**AMENDMENT IN THE NATURE OF A SUBSTITUTE**

**TO H.R. 9393**

**OFFERED BY MR. GUTHRIE OF KENTUCKY**

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Lower Costs, More Transparency Act of 2026''.

# TITLE I—HEALTH CARE PRICE TRANSPARENCY

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

(a) MEDICARE.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end the following new section:

**''SEC. 1899D. PRICE TRANSPARENCY.**

''(a) HOSPITAL TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2028, each specified hospital that receives payment under this title for furnishing items and services shall comply with the price transparency requirement described in paragraph (2).

''(2) REQUIREMENT DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a specified hospital, that such hospital—

''(i) in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge), and update not less frequently than annually (or at such greater frequency as may be specified by the Secretary)—

''(I) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

''(II) information—

''(aa) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that

are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

''(bb) that includes, with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished;

''(ii) compile and make public (on an annual basis) each type 2 national provider identifier associated with the hospital or a unit of the hospital;

''(iii) in accordance with a method and format established by the Secretary, compile and make public (on an annual basis)—

''(I) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the hospital—

''(aa) has directly or indirectly an ownership interest of 5 percent or more in the hospital;

''(bb) has a partnership interest of 5 percent or more in the hospital;

''(cc) has managing control of 5 percent or more of the hospital;

''(dd) has a mortgage interest of 5 percent or more in the hospital; or

''(ee) has a security interest of 5 percent or more in the hospital; and

''(II) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with re-

spect to the hospital in the preceding 1-year period; and

"(iv) submit to the Secretary (in a form and manner specified by the Secretary and on an annual basis) an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such hospital, that all information made public pursuant to this subparagraph is complete and accurate.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a specified hospital, the following:

"(i) A plain language description (as specified by the Secretary) of each item or service, accompanied by, as applicable, commonly recognized billing code sets, including the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, or other ap-

plicable identifier determined appropriate by the Secretary.

''(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

''(iii) For each such item or service when provided in, as applicable, the inpatient and outpatient department settings—

''(I) the discounted cash price, as applicable, expressed as a dollar amount; or

''(II) in the case no discounted cash price is available for such item or service, the median cash price charged by the hospital (not including charity care) to self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount.

''(iv) With respect to prices made public pursuant to subparagraph (A)(i)(II), a link to a consumer-friendly document that clearly explains the hos-

pital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining prices.

''(v) The payer-specific negotiated charges, as applicable, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting.

''(vi) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, not including any such charge that is $0.

''(vii) Any other additional information the Secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for specified hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i)(I) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to subparagraph (A)(i)(II). Such methods and formats—

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

''(I) standard charges pursuant to subparagraph (A)(i)(I), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary); and

''(II) prices pursuant to subparagraph (A)(i)(II), ensure that such prices are made available in a consumer-friendly format (as specified by the Secretary);

''(ii) may be similar to any template made available by the Centers for Medicare

& Medicaid Services as of the date of the enactment of this subparagraph;

''(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

''(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(3) MONITORING COMPLIANCE.—The Secretary shall establish processes to monitor and assess specified hospitals' compliance with this subsection. Such processes shall include processes relating to the following:

''(A) The evaluation and analysis of complaints made by individuals or other entities relating to such hospitals' compliance with this subsection.

''(B) The use of audits to ensure such hospitals' compliance with this subsection.

''(C) The obtaining of additional information from such hospitals to determine such hospitals' compliance with this subsection (as determined appropriate by the Secretary).

''(4) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a specified hospital that fails to comply with the requirements of this subsection—

''(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements); and

''(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

''(I) the Secretary shall, not later than 60 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such re-

quirements, the Secretary shall either—

"(aa) submit to such hospital a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements; or

"(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

"(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—Subject to clause (viii), in addition to any other enforcement actions or penalties that may apply under another provision of Federal law, a specified hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 90 days after

such request is made (or, if such hospital has submitted such a corrective action plan not later than 45 days after the date such request was made, by the date that is 90 days after the date of the submission of such corrective action plan), and a specified hospital with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

''(I) in the case of a specified hospital with 30 or fewer beds, $342 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

''(II) in the case of a specified hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

''(III) in the case of a specified hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a specified hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day

following such 1-year period, $25 per bed per day); and

''(V) in the case of a specified hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been non-compliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $35 per bed per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

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

''(II) the limitations on the per bed per day amount of any penalty applicable under any of subclauses (II) through (V) of clause (i); and

''(III) the amounts specified in clause (iii)(II).

"(iii) PERSISTENT NONCOMPLIANCE.—

"(I) IN GENERAL.—In the case of a specified hospital (other than a specified hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection for two or more 6-month periods during any 3-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

"(II) SPECIFIED AMOUNT.—For purposes of subclause (I), the amount specified in this subclause is, with respect to a specified hospital—

"(aa) with more than 30 beds but fewer than 101 beds, an amount that is not less than

$500,000 and not more than $1,000,000;

''(bb) with more than 100 beds but fewer than 301 beds, an amount that is greater than $1,000,000 and not more than $2,000,000;

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

''(dd) with more than 500 beds, and amount that is not less than $5,000,000 and not more than $10,000,000.

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(I) HOSPITALS LOCATED IN RURAL OR UNDERSERVED AREAS.—

''(aa) IN GENERAL.—Subject to item (bb), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable

under this subparagraph with respect to a specified hospital located in a rural or underserved area (as defined by the Secretary) if the Secretary determines that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

''(bb) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under item (aa) with respect to a specified hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a specified hospital during a 6-year period.

"(II) REDUCTION IF HEARING WAIVED.—The Secretary may reduce any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the specified hospital that is the subject of such penalty agrees to waive any right of such hospital to a hearing before an administrative law judge with respect to the imposition of such penalty.

"(v) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to a specified hospital on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such hospital's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health

emergency, or other similar or unexpected catastrophe or similar situation).

''(vi) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to specified hospitals requesting such assistance.

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

''(viii) NONDUPLICATION OF CERTAIN PENALTIES.—

''(I) IN GENERAL.—The Secretary may not subject a specified hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this subsection for a period if the Secretary has imposed a civil mone-

tary penalty on such hospital under section 2718(f) of the Public Health Service Act for failure to comply with the provisions of such section for such period.

''(II) PRIORITIZATION.—In the case of a hospital that the Secretary determines to be in violation of the provisions of this subsection and of section 2718(f) of the Public Health Service Act, the Secretary shall impose penalties as prescribed in such section 2718(f) in lieu of any penalties prescribed in this subsection.

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

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

''(ii) the number of notifications described in subparagraph (A)(i) sent by the Secretary;

''(iii) the identity of each specified hospital that was sent such a notification and a description of the nature of such hospital's noncompliance with this subsection;

''(iv) the amount of any civil monetary penalty imposed on such hospital under subparagraph (B);

''(v) whether such hospital subsequently came into compliance with this subsection;

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

''(I) the name of any specified hospital that received such a waiver or reduction;

''(II) the dollar amount of each such penalty so waived or reduced; and

''(III) the rationale for the granting of each such waiver or reduction, but only to the extent that such rationale does not make public commercially sensitive information; and

''(vii) any other information as determined by the Secretary.

''(b) ENSURING ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing this section, the Secretary shall through rulemaking ensure that a provider of services or supplier making public charges and prices pursuant to this section takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the provision of interpretation services or the provision of translations of charges and information.

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

''(1) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

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

''(3) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that a provider of services or supplier has negotiated with a third party payer for an item or service.

''(4) SHOPPABLE SERVICE.—The term 'shoppable service' means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

''(5) SPECIFIED HOSPITAL.—The term 'specified hospital' means a hospital (as defined in section 1861(e)), a critical access hospital (as defined in section 1861(mmm)(1)), or a rural emergency hospital (as defined in section 1861(kkk)).

''(6) THIRD PARTY PAYER.—The term 'third party payer' means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.''.

(2) RULE OF CONSTRUCTION.—Nothing in the amendments made by this subsection may be construed to impede, prohibit, or prevent the Secretary of Health and Human Services from implementing, executing, carrying out, or enforcing the requirements of section 2718(f) of the Public Health Service Act.

(b) PHSA.—

(1) IN GENERAL.—Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18) is amended by adding at the end the following new subsection:

''(f) TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2028, each hospital operating within the United States (including a specified hospital (as defined in section 1899D of the Social Security Act)) shall comply with the price transparency requirement described in paragraph (2).

''(2) REQUIREMENT DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a hospital, that such hospital—

''(i) in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge), and update not less frequently than annually (or at such greater frequency as may be specified by the Secretary)—

''(I) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

''(II) information—

''(aa) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300

shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

''(bb) that includes, with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished;

''(ii) compile and make public (on an annual basis) each type 2 national provider identifier associated with the hospital or a unit of the hospital;

''(iii) in accordance with a method and format established by the Secretary, compile and make public (on an annual basis)—

''(I) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the hospital—

"(aa) has directly or indirectly an ownership interest of 5 percent or more in the hospital;

"(bb) has a partnership interest of 5 percent or more in the hospital;

"(cc) has managing control of 5 percent or more of the hospital;

"(dd) has a mortgage interest of 5 percent or more in the hospital; or

"(ee) has a security interest of 5 percent or more in the hospital; and

"(II) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with respect to the hospital in the preceding 1-year period; and

"(iv) submit to the Secretary (in a form and manner specified by the Secretary and on an annual basis) an attestation, signed by the chief executive officer,

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

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a hospital, the following:

''(i) A plain language description (as specified by the Secretary) of each item or service, accompanied by, as applicable, commonly recognized billing code sets, including the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, or other applicable identifier determined appropriate by the Secretary.

''(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

''(iii) For each such item or service when provided in, as applicable, the inpatient and outpatient department settings—

''(I) the discounted cash price, as applicable, expressed as a dollar amount; or

''(II) in the case no discounted cash price is available for such item or service, the median cash price charged by the hospital (not including charity care) to self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount.

''(iv) With respect to prices made public pursuant to subparagraph (A)(i)(II), a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining prices.

''(v) The payer-specific negotiated charges, as applicable, clearly associated with the name of the third party payer and plan and expressed as a dollar amount,

that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting.

''(vi) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, not including any such charge that is $0.

''(vii) Any other additional information the Secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i)(I) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to

subparagraph (A)(i)(II). Such methods and formats—

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

''(I) standard charges pursuant to subparagraph (A)(i)(I), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary); and

''(II) prices pursuant to subparagraph (A)(i)(II), ensure that such prices are made available in a consumer-friendly format (as specified by the Secretary);

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

''(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

''(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(3) MONITORING COMPLIANCE.—The Secretary shall establish processes to monitor and assess hospitals' compliance with this subsection. Such processes shall include processes relating to the following:

''(A) The evaluation and analysis of complaints made by individuals or other entities relating to such hospitals' compliance with this subsection.

''(B) The use of audits to ensure such hospitals' compliance with this subsection.

''(C) The obtaining of additional information from such hospitals to determine such hospitals' compliance with this subsection (as determined appropriate by the Secretary).

''(4) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a hospital that fails to comply with the requirements of this subsection—

''(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall sub-

mit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements); and

''(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

''(I) the Secretary shall, not later than 60 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such hospital a request for a corrective action plan (to be submitted not later than 45 days after such re-

quest is made) to comply with such requirements; or

''(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—Subject to clause (viii), in addition to any other enforcement actions or penalties that may apply under another provision of Federal law, a hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 90 days after such request is made (or, if such hospital has submitted such a corrective action plan not later than 45 days after the date such request was made, by the date that is 90 days after the date of the submission of such corrective action plan), and a hospital with respect to

which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

''(I) in the case of a hospital with 30 or fewer beds, $342 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

''(II) in the case of a hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day

following such 1-year period, $15 per bed per day);

''(III) in the case of a hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

''(V) in the case of a hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period

or longer, beginning with the first day following such 1-year period, $35 per bed per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

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

''(II) the limitations on the per bed per day amount of any penalty applicable under any of subclauses (II) through (V) of clause (i); and

''(III) the amounts specified in clause (iii)(II).

''(iii) PERSISTENT NONCOMPLIANCE.—

''(I) IN GENERAL.—In the case of a hospital (other than a hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the

provisions of this subsection for two or more 6-month periods during any 3-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

''(II) SPECIFIED AMOUNT.—For purposes of subclause (I), the amount specified in this subclause is, with respect to a hospital—

''(aa) with more than 30 beds but fewer than 101 beds, an amount that is not less than $500,000 and not more than $1,000,000;

''(bb) with more than 100 beds but fewer than 301 beds, an amount that is greater than $1,000,000 and not more than $2,000,000;

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

"(dd) with more than 500 beds, and amount that is not less than $5,000,000 and not more than $10,000,000.

"(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

"(I) HOSPITALS LOCATED IN RURAL OR UNDERSERVED AREAS.—

"(aa) IN GENERAL.—Subject to item (bb), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a hospital located in a rural or underserved area (as defined by the Secretary) if the Secretary determines that imposition of such penalty would result in an immediate threat to access

to care for individuals in the service area of such hospital.

''(bb) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under item (aa) with respect to a hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a hospital during a 6-year period.

''(II) REDUCTION IF HEARING WAIVED.—The Secretary may reduce any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the hospital that is the subject of such penalty agrees to waive any right of such

hospital to a hearing before an administrative law judge with respect to the imposition of such penalty.

''(v) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to a hospital on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such hospital's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other similar or unexpected catastrophe or similar situation).

''(vi) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to hospitals requesting such assistance.

''(vii) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A

of the Social Security Act (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(viii) NONDUPLICATION OF CERTAIN PENALTIES.—

''(I) IN GENERAL.—The Secretary may not subject a hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this subsection for a period if the Secretary has imposed a civil monetary penalty on such hospital under section 1899D of the Social Security Act for failure to comply with the provisions of such section for such period.

''(II) PRIORITIZATION.—In the case of a hospital that the Secretary determines to be in violation of the provisions of this subsection and of section 1899D of the Social Security

Act, the Secretary shall impose penalties as prescribed in this subsection in lieu of any penalties prescribed in such section 1899D.

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

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

''(ii) the number of notifications described in subparagraph (A)(i) sent by the Secretary;

''(iii) the identity of each hospital that was sent such a notification and a description of the nature of such hospital's noncompliance with this subsection;

''(iv) the amount of any civil monetary penalty imposed on such hospital under subparagraph (B);

''(v) whether such hospital subsequently came into compliance with this subsection;

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

''(I) the name of any hospital that received such a waiver or reduction;

''(II) the dollar amount of each such penalty so waived or reduced; and

''(III) the rationale for the granting of each such waiver or reduction, but only to the extent that such rationale does not make public commercially sensitive information; and

''(vii) any other information as determined by the Secretary.

''(5) ENSURING ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing this subsection,

the Secretary shall through rulemaking ensure that a hospital making public charges and prices pursuant to this subsection takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.

''(6) DEFINITIONS.—For purposes of this subsection:

''(A) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

''(B) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on a hospital's chargemaster (or similar list of prices), absent any discounts.

''(C) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that a hospital has negotiated with a third party payer for an item or service.

''(D) SHOPPABLE SERVICE.—The term 'shoppable service' means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

''(E) THIRD PARTY PAYER.—The term 'third party payer' means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.''.

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

(A) in subsection (b)(3), by inserting ''(other than the provisions of subsection (f))'' after ''this section''; and

(B) in subsection (e), by adding at the end the following new sentence: ''The preceding provisions of this subsection shall not apply beginning on January 1, 2028.''.

(3) RULE OF CONSTRUCTION.—Nothing in the amendments made by this subsection may be construed to impede, prohibit, or prevent the Secretary of Health and Human Services from implementing,

executing, carrying out, or enforcing the requirements of section 1899D of the Social Security Act.

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

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

(1) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively; and

(2) by inserting after subsection (a) the following new subsection:

''(b) CLINICAL DIAGNOSTIC LABORATORY PRICE TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2028, any applicable laboratory that receives payment under this title for furnishing any specified clinical diagnostic laboratory test under this title shall—

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

''(B) update such information not less frequently than annually (or at such greater frequency as the Secretary may specify);

''(C) in accordance with a method and format established by the Secretary, compile and make public (on an annual basis)—

''(i) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the laboratory—

''(I) has directly or indirectly an ownership interest of 5 percent or more in the laboratory;

''(II) has a partnership interest of 5 percent or more in the laboratory;

''(III) has managing control of 5 percent or more of the laboratory;

''(IV) has a mortgage interest of 5 percent or more in the laboratory; or

''(V) has a security interest of 5 percent or more in the laboratory; and

''(ii) such information as the Secretary may require with respect to any

changes in ownership, mergers, acquisitions, or consolidations with respect to the laboratory in the preceding 1-year period; and

''(D) submit to the Secretary on an annual basis an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such laboratory, that all such information is complete and accurate.

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to an applicable laboratory and a specified clinical diagnostic laboratory test, the discounted cash price for such test (or, if no such price exists, the gross charge for such test).

''(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format—

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

icaid Services (as described in section 1899D(a)(2)(C)(ii));

''(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

''(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(4) INCLUSION OF ANCILLARY SERVICES.—Any price or charge for a specified clinical diagnostic laboratory test furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the price or charge (as applicable) for any ancillary item or service (such as specimen collection services) that would normally be furnished by such laboratory as part of such test, as specified by the Secretary.

''(5) ENFORCEMENT.—

''(A) IN GENERAL.—In the case that the Secretary determines that an applicable laboratory is not in compliance with paragraph (1)—

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

"(ii) if such laboratory continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent, the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such laboratory was failing to comply with such paragraph) during which such failure is ongoing.

"(B) INCREASE AUTHORITY.—In applying this paragraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (A)(ii).

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

''(6) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to applicable laboratories requesting such assistance.

''(7) DEFINITIONS.—In this subsection:

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' has the meaning given such term in section 414.502, of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by—

''(i) a specified hospital pursuant to subsection (a);

''(ii) a hospital pursuant to section 2718(f) of the Public Health Service Act; or

''(iii) an ambulatory surgical center pursuant to subsection (d).

''(B) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—The term 'specified clinical diagnostic laboratory test' means a clinical

diagnostic laboratory test that is included on the list of shoppable services specified by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(A)(i)(II)), other than an advanced diagnostic laboratory test (as defined in section 1834A(d)(5)).''.

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

Section 1899D of the Social Security Act, as added by section 101 and amended by section 102, is further amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection:

''(c) IMAGING SERVICES PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1, 2028, each provider of services and supplier that receives payment under this title for furnishing a specified imaging service, other than such a provider or supplier with respect to which standard charges and prices for such services furnished by such provider or supplier are made available by a specified hospital pursuant to subsection (a), a hospital pursuant to section 2718(f) of the Public Health Service Act, or

an ambulatory surgical center pursuant to subsection (d), shall—

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

''(B) update such information not less frequently than annually (or at such greater frequency as the Secretary may specify);

''(C) in accordance with a method and format established by the Secretary, compile and make public (on an annual basis)—

''(i) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the provider of services or supplier—

''(I) has directly or indirectly an ownership interest of 5 percent or more in the provider of services or supplier;

''(II) has a partnership interest of 5 percent or more in the provider of services or supplier;

''(III) has managing control of 5 percent or more of the provider of services or supplier;

''(IV) has a mortgage interest of 5 percent or more in the provider of services or supplier; or

''(V) has a security interest of 5 percent or more in the provider of services or supplier; and

''(ii) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with respect to the provider of services or supplier in the preceding 1-year period; and

''(D) submit to the Secretary on an annual basis an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such provider or supplier, that all such information is complete and accurate.

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a provider of services or supplier and a specified imaging service, the discounted cash price for such service (or, if no such price exists, the gross charge for such service).

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

''(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(C)(ii));

''(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

''(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rule-

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

''(5) ENFORCEMENT.—

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

''(i) not later than 30 days after such determination, the Secretary shall notify such provider or supplier of such determination;

''(ii) upon request of the Secretary, such provider or supplier shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such paragraph; and

''(iii) if such provider or supplier continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent (or, in the case of such a provider or supplier that has submitted a corrective action plan described in clause (ii) in response to a request so described, after the date that is 90 days after

such submission), the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such provider or supplier was failing to comply with such paragraph) during which such failure to comply or failure to submit is ongoing.

''(B) INCREASE AUTHORITY.—In applying this paragraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase the amount of the civil monetary penalty under subparagraph (A)(iii).

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

''(D) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may waive or reduce any penalty otherwise applicable with respect to a provider of services or supplier under this subparagraph if the Secretary determines that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such provider or supplier.

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

''(E) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to providers of services and suppliers requesting such assistance.

''(6) DEFINITION.—In this subsection, the term 'specified imaging service' means an imaging service that is included on the list of Centers for Medicare & Medicaid Services-specified shoppable services (as described in subsection (a)(2)(A)(i)(II)).''.

**SEC. 104. AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.**

Section 1899D of the Social Security Act, as added by section 101 and amended by sections 102 and 103, is further amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following new subsection:

''(d) AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.—

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

''(2) REQUIREMENT DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this subsection is, with respect to an ambulatory surgical center, that such center—

''(i) in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of

charge), and update not less frequently than annually (or at such greater frequency as may be specified by the Secretary)—

''(I) all of the ambulatory surgical center's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such center;

''(II) information on the ambulatory surgical center's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services (as specified by the Secretary) that are furnished by such surgical center, and as many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

''(III) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the ambulatory surgical center, an indication that such service is not so furnished; and

''(ii) in accordance with a method and format established by the Secretary, compile and make public (on an annual basis)—

''(I) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the ambulatory surgical center—

''(aa) has directly or indirectly an ownership interest of 5 percent or more in the ambulatory surgical center;

''(bb) has a partnership interest of 5 percent or more in the ambulatory surgical center;

''(cc) has managing control of 5 percent or more of the ambulatory surgical center;

"(dd) has a mortgage interest of 5 percent or more in the ambulatory surgical center; or

"(ee) has a security interest of 5 percent or more in the ambulatory surgical center; and

"(II) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with respect to the ambulatory surgical center in the preceding 1-year period; and

"(iii) submit to the Secretary on an annual basis an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such center, that all information made public pursuant to this subparagraph is complete and accurate.

"(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable,

made public by an ambulatory surgical center, the following:

''(i) A plain language description (as specified by the Secretary) of each item or service, accompanied by, as applicable, commonly recognized billing code sets, including the Healthcare Common Procedure Coding System code, the national drug code, or other applicable identifier determined appropriate by the Secretary.

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

''(iii) For each such item or service—

''(I) the discounted cash price, as applicable, expressed as a dollar amount; or

''(II) in the case no discounted cash price is available for an item or service, the median cash price charged by the center to self-pay individuals (not including charity care) for such item or service for the previous three years, expressed as a dollar amount.

''(iv) Any other additional information the Secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for ambulatory surgical centers to use in making public standard charges pursuant to subparagraph (A)(i)(I) and a standard, uniform method and format for such centers to use in making public prices pursuant to subparagraph (A)(i)(II). Any such method and format—

''(i) shall, in the case of—

''(I) standard charges made public by an ambulatory surgical center under subparagraph (A)(i)(I), ensure that such charges are made available in a machine-readable format (or successor technology); and

''(II) prices made public by an ambulatory surgical center under subparagraph (A)(i)(II), ensure that such prices are made available in a consumer-friendly format (as specified by the Secretary);

''(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(C)(ii));

''(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

''(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(3) MONITORING COMPLIANCE.—The Secretary shall establish processes to monitor and assess ambulatory surgical centers' compliance with this subsection. Such processes shall include processes relating to the following:

''(A) The evaluation and analysis of complaints made by individuals or other entities re-

lating to such centers' compliance with this subsection.

"(B) The use of audits to ensure such centers' compliance with this subsection.

"(C) The obtaining of additional information from such centers to determine such centers' compliance with this subsection (as determined appropriate by the Secretary).

"(4) ENFORCEMENT.—

"(A) IN GENERAL.—In the case of an ambulatory surgical center that fails to comply with the requirements of this subsection—

"(i) the Secretary shall notify such ambulatory surgical center of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

"(ii) upon request of the Secretary, the ambulatory surgical center shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such requirements.

"(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of Federal law, an ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of an ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described and has failed to comply with such requirements by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such center was not complying with such requirements) during which such failure is ongoing (not to exceed $300 per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to failures to comply occurring in 2029 or a

subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to an ambulatory surgical center under clause (i).

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

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(I) CENTERS LOCATED IN RURAL OR UNDERSERVED AREAS.—

''(aa) IN GENERAL.—Subject to item (bb), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to an ambulatory surgical

center located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such center.

''(bb) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under item (aa) with respect to an ambulatory surgical center more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a center more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to an ambulatory surgical center during a 6-year period.

''(II) REDUCTION IF HEARING WAIVED.—The Secretary may reduce

any penalty otherwise applicable under this subparagraph (as reduced, if applicable, under subclause (I)) by not more than 35 percent if the ambulatory surgical center that is the subject of such penalty agrees to waive any right of such center to a hearing before an administrative law judge with respect to the imposition of such penalty.

''(5) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to ambulatory surgical centers requesting such assistance.''.

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

(a) PRICE TRANSPARENCY REQUIREMENTS.—

(1) IRC.—

(A) IN GENERAL.—Section 9819 of the Internal Revenue Code of 1986 is amended—

(i) in the header, by striking ''**MAINTENANCE OF PRICE COMPARISON TOOL**'' and inserting ''**TRANSPARENCY IN COVERAGE**'';

(ii) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2028.—

''(1) IN GENERAL.—A group health plan'';

(iii) in subsection (a), as inserted by clause (ii), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2028.''; and

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

''(b) TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, a group health plan shall provide a participant or beneficiary, in a timely manner upon request of the participant or beneficiary, information on the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant or beneficiary's plan that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in

paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and provided at no cost to such participant or beneficiary) that meets such requirements as the Secretary may specify.

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

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum allowed amount or other dollar amount described in such subparagraph).

''(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to a participant and such participant's beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

''(F) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan.

''(G) Any financial incentives (such as any credit, payment, or other benefit provided by such plan) available to the participant or beneficiary with respect to such item or service furnished by such provider known at the time such request is made.

''(H) In the case such item or service is an applicable spread price drug dispensed by a pharmacy—

''(i) a specification that such item or service is such an applicable spread price drug;

''(ii) the amount of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy;

''(iii) a plain language statement specified by the Secretary that explains the concept of spread pricing and how such

item's status as such an applicable spread price drug may impact the amount such plan pays for such drug and cost sharing amounts for such drug described in subparagraph (C); and

''(iv) a plain language statement specified by the Secretary informing the participant or beneficiary of the participant's or beneficiary's ability to obtain a summary document relating to drug pricing information described in section 9826(b)(2)(B)(ii).

''(I) Any other information determined appropriate by the Secretary.

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

''(A) is based on an Internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

''(ii) all providers that are participating providers with respect to such item or service; or

''(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;

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

''(G) meets any other requirement determined appropriate by the Secretary, including requirements to ensure the accessibility and

usability of information provided through such tool.

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

''(c) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on

which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such provider (other than a provider that is an excluded provider with respect to such item or service), an indication of whether, during the 1-year period beginning 18 months before the date such information is made public, such provider submitted a claim for such item or service to such plan for which payment was made (in whole or in part) under such plan.

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first

day of the month in which such information is made public with each provider that is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 6-month period beginning 9 months before the date such information is made public (or such other period as may be specified by the Secretary) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than such an amount with respect to an item or service furnished by a provider that, during such period, submitted fewer than 11 claims for such item or service to such plan.

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance). Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely available format through a publicly available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other cre-

dentials or undertake other steps as may be specified by the Secretary.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

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

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2028, each group health plan shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan with respect to such plan during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information

used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) OWNERSHIP INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public (on an annual basis), in accordance with a method and format established by the Secretary, the ownership information described in paragraph (2).

''(2) OWNERSHIP INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan—

''(A) the legal business name, tax status, business structure, type of organization, and

business address of each entity that, with respect to the group health plan—

''(i) has directly or indirectly an ownership interest of 5 percent or more in the group health plan;

''(ii) has a partnership interest of 5 percent or more in the group health plan;

''(iii) has managing control of 5 percent or more of the group health plan;

''(iv) has a mortgage interest of 5 percent or more in the group health plan; or

''(v) has a security interest of 5 percent or more in the group health plan; and

''(B) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with respect to the group health plan in the preceding 1-year period.

''(e) ATTESTATION.—Each group health plan shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan, of such plan's compliance with the provisions of this section. Such attestation shall include a link to the website (or other successor technology) where rate and payment

information required to be made public under subsection (c) may be accessed.

''(f) ACCESSIBILITY.—A group health plan shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(g) PBM DISCLOSURE OF APPLICABLE SPREAD PRICE DRUGS.—An entity providing pharmacy benefit management services on behalf of a group health plan shall disclose to such plan, at such time and in such manner as specified by the Secretary to ensure that information provided under subsection (b) and rate and payment information made public under subsection (c) is timely and accurate—

''(1) a list of drugs (identified by national drug codes) for which benefits are available under such plan that are applicable spread price drugs; and

''(2) with respect to each drug included on such list and each pharmacy with a contractual relationship for furnishing such drug under such plan, a

specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(h) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan, a drug for which benefits are available under such plan and with respect to which, at the time a disclosure described in subsection (g) is required to be made by an entity providing pharmacy benefit management services on behalf of such plan—

''(A) a contract is in effect between such entity and a pharmacy for the dispensing of such drug under such plan; and

''(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan and an item or service furnished by a provider that is a participating provider with respect to such

plan and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

''(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan for the dispensing of such drug

under such plan, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan for the dispensing of such drug under such plan, that amount that such plan has agreed to pay to such entity for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such plan has agreed to pay such entity for such drug under any other compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.''.

(B) CLERICAL AMENDMENT.—The item relating to section 9819 of the table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended to read as follows:

''Sec. 9819. Transparency in coverage.''.

(2) PHSA.—

(A) IN GENERAL.—Section 2799A–4 of the Public Health Service Act (42 U.S.C. 300gg–114) is amended—

(i) in the header, by striking ''**MAINTENANCE OF PRICE COMPARISON TOOL**'' and inserting ''**TRANSPARENCY IN COVERAGE**'';

(ii) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2028.—

''(1) IN GENERAL.—A group health plan'';

(iii) in subsection (a), as inserted by clause (ii), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2028.''; and

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

''(b) TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide a participant, beneficiary, or enrollee, in a timely manner upon request of the participant, beneficiary, or enrollee, information on the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant, beneficiary, or enrollee's plan or coverage that the participant, beneficiary, or enrollee would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant, beneficiary, or enrollee through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant, beneficiary, or enrollee, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group or individual health insurance coverage furnished by a health care provider to an individual enrolled under such plan or coverage, the following:

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such individual may be liable for additional charges.

''(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the individual will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated

using the maximum allowed amount or other dollar amount described in such subparagraph).

''(D) The amount the individual has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to individuals enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such individual has accrued towards such limitation with respect to such item or service.

''(F) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or coverage.

''(G) Any financial incentives (such as any credit, payment, or other benefit provided by such plan or issuer) available to the individual with respect to such item or service furnished

by such provider known at the time such request is made.

''(H) In the case such item or service is an applicable spread price drug dispensed by a pharmacy—

''(i) a specification that such item or service is such an applicable spread price drug;

''(ii) the amount of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy;

''(iii) a plain language statement specified by the Secretary that explains the concept of spread pricing and how such item's status as such an applicable spread price drug may impact the amount such plan or coverage pays for such drug and cost sharing amounts for such drug described in subparagraph (C); and

''(iv) except in the case of individual health insurance coverage, a plain language statement specified by the Secretary

informing the participant or beneficiary of the participant's or beneficiary's ability to obtain a summary document relating to drug pricing information described in section 2799A–11(b)(2)(B)(ii).

''(I) Any other information determined appropriate by the Secretary.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

''(ii) all providers that are participating providers with respect to such item or service; or

''(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;;

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

''(G) meets any other requirement determined appropriate by the Secretary, including requirements to ensure the accessibility and usability of information provided through such tool.

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

''(c) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group or individual health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group or individual health insurance coverage, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage,—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan

or coverage provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such provider (other than a provider that is an excluded provider with respect to such item or service), an indication of whether, during the 1-year period beginning 18 months before the date such information is made public, such provider submitted a claim for such item or service to such plan or coverage for which payment was made (in whole or in part) under such plan or coverage.

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that

is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan or coverage (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan or coverage during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan or

coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 6-month period beginning 9 months before the date such information is made public (or such other period as may be specified by the Secretary) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than such an amount with respect to an item or service furnished by a provider that, during such period, submitted fewer than 11 claims for such item or service to such plan or coverage.

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under

this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance). Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials or undertake other steps as may be specified by the Secretary.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

''(4) USER INSTRUCTIONS.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall make available to the public instructions written in plain language explaining how individuals may search for information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish through subregulatory guidance a template that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such

plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) OWNERSHIP INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group or individual health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public (on an annual basis), in accordance with a method and format established by the Secretary, the ownership information described in paragraph (2).

''(2) OWNERSHIP INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage—

''(A) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the plan or issuer—

''(i) has directly or indirectly an ownership interest of 5 percent or more in the plan or issuer;

''(ii) has a partnership interest of 5 percent or more in the plan or issuer;

''(iii) has managing control of 5 percent or more of the plan or issuer;

''(iv) has a mortgage interest of 5 percent or more in the plan or issuer; or

''(v) has a security interest of 5 percent or more in the plan or issuer; and

''(B) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolida-

tions with respect to the plan or issuer in the preceding 1-year period.

''(e) ATTESTATION.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan or issuer, of such plan's or coverage's compliance with the provisions of this section. Such attestation shall include a link to the website (or other successor technology) where rate and payment information required to be made public under subsection (c) may be accessed.

''(f) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(g) PBM DISCLOSURE OF APPLICABLE SPREAD PRICE DRUGS.—

''(1) IN GENERAL.—An entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group or individual health insurance coverage shall disclose to such plan or coverage, at such time and in such manner as specified by the Secretary to ensure that information provided under subsection (b) and rate and payment information made public under subsection (c) is timely and accurate—

''(A) a list of drugs (identified by national drug codes) for which benefits are available under such plan that are applicable spread price drugs; and

''(B) with respect to each drug included on such list and each pharmacy with a contractual relationship for furnishing such drug under such plan or coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(2) ENFORCEMENT.—

''(A) IN GENERAL.—An entity providing pharmacy benefit management services on be-

half of a specified group health plan or health insurance issuer offering specified group or individual health insurance coverage that fails to make a disclosure with respect to such plan or coverage in accordance with paragraph (1) shall be subject to a civil monetary penalty in an amount of $10,000 for each day during which such failure to disclose is ongoing.

''(B) FALSE INFORMATION.— An entity providing pharmacy benefit management services on behalf of a specified group health plan or health insurance issuer offering specified group or individual health insurance coverage that knowingly provides false information under this subsection with respect to such plan or coverage shall be subject to a civil monetary penalty in an amount not to exceed $100,000 for each item of false information. Such civil monetary penalty shall be in addition to other penalties as may be prescribed by law.

''(C) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsections (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this sub-

section in the same manner as such provisions apply to a penalty or proceeding under such section.

''(D) DEFINITIONS.—In this paragraph, the terms 'specified group health plan' and 'specified group or individual health insurance coverage' mean a group health plan or group or individual health insurance coverage (as applicable) to which the requirements of subparts I and II of part A and this part apply in accordance with section 2722.

''(h) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan or group or individual health insurance coverage, a drug for which benefits are available under such plan or coverage and with respect to which, at the time a disclosure described in subsection (g) is required to be made by an entity providing pharmacy benefit management services on behalf of such plan or coverage—

''(A) a contract is in effect between such entity and a pharmacy for the dispensing of such drug under such plan or coverage; and

''(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

''(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or

issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant, beneficiary, or enrollee.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a phar-

macy to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, that amount that such plan or coverage has agreed to pay to such entity for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such plan or coverage has agreed to pay such entity for such drug under any other compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant, beneficiary, or enrollee.''.

(B) CONFORMING AMENDMENTS.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–22) is amended by striking ''(other than section 2799A–11)'' each place it appears and inserting ''(other than sections 2799A–4(f) and 2799A–11)'' in each such place.

(3) ERISA.—

(A) IN GENERAL.—Section 719 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185h) is amended—

(i) in the header, by striking ''**MAINTENANCE OF PRICE COMPARISON TOOL**'' and inserting ''**TRANSPARENCY IN COVERAGE**'';

(ii) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2028.—

''(1) IN GENERAL.—A group health plan'';

(iii) in subsection (a), as inserted by clause (ii), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2028.''; and

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

''(b) TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, a group health plan and a health insurance issuer offering group health insurance coverage shall provide a participant or

beneficiary, in a timely manner upon request of the participant or beneficiary, information on the amount of cost-sharing (including deductibles, co-payments, and coinsurance) under the participant or beneficiary's plan or coverage that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and provided at no cost to such participant or beneficiary) that meets such requirements as the Secretary may specify.

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group health insurance coverage furnished by a health care provider to a participant or beneficiary of such plan or coverage, the following:

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(C) The estimated amount of cost-sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum allowed amount or other dollar amount described in such subparagraph).

''(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to a participant and such participant's beneficiaries

enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

''(F) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or coverage.

''(G) Any financial incentives (such as any credit, payment, or other benefit provided by such plan or issuer) available to the participant or beneficiary with respect to such item or service furnished by such provider known at the time such request is made.

''(H) In the case such item or service is an applicable spread price drug dispensed by a pharmacy—

''(i) a specification that such item or service is such an applicable spread price drug;

"(ii) the amount of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy;

"(iii) a plain language statement specified by the Secretary that explains the concept of spread pricing and how such item's status as such an applicable spread price drug may impact the amount such plan or coverage pays for such drug and cost sharing amounts for such drug described in subparagraph (C); and

"(iv) a plain language statement specified by the Secretary informing the participant or beneficiary of the participant's or beneficiary's ability to obtain a summary document relating to drug pricing information described in section 726(b)(2)(B)(ii).

"(I) Any other information determined appropriate by the Secretary.

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

group health insurance coverage meets the requirements of this paragraph if such tool—

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

''(ii) all providers that are participating providers with respect to such item or service; or

''(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;;

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

''(G) meets any other requirement determined appropriate by the Secretary, including requirements to ensure the accessibility and usability of information provided through such tool.

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

''(c) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group health insurance coverage, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan or coverage provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such provider (other than a provider that is an excluded provider with respect to such item or service), an indication of whether, during the 1-year period beginning 18 months

before the date such information is made public, such provider submitted a claim for such item or service to such plan or coverage for which payment was made (in whole or in part) under such plan or coverage.

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan or coverage (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect

to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan or coverage during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan or coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 6-month period begin-

ning 9 months before the date such information is made public (or such other period as may be specified by the Secretary) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than such an amount with respect to an item or service furnished by a provider that, during such period, submitted fewer than 11 claims for such item or service to such plan or coverage.

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance). Such requirements shall ensure that such files are limited to an appropriate size, do not

include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely available format through a publicly available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials or undertake other steps as may be specified by the Secretary.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

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

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) OWNERSHIP INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2028, each group health plan and health insurance issuer offering group health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public (on an annual basis), in accordance with a method and format established by the Secretary, the ownership information described in paragraph (2).

''(2) OWNERSHIP INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage—

''(A) the legal business name, tax status, business structure, type of organization, and business address of each entity that, with respect to the plan or issuer—

''(i) has directly or indirectly an ownership interest of 5 percent or more in the plan or issuer;

''(ii) has a partnership interest of 5 percent or more in the plan or issuer;

''(iii) has managing control of 5 percent or more of the plan or issuer;

''(iv) has a mortgage interest of 5 percent or more in the plan or issuer; or

''(v) has a security interest of 5 percent or more in the plan or issuer; and

''(B) such information as the Secretary may require with respect to any changes in ownership, mergers, acquisitions, or consolidations with respect to the plan or issuer in the preceding 1-year period.

''(e) ATTESTATION.—Each group health plan and health insurance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan or issuer, of such plan's or coverage's compliance with the provisions of this section. Such attestation shall include a link to the website (or other successor technology) where rate and payment information required to be made public under subsection (c) may be accessed.

''(f) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group health insurance coverage shall take reasonable steps (as specified by the

Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(g) PBM DISCLOSURE OF APPLICABLE SPREAD PRICE DRUGS.—An entity providing pharmacy benefit management services on behalf of a group health plan or group health insurance coverage shall disclose to such plan or coverage, at such time and in such manner as specified by the Secretary to ensure that information provided under subsection (b) and rate and payment information made public under subsection (c) is timely and accurate—

''(1) a list of drugs (identified by national drug codes) for which benefits are available under such plan that are applicable spread price drugs; and

''(2) with respect to each drug included on such list and each pharmacy with a contractual relationship for furnishing such drug under such plan or coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified re-

imbursement amount for such drug so dispensed by such pharmacy.

''(h) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan or group health insurance coverage, a drug for which benefits are available under such plan or coverage and with respect to which, at the time a disclosure described in subsection (g) is required to be made by an entity providing pharmacy benefit management services on behalf of such plan or coverage—

''(A) a contract is in effect between such entity and a pharmacy for the dispensing of such drug under such plan or coverage; and

''(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (re-

flected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

''(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group health insurance coverage, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan or group health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy

benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan or group health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, that amount that such plan or coverage has agreed to pay to such entity for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such plan or coverage has agreed to pay such entity for such drug under any other

compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.''.

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

''Sec. 719. Transparency in coverage.''.

(b) APPLICATION PROGRAMMING INTERFACE REPORT.—Not later than January 1, 2028, and annually thereafter, the Secretary of Health and Human Services shall, in consultation with the Office of the National Coordinator for Health Information Technology, Department of Labor, the Department of the Treasury, and stakeholders, submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the use of standards-based application programming interfaces (in this subsection referred to as ''APIs'') to facilitate access to health care price transparency information and the interoperability of other medical information. Such report shall include an evaluation of the capacity of the Department of Health and Human Services, the De-

partment of Labor, and the Department of the Treasury to regulate and implement standards related to APIs and recommendations for improving such capacity. Such report shall include the following:

(1) A description of current use, and proposed use, of APIs under Federal rules to facilitate interoperability, including information related to capacity constraints within the agencies, barriers to adoption, privacy and security, administrative burdens and efficiencies, care coordination, and levels of compliance.

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

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

(4) An analysis of the benefits and challenges of implementing standards-based APIs for price transparency data, including the ability for consumers to access rate and payment information and the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the consumer's

plan through third-party internet-based tools and applications.

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

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

(7) An analysis of the cost of API standards implementation on issuers, employers, and other private-sector entities.

(8) An analysis of the ability of State regulators to enforce API standards and the costs to the Federal Government and States to regulate and enforce API standards.

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

(c) PROVIDER TOOL REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Med-

icaid Services, shall, in consultation with stakeholders, conduct a study and submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the usefulness and feasibility of the establishment of a provider tool by a group health plan, or a health insurance issuer offering group or individual health insurance coverage, in facilitating the provision of information made available pursuant to the amendments made by subsection (a). Such report shall include the following:

(A) A description of the feasibility of establishing a requirement for the various types of plans and coverage to offer such a provider tool, including any challenges to establishing a provider tool using the same technology platform as the self-service tool described in such amendments.

(B) An evaluation on the usefulness of a provider tool to aid patient-decision making and how such tool would coordinate with other information available to a patient and their pro-

vider under other Federal requirements in place or under consideration.

(C) An evaluation of whether the information provided by such tool would be duplicative of the advanced explanation of benefits required under Federal law or any other existing requirement.

(D) A description of the usability and expected utilization of such tool among providers, including among different provider types.

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

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

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

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

(iii) care coordination and quality;

(iv) plan premiums;

(v) overall health care spending and utilization; and

(vi) health care access in rural areas.

(G) An analysis of the feasibility of a provider tool to include additional functionality to facilitate and improve the administration of the

requirements on providers to submit notifications to such plan or coverage under section 2799B–6 of the Public Health Service Act and the requirements on such plan or coverage to provide an advanced explanation of benefits to individuals under section 2799A–1(f) of such Act.

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

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

(J) An analysis of the burden and cost of the creation of a provider tool by plans and coverage on providers, issuers, employers, and other private-sector entities.

(K) An analysis of the ability of state regulators to enforce provider tool standards and the costs to the Department and states to regulate and enforce provider tool standards.

(2) DEFINITION.—The term ''provider tool'' means a tool designed to facilitate the provision of information made available pursuant to the amendments made by subsection (a) and established by a

group health plan or a health insurance issuer offering group or individual health insurance coverage that allows providers to access the information such plan or coverage must provide through the self-service tool described in such amendments to an individual with whom the provider is actively treating at the time of such request, upon the request of the provider, and with the consent of such individual.

(d) REPORTS.—

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

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

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

(C) recommendations relating to improving such enforcement; and

(D) recommendations relating to improving public disclosure, and public awareness, of information required to be made available by group health plans and health insurance issuers pursuant to such amendments.

(2) PRICES.—Not later than January 1, 2029, and biennially thereafter, the Secretaries of Health and Human Services, Labor, and the Treasury shall jointly submit to Congress a report containing an assessment of differences in negotiated prices (and any trends in such prices) in the private market between—

(A) rural and urban areas;

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

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

(D) nonprofit and for-profit hospitals;

(E) nonprofit and for-profit insurers; and

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

(e) QUALITY REPORT.—Not later than 1 year after the date of enactment of this subsection, the Secretaries of Health and Human Services, Labor, and the Treasury shall jointly submit to Congress a report on the feasibility of including data relating to the quality of health care items and services with the price transparency information required to be made available under the amendments

made by subsection (a). Such report shall include recommendations for legislative and regulatory actions to identify appropriate metrics for assessing and comparing quality of care.

(f) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by subsection (a) may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158), for any plan year beginning before January 1, 2028.

**SEC. 106. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.**

(a) ERISA AMENDMENTS.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.), as amended by section 6701(b) of the Consolidated Appropriations Act, 2026, is amended by adding at the end the following:

**''SEC. 727. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.**

''(a) IN GENERAL.—For plan years beginning on January 1 of the year that begins on or after the date

that is 1 year after the date of enactment of this section, no agreement between a group health plan (as defined in section 733(a)), the plan sponsor of such plan (as defined in section 3(16)(B)), the plan administrator of such plan (as defined in section 3(16)(A)), or a business associate of such plan (as defined in section 160.103 of title 45, Code of Federal Regulations) (or health insurance issuer offering group health insurance coverage in connection with such a plan), and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from providing the information described in subsection (b).

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than once every 6 months, a health plan service provider shall provide to the group health plan or health insurance issuer

the following information at no cost to the group health plan or health insurance issuer:

"(A) The information described in section 724(a)(1)(B).

"(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan or health insurance issuer to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

"(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and

administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider or its subcontractors in rebates, fees, contractual arrangements, and all other remuneration for administrative and other services.

''(E) All payment data and reconciliation information related to alternative compensation arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan or health insurance issuer paid fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) MANNER OF PROVIDING INFORMATION OR DATA.—

''(A) IN GENERAL.—A health plan service provider shall provide information or data under paragraph (1) in a manner consistent with the privacy regulations promulgated under

section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—A health plan service provider that submits information or data under this subsection shall ensure that such information or data contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a health plan service provider shall comply with section 164.504(f)

of title 45, Code of Federal Regulations (or a successor regulation).

''(C) RULE OF CONSTRUCTION.—

''(i) IN GENERAL.—Nothing in this subsection shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) CIVIL RIGHTS LAWS.—Nothing in this subsection shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of

the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, a health plan service provider shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for health plan service providers to submit information or data under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A health plan service provider receiving data or information under paragraph (1) may disclose such information only to the entity from which the information or data was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this subsection shall prevent a health plan serv-

ice provider from placing reasonable restrictions on the public disclosure of the information or data described in paragraph (1), except that such provider may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury.

''(G) LIMITATION.—This paragraph shall not be construed to abridge or limit the disclosure requirements under this subsection or to impose additional privacy or security requirements on health plan service providers or plan sponsors.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) IN GENERAL.—A group health plan receiving information under paragraph (1) may disclose such information only—

''(i) to the entity from which the information was received or to that entity's business associates or to the group health plan's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

"(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164 (subparts A and E)).

"(B) AVAILABILITY OF INFORMATION.—To the extent the information required by this subsection is made available to the health insurance issuer offering group health insurance coverage, the health insurance issuer shall make such information available, at the same time, in the same format, and at no cost, to the group health plan.

"(C) FAILURE TO PROVIDE INFORMATION.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 502 within 90 days of becoming aware of a violation of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under the Act.

''(4) DATA FORMAT STANDARDS.—All data and information provided pursuant to this subsection shall comply with the following standards:

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with transactions standards adopted under HIPAA, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be in ASC X12N 837 format, as transmitted by the provider, or, in the case of paper claims, converted to the ASC X12N 837 electronic format (or successor formats).

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format, as transmitted by the provider, or in the case of paper claims, converted to the NCPDP electronic format.

''(iii) Such data shall be provided at no cost to the group health plan.

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan

service provider shall be provided to the group health plan or health insurance issuer in the ASC X12N 835 format in accordance with transaction standards adopted under HIPAA, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan or health insurance issuer.

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary of Health and Human Services pursuant to the authority provided under section 1173 of the Social Security Act (42 U.S.C. 1320d–2).

''(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement between a group health plan, the plan sponsor, the plan administrator, or a business associate of such plan or a health insurance issuer and a health plan service provider that unduly delays or limits a group health plan's or health insurance issuer's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a group health plan

or health insurance issuer enters into such agreement, shall be deemed void as against public policy.

''(d) PENALTIES FOR NON-COMPLIANCE.—Any failure by a health plan service provider to comply with the requirements of this section shall result in the imposition of a civil penalty of $100,000 for each day the violation continues, in addition to any other penalties prescribed by law.

''(e) REGULATIONS.—The Secretary shall implement this section through notice and comment rulemaking in accordance with section 553 of title 5, United States Code, and shall include provisions to ensure that there is not duplicative reporting from contractors and subcontractors.''.

(2) PENALTY.—

(A) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following new paragraph:

''(14) The Secretary may assess a civil penalty against any person of $100,000 per day for each violation by any person of section 727.''.

(B) TECHNICAL AMENDMENT.—Paragraph (6) of section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C.

1132(a)) is amended by striking ''or (9)'' and inserting it with the phrase ''(9), (13), or (14)''.

(b) PHSA AMENDMENTS.—

(1) IN GENERAL.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–111 et seq.), as amended by section 6701(a) of the Consolidated Appropriations Act, 2026, is amended by adding at the end the following:

**''SEC. 2799A–12. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.**

''(a) IN GENERAL.—For plan years beginning on January 1 of the year that begins on or after the date that is 1 year after the date of enactment of this section, no agreement between a group health plan that is a self-funded, non-Federal governmental plan, as defined in section 2791(d)(8)(C) (42 U.S.C. 300gg–91(d)(8)(C)) or health insurance issuer offering individual or group health coverage, a health insurance issuer that is operating as a third party administrator, and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to in this section as a 'health plan service provider') is permissible if such agreement limits

(or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to such group health plans and heath insurance issuers in a manner that prevents any health plan service provider from providing the information described in subsection (b)).

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 1 year after the date of enactment of this section, not less frequently than once every 6 months, a health plan service provider shall provide to the group health plan that is a self-funded, non-Federal governmental plan or the health insurance issuer the following information at no cost to the plan or issuer:

''(A) The information described in section 2799A–9(a)(1)(B) (42 U.S.C. 300gg–119(a)(1)(B)).

''(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a

manner sufficiently detailed to enable the group health plan or issuer to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

''(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider to its subcontractors in rebates, fees, contractual arrangements, and all other remuneration for administrative and other services.

''(E) All payment data, calculation methodologies, and reconciliation information related to alternative compensation arrangements, including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capi-

tation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan paid fees, incurred obligations, or made payments in connection with the group health plan or issuer related to such arrangements.

''(2) MANNER OF PROVIDING INFORMATION OR DATA.—

''(A) IN GENERAL.—A health plan service provider shall provide information or data under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—A health plan service provider that submits information or data under this subsection shall ensure that such information or data contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a health plan service provider shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation).

''(C) RULE OF CONSTRUCTION.—

''(i) IN GENERAL.—Nothing in this subsection shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) CIVIL RIGHTS LAWS.—Nothing in this subsection shall be construed to affect the application of any Federal or State privacy or civil rights law, including the

HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, a health plan service provider shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for health plan service providers to submit information or data under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A health plan service provider receiving

data or information under paragraph (1) may disclose such information only to the entity from which the information or data was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this subsection shall prevent a health plan service provider from placing reasonable restrictions on the public disclosure of the information or data described in paragraph (1), except that such provider may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury.

''(G) LIMITATION.—This paragraph shall not be construed to abridge or limit the disclosure requirements under this subsection or to impose additional privacy or security requirements on health plan service providers or plan sponsors.

''(3) DISCLOSURE AND REDISCLOSURE.—

"(A) IN GENERAL.— A group health plan that is a self-funded, non-Federal governmental plan receiving information under paragraph (1) may disclose such information only—

"(i) to the entity from which the information was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

"(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. part 160 and subparts A and E of part 164).

"(B) AVAILABILITY OF INFORMATION.—To the extent the information required by this subsection is made available to the health insurance issuer offering group health insurance coverage, the health insurance issuer shall make such information available, at the same time, in the same format, and at no cost, to the group health plan.

"(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan that is a self-funded, non-Federal governmental plan, or a health plan service provider providing services with respect

to such a plan, from placing reasonable restrictions on the public disclosure of the information described in paragraph (1), except that such plan or entity may not restrict disclosure of such information to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or the Comptroller General of the United States.

''(D) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 2723(b) (42 U.S.C. 300gg–22(b)) within 90 days of becoming aware of a violation of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under this Act.

''(4) DATA FORMAT STANDARDS.—All data and information provided pursuant to this subsection shall comply with the following standards:

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with standards adopted under HIPAA as described in subpart K of part 162 of title 45, Code of Federal Regulations, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be provided to the group health plan that is a self-funded, non-Federal governmental plan in the ASC X12N 837 format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format.

''(iii) The files shall be unmodified copies of the files sent from the provider. In the event that paper claims are sent by the provider, they shall be converted to the appropriate standard electronic format. Such data shall be provided at no cost to the group health plan.

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group

health plan or health insurance issuer in the ASC X12N 835 format, in accordance with standards and operating rules adopted under HIPAA at subpart P of part 162 of title 45, Code of Federal Regulations, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan.

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary pursuant to the authority provided under section 1173 of the Social Security Act ( 42 U.S.C. 1320d–2).

''(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement that unduly delays or limits a group health plan that is a self-funded, non-Federal governmental plan's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a self-funded, non-Federal governmental plan enters into such agreement, shall be deemed void as against public policy.

''(d) REGULATIONS.—The Secretary shall implement this section through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.''.

(2) PENALTY.—Section 2723(b) of the Public Health Service Act (42 U.S.C. 300gg–22(b)) is amended by adding at the end the following:

''(4) ENFORCEMENT AUTHORITY RELATING TO HEALTH PLAN SERVICE PROVIDERS.—Notwithstanding any provisions to the contrary, the Secretary may assess a penalty against a health plan service provider, as defined in section 2799A–12(a) (42 U.S.C. 300gg–121(a)), of $100,000 per day for each violation of such section, pursuant to substantially similar processes and procedures as those set forth in section 2723(b)(2)(D) through (G) (42 U.S.C. 300gg–121(b)(2)(D) through (G)).''.

(c) INTERNAL REVENUE CODE.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

**''SEC. 9826. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.**

''(a) IN GENERAL.—For plan years beginning on January 1 of the year that begins on or after the date that is 1 year after the date of enactment of this section,

no agreement between a group health plan that is a self-funded, non-Federal governmental plan, as defined in section 2791(d)(8)(C) of the Public Health Service Act, and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to in this section as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to such group health plans in a manner that prevents any plan or entity from providing the information described in subsection (b).

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 1 year after the date of enactment of this section, not less frequently than once every 6 months, a health plan service provider shall provide to the group health plan that is a self-funded, non-Federal governmental plan the following information at no cost to the plan:

''(A) The information described in section 2799A–9(a)(1)(B) (42 U.S.C. 300gg–119(a)(1)(B)).

''(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

''(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider to its subcontractors in rebates, fees, contractual

arrangements, and all other remuneration for administrative and other services.

''(E) All payment data, calculation methodologies and reconciliation information related to alternative compensation arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan paid fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) MANNER OF PROVIDING INFORMATION OR DATA.—

''(A) IN GENERAL.—A health plan service provider shall provide information or data under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability

Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—A health plan service provider that submits information or data under this subsection shall ensure that such information or data contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—In carrying out this subsection, a health plan service provider shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation).

''(C) RULE OF CONSTRUCTION.—

''(i) IN GENERAL.—Nothing in this subsection shall be construed to modify the

requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

''(ii) CIVIL RIGHTS LAWS.—Nothing in this subsection shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(D) WRITTEN NOTICE.—Each plan year, a health plan service provider shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the

requirement for health plan service providers to submit information or data under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(E) LIMITATION TO BUSINESS ASSOCIATES.—A health plan service provider receiving data or information under paragraph (1) may disclose such information only to the entity from which the information or data was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

''(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this subsection shall prevent a health plan service provider from placing reasonable restrictions on the public disclosure of the information or data described in paragraph (1), except that such provider may not restrict disclosure of such report to the Department of Health and

Human Services, the Department of Labor, or the Department of the Treasury.

''(G) LIMITATION.—This paragraph shall not be construed to abridge or limit the disclosure requirements under this subsection or to impose additional privacy or security requirements on health plan service providers or plan sponsors.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) IN GENERAL.— A group health plan that is a self-funded, non-Federal governmental plan receiving information under paragraph (1) may disclose such information only—

''(i) to the entity from which the information was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

''(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. part 160 and subparts A and E of part 164).

''(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan that is a self-funded, non-Federal governmental plan, or a health plan

service provider providing services with respect to such a plan, from placing reasonable restrictions on the public disclosure of the information described in paragraph (1), except that such plan or entity may not restrict disclosure of such information to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or the Comptroller General of the United States.

''(C) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 2723(b) (42 U.S.C. 300gg–22(b)) within 90 days of becoming aware of a violation of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under this Act.

''(4) DATA FORMAT STANDARDS.—All data and information provided pursuant to this subsection shall comply with the following standards:

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with standards adopted under HIPAA as described in subpart K of part 162 of title 45, Code of Federal Regulations, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be provided to the group health plan that is a self-funded, non-Federal governmental plan in the ASC X12N 837 format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format.

''(iii) The files shall be unmodified copies of the files sent from the provider. In the event that paper claims are sent by the provider, they shall be converted to the appropriate standard electronic format. Such data shall be provided at no cost to the group health plan.

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group

health plan or health insurance issuer in the ASC X12N 835 format, in accordance with standards and operating rules adopted under HIPAA at subpart P of part 162 of title 45, Code of Federal Regulations, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan.

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary pursuant to the authority provided under section 1173 of the Social Security Act ( 42 U.S.C. 1320d–2).

''(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement that unduly delays or limits a group health plan that is a self-funded, non-Federal governmental plan's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a self-funded, non-Federal governmental plan enters into such agreement, shall be deemed void as against public policy.

''(d) REGULATIONS.—The Secretary shall implement this section through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.''.

**SEC. 107. REPORT ON CERTAIN OWNERSHIP INFORMATION.**

(a) IN GENERAL.—Not later than December 31, 2029, and annually thereafter through December 31, 2033, the Secretary shall post on a publicly available website of the Department of Health and Human Services a report on the ownership of specified entities during the previous 1-year period. Such report shall include the following:

(1) The total number of specified entities (as identified by the National Provider Identifier).

(2) With respect to each such specified entity—

(A) the business structure of such specified entity (as determined in accordance with subsection (b));

(B) the type of organization of such specified entity (as determined in accordance with subsection (c));

(C) the number of owners of such specified entity;

(D) any change in ownership of such specified entity during such period;

(E) any change in the tax status of such specified entity during such period; and

(F) as applicable, the name, address, and business structure of the parent company of such specified entity (including the business type of such parent company, as determined under subsection (b), and the tax status of such parent company).

(3) An analysis of trends in horizontal and vertical consolidation of specified entities, disaggregated by business structure and provider type.

(b) BUSINESS STRUCTURE.—For purposes of subsection (a)(2), the Secretary shall determine which of the following business structures apply to a specified entity (or the parent company of such specified entity), and shall identify such structures as privately held or publicly traded:

(1) Corporation.

(2) Limited liability company.

(3) General partnership.

(4) Limited partnership.

(5) Individual.

(6) Federal Government.

(7) State government.

(c) TYPES OF ORGANIZATION.—For purposes of subsection (a)(2), the Secretary shall determine which of the following types of organization apply to a specified entity (or the parent company of such specified entity), and shall identify such organizations as privately held or publicly traded:

(1) Bank or other financial institution.

(2) Consulting firm.

(3) Holding company.

(4) Investment firm (other than a private equity company).

(5) Management services company.

(6) Medical provider or supplier.

(7) Medical staffing company.

(8) Private equity company.

(9) Real estate investment trust.

(d) SPECIFIED ENTITY DEFINED.—In this section, the term ''specified entity'' means—

(1) a hospital;

(2) a clinical laboratory;

(3) a provider or supplier of imaging services;

(4) an ambulatory surgical center;

(5) a physician-owned physician practice with more than 25 physicians for a year; and

(6) a physician practice that is not physician-owned.

**SEC. 108. FUNDING.**

There are appropriated, out of any monies in the Treasury not otherwise obligated, $20,000,000 for fiscal year 2026 for purposes of carrying out the provisions of, and the amendments made by, this title, to remain available until expended.

# TITLE II—INSURANCE ACCOUNTABILITY

**SEC. 201. DISPLAYING PRIOR AUTHORIZATION RATES.**

(a) PHSA.—Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–111 et seq.), as amended by section 106(b), is further amended by adding at the end the following new section:

**"SEC. 2799A–13. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.**

''(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that imposes any prior authorization requirement with respect to an item or service furnished under such plan or coverage during a plan year beginning on or after January 1, 2028, such plan or issuer shall, at a time and in a manner specified by the Secretary (but not less frequently than annually), sub-

mit to the Secretary and make available on a public website of the plan or issuer the following information:

''(1) A list of all items and services that were subject to a prior authorization requirement under the plan or coverage during such plan year.

''(2) The percentage and number of prior authorization requests approved during such plan year by the plan or issuer in an initial determination and the percentage and number of prior authorization requests denied during such plan year by such plan or issuer in an initial determination (both in the aggregate and categorized by each item and service).

''(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan or issuer in an initial determination and that were subsequently appealed (both in the aggregate and categorized by each item and service).

''(4) The percentage and number of resolved appeals of such requests that resulted in approval of coverage of the item or service that was the subject of such request, categorized by each item and service and categorized by each level of appeal (including judicial review).

''(5) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests that were approved, by the plan or issuer during such plan year solely through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary (both in the aggregate and categorized by each item and service).

''(6) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan or issuer and a determination by the plan or issuer with respect to such request for each such item and service (excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan or issuer), broken out by prior authorization requests that were expedited because the application of the normal time frame for making a determination could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function and such requests that were not so expedited.

''(7) The percentage and number of prior authorization requests that were excluded from each calculation described in paragraph (6) based on the plan or issuer's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan or issuer.

''(8) The percentage and number of occasions in which, during a surgical or medical procedure involving the furnishing of an item or service with respect to which the plan or issuer had approved a prior authorization request, the provider furnishing such item or service determined that a different or additional item or service was medically necessary, and a specification of whether such plan or issuer subsequently approved the furnishing of such different or additional item or service.

''(9) A disclosure and description of any technology described in paragraph (5) that the plan or issuer utilized during such plan year in making determinations with respect to prior authorization requests.

''(10) The number of complaints received by such plan or issuer that were related to a prior authorization requirement.

''(11) Such other information as the Secretary determines appropriate.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan or health insurance issuer offering group or individual health insurance coverage under subsection (a) shall be so submitted and published on the plan or coverage level (as applicable) and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan or all health insurance coverage offered by such issuer that are offered within the same insurance market). For purposes of the preceding sentence, the term 'insurance market' means the individual market, the small group market, and the large group market.''.

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 106(a), is further amended by adding at the end the following new section:

**"SEC. 728. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.**

"(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group health insurance coverage that imposes any prior authorization requirement with respect to an item or service furnished under such plan or coverage during a plan year beginning on or after January 1, 2028, such plan or issuer shall, at a time and in a manner specified by the Secretary (but not less frequently than annually), submit to the Secretary and make available on a public website of the plan or issuer the following information:

"(1) A list of all items and services that were subject to a prior authorization requirement under the plan or coverage during such plan year.

"(2) The percentage and number of prior authorization requests approved during such plan year by the plan or issuer in an initial determination and the percentage and number of prior authorization requests denied during such plan year by such plan or issuer in an initial determination (both in the aggregate and categorized by each item and service).

"(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan or issuer in an initial determination and that were subsequently appealed (both

in the aggregate and categorized by each item and service).

''(4) The percentage and number of resolved appeals of such requests that resulted in approval of coverage of the item or service that was the subject of such request, categorized by each item and service and categorized by each level of appeal (including judicial review).

''(5) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests that were approved, by the plan or issuer during such plan year solely through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary (both in the aggregate and categorized by each item and service).

''(6) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan or issuer and a determination by the plan or issuer with respect to such request for each such item and service (excluding any such requests that were not submitted with the medical or

other documentation required to be submitted by the plan or issuer), broken out by prior authorization requests that were expedited because the application of the normal time frame for making a determination could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function and such requests that were not so expedited.

''(7) The percentage and number of prior authorization requests that were excluded from each calculation described in paragraph (6) based on the plan or issuer's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan or issuer.

''(8) The percentage and number of occasions in which, during a surgical or medical procedure involving the furnishing of an item or service with respect to which the plan or issuer had approved a prior authorization request, the provider furnishing such item or service determined that a different or additional item or service was medically necessary, and a specification of whether such plan or issuer subsequently approved the furnishing of such different or additional item or service.

''(9) A disclosure and description of any technology described in paragraph (5) that the plan or issuer utilized during such plan year in making determinations with respect to prior authorization requests.

''(10) The number of complaints received by such plan or issuer that were related to a prior authorization requirement.

''(11) Such other information as the Secretary determines appropriate.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan or health insurance issuer offering group health insurance coverage under subsection (a) shall be so submitted and published on the plan or coverage level (as applicable) and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan or all health insurance coverage offered by such issuer that are offered within the same insurance market). For purposes of the preceding sentence, the term 'insurance market' means the individual market, the small group market, and the large group market.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 note) is amended by inserting after the item relating to section 726 the following new item:

''Sec. 728. Prior authorization transparency requirements.''.

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 106(c), is further amended by adding at the end the following new section:

**''SEC. 9828. PRIOR AUTHORIZATION TRANSPARENCY REQUIREMENTS.**

''(a) IN GENERAL.—In the case of a group health plan that imposes any prior authorization requirement with respect to an item or service furnished under such plan during a plan year beginning on or after January 1, 2028, such plan shall, at a time and in a manner specified by the Secretary (but not less frequently than annually), submit to the Secretary and make available on a public website of the plan the following information:

''(1) A list of all items and services that were subject to a prior authorization requirement under the plan during such plan year.

''(2) The percentage and number of prior authorization requests approved during such plan year

by the plan in an initial determination and the percentage and number of prior authorization requests denied during such plan year by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(3) The percentage and number of prior authorization requests that were denied during such plan year by the plan or issuer in an initial determination and that were subsequently appealed (both in the aggregate and categorized by each item and service).

''(4) The percentage and number of resolved appeals of such requests that resulted in approval of coverage of the item or service that was the subject of such request, categorized by each item and service and categorized by each level of appeal (including judicial review).

''(5) The percentage and number of prior authorization requests that were denied, and the percentage and number of prior authorization requests that were approved, by the plan during such plan year solely through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by

the Secretary (both in the aggregate and categorized by each item and service).

''(6) The average and the median amount of time (in hours) that elapsed during such plan year between the submission of a prior authorization request to the plan and a determination by the plan with respect to such request for each such item and service (excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan), broken out by prior authorization requests that were expedited because the application of the normal time frame for making a determination could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function and such requests that were not so expedited.

''(7) The percentage and number of prior authorization requests that were excluded from each calculation described in paragraph (6) based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(8) The percentage and number of occasions in which, during a surgical or medical procedure involving the furnishing of an item or service with re-

spect to which the plan had approved a prior authorization request, the provider furnishing such item or service determined that a different or additional item or service was medically necessary, and a specification of whether such plan or issuer subsequently approved the furnishing of such different or additional item or service.

''(9) A disclosure and description of any technology described in paragraph (5) that the plan or issuer utilized during such plan year in making determinations with respect to prior authorization requests.

''(10) The number of complaints received by such plan that were related to a prior authorization requirement.

''(11) Such other information as the Secretary determines appropriate.

''(b) MANNER OF PUBLICATION.—Information submitted and published by a group health plan under subsection (a) shall be so submitted and published on the plan or coverage level (as applicable) and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all group health plans of the sponsor of such plan). For purposes of the

preceding sentence, the term 'insurance market' means the small group market and the large group market.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9828. Prior authorization transparency requirements.''.

**SEC. 202. ENSURING HEALTH INSURER ACCOUNTABILITY THROUGH PUBLISHING OF OVERHEAD COSTS AND CLAIM PAYMENTS.**

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

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

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

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

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

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

''(A) IN GENERAL.—A health insurance issuer offering group or individual health insur-

ance coverage (including a grandfathered health plan) shall, with respect to each plan year beginning on or after January 1, 2028, submit to the Secretary and publish on the public website of such issuer the following information in a consumer-friendly format and in such form and manner as the Secretary shall specify:

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

''(ii) The explanation described in paragraph (1)(C).

''(iii) The percentage of total premium revenue expended on Federal and State taxes and licensing or regulatory fees.

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

''(B) MANNER OF PUBLICATION.—Information submitted and published by a health insurance issuer under subparagraph (A) shall be so submitted and published at the issuer level and shall in addition, if determined appropriate by the Secretary, be so submitted and published

in the aggregate in such manner as specified by the Secretary (such as across all such coverage offered by such issuer that are offered within the same State or the same insurance market (individual, small group, or large group)).''.

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

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

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2028, a contract under this section with an MA organization shall require the organization, with respect to each MA plan offered by such organization during such plan year, to submit to the Secretary and publish on the public website of such organization the following information in a consumer-friendly format specified by the Secretary:

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

''(ii) The amount and percentage of such revenue expended on incurred claims (as determined in accordance with paragraphs (2) through (4) of section 422.2420(b) of title 42, Code of Federal Regulations (or a successor regulation)).

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

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

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

''(B) MANNER OF PUBLICATION.—Information submitted and published by an MA organization under subparagraph (A) shall be so

submitted and published at the MA plan level and shall in addition, if determined appropriate by the Secretary, be so submitted and published in the aggregate in such manner as specified by the Secretary (such as across all MA plans offered by such organization).''.

**SEC. 203. PROMOTING COMPARABILITY OF QUALIFIED HEALTH PLANS OFFERED THROUGH AN EXCHANGE.**

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

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

''(i) through which'';

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

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

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

Exchange for a previous plan year, the most recent information submitted to such Exchange with respect to such plan by the health insurance issuer of such plan under sections 2718(a)(2) and 2799A–13 of the Public Health Service Act;''.

**SEC. 204. GUIDANCE ON PROVISION OF CERTAIN INSURANCE INFORMATION IN STANDARDIZED, PLAIN LANGUAGE FORMAT.**

(a) IN GENERAL.—Not later than January 1, 2028, the Secretary shall update guidance implementing section 2715 of the Public Health Service Act (42 U.S.C. 300gg–15) and section 1852(c) of the Social Security Act (42 U.S.C. 1395w–22(c)) as necessary to ensure that such guidance includes standards for group health plans, health insurance issuers offering group or individual health insurance coverage, and MA organizations offering MA plans (including MA–PD plans) to provide information on the benefits and coverage available under the applicable plan or coverage in a standardized, plain language format with respect to the following aspects of the plan or coverage (to the extent applicable):

(1) Any monthly premium.

(2) Any annual deductible.

(3) Any out-of-pocket limit.

(4) The plan or coverage type (such as health maintenance organization or preferred provider organization).

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

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

(A) Primary care.

(B) Specialist care.

(C) Urgent care.

(D) Emergency department care.

(E) Imaging.

(F) Inpatient hospital care.

(G) Outpatient facility care.

(H) Laboratory, diagnostic, and X-ray services.

(I) Preferred brand name drugs.

(J) Generic drugs.

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

(A) Specialist referral policies.

(B) The availability of wellness programs.

(C) The availability of disease management programs.

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

(E) Coverage of preventive care services.

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

(b) CONSULTATION.—In updating guidance described in subsection (a) with respect to section 2715 of the Public Health Service Act (42 U.S.C. 300gg–15), the Secretary shall consult with the Secretary of Labor and the Secretary of the Treasury.

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

(d) DEFINITIONS.—In this section:

(1) MEDICARE ADVANTAGE TERMS.—The terms ''MA organization'' and ''MA plan'' have the meanings given each such term for purposes of part C of

title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

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

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

**SEC. 205. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.**

Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of an MA plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (5)) during a plan year beginning on or after January 1, 2029, such plan shall—

''(A) establish the electronic prior authorization program described in paragraph (2);

"(B) meet the transparency requirements specified in paragraph (3); and

"(C) meet the enrollee protection standards specified pursuant to paragraph (4).

"(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—

"(i) a prior authorization request from a provider to an MA plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider; and

"(ii) any supporting documentation relating to such request or response.

"(B) ELECTRONIC TRANSMISSION.—

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

transmission described in subparagraph (A).

''(ii) STANDARDS.—An electronic transmission described in subparagraph (A) shall comply with applicable technical standards and other requirements to promote the standardization and streamlining of electronic transactions adopted by the Secretary.

''(3) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the transparency requirements specified in this paragraph are, with respect to an MA plan and a plan year, the following:

''(i) The plan, at a time and in a manner specified by the Secretary, shall submit to the Secretary and post on the public website of such plan the following information with respect to such plan year:

''(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan.

''(II) The percentage and number of specified requests (as defined in

subparagraph (F)) approved by the plan in an initial determination and the percentage and number of specified requests denied by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(III) The percentage and number of specified requests that were denied by the plan in an initial determination and that were subsequently appealed.

''(IV) The percentage and number of appeals of specified requests resolved, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

''(V) The percentage and number of specified requests that were denied, and the percentage and number of

specified requests that were approved, by the plan through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(VI) The average and the median amount of time (in hours) that elapsed between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service (excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan), categorized by such requests that were for expedited determinations (as described in subsection (g)(3)) and such requests that were not for expedited determinations.

''(VII) The percentage and number of specified requests that were excluded from the calculation described

in subclause (VI) based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(VIII) The percentage and number of instances in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior authorization request, the provider furnishing such item or service determined that a different or additional item or service was medically necessary, and a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

''(IX) A disclosure and description of any technology described in subclause (V) that the plan utilized in making determinations with respect to specified requests.

''(X) The number of grievances (as described in subsection (f)) received by such plan that were related to a prior authorization requirement.

''(XI) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider that seeks to enter into a contract with such plan to furnish applicable items and services under such plan, the list described in clause (i)(I) and any policies or procedures used by the plan for making determinations with respect to prior authorization requests;

''(II) to each such provider that enters into such a contract, access to the criteria used by the plan for making such determinations and an itemization of the medical or other documentation required to be submitted by a provider with respect to such a request; and

''(III) to an enrollee of the plan, upon request, access to such criteria.

''(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of the information described in subparagraph (A)(i) submitted to the Secretary with respect to a plan year, an MA plan may elect to include information regarding the percentage and number of specified requests made with respect to an item or service that were denied by the plan in an initial determination based on such requests failing to demonstrate that individuals requesting to receive such item or service met the clinical criteria used by such plan to receive such item or service.

''(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, establish requirements for MA plans regarding the provision of—

''(i) access to criteria described in subparagraph (A)(ii)(II) to providers in accordance with such subparagraph; and

''(ii) access to such criteria to enrollees in accordance with subparagraph (A)(ii)(III).

''(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information de-

scribed in subparagraph (A)(i) and subparagraph (B) on a public website of the Centers for Medicare & Medicaid Services. Such information shall be so published on an individual plan level and may in addition be aggregated in such manner as determined appropriate by the Secretary.

''(E) MEDPAC REPORT.—Not later than the first June 15 occurring after the date that is 2 years after the date information submitted under subparagraph (A)(i) is made available to the Medicare Payment Advisory Commission, the Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency of appeals and overturned decisions. The Commission shall provide recommendations, as appropriate, on any improvement that should be made to the electronic prior authorization programs of MA plans.

''(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term 'specified request' means a prior authorization request

made with respect to an applicable item or service.

''(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(C), with respect to the use of prior authorization by MA plans for applicable items and services, the enrollee protection standards specified in this paragraph are—

''(A) the adoption of transparent prior authorization programs developed in consultation with enrollees and with providers with contracts in effect with such plans for furnishing such items and services under such plans;

''(B) allowing for the waiver or modification of prior authorization requirements based on the performance of such providers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

''(C) conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from physicians who meet such criteria as may be specified by the Secretary and other stakeholders (including enrollees and providers with

such contracts in effect) and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

''(5) APPLICABLE ITEM OR SERVICE DEFINED.—For purposes of this subsection, the term 'applicable item or service' means, with respect to an MA plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) REPORTS TO CONGRESS.—

''(A) GAO.—Not later than January 1, 2032, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by MA plans.

''(B) HHS.—

''(i) THE SECRETARY.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and again not later than the end of the seventh plan year after such date of enactment and the ninth plan year after

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

''(I) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

''(II) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.

''(ii) CMS.—Not later than January 1, 2032, the Centers for Medicare & Medicaid Services and the Office of National Coordinator for Health Information Technology shall submit to Congress and publish on the internet website of the Centers for Medicare & Medicaid Services a report that—

''(I) defines the term 'real-time decision' and details how the definition for such term may be updated based on any technological advances;

''(II) using the data submitted to the Secretary under paragraph

(3)(A)(i), details a process for real-time decisions for routinely approved items and services for purposes of the electronic prior authorization program described in paragraph (2) (which the Secretary may, if determined appropriate by the Secretary, require to be implemented by MA plans as part of such program pursuant to subsection (g)); and

''(III) includes an analysis of—

''(aa) items and services that are routinely approved;

''(bb) items and services identified in item (aa) that could be subject to real-time decisions;

''(cc) whether requiring real-time decisions for such items and services could—

''(AA) improve enrollee access to benefits covered under the original medicare fee-for-service program under parts A and B;

"(BB) produce operational efficiencies for providers and MA plans; and

"(CC) reduce health disparities for enrollees of MA plans in rural and low-income communities; and

"(dd) how determinations of routinely approved items and services made solely through automation and artificial intelligence by MA plans impact patient access, including disparities in access for rural and low-income enrollees of MA plans.".

**SEC. 206. REQUIRING THE INCLUSION OF CERTAIN INFORMATION IN ENCOUNTER DATA.**

Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

"(j) INCLUSION OF CERTAIN INFORMATION IN ENCOUNTER DATA.—

"(1) IN GENERAL.—In the case of any encounter data submitted by an MA organization with respect to an item or service furnished to an individual

under an MA plan offered by such organization during a plan year beginning on or after January 1, 2028, the Secretary shall require that such data include—

''(A) the allowed amount for such item or service or, in the case such item or service is furnished under a payment arrangement other than a fee-for-service arrangement (such as a capitated or value-based payment arrangement), an amount that accounts for any payment made for such item or service under such payment arrangement, calculated using an allocation method specified by the Secretary;

''(B) the amount of cost sharing (including deductibles, copayments, and coinsurance) imposed for such item or service;

''(C) in the case such individual was furnished, during such plan year before such item or service was so furnished, an in-home health risk assessment from a specified assessment entity, an indicator that such individual was so furnished such an assessment by such an entity; and

''(D) in the case such individual was furnished, during such plan year before such item

or service was so furnished, an in-home health risk assessment from an assessment entity not described in subparagraph (C), an indicator (distinct from the indicator described in such subparagraph) that such individual was so furnished such an assessment by such an entity.

''(2) INCLUSION OF DATA IN WAREHOUSE.—The Secretary shall include any data required to be included as part of encounter data under paragraph (1) in the Chronic Conditions Data Warehouse (or a successor data warehouse) maintained by the Centers for Medicare & Medicaid Services.

''(3) DEFINITIONS.—In this subsection:

''(A) ASSESSMENT ENTITY.—The term 'assessment entity' means an entity with a focus on furnishing in-home health risk assessments, as specified by the Secretary.

''(B) SPECIFIED ASSESSMENT ENTITY.—The term 'specified assessment entity' means, with respect to an MA organization and a plan year, an assessment entity with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such organization) is a per-

son with an ownership or control interest (as so defined).''.

**SEC. 207. INCREASING DATA TRANSPARENCY FOR SUPPLEMENTAL BENEFITS UNDER MEDICARE ADVANTAGE.**

(a) IN GENERAL.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)), as amended by section 202(b), is further amended by adding at the end the following new paragraph:

''(8) REPORTING OF ENROLLEE-LEVEL DATA ON SUPPLEMENTAL BENEFITS.—

''(A) IN GENERAL.—Beginning with plan years beginning on or after January 1, 2029, a contract under this section with an MA organization shall require the organization to submit to the Secretary, for each MA plan offered by the organization, enrollee-level data on supplemental benefits (by item or service, or category of item or service, as determined appropriate by the Secretary, and National Provider Identifier (if applicable)), including eligibility for such benefits, the benefit category applicable with respect to each such benefit, and data on utilization of and payments for such benefits (including the total amount spent by the plan for each

enrollee who utilized such benefits and the total out-of-pocket cost per utilization for each enrollee).

''(B) DATA ACCESS.—

''(i) IN GENERAL.—Not later than January 1 of the year that is two years after the beginning of a plan year for which data is submitted under subparagraph (A), the Secretary shall—

''(I) upon request, make such data available to individuals and entities for the purpose of conducting—

''(aa) evaluations and other analyses to support the program under this title; and

''(bb) other health care related research; and

''(II) make available on the internet website of the Centers for Medicare & Medicaid Services a public use data file containing such data in de-identified form.

''(ii) CONFIDENTIALITY.—In making data available under clause (i)(I), the Secretary shall have in place procedures to

safeguard the privacy and security of any individually identifiable enrollee information.''.

(b) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall affect the collection of information as proposed, or so finalized, pursuant to—

(1) the notice entitled ''Agency Information Collection Activities: Proposed Collection; Comment Request'', published in the Federal Register on March 14, 2023 (88 Fed. Reg. 15726); or

(2) the notice entitled ''Agency Information Collection Activities: Submission for OMB Review; Comment Request'', published in the Federal Register on September 25, 2023 (88 Fed. Reg. 65689).

**SEC. 208. IMPLEMENTATION FUNDING.**

There are appropriated, out of any monies in the Treasury not otherwise obligated, $40,000,000 for fiscal year 2026 for purposes of carrying out the provisions of, and the amendments made by, this title, to remain available until expended.

**SEC. 209. MEDICARE IMPROVEMENT FUND.**

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$2,062,000,000'' and inserting ''$2,014,000,000''.

# TITLE III—LOWERING DRUG PRICES

**SEC. 301. BIOSIMILAR BIOLOGICAL PRODUCTS.**

(a) IN GENERAL.—Section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) is amended—

(1) in the subsection heading, by striking ''OR INTERCHANGEABLE'';

(2) in paragraph (2)—

(A) by striking subparagraph (B);

(B) by redesignating clauses (ii) and (iii) of subparagraph (A) as subparagraphs (B) and (C), respectively, and adjusting the margins accordingly;

(C) in subparagraph (A)—

(i) in clause (i), by redesignating subclauses (I) through (V) as clauses (i) through (v), respectively, and adjusting the margins accordingly;

(ii) in clause (i), as so redesignated by clause (i) of this subparagraph, by redesignating items (aa) through (cc) as subclauses (I) through (III), respectively, and adjusting the margins accordingly;

(iii) in subclause (II) of clause (i), as so redesignated by clause (ii) of this sub-

paragraph, by striking ''item (aa) or (cc)'' and inserting ''subclause (I) or (III)''; and

(iv) by striking ''(A) IN GENERAL'' and all that follows through ''An application submitted under this subsection shall include information'' and inserting the following:

''(A) IN GENERAL.—An application submitted under this subsection shall include information'';

(D) in subparagraph (B), as so redesignated by subparagraph (B) of this paragraph, by striking ''clause (i)(I)'' and inserting ''subparagraph (A)(i)''; and

(E) in subparagraph (C), as so redesignated by subparagraph (B) of this paragraph, by redesignating subclauses (I) through (III) as clauses (i) through (iii), respectively, and by adjusting the margins accordingly;

(3) by amending subparagraph (A) of paragraph (3) to read as follows:

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the bio-

logical product is biosimilar to the reference product; and'';

(4) by amending paragraph (4) to read as follows:

''(4) INTERCHANGEABILITY.—

''(A) IN GENERAL.—A biological product licensed under this subsection shall be deemed to be interchangeable with the reference product, subject to subparagraph (B).

''(B) TIMING OF DEEMED INTERCHANGEABILITY.—

''(i) LICENSURE ON OR AFTER DATE OF ENACTMENT.—A biological product licensed under this subsection on or after the date of enactment of the Lower Costs, More Transparency Act of 2026 (referred to in this clause as the 'applicable biological product') shall be deemed to be interchangeable with the reference product upon such licensure, unless the applicable biological product relied on the same reference product as another biological product for which—

''(I) licensure under this subsection was in effect on the day before

the date of enactment of the such Act; and

''(II) a first interchangeable exclusivity period under paragraph (6) (as in effect on the day before the date of enactment of such Act) is in effect on the date of licensure of the applicable biological product,

in which case the applicable biological product shall be deemed interchangeable with the reference product under this paragraph on the date on which the exclusivity period described in subclause (II) ends.

''(ii) LICENSURE PRIOR TO DATE OF ENACTMENT.—A biological product licensed under this subsection prior to the date of enactment of the Lower Costs, More Transparency Act of 2026 (referred to in this clause as the 'applicable biological product') shall be deemed to be interchangeable with the reference product on such date, unless the applicable biological product relied on the same reference product as another biological product for which—

''(I) licensure under this subsection was in effect on the day before the date of enactment of such Act; and

''(II) a first interchangeable exclusivity period under paragraph (6) (as in effect on the day before the date of enactment of such Act) is in effect on the date of enactment of such Act,

in which case the applicable biological product shall be deemed interchangeable with the reference product under this paragraph on the date on which the exclusivity period described in subclause (II) ends.'';

(5) by amending paragraph (6) to read as follows:

''(6) PRESERVING FIRST INTERCHANGEABLE EXCLUSIVITY WITH RESPECT TO CERTAIN BIOLOGICAL PRODUCTS.—With respect to a biological product licensed under this subsection before the date of enactment of the Lower Costs, More Transparency Act of 2026, for which there was an unexpired period of first interchangeable exclusivity under this subsection (as then in effect), such unexpired exclu-

sivity period shall remain in effect for the duration of such period.''; and

(6) in paragraph (8)(D)—

(A) in clause (i), by striking ''class; and'' and inserting ''class.'';

(B) by striking clause (ii); and

(C) by striking ''description of—'' and all that follows through ''criteria that the Secretary'' and inserting ''description of the criteria that the Secretary''.

(b) CONFORMING AMENDMENTS.—

(1) Section 351(i)(3) of the Public Health Service Act (42 U.S.C. 262(i)(3)) is amended by striking ''that is shown to meet the standards described in subsection (k)(4)'' and inserting ''licensed under subsection (k)''.

(2) Section 352A of the Public Health Service Act (42 U.S.C. 263–1) is amended by striking ''and interchangeable biosimilar biological products'' each place it appears.

(3) Section 744G(14) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379j–51(14)) is amended by striking '', including a supplement requesting that the Secretary determine that the biosimilar biological product meets the standards for

interchangeability described in section 351(k)(4) of the Public Health Service Act''.

(4) Section 505B(l) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c(l)) to read as follows:

''(l) BIOSIMILAR BIOLOGICAL PRODUCTS.—A biological product for which an application is submitted under section 351(k) of the Public Health Service Act shall not be considered to have a new active ingredient for purposes of this section, unless—

''(1) the application seeks licensure for a claimed indication that has been approved for the reference product in a relevant pediatric population or for which there is a deferral of the pediatric assessment under paragraph (4) for the reference product; and

''(2) a pediatric assessment or investigation under this section would not involve the development of a biological product with a strength, dosage form, route of administration, or condition of use that could not be licensed under section 351(k) of the Public Health Service Act.''.

(c) GUIDANCE.—The Secretary shall—

(1) not later than 18 months after the date of enactment of this Act, update existing draft and

final guidance, as appropriate, to reflect the amendments made by this Act, including by revising or revoking the guidance document titled ''Considerations in Demonstrating Interchangeability With a Reference Product'' (May 2019) and ''Considerations in Demonstrating Interchangeability With a Reference Product: Update'' (June 2024);

(2) not later than 18 months after the date of enactment of this Act, issue or revise guidance, as appropriate, on review and approval of biosimilar biological products under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) relating to the data and information that an applicant is required to submit to support a determination that a biosimilar biological product that is the subject of an application under such section is biosimilar to the reference product (as defined in section 351(i) of such Act (42 U.S.C. 262(i))); and

(3) not later than 18 months after the comment period closes on the guidance under paragraphs (1) and (2), issue revised draft or final versions of such guidances.

**SEC. 302. ASSESSMENT OF PHARMACODYNAMICS OR EFFICACY IN CLINICAL STUDIES REQUIRED FOR LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR.**

(a) IN GENERAL.—Section 351(k)(2) of the Public Health Service Act (42 U.S.C. 262(k)(2)), as amended by section 301, is further amended—

(1) in subparagraph (A)(i), as redesignated by section 301(a)(2)(C)—

(A) in subclause (II), as so redesignated—

(i) by striking ''subclause (I) or (III)'' and inserting ''subclause (I), (II), or (III)''; and

(ii) by striking ''and'' at the end; and

(B) by striking subclause (III), as redesignated by section 301(a)(2)(C), and inserting the following:

''(III) an assessment of pharmacokinetics and immunogenicity (which may rely on, or consist of, a clinical pharmacokinetics study or studies or a study or studies described in subclause (I) or (IV), as appropriate); and

''(IV) a clinical study or studies required by the Secretary pursuant to

subparagraph (D) to support a demonstration that no clinically meaningful differences exist between the biological product and reference product with respect to safety, purity, and potency;''; and

(2) by adding at the end the following:

''(D) LIMITATION ON REQUIRING ADDITIONAL CLINICAL STUDY OR STUDIES.—

''(i) IN GENERAL.—The Secretary may only require an additional clinical study or studies described in subparagraph (A)(i)(IV), including a study or studies that include an assessment of pharmacodynamics or efficacy, if the Secretary determines that such study or studies are necessary, in combination with the other studies described in subparagraph (A)(i), to demonstrate biosimilarity and provides written notice of such determination to the sponsor of the proposed biosimilar biological product.

''(ii) TIMING OF ISSUANCE OF WRITTEN NOTICE.—Written notice under clause (i) shall be provided not later than—

''(I) in the case of the Secretary granting a request for a biosimilar biological product development meeting and the sponsor of the biosimilar biological product involved requesting at such meeting that the Secretary determine whether such additional clinical study or studies are necessary, the date on which the Secretary issues meeting minutes for such meeting, unless the Secretary describes in the meeting minutes why an assessment of the need for such study or studies cannot be made at that time; or

''(II) in the case that no such request is made or if the Secretary was unable to make the assessment under subclause (I), the date that is 60 days after the date of the submission of an application under this subsection.

''(iii) DETERMINATION RELATING TO PROPOSED BIOSIMILAR BIOLOGICAL PRODUCTS.—At the written request of the sponsor of a proposed biosimilar biological product, the Secretary shall determine that

a study or studies described in subparagraph (A)(i)(IV) that includes the assessment of pharmacodynamics, or efficacy are unnecessary to support a determination that the biological product is biosimilar to the reference product, unless the Secretary provides a written response, within an agreed upon period after receipt of the written request, that includes a written justification as to why such study or studies are necessary or why an assessment of the need for such study or studies cannot be made at that time.''.

(b) REPEAL OF REQUIREMENT RELATING TO CONDUCT OF REVIEWS.—Section 351(k)(5) of the Public Health Service Act (42 U.S.C. 262(k)(5)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

(c) APPLICABILITY.—The amendments made by subsection (a) shall apply with respect to—

(1) a biosimilar product development meeting request submitted on or after the date of enactment of this Act; and

(2) an application submitted under section 351(k) of the Public Health Service Act (42 U.S.C. 262(k)) on or after the date of enactment of this Act.

**SEC. 303. DENIAL OF PETITIONS WHOSE PRIMARY PURPOSE IS TO DELAY APPROVAL OF CERTAIN APPLICATIONS.**

(a) IN GENERAL.—Section 505(q)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(q)(1))—

(1) in subparagraph (A), by amending clause (i) to read as follows:

''(i) the request is—

''(I) in writing;

''(II) a petition submitted to the Secretary pursuant to section 10.30, 10.31, or 10.35 of title 21, Code of Federal Regulations (or any successor regulations); and

''(III) submitted not later than the date that is 60 days after the information upon which the petition is based first became known to, or reasonably should have been known by, the party on whose behalf the petition is submitted; and'';

(2) by amending subparagraph (E) to read as follows:

''(E) DENIAL BASED ON INTENT TO DELAY.—

''(i) IN GENERAL.—If the Secretary determines that a petition or a supplement to the petition was submitted with the primary purpose of delaying the approval of an application or the petition does not on its face raise valid scientific or regulatory issues, the Secretary may deny the petition at any point based on such determination.

''(ii) FACTORS.—The Secretary may issue guidance to describe the factors that will be used to determine under this subparagraph whether a petition is submitted with the primary purpose of delaying the approval of an application. Such factors shall include the following:

''(I) Submission of a petition where it appears, based on the date that relevant information relied upon in the petition became known to the petitioner (or reasonably should have been known to the petitioner), that

the petitioner has taken an unreasonable length of time to submit the petition.

''(II) Submission of multiple or serial petitions raising issues that reasonably could have been known to the petitioner at the time of submission of the earlier petition or petitions.

''(III) Submission of a petition close in time to a known, first date upon which an application under subsection (b)(2) or (j) of this section or under section 351(k) of the Public Health Service Act could be approved (such as submission close in time to the expiration of a blocking patent or exclusivity).

''(IV) Submission of a petition without any data or information in support of the scientific positions set forth in the petition.

''(V) Submission of a petition raising the same or substantially similar issues as a prior petition to which the Food and Drug Administration

has already substantively responded, particularly where the subsequent submission closely follows in time the earlier response.

''(VI) Submission of a petition concerning standards for approval of a drug product for which—

''(aa) the Food and Drug Administration has provided an opportunity for public input (such as when the Food and Drug Administration has issued draft or final product-specific guidance applicable to the drug product); and

''(bb) the petitioner has not provided comment other than through the petition.

''(VII) Submission of a petition requesting that other applicants must meet standards for testing, data, or labeling for their products that are more onerous or rigorous than the standards applicable to the applicable listed drug, reference product, or the

petitioner's version of the same drug or product.

"(VIII) Other relevant considerations, including the history of the petitioner with the Food and Drug Administration (such as whether the petitioner has a history of submitting petitions which the Food and Drug Administration has determined were submitted with the primary purpose of delay).";

(3) by striking subparagraph (F);

(4) by redesignating subparagraphs (G) through (I) as subparagraphs (F) through (H), respectively; and

(5) in subparagraph (H), as so redesignated, by striking "'submission of this petition'" and inserting "'submission of this document'".

(b) EXHAUSTION OF ADMINISTRATIVE REMEDIES.—Section 505(q)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(q)(2)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by striking "WITHIN 150 DAYS";

(B) in clause (i), by striking ''during the 150-day period referred to in paragraph (1)(F),''; and

(C) by amending clause (ii) to read as follows:

''(ii) on or after the date that is 151 days after the date of submission of the petition, the Secretary approves or has approved the application that is the subject of the petition without having made such a final decision.''; and

(2) by amending subparagraph (B) to read as follows:

''(B) DISMISSAL OF CERTAIN CIVIL ACTIONS.—

''(i) PETITION.—If a person files a civil action against the Secretary in which a person seeks to set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act without first submitting a petition to the Secretary under paragraph (1) that describes all information and arguments that

form the basis of the relief requested in such civil action, the court shall dismiss without prejudice the action for failure to exhaust administrative remedies.

''(ii) TIMELINESS.—If a person files a civil action against the Secretary in which a person seeks to set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of the Public Health Service Act after the date described in paragraph (1)(A)(i), the court shall dismiss with prejudice the action for failure to timely file a petition.

''(iii) FINAL RESPONSE.—If a civil action is filed against the Secretary with respect to any issue raised in a petition timely filed under paragraph (1) in which the petitioner requests that the Secretary take any form of action that could, if taken, set aside, delay, rescind, withdraw, or prevent submission, review, or approval of an application submitted under subsection (b)(2) or (j) of this section or section 351(k) of

the Public Health Service Act before the Secretary has taken final agency action on the petition within the meaning of subparagraph (A), the court shall dismiss without prejudice the action for failure to exhaust administrative remedies.''.

(c) REMOVAL OF BIOLOGICAL PRODUCTS FROM EXCEPTIONS.—Section 505(q)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(q)(4)) is amended—

(1) by striking subparagraph (B);

(2) in subparagraph (A)—

(A) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly; and

(B) by striking ''; and'' at the end and inserting a period; and

(3) by striking ''(4) EXCEPTIONS'' and all that follows through ''This subsection does not'' and inserting the following:

''(4) EXCEPTIONS.—This subsection does not''.

**SEC. 304. PRIORITY NONPRESCRIPTION DRUGS.**

(a) IN GENERAL.—The Federal Food, Drug, and Cosmetic Act is amended by inserting after section 506L (21 U.S.C. 356l) the following:

**"SEC. 506M. PRIORITY NONPRESCRIPTION DRUGS.**

"(a) IN GENERAL.—

"(1) DESIGNATION.—The Secretary may, at the request of the sponsor of a nonprescription drug, designate as a priority nonprescription drug under this section a drug intended for nonprescription use that is subject to an application submitted (or to be submitted) under section 505(b), if the Secretary determines that the drug meets the criteria specified in subsection (d).

"(2) NONPRESCRIPTION DEFINED.—In this section, the term 'nonprescription' means, with respect to a drug, that such drug is not subject to section 503(b)(1).

"(b) REQUEST FOR DESIGNATION.—The sponsor of a drug subject to a pending application under section 505(b) for nonprescription use may request that the Secretary designate the drug as a priority nonprescription drug.

"(c) DESIGNATION.—Not later than 60 calendar days after the receipt of a request under subsection (b), the Secretary shall determine whether a drug meets the criteria for designation as a priority nonprescription drug under this section, and if so, make such designation.

"(d) CRITERIA.—

''(1) ELIGIBILITY.—Except as provided in paragraph (2), a drug described in subsection (a) is eligible for designation as a priority nonprescription drug if—

''(A) the drug is intended for a novel nonprescription indication that could provide a meaningful public health benefit;

''(B) the drug is a new molecular entity; or

''(C) the drug contains an active ingredient that has never been available in a nonprescription drug.

''(2) EXCLUSION.—A drug is not eligible for designation as a priority nonprescription drug if the drug is subject to a risk evaluation and mitigation strategy under section 505–1 or if the drug is a controlled substance (as defined in section 102 of the Controlled Substances Act).

''(e) ACTIONS.—If the Secretary designates a drug as a priority nonprescription drug, the Secretary shall take such actions as are appropriate to facilitate the development of, and expedite the review of, an application or supplement to an application for such drug, which may include—

''(1) holding meetings with the sponsor and the review team throughout the development of the drug;

''(2) providing timely advice to, and interactive communication with, the sponsor regarding the development of the drug to ensure that the development program to gather the nonclinical and clinical data necessary to demonstrate the inapplicability of the criteria described in section 503(b)(1) is as efficient as practicable;

''(3) involving senior managers and experienced review staff, as appropriate, in a collaborative, cross-disciplinary review;

''(4) assigning a cross-disciplinary project lead for the Food and Drug Administration team to facilitate an efficient review of the development program and to serve as a scientific liaison between the review team and the sponsor; and

''(5) taking steps to ensure that the design of any necessary nonclinical or clinical trials is as efficient as practicable, when scientifically appropriate, including reliance on real world evidence.

''(f) LIST OF CONDITIONS.—

''(1) ESTABLISHMENT.—Not later than 18 months after the date of enactment of this section,

the Secretary shall publish in the Federal Register a list of conditions for which a nonprescription drug, if developed for the condition, could provide meaningful public health benefit.

''(2) PUBLIC COMMENT.—The Secretary shall provide a period of not less than 30 days for public comment on—

''(A) the list under paragraph (1); and

''(B) any updates to such list.''.

(b) RULE OF CONSTRUCTION.—The amendment made by subsection (a) shall not be construed to alter the evidentiary standards or the information required for approval of a nonprescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355).

(c) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing—

(1) the number of nonprescription drugs for which a sponsor requested that the Secretary designate such a drug as a priority nonprescription drug under section 506M of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a);

(2) the number of nonprescription drugs for which the Secretary approved such request;

(3) the number of priority nonprescription drugs (as designated under such section) for which the Secretary approved an application under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355);

(4) an overview of the resources used to implement such section; and

(5) any recommendation on further improvement on increasing over-the-counter drug approvals using a framework similar to the designation framework established in such section.

(d) SUNSET DATE.—The authority provided to the Secretary of Health and Human Services under section 506M of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), shall cease to be effective September 30, 2032.

# TITLE IV—EXPANDING ACCESS TO CARE

## SECTION 401. REQUIRED PRIMARY HEALTH SERVICES OF COMMUNITY HEALTH CENTERS.

(a) INCLUSION OF BEHAVIORAL AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.—Section 330(b)(1)(A)(i) of the Public Health Service Act (42 U.S.C. 254b(b)(1)(A)(i)) is amended—

(1) in subclause (IV), by striking ''and'' at the end;

(2) in subclause (V), by striking the semicolon at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(VI) behavioral and mental health and substance use disorder services;''.

(b) CONFORMING AMENDMENT.—Section 330(b)(2) of the Public Health Service Act (42 U.S.C. 254b(b)(2)) is amended—

(1) by striking subparagraph (A); and

(2) by redesignating subparagraphs (B), (C), and (D) as subparagraphs (A), (B), and (C), respectively.

**SEC. 402. NUTRITION EDUCATION AND CHRONIC DISEASE PREVENTION AT FEDERALLY QUALIFIED HEALTH CENTERS.**

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) by redesignating subsection (r) as subsection (s); and

(2) by inserting after subsection (q) the following:

''(r) NUTRITION EDUCATION AND CHRONIC DISEASE PREVENTION INITIATIVE.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall support health centers in integrating and expanding evidence-based nutrition education and counseling into primary care delivery and workforce training.

''(2) USE OF FUNDS.—In carrying out paragraph (1), the Secretary may utilize funding, made available under section 10503(b)(4) of the Patient Protection and Affordable Care Act, to award a grant, contract, or cooperative agreement, and may provide technical assistance, to a health center for—

''(A) patient-centered nutrition education and counseling services;

''(B) integration of nutrition assessment and dietary counseling into chronic disease management;

''(C) training and continuing education in nutrition science and dietary counseling for health center providers in health centers;

''(D) establishing and maintaining interdisciplinary models of care that incorporate reg-

istered dietitians, community health workers, and other appropriate professionals;

''(E) developing culturally and linguistically appropriate nutrition education materials; and

''(F) evaluating clinical and cost outcomes associated with nutrition interventions.

''(3) PARTICIPATION OF AFFILIATED ENTITIES.—A health center may affiliate with an academic medical center or medical school in carrying out activities receiving assistance under this subsection.

''(4) PRIORITY.—In making awards under this subsection, the Secretary shall prioritize health centers serving populations with high rates of diet-related chronic disease, food insecurity, or other nutrition-related health disparities.

''(5) SUPPLEMENT, NOT SUPPLANT.—Funds made available to carry out this subsection shall supplement, and not supplant, other Federal, State, local, or private funding used for similar purposes.

''(6) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this subsection, the Secretary shall submit to Congress a report that—

''(A) describes the use of funds under this subsection;

''(B) evaluates improvements in patient outcomes related to chronic disease indicators attributable to activities receiving assistance under this subsection;

''(C) assesses improvements in workforce training participation and competency development attributable to activities receiving assistance under this subsection; and

''(D) estimates potential cost savings to Federal health care programs attributable to nutrition interventions receiving assistance under this subsection.''.

**SEC. 403. FUNDING.**

Section 10503(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)) is amended—

(1) in paragraph (1)(K), by striking ''and'' at the end;

(2) in paragraph (2)(L), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(3) to be transferred to the Secretary of Health and Human Services to provide enhanced funding to provide the services specified in subclause

(VI) of section 330(b)(1)(A)(i) of the Public Health Service Act, $250,000,000 for each of fiscal years 2027 and 2028; and

''(4) to be transferred to the Secretary of Health and Human Services to provide enhanced funding to provide the services specified in section 330(r) of the Public Health Service Act, $125,000,000 for each of fiscal years 2027 and 2028.''.

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