORMING AMENDMENT.—Para-
9 graph (6) of section 502(a) of such Act is
10 amended by striking “or (9)” and inserting
11 “(9), or (13)”.

12 (3) EXISTING PROVISIONS VOID.—Section 410
13 of such Act is amended by adding at the end the fol-
14 lowing new subsection:

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

17 “(1) unduly delays or limits a plan fiduciary
18 from accessing the de-identified claims and encoun-
19 ter information or data described in section
20 724(a)(1)(B); or

21 “(2) violates the requirements of section
22 408(b)(2)(C).”.

23 (4) TECHNICAL AMENDMENT.—Clause (i) of
24 section 408(b)(2)(B) of such Act is amended by

1 striking “this clause” and inserting “this para-
2 graph”.

3 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
4 ITY INFORMATION.—Section 724(a)(3) of the Employee
5 Retirement Income Security Act (29 U.S.C. 1185m(a)(3))
6 is amended to read as follows:

7 “(3) ATTESTATION.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (C), the plan fiduciary of a group health
10 plan or health insurance issuer offering group
11 health insurance coverage shall annually submit
12 to the Secretary an attestation that such plan
13 or issuer of such coverage is in compliance with
14 the requirements of this subsection. Such attes-
15 tation shall also include a statement verifying
16 that—

17 “(i) the information or data described
18 under subparagraphs (A) and (B) of para-
19 graph (1) is available upon request and
20 provided to the plan fiduciary, the plan ad-
21 ministrator, or the issuer in a timely man-
22 ner; and

23 “(ii) there are no terms in the agree-
24 ment under such paragraph (1) that di-
25 rectly or indirectly restrict or unduly delay

1 a plan fiduciary, the plan administrator, or
2 the issuer from auditing, reviewing, or oth-
3 erwise accessing such information, except
4 as permitted under section 408(b)(2)(C).

5 “(B) LIMITATION ON SUBMISSION.—Sub-
6 ject to clause (ii), a group health plan or issuer
7 offering group health insurance coverage may
8 not enter into an agreement with a third-party
9 administrator or other service provider to sub-
10 mit the attestation required under subpara-
11 graph (A).

12 “(C) EXCEPTION.—In the case of a group
13 health plan or issuer offering group health in-
14 surance coverage that is unable to obtain the
15 information or data needed to submit the attes-
16 tation required under subparagraph (A), such
17 plan or issuer may submit a written statement
18 in lieu of such attestation that includes—

19 “(i) an explanation of why such plan
20 or issuer was unsuccessful in obtaining
21 such information or data, including wheth-
22 er such plan or issuer was limited or pre-
23 vented from auditing, reviewing, or other-
24 wise accessing such information or data;

1 “(ii) a description of the efforts made
2 by the plan fiduciary to remove any gag
3 clause provisions from the agreement
4 under paragraph (1); and

5 “(iii) a description of any response by
6 the third-party administrator or other serv-
7 ice provider with respect to efforts to com-
8 ply with the attestation requirement under
9 subparagraph (A).”.

10 (c) REPORT ON PLAN ASSETS.—Not later than 1
11 year after the date of enactment of this Act, the Secretary
12 of Labor shall submit to the Committee on Education and
13 the Workforce of the House of Representatives a report
14 on the status of de-identified claims and encounter infor-
15 mation or data described in section 724(a)(1)(B) of the
16 Employee Retirement Income Security Act of 1974 (29
17 U.S.C. 1185m), including information on the following:

18 (1) Whether changes to regulations or guidance
19 would permit such information or data to be deemed
20 a group health plan asset (as defined under section
21 3(42) of such Act).

22 (2) Whether restrictions on the ability of a plan
23 fiduciary to access such information or data violates
24 a requirement of current law.

1 (3) The existing regulatory authority of the
2 Secretary to clarify whether such information or
3 data is the property of a group health plan, rather
4 than a service provider.

5 (4) Legislative actions that may be taken to es-
6 tablish that such information or data related to a
7 plan belongs to a group health plan and is handled
8 in the best interests of plan participants and bene-
9 ficiaries.

10 (d) **EFFECTIVE DATE.**—The amendments made by
11 subsections (a) and (b) shall apply with respect to a plan
12 beginning with the first plan year that begins on or after
13 the date that is 1 year after the date of enactment of this
14 Act.

15 **SEC. 402. HIDDEN FEES DISCLOSURE REQUIREMENTS .**

16 (a) **CLARIFICATION OF THE APPLICATION OF FEE**
17 **DISCLOSURE REQUIREMENTS TO COVERED SERVICE PRO-**
18 **VIDERS.—**

19 (1) **SERVICES.**—Clause (ii)(I)(bb) of section
20 408(b)(2)(B) of the Employee Retirement Income
21 Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is
22 amended—

23 (A) in subitem (AA) by striking “Broker-
24 age services,” and inserting “Services (includ-
25 ing brokerage services),”; and

1 (B) in subitem (BB)—

2 (i) by striking “Consulting,” and in-
3 serting “Other services,”; and

4 (ii) by inserting “any of the fol-
5 lowing:” before “plan design”.

6 (2) DISCLOSURES.—Clause (iii)(III) of section
7 408(b)(2)(B) of the Employee Retirement Income
8 Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is
9 amended by striking “, either in the aggregate or by
10 service,” and inserting “by service”.

11 (b) STRENGTHENING DISCLOSURE REQUIREMENTS
12 WITH RESPECT TO PHARMACY BENEFIT MANAGERS AND
13 THIRD PARTY ADMINISTRATORS FOR GROUP HEALTH
14 PLANS.—

15 (1) CERTAIN ARRANGEMENTS FOR PBM SERV-
16 ICES CONSIDERED AS INDIRECT.—

17 (A) IN GENERAL.—Clause (i) of section
18 408(b)(2)(B) of the Employee Retirement In-
19 come Security Act of 1974 (29 U.S.C.
20 1108(b)(2)(B)) is amended—

21 (i) by striking “requirements of this
22 clause” and inserting “requirements of this
23 subparagraph”; and

24 (ii) by adding at the end the fol-
25 lowing: “For purposes of applying section

1 406(a)(1)(C) with respect to a transaction
2 described under this subparagraph, a con-
3 tract or arrangement for services between
4 a covered plan and a health insurance
5 issuer providing health insurance coverage
6 in connection with the covered plan in
7 which the health insurance issuer con-
8 tracts, in connection with such plan, with
9 a service provider for pharmacy benefit
10 management services shall be considered to
11 constitute an indirect furnishing of goods,
12 services, or facilities between the plan and
13 the service provider acting as the party in
14 interest.”.

15 (B) HEALTH INSURANCE ISSUER AND
16 HEALTH INSURANCE COVERAGE DEFINED.—
17 Clause (ii)(I)(aa) of section 408(b)(2)(B) of
18 such Act (29 U.S.C. 1108(b)(2)(B)) is amended
19 by inserting before the period at the end “and
20 the terms ‘health insurance coverage’ and
21 ‘health insurance issuer’ have the meanings
22 given such terms in section 733(b)”.

23 (C) TECHNICAL AMENDMENT.—Clause
24 (ii)(I)(aa) of section 408(b)(2)(B) of the Em-
25 ployee Retirement Income Security Act of 1974

1 (29 U.S.C. 1108(b)(2)(B)) is further amended
2 by inserting “in” after “defined”.

3 (2) SPECIFIC DISCLOSURE REQUIREMENTS
4 WITH RESPECT TO PHARMACY BENEFIT MANAGE-
5 MENT SERVICES.—

6 (A) IN GENERAL.—Clause (iii) of section
7 408(b)(2)(B) of such Act (29 U.S.C.
8 1108(b)(2)(B)) is amended by adding at the
9 end the following:

10 “(VII) With respect to a contract or ar-
11 rangement with the covered plan in connection
12 with the provision of pharmacy benefit manage-
13 ment services, as part of the description re-
14 quired under subclauses (III) and (IV)—

15 “(aa) all compensation described in
16 clause (ii)(I)(dd)(AA), including fees, re-
17 bates, alternative discounts, co-payment
18 offsets, and other remuneration expected
19 to be received by the covered service pro-
20 vider, an affiliate, or a subcontractor from
21 a pharmaceutical manufacturer, dis-
22 tributor, rebate aggregator, accumulator,
23 and maximizer, group purchasing organiza-
24 tion, or any other third party;

1 “(bb) the amount and form of any re-
2 bates, discounts, or price concessions, in-
3 cluding the amount expected to be passed
4 through to the plan sponsor or the partici-
5 pants and beneficiaries under the covered
6 plan;

7 “(cc) all compensation expected to be
8 received by the covered service provider, an
9 affiliate, or a subcontractor as a result of
10 paying a lower amount for the drug than
11 the amount charged as a copayment, coin-
12 surance amount, or deductible;

13 “(dd) all compensation expected to be
14 received by the covered service provider, an
15 affiliate, or a subcontractor as a result of
16 paying pharmacies less than what is
17 charged the health plan, plan sponsor, or
18 participants and beneficiaries under the
19 covered plan; and

20 “(ee) all compensation expected to be
21 received by the covered service provider, an
22 affiliate, or a subcontractor from drug
23 manufacturers and any other third party
24 in exchange for—

1 “(AA) administering, invoicing,
2 allocating, or collecting rebates related
3 to the covered plan;

4 “(BB) providing business serv-
5 ices and activities, including providing
6 access to drug utilization data;

7 “(CC) keeping a percentage of
8 the list price of a drug; or

9 “(DD) any other reason related
10 to the role of a covered service pro-
11 vider as a conduit between the drug
12 manufacturers or any other third
13 party and the covered plan.”.

14 (B) ANNUAL DISCLOSURE.—Clause (v) of
15 section 408(b)(2)(B) of such Act (29 U.S.C.
16 1108(b)(2)(B)) is amended by adding at the
17 end the following:

18 “(III) A covered service provider, with re-
19 spect to a contract or arrangement with the
20 covered plan in connection with providing phar-
21 macy benefit management services, shall dis-
22 close, on an annual basis not later than 60 days
23 after the beginning of the current plan year, to
24 a responsible plan fiduciary, in writing, the fol-

1 lowing with respect to the twelve months pre-
2 ceding the current plan year:

3 “(aa) All direct compensation de-
4 scribed in subclause (III) of clause (iii)
5 and indirect compensation described in
6 subclause (IV) of clause (iii) received by
7 the covered service provider (including
8 such compensation described in subclause
9 (VII) of clause (iii)).

10 “(bb) For each drug covered under
11 the covered plan, the amount by which the
12 price for the drug paid by the plan exceeds
13 the amount paid to pharmacies by the cov-
14 ered service provider.

15 “(cc) The total gross spending by the
16 covered plan on drugs (excluding rebates,
17 discounts, or other price concessions).

18 “(dd) The total net spending by the
19 covered plan on drugs.

20 “(ee) The total gross spending at all
21 pharmacies wholly or partially owned by
22 the covered service provider or any entity
23 affiliated with the covered service provider,
24 including mail-order, specialty and retail

1 pharmacies, with a breakdown by indi-
2 vidual pharmacy location.

3 “(ff) The aggregate amount of
4 clawback from such pharmacies, including
5 mail-order, specialty, and retail phar-
6 macies.

7 “(AA) categorical explanations
8 (grouped by the reason for clawback,
9 such as contractual true-up provi-
10 sions, overpayments, or non-covered
11 medication dispensed, and including
12 information on the amount in each
13 category that was passed through to
14 the covered plan and to participants
15 and beneficiaries of the covered plan);
16 or

17 “(BB) individual explanations for
18 such clawbacks.

19 “(gg) Total aggregate amounts of fees
20 collected by the covered service provider,
21 an affiliate, or a subcontractor in connec-
22 tion with the provision of pharmacy benefit
23 management services to the covered plan.

24 “(hh) Any other information specified
25 by the Secretary through regulations or

1 guidance that may be necessary for a re-
2 sponsible plan fiduciary to consider the
3 merits of the contract or arrangement with
4 the covered service provider and any con-
5 flicts of interest that may exist.”.

6 (C) PHARMACY BENEFIT MANAGEMENT
7 SERVICES DEFINED.—Clause (ii)(I) of section
8 408(b)(2)(B) of such Act (29 U.S.C.
9 1108(b)(2)(B)) is amended by adding at the
10 end the following:

11 “(gg) The term ‘pharmacy benefit
12 management services’ includes any services
13 provided by a covered service provider to a
14 covered plan with respect to the adminis-
15 tration of prescription drug benefits under
16 the covered plan, including—

17 “(AA) the processing and pay-
18 ment of claims;

19 “(BB) design of pharmacy net-
20 works;

21 “(CC) negotiation, aggregation,
22 and distribution of rebates, discounts,
23 and other price concessions;

24 “(DD) formulary design and
25 maintenance;

1 “(EE) operation of pharmacies
2 (whether retail, mail order, specialty
3 drug, or otherwise);

4 “(FF) recordkeeping;

5 “(GG) utilization review;

6 “(HH) adjudication of claims;

7 and

8 “(II) any other services specified
9 by the Secretary through guidance or
10 rulemaking.”.

11 (D) CLAWBACK DEFINED.—Clause (ii)(I)
12 of section 408(b)(2)(B) of such Act (29 U.S.C.
13 1108(b)(2)(B)), as amended by subparagraph
14 (C), is amended by adding at the end the fol-
15 lowing:

16 “(hh) The term ‘clawback’ means
17 amounts collected by a provider of phar-
18 macy benefit management services from a
19 pharmacy for copayments collected from a
20 participant or beneficiary in excess of the
21 contracted rate.”.

22 (3) SPECIFIC DISCLOSURE REQUIREMENTS
23 WITH RESPECT TO THIRD PARTY ADMINISTRATION
24 SERVICES FOR GROUP HEALTH PLANS.—

1 (A) IN GENERAL.—Clause (iii) of section
2 408(b)(2)(B) of such Act (29 U.S.C.
3 1108(b)(2)(B)), as amended by paragraph
4 (2)(A), is amended by adding at the end the
5 following:

6 “(VIII) With respect to a contract or ar-
7 rangement with the covered plan in connection
8 with the provision of third party administration
9 services for group health plans, as part of the
10 description required under subclauses (III) and
11 (IV)—

12 “(aa) the amount and form of any re-
13 bates, discounts, savings fees, refunds, or
14 amounts received from providers and facili-
15 ties, including the amounts that will be re-
16 tained by the covered service provider as a
17 fee;

18 “(bb) the amount and form of fees ex-
19 pected to be received from other service
20 providers in relation to the covered plan,
21 including the amounts that will be retained
22 by the covered service provider as a fee;
23 and

24 “(cc) the amount and form of ex-
25 pected recoveries by the covered service

1 provider, including the amounts that will
2 be retained by the covered service provider
3 as a fee (disaggregated by category), as a
4 result of—

5 “(AA) overpayments;

6 “(BB) erroneous payments;

7 “(CC) uncashed checks or incom-
8 plete payments;

9 “(DD) billing errors;

10 “(EE) subrogation;

11 “(FF) fraud; or

12 “(GG) any other reason on behalf
13 of the covered plan.”.

14 (B) ANNUAL DISCLOSURE.—Clause (v) of
15 section 408(b)(2)(B) of such Act (29 U.S.C.
16 1108(b)(2)(B)), as amended by paragraph
17 (2)(B), is amended by adding at the end the
18 following:

19 “(IV) A covered service provider, with re-
20 spect to a contract or arrangement with the
21 covered plan in connection with providing third
22 party administration services for group health
23 plans, shall disclose, on an annual basis not
24 later than 60 days after the beginning of the
25 current plan year, to a responsible plan fidu-

1 ciary, in writing, the following with respect to
2 the twelve months preceding the current plan
3 year:

4 “(aa) All direct compensation de-
5 scribed in subclause (III) of clause (iii).

6 “(bb) All indirect compensation de-
7 scribed in subclause (IV) of clause (iii) re-
8 ceived by the covered service provider, an
9 affiliate, or a subcontractor (including such
10 compensation described in subclause (VIII)
11 of clause (iii)).

12 “(cc) The aggregate amount for which
13 the covered service provider, an affiliate, or
14 a subcontractor received indirect com-
15 pensation and the estimated amount of
16 cost-sharing incurred by plan participants
17 and beneficiaries as a result.

18 “(dd) The total gross spending by the
19 covered plan on all costs and fees arising
20 under or paid under the administrative
21 services agreement with the covered service
22 provider (not including any amounts de-
23 scribed in items (aa) through (cc) of clause
24 (iii)(VIII)).

1 “(ee) The total net spending by the
2 covered plan on all costs and fees arising
3 under or paid under the administrative
4 services agreement with the covered service
5 provider.

6 “(ff) The aggregate fees collected by
7 the covered service provider, an affiliate, or
8 a subcontractor.

9 “(gg) Any other information specified
10 by the Secretary through regulations or
11 guidance that may be necessary for a re-
12 sponsible plan fiduciary to consider the
13 merits of the contract or arrangement with
14 the covered service provider and any con-
15 flicts of interest that may exist.”.

16 (C) THIRD PARTY ADMINISTRATION SERV-
17 ICES FOR GROUP HEALTH PLANS DEFINED.—
18 Clause (ii)(I) of section 408(b)(2)(B) of such
19 Act (29 U.S.C. 1108(b)(2)(B)), as amended by
20 paragraph (2)(C), is amended by adding at the
21 end the following:

22 “(ii) The term ‘third party adminis-
23 tration services for group health plans’ in-
24 cludes any services provided by a covered
25 service provider, an affiliate, or a subcon-

1 tractor to a covered plan with respect to
2 the administration of health benefits under
3 the covered plan, including—

4 “(AA) the processing, repricing,
5 and payment of claims;

6 “(BB) design, creation, and
7 maintenance of provider networks;

8 “(CC) negotiation of discounts
9 off gross rates;

10 “(DD) benefit and plan design;

11 “(EE) negotiation of payment
12 rates;

13 “(FF) recordkeeping;

14 “(GG) utilization review;

15 “(HH) adjudication of claims;

16 “(II) regulatory compliance; and

17 “(JJ) any other services set forth
18 in an administrative services agree-
19 ment or similar agreement or specified
20 by the Secretary through rule-
21 making.”.

22 (4) RULE OF CONSTRUCTION.—Nothing in the
23 amendments made by this section shall be construed
24 to imply that a practice in relation to which a cov-
25 ered service provider is required to provide informa-

1 tion as a result of such amendments is permissible
2 under Federal law.

3 (5) EFFECTIVE DATE.—No contract or ar-
4 rangement entered into prior to January 1, 2025,
5 shall be subject to the requirements of subsection
6 (b).

7 (c) IMPLEMENTATION.—Not later than 1 year after
8 the date of enactment of this Act, the Secretary of Labor
9 shall issue notice and comment rulemaking as necessary
10 to implement the provisions of this section. The Secretary
11 shall ensure that such rulemaking—

12 (1) accounts for the varied compensation prac-
13 tices of covered service providers (as defined under
14 section 408(b)(2)(B); and

15 (2) establishes standards for the disclosure of
16 expected compensation by such covered service pro-
17 viders.

18 **SEC. 403. PRESCRIPTION DRUG PRICE INFORMATION RE-**
19 **QUIREMENT.**

20 (a) PHSA.—

21 (1) IN GENERAL.—Part D of title XXVII of the
22 Public Health Service Act, as amended by section
23 106, is further amended by adding at the end the
24 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.), as
20 amended by section 106, is further amended by add-
21 ing at the end the following new section:

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 as amended by section 106, is further amended by
12 inserting after the item relating to section 726 the
13 following new item:

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

14 (c) IRC.—

15 (1) IN GENERAL.—Subchapter B of chapter
16 100 of the Internal Revenue Code of 1986, as
17 amended by section 106, is further amended by add-
18 ing at the end the following:

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

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

21 “(1) not restrict, directly or indirectly, any
22 pharmacy that dispenses a prescription drug to a
23 participant or beneficiary in the plan from informing
24 (or penalize such pharmacy for informing) a partici-
25 pant or beneficiary of any differential between the

1 participant's or beneficiary's out-of-pocket cost
2 under the plan with respect to acquisition of the
3 drug and the amount an individual would pay for ac-
4 quisition of the drug without using any group health
5 plan or health insurance coverage; and

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

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

24 (2) CLERICAL AMENDMENT.—The table of sec-
25 tions for subchapter B of chapter 100 of the Inter-

1 nal Revenue Code of 1986, as amended by section
2 106, is further amended by adding at the end the
3 following new item:

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

4 **SEC. 404. IMPLEMENTATION FUNDING.**

5 (a) IN GENERAL.—For the purposes described in
6 subsection (b), and in addition to amounts otherwise avail-
7 able for such purposes there are appropriated, out of
8 amounts in the Treasury not otherwise appropriated, to
9 the Secretary of Labor \$12,000,000, for fiscal year 2024,
10 to remain available through fiscal year 2029.

11 (b) PERMITTED PURPOSES.—The purposes described
12 in this subsection are limited to the following purposes,
13 insofar as such purposes are to carry out the provisions
14 of, including the amendments made by, title I and IV:

15 (1) Preparing, drafting, and issuing proposed
16 and final regulations or interim regulations.

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

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

20 (4) Enforcement of such provisions.

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

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

24 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—

25 The Secretary described in subsection (a) shall annually

1 submit, no later than September 1st of each year, to the
2 Committees on Education and Workforce and on Appro-
3 priations of the House of Representatives and the Com-
4 mittees on Health, Education, Labor, and Pensions and
5 on Appropriations of the Senate a report on funds ex-
6 pended pursuant to funds appropriated under this section.