

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:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Lower Costs, More
3 Transparency Act of 2026”.

4 TITLE I—HEALTH CARE PRICE
5 TRANSPARENCY

6 SEC. 101. HOSPITAL PRICE TRANSPARENCY.

7 (a) MEDICARE.—

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

12 “SEC. 1899D. PRICE TRANSPARENCY.

13 “(a) HOSPITAL TRANSPARENCY REQUIREMENT.—

14 “(1) IN GENERAL.—Beginning January 1,
15 2028, each specified hospital that receives payment
16 under this title for furnishing items and services
17 shall comply with the price transparency require-
18 ment described in paragraph (2).

1 “(2) REQUIREMENT DESCRIBED.—

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

6 “(i) in accordance with a method and
7 format established by the Secretary under
8 subparagraph (C), compile and make pub-
9 lic (without subscription and free of
10 charge), and update not less frequently
11 than annually (or at such greater fre-
12 quency as may be specified by the Sec-
13 retary)—

14 “(I) all of the hospital’s standard
15 charges (including the information de-
16 scribed in subparagraph (B)) for each
17 item and service furnished by such
18 hospital;

19 “(II) information—

20 “(aa) on the hospital’s
21 prices (including the information
22 described in subparagraph (B))
23 for as many of the Centers for
24 Medicare & Medicaid Services-
25 specified shoppable services that

1 are furnished by the hospital,
2 and as many additional hospital-
3 selected shoppable services (or all
4 such additional services, if such
5 hospital furnishes fewer than 300
6 shoppable services) as may be
7 necessary for a combined total of
8 at least 300 shoppable services;
9 and

10 “(bb) that includes, with re-
11 spect to each Centers for Medi-
12 care & Medicaid Services-speci-
13 fied shoppable service that is not
14 furnished by the hospital, an in-
15 dication that such service is not
16 so furnished;

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

21 “(iii) in accordance with a method
22 and format established by the Secretary,
23 compile and make public (on an annual
24 basis)—

1 “(I) the legal business name, tax
2 status, business structure, type of or-
3 ganization, and business address of
4 each entity that, with respect to the
5 hospital—

6 “(aa) has directly or indi-
7 rectly an ownership interest of 5
8 percent or more in the hospital;

9 “(bb) has a partnership in-
10 terest of 5 percent or more in the
11 hospital;

12 “(cc) has managing control
13 of 5 percent or more of the hos-
14 pital;

15 “(dd) has a mortgage inter-
16 est of 5 percent or more in the
17 hospital; or

18 “(ee) has a security interest
19 of 5 percent or more in the hos-
20 pital; and

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

1 spect to the hospital in the preceding
2 1-year period; and

3 “(iv) submit to the Secretary (in a
4 form and manner specified by the Sec-
5 retary and on an annual basis) an attesta-
6 tion, signed by the chief executive officer,
7 chief financial officer, or other comparable
8 official (as specified by the Secretary) of
9 such hospital, that all information made
10 public pursuant to this subparagraph is
11 complete and accurate.

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

18 “(i) A plain language description (as
19 specified by the Secretary) of each item or
20 service, accompanied by, as applicable,
21 commonly recognized billing code sets, in-
22 cluding the Healthcare Common Procedure
23 Coding System code, the diagnosis-related
24 group, the national drug code, or other ap-

1 applicable identifier determined appropriate
2 by the Secretary.

3 “(ii) The gross charge, as applicable,
4 expressed as a dollar amount, for each
5 such item or service, when provided in, as
6 applicable, the inpatient setting and out-
7 patient department setting.

8 “(iii) For each such item or service
9 when provided in, as applicable, the inpa-
10 tient and outpatient department settings—

11 “(I) the discounted cash price, as
12 applicable, expressed as a dollar
13 amount; or

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

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

1 pital’s charity care policy that includes, if
2 applicable, any sliding scale payment struc-
3 ture employed for determining prices.

4 “(v) The payer-specific negotiated
5 charges, as applicable, clearly associated
6 with the name of the third party payer and
7 plan and expressed as a dollar amount,
8 that apply to each such item or service
9 when provided in, as applicable, the inpa-
10 tient setting and outpatient department
11 setting.

12 “(vi) The de-identified maximum and
13 minimum negotiated charges, as applica-
14 ble, for each such item or service, not in-
15 cluding any such charge that is \$0.

16 “(vii) Any other additional informa-
17 tion the Secretary may require (in con-
18 sultation with stakeholders) for the pur-
19 pose of improving the accuracy of, or ena-
20 bling consumers to easily understand and
21 compare, standard charges and prices for
22 an item or service, except information that
23 is duplicative of any other reporting re-
24 quirement under this subsection.

1 “(C) UNIFORM METHOD AND FORMAT.—

2 Not later than January 1, 2028, the Secretary
3 shall establish a standard, uniform method and
4 format for specified hospitals to use in com-
5 piling and making public standard charges pur-
6 suant to subparagraph (A)(i)(I) and a stand-
7 ard, uniform method and format for such hos-
8 pitals to use in compiling and making public
9 prices pursuant to subparagraph (A)(i)(II).

10 Such methods and formats—

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

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

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

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

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

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

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

10 “(3) MONITORING COMPLIANCE.—The Sec-
11 retary shall establish processes to monitor and as-
12 sess specified hospitals’ compliance with this sub-
13 section. Such processes shall include processes relat-
14 ing to the following:

15 “(A) The evaluation and analysis of com-
16 plaints made by individuals or other entities re-
17 lating to such hospitals’ compliance with this
18 subsection.

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

21 “(C) The obtaining of additional informa-
22 tion from such hospitals to determine such hos-
23 pitals’ compliance with this subsection (as de-
24 termined appropriate by the Secretary).

25 “(4) ENFORCEMENT.—

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

4 “(i) not later than 30 days after the
5 date on which the Secretary determines
6 such failure exists, the Secretary shall sub-
7 mit to such hospital a notification of such
8 determination (which may include, as de-
9 termined appropriate by the Secretary, a
10 request for a corrective action plan (to be
11 submitted not later than 45 days after
12 such request is made) to comply with such
13 requirements); and

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

18 “(I) the Secretary shall, not later
19 than 60 days after such notification is
20 sent, determine whether such hospital
21 is in compliance with such require-
22 ments; and

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

1 quirements, the Secretary shall ei-
2 ther—

3 “(aa) submit to such hos-
4 pital a request for a corrective
5 action plan (to be submitted not
6 later than 45 days after such re-
7 quest is made) to comply with
8 such requirements; or

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

16 “(B) CIVIL MONETARY PENALTY.—

17 “(i) IN GENERAL.—Subject to clause
18 (viii), in addition to any other enforcement
19 actions or penalties that may apply under
20 another provision of Federal law, a speci-
21 fied hospital that has received a request
22 for a corrective action plan under clause (i)
23 or (ii) of subparagraph (A) and fails to
24 comply with the requirements of this sub-
25 section by the date that is 90 days after

1 such request is made (or, if such hospital
2 has submitted such a corrective action plan
3 not later than 45 days after the date such
4 request was made, by the date that is 90
5 days after the date of the submission of
6 such corrective action plan), and a speci-
7 fied hospital with respect to which the Sec-
8 retary has made a determination described
9 in clause (ii)(II)(bb) of such subparagraph,
10 shall be subject to a civil monetary penalty
11 of an amount specified by the Secretary for
12 each day (beginning with the day on which
13 the Secretary first determined that such
14 hospital was not complying with such re-
15 quirements) during which such failure was
16 ongoing. Such amount shall not exceed—

17 “(I) in the case of a specified
18 hospital with 30 or fewer beds, \$342
19 per day (or, in the case of such a hos-
20 pital that has been noncompliant with
21 such requirements for a 1-year period
22 or longer, beginning with the first day
23 following such 1-year period, \$400 per
24 day);

1 “(II) in the case of a specified
2 hospital with more than 30 beds but
3 fewer than 101 beds, \$12.50 per bed
4 per day (or, in the case of such a hos-
5 pital that has been noncompliant with
6 such requirements for a 1-year period
7 or longer, beginning with the first day
8 following such 1-year period, \$15 per
9 bed per day);

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

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

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

3 “(V) in the case of a specified
4 hospital with more than 500 beds,
5 \$25 per bed per day (or, in the case
6 of such a hospital that has been non-
7 compliant with such requirements for
8 a 1-year period or longer, beginning
9 with the first day following such 1-
10 year period, \$35 per bed per day).

11 “(ii) INCREASE AUTHORITY.—In ap-
12 plying this subparagraph with respect to
13 failures to comply occurring in 2029 or a
14 subsequent year, the Secretary may
15 through notice and comment rulemaking
16 increase—

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

20 “(II) the limitations on the per
21 bed per day amount of any penalty
22 applicable under any of subclauses
23 (II) through (V) of clause (i); and

24 “(III) the amounts specified in
25 clause (iii)(II).

1 “(iii) PERSISTENT NONCOMPLI-
2 ANCE.—

3 “(I) IN GENERAL.—In the case
4 of a specified hospital (other than a
5 specified hospital with 30 or fewer
6 beds) that the Secretary has deter-
7 mined to be knowingly and willfully
8 noncompliant with the provisions of
9 this subsection for two or more 6-
10 month periods during any 3-year pe-
11 riod, the Secretary may increase any
12 penalty otherwise applicable under
13 this subparagraph by the amount
14 specified in subclause (II) with respect
15 to such hospital and may require such
16 hospital to complete such additional
17 corrective actions plans as the Sec-
18 retary may specify.

19 “(II) SPECIFIED AMOUNT.—For
20 purposes of subclause (I), the amount
21 specified in this subclause is, with re-
22 spect to a specified hospital—

23 “(aa) with more than 30
24 beds but fewer than 101 beds, an
25 amount that is not less than

1 \$500,000 and not more than
2 \$1,000,000;

3 “(bb) with more than 100
4 beds but fewer than 301 beds, an
5 amount that is greater than
6 \$1,000,000 and not more than
7 \$2,000,000;

8 “(cc) with more than 300
9 beds but fewer than 501 beds, an
10 amount that is greater than
11 \$2,000,000 and not more than
12 \$4,000,000; and

13 “(dd) with more than 500
14 beds, and amount that is not less
15 than \$5,000,000 and not more
16 than \$10,000,000.

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

19 “(I) HOSPITALS LOCATED IN
20 RURAL OR UNDERSERVED AREAS.—

21 “(aa) IN GENERAL.—Sub-
22 ject to item (bb), the Secretary
23 may waive any penalty, or reduce
24 any penalty by not more than 75
25 percent, otherwise applicable

1 under this subparagraph with re-
2 spect to a specified hospital lo-
3 cated in a rural or underserved
4 area (as defined by the Sec-
5 retary) if the Secretary deter-
6 mines that imposition of such
7 penalty would result in an imme-
8 diate threat to access to care for
9 individuals in the service area of
10 such hospital.

11 “(bb) LIMITATION ON AP-
12 PPLICATION.—The Secretary may
13 not elect to waive a penalty
14 under item (aa) with respect to a
15 specified hospital more than once
16 in a 6-year period and may not
17 elect to reduce such a penalty
18 with respect to such a hospital
19 more than once in such a period.
20 Nothing in the preceding sen-
21 tence shall be construed as pro-
22 hibiting the Secretary from both
23 waiving and reducing a penalty
24 with respect to a specified hos-
25 pital during a 6-year period.

1 “(II) REDUCTION IF HEARING
2 WAIVED.—The Secretary may reduce
3 any penalty otherwise applicable
4 under this subparagraph (as reduced,
5 if applicable, under subclause (I)) by
6 not more than 35 percent if the speci-
7 fied hospital that is the subject of
8 such penalty agrees to waive any right
9 of such hospital to a hearing before
10 an administrative law judge with re-
11 spect to the imposition of such pen-
12 alty.

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

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

3 “(vi) PROVISION OF TECHNICAL AS-
4 SISTANCE.—The Secretary shall, to the ex-
5 tent practicable, provide technical assist-
6 ance relating to compliance with the provi-
7 sions of this subsection to specified hos-
8 pitals requesting such assistance.

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

17 “(viii) NONDUPLICATION OF CERTAIN
18 PENALTIES.—

19 “(I) IN GENERAL.—The Sec-
20 retary may not subject a specified
21 hospital to a civil monetary penalty
22 under this subparagraph with respect
23 to noncompliance with the provisions
24 of this subsection for a period if the
25 Secretary has imposed a civil mone-

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

6 “(II) PRIORITIZATION.—In the
7 case of a hospital that the Secretary
8 determines to be in violation of the
9 provisions of this subsection and of
10 section 2718(f) of the Public Health
11 Service Act, the Secretary shall im-
12 pose penalties as prescribed in such
13 section 2718(f) in lieu of any pen-
14 alties prescribed in this subsection.

15 “(C) PUBLICATION OF HOSPITAL PRICE
16 TRANSPARENCY INFORMATION.—Beginning on
17 January 1, 2028, the Secretary shall make pub-
18 licly available on the website of the Centers for
19 Medicare & Medicaid Services information with
20 respect to compliance with the requirements of
21 this subsection and enforcement activities un-
22 dertaken by the Secretary under this sub-
23 section. Such information shall be updated in
24 real time (if practicable) and include—

1 “(i) the number of reviews of compli-
2 ance with this subsection undertaken by
3 the Secretary;

4 “(ii) the number of notifications de-
5 scribed in subparagraph (A)(i) sent by the
6 Secretary;

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

12 “(iv) the amount of any civil monetary
13 penalty imposed on such hospital under
14 subparagraph (B);

15 “(v) whether such hospital subse-
16 quently came into compliance with this
17 subsection;

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

22 “(I) the name of any specified
23 hospital that received such a waiver or
24 reduction;

1 “(II) the dollar amount of each
2 such penalty so waived or reduced;
3 and

4 “(III) the rationale for the grant-
5 ing of each such waiver or reduction,
6 but only to the extent that such ra-
7 tionale does not make public commer-
8 cially sensitive information; and

9 “(vii) any other information as deter-
10 mined by the Secretary.

11 “(b) ENSURING ACCESSIBILITY THROUGH IMPLE-
12 MENTATION.—In implementing this section, the Secretary
13 shall through rulemaking ensure that a provider of serv-
14 ices or supplier making public charges and prices pursuant
15 to this section takes reasonable steps (as specified by the
16 Secretary) to ensure the accessibility of such charges and
17 information to individuals with limited English pro-
18 ficiency. Such steps may include the provision of interpre-
19 tation services or the provision of translations of charges
20 and information.

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

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

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

7 “(3) PAYER-SPECIFIC NEGOTIATED CHARGE.—
8 The term ‘payer-specific negotiated charge’ means
9 the charge that a provider of services or supplier has
10 negotiated with a third party payer for an item or
11 service.

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

17 “(5) SPECIFIED HOSPITAL.—The term ‘speci-
18 fied hospital’ means a hospital (as defined in section
19 1861(e)), a critical access hospital (as defined in
20 section 1861(mmm)(1)), or a rural emergency hos-
21 pital (as defined in section 1861(kkk)).

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

1 (2) RULE OF CONSTRUCTION.—Nothing in the
2 amendments made by this subsection may be con-
3 strued to impede, prohibit, or prevent the Secretary
4 of Health and Human Services from implementing,
5 executing, carrying out, or enforcing the require-
6 ments of section 2718(f) of the Public Health Serv-
7 ice Act.

8 (b) PHSA.—

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

13 “(f) TRANSPARENCY REQUIREMENT.—

14 “(1) IN GENERAL.—Beginning January 1,
15 2028, each hospital operating within the United
16 States (including a specified hospital (as defined in
17 section 1899D of the Social Security Act)) shall
18 comply with the price transparency requirement de-
19 scribed in paragraph (2).

20 “(2) REQUIREMENT DESCRIBED.—

21 “(A) IN GENERAL.—For purposes of para-
22 graph (1), the price transparency requirement
23 described in this paragraph is, with respect to
24 a hospital, that such hospital—

1 “(i) in accordance with a method and
2 format established by the Secretary under
3 subparagraph (C), compile and make pub-
4 lic (without subscription and free of
5 charge), and update not less frequently
6 than annually (or at such greater fre-
7 quency as may be specified by the Sec-
8 retary)—

9 “(I) all of the hospital’s standard
10 charges (including the information de-
11 scribed in subparagraph (B)) for each
12 item and service furnished by such
13 hospital;

14 “(II) information—

15 “(aa) on the hospital’s
16 prices (including the information
17 described in subparagraph (B))
18 for as many of the Centers for
19 Medicare & Medicaid Services-
20 specified shoppable services that
21 are furnished by the hospital,
22 and as many additional hospital-
23 selected shoppable services (or all
24 such additional services, if such
25 hospital furnishes fewer than 300

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

5 “(bb) that includes, with re-
6 spect to each Centers for Medi-
7 care & Medicaid Services-speci-
8 fied shoppable service that is not
9 furnished by the hospital, an in-
10 dication that such service is not
11 so furnished;

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

16 “(iii) in accordance with a method
17 and format established by the Secretary,
18 compile and make public (on an annual
19 basis)—

20 “(I) the legal business name, tax
21 status, business structure, type of or-
22 ganization, and business address of
23 each entity that, with respect to the
24 hospital—

1 “(aa) has directly or indi-
2 rectly an ownership interest of 5
3 percent or more in the hospital;

4 “(bb) has a partnership in-
5 terest of 5 percent or more in the
6 hospital;

7 “(cc) has managing control
8 of 5 percent or more of the hos-
9 pital;

10 “(dd) has a mortgage inter-
11 est of 5 percent or more in the
12 hospital; or

13 “(ee) has a security interest
14 of 5 percent or more in the hos-
15 pital; and

16 “(II) such information as the
17 Secretary may require with respect to
18 any changes in ownership, mergers,
19 acquisitions, or consolidations with re-
20 spect to the hospital in the preceding
21 1-year period; and

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

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

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

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

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

1 “(iii) For each such item or service
2 when provided in, as applicable, the inpa-
3 tient and outpatient department settings—

4 “(I) the discounted cash price, as
5 applicable, expressed as a dollar
6 amount; or

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

15 “(iv) With respect to prices made
16 public pursuant to subparagraph
17 (A)(i)(II), a link to a consumer-friendly
18 document that clearly explains the hos-
19 pital’s charity care policy that includes, if
20 applicable, any sliding scale payment struc-
21 ture employed for determining prices.

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

1 that apply to each such item or service
2 when provided in, as applicable, the inpa-
3 tient setting and outpatient department
4 setting.

5 “(vi) The de-identified maximum and
6 minimum negotiated charges, as applica-
7 ble, for each such item or service, not in-
8 cluding any such charge that is \$0.

9 “(vii) Any other additional informa-
10 tion the Secretary may require (in con-
11 sultation with stakeholders) for the pur-
12 pose of improving the accuracy of, or ena-
13 bling consumers to easily understand and
14 compare, standard charges and prices for
15 an item or service, except information that
16 is duplicative of any other reporting re-
17 quirement under this subsection.

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

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

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

5 “(I) standard charges pursuant
6 to subparagraph (A)(i)(I), ensure that
7 such charges are made available in a
8 machine-readable format (or a suc-
9 cessor technology specified by the Sec-
10 retary); and

11 “(II) prices pursuant to subpara-
12 graph (A)(i)(II), ensure that such
13 prices are made available in a con-
14 sumer-friendly format (as specified by
15 the Secretary);

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

20 “(iii) shall meet such standards as de-
21 termined appropriate by the Secretary in
22 order to ensure the accessibility and
23 usability of such charges and prices; and

1 “(iv) shall be updated as determined
2 appropriate by the Secretary, in consulta-
3 tion with stakeholders.

4 “(3) MONITORING COMPLIANCE.—The Sec-
5 retary shall establish processes to monitor and as-
6 sess hospitals’ compliance with this subsection. Such
7 processes shall include processes relating to the fol-
8 lowing:

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

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

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

19 “(4) ENFORCEMENT.—

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

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

1 mit to such hospital a notification of such
2 determination (which may include, as de-
3 termined appropriate by the Secretary, a
4 request for a corrective action plan (to be
5 submitted not later than 45 days after
6 such request is made) to comply with such
7 requirements); and

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

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

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

22 “(aa) submit to such hos-
23 pital a request for a corrective
24 action plan (to be submitted not
25 later than 45 days after such re-

1 quest is made) to comply with
2 such requirements; or

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

10 “(B) CIVIL MONETARY PENALTY.—

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

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

11 “(I) in the case of a hospital with
12 30 or fewer beds, \$342 per day (or, in
13 the case of such a hospital that has
14 been noncompliant with such require-
15 ments for a 1-year period or longer,
16 beginning with the first day following
17 such 1-year period, \$400 per day);

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

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

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

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

21 “(V) in the case of a hospital
22 with more than 500 beds, \$25 per bed
23 per day (or, in the case of such a hos-
24 pital that has been noncompliant with
25 such requirements for a 1-year period

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

4 “(ii) INCREASE AUTHORITY.—In ap-
5 plying this subparagraph with respect to
6 failures to comply occurring in 2029 or a
7 subsequent year, the Secretary may
8 through notice and comment rulemaking
9 increase—

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

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

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

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

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

1 provisions of this subsection for two
2 or more 6-month periods during any
3 3-year period, the Secretary may in-
4 crease any penalty otherwise applica-
5 ble under this subparagraph by the
6 amount specified in subclause (II)
7 with respect to such hospital and may
8 require such hospital to complete such
9 additional corrective actions plans as
10 the Secretary may specify.

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

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

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

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

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

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

12 “(I) HOSPITALS LOCATED IN
13 RURAL OR UNDERSERVED AREAS.—

14 “(aa) IN GENERAL.—Sub-
15 ject to item (bb), the Secretary
16 may waive any penalty, or reduce
17 any penalty by not more than 75
18 percent, otherwise applicable
19 under this subparagraph with re-
20 spect to a hospital located in a
21 rural or underserved area (as de-
22 fined by the Secretary) if the
23 Secretary determines that imposi-
24 tion of such penalty would result
25 in an immediate threat to access

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

3 “(bb) LIMITATION ON AP-
4 PPLICATION.—The Secretary may
5 not elect to waive a penalty
6 under item (aa) with respect to a
7 hospital more than once in a 6-
8 year period and may not elect to
9 reduce such a penalty with re-
10 spect to such a hospital more
11 than once in such a period. Noth-
12 ing in the preceding sentence
13 shall be construed as prohibiting
14 the Secretary from both waiving
15 and reducing a penalty with re-
16 spect to a hospital during a 6-
17 year period.

18 “(II) REDUCTION IF HEARING
19 WAIVED.—The Secretary may reduce
20 any penalty otherwise applicable
21 under this subparagraph (as reduced,
22 if applicable, under subclause (I)) by
23 not more than 35 percent if the hos-
24 pital that is the subject of such pen-
25 alty agrees to waive any right of such

1 hospital to a hearing before an admin-
2 istrative law judge with respect to the
3 imposition of such penalty.

4 “(v) **HARDSHIP EXEMPTION.**—Not-
5 withstanding any limit on the waiver or re-
6 duction of a penalty under clause (iv), the
7 Secretary may waive any penalty with re-
8 spect to a hospital on a case-by-case basis
9 if the Secretary determines that a cir-
10 cumstance exists interfering with such hos-
11 pital’s ability to comply with the provisions
12 of this subsection (such as a natural dis-
13 aster (as defined in section 602(a) of the
14 Robert T. Stafford Disaster Relief and
15 Emergency Assistance Act), a public health
16 emergency, or other similar or unexpected
17 catastrophe or similar situation).

18 “(vi) **PROVISION OF TECHNICAL AS-**
19 **SISTANCE.**—The Secretary shall, to the ex-
20 tent practicable, provide technical assist-
21 ance relating to compliance with the provi-
22 sions of this subsection to hospitals re-
23 questing such assistance.

24 “(vii) **APPLICATION OF CERTAIN PRO-**
25 **VISIONS.**—The provisions of section 1128A

1 of the Social Security Act (other than sub-
2 sections (a) and (b) of such section) shall
3 apply to a civil monetary penalty imposed
4 under this subparagraph in the same man-
5 ner as such provisions apply to a civil mon-
6 etary penalty imposed under subsection (a)
7 of such section.

8 “(viii) NONDUPLICATION OF CERTAIN
9 PENALTIES.—

10 “(I) IN GENERAL.—The Sec-
11 retary may not subject a hospital to a
12 civil monetary penalty under this sub-
13 paragraph with respect to noncompli-
14 ance with the provisions of this sub-
15 section for a period if the Secretary
16 has imposed a civil monetary penalty
17 on such hospital under section 1899D
18 of the Social Security Act for failure
19 to comply with the provisions of such
20 section for such period.

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

1 Act, the Secretary shall impose pen-
2 alties as prescribed in this subsection
3 in lieu of any penalties prescribed in
4 such section 1899D.

5 “(C) PUBLICATION OF HOSPITAL PRICE
6 TRANSPARENCY INFORMATION.—Beginning on
7 January 1, 2028, the Secretary shall make pub-
8 licly available on the website of the Centers for
9 Medicare & Medicaid Services information with
10 respect to compliance with the requirements of
11 this subsection and enforcement activities un-
12 dertaken by the Secretary under this sub-
13 section. Such information shall be updated in
14 real time (if practicable) and include—

15 “(i) the number of reviews of compli-
16 ance with this subsection undertaken by
17 the Secretary;

18 “(ii) the number of notifications de-
19 scribed in subparagraph (A)(i) sent by the
20 Secretary;

21 “(iii) the identity of each hospital that
22 was sent such a notification and a descrip-
23 tion of the nature of such hospital’s non-
24 compliance with this subsection;

1 “(iv) the amount of any civil monetary
2 penalty imposed on such hospital under
3 subparagraph (B);

4 “(v) whether such hospital subse-
5 quently came into compliance with this
6 subsection;

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

11 “(I) the name of any hospital
12 that received such a waiver or reduc-
13 tion;

14 “(II) the dollar amount of each
15 such penalty so waived or reduced;
16 and

17 “(III) the rationale for the grant-
18 ing of each such waiver or reduction,
19 but only to the extent that such ra-
20 tionale does not make public commer-
21 cially sensitive information; and

22 “(vii) any other information as deter-
23 mined by the Secretary.

24 “(5) ENSURING ACCESSIBILITY THROUGH IM-
25 PLEMENTATION.—In implementing this subsection,

1 the Secretary shall through rulemaking ensure that
2 a hospital making public charges and prices pursu-
3 ant to this subsection takes reasonable steps (as
4 specified by the Secretary) to ensure the accessibility
5 of such charges and information to individuals with
6 limited English proficiency. Such steps may include
7 the hospital's provision of interpretation services or
8 the hospital's provision of translations of charges
9 and information.

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

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

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

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

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

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

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

14 (A) in subsection (b)(3), by inserting
15 “(other than the provisions of subsection (f))”
16 after “this section”; and

17 (B) in subsection (e), by adding at the end
18 the following new sentence: “The preceding pro-
19 visions of this subsection shall not apply begin-
20 ning on January 1, 2028.”.

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

1 executing, carrying out, or enforcing the require-
2 ments of section 1899D of the Social Security Act.

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

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

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

9 (2) by inserting after subsection (a) the fol-
10 lowing new subsection:

11 “(b) CLINICAL DIAGNOSTIC LABORATORY PRICE
12 TRANSPARENCY REQUIREMENT.—

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

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

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

4 “(C) in accordance with a method and for-
5 mat established by the Secretary, compile and
6 make public (on an annual basis)—

7 “(i) the legal business name, tax sta-
8 tus, business structure, type of organiza-
9 tion, and business address of each entity
10 that, with respect to the laboratory—

11 “(I) has directly or indirectly an
12 ownership interest of 5 percent or
13 more in the laboratory;

14 “(II) has a partnership interest
15 of 5 percent or more in the labora-
16 tory;

17 “(III) has managing control of 5
18 percent or more of the laboratory;

19 “(IV) has a mortgage interest of
20 5 percent or more in the laboratory;
21 or

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

24 “(ii) such information as the Sec-
25 retary may require with respect to any

1 changes in ownership, mergers, acquisi-
2 tions, or consolidations with respect to the
3 laboratory in the preceding 1-year period;
4 and

5 “(D) submit to the Secretary on an annual
6 basis an attestation, signed by the chief execu-
7 tive officer, chief financial officer, or other com-
8 parable official (as specified by the Secretary)
9 of such laboratory, that all such information is
10 complete and accurate.

11 “(2) INFORMATION DESCRIBED.—For purposes
12 of paragraph (1), the information described in this
13 paragraph is, with respect to an applicable labora-
14 tory and a specified clinical diagnostic laboratory
15 test, the discounted cash price for such test (or, if
16 no such price exists, the gross charge for such test).

17 “(3) UNIFORM METHOD AND FORMAT.—Not
18 later than January 1, 2028, the Secretary shall es-
19 tablish a standard, uniform method and format for
20 applicable laboratories to use in compiling and mak-
21 ing public information pursuant to paragraph (1).
22 Such method and format—

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

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

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

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

10 “(4) INCLUSION OF ANCILLARY SERVICES.—
11 Any price or charge for a specified clinical diagnostic
12 laboratory test furnished by an applicable laboratory
13 made publicly available in accordance with para-
14 graph (1) shall include the price or charge (as appli-
15 cable) for any ancillary item or service (such as
16 specimen collection services) that would normally be
17 furnished by such laboratory as part of such test, as
18 specified by the Secretary.

19 “(5) ENFORCEMENT.—

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

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

1 “(ii) if such laboratory continues to
2 fail to comply with such paragraph after
3 the date that is 90 days after such notifi-
4 cation is sent, the Secretary may impose a
5 civil monetary penalty in an amount not to
6 exceed \$300 for each day (beginning with
7 the day on which the Secretary first deter-
8 mined that such laboratory was failing to
9 comply with such paragraph) during which
10 such failure is ongoing.

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

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

1 “(6) PROVISION OF TECHNICAL ASSISTANCE.—

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

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

7 “(A) APPLICABLE LABORATORY.—The
8 term ‘applicable laboratory’ has the meaning
9 given such term in section 414.502, of title 42,
10 Code of Federal Regulations (or a successor
11 regulation), except that such term does not in-
12 clude a laboratory with respect to which stand-
13 ard charges and prices for specified clinical di-
14 agnostic laboratory tests furnished by such lab-
15 oratory are made available by—

16 “(i) a specified hospital pursuant to
17 subsection (a);

18 “(ii) a hospital pursuant to section
19 2718(f) of the Public Health Service Act;
20 or

21 “(iii) an ambulatory surgical center
22 pursuant to subsection (d).

23 “(B) SPECIFIED CLINICAL DIAGNOSTIC
24 LABORATORY TEST.—The term ‘specified clin-
25 ical diagnostic laboratory test’ means a clinical

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

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

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

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

13 (2) by inserting after subsection (b) the fol-
14 lowing new subsection:

15 “(c) IMAGING SERVICES PRICE TRANSPARENCY.—

16 “(1) IN GENERAL.—Beginning January 1,
17 2028, each provider of services and supplier that re-
18 ceives payment under this title for furnishing a spec-
19 ified imaging service, other than such a provider or
20 supplier with respect to which standard charges and
21 prices for such services furnished by such provider
22 or supplier are made available by a specified hospital
23 pursuant to subsection (a), a hospital pursuant to
24 section 2718(f) of the Public Health Service Act, or

1 an ambulatory surgical center pursuant to sub-
2 section (d), shall—

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

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

12 “(C) in accordance with a method and for-
13 mat established by the Secretary, compile and
14 make public (on an annual basis)—

15 “(i) the legal business name, tax sta-
16 tus, business structure, type of organiza-
17 tion, and business address of each entity
18 that, with respect to the provider of serv-
19 ices or supplier—

20 “(I) has directly or indirectly an
21 ownership interest of 5 percent or
22 more in the provider of services or
23 supplier;

1 “(II) has a partnership interest
2 of 5 percent or more in the provider
3 of services or supplier;

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

7 “(IV) has a mortgage interest of
8 5 percent or more in the provider of
9 services or supplier; or

10 “(V) has a security interest of 5
11 percent or more in the provider of
12 services or supplier; and

13 “(ii) such information as the Sec-
14 retary may require with respect to any
15 changes in ownership, mergers, acquisi-
16 tions, or consolidations with respect to the
17 provider of services or supplier in the pre-
18 ceding 1-year period; and

19 “(D) submit to the Secretary on an annual
20 basis an attestation, signed by the chief execu-
21 tive officer, chief financial officer, or other com-
22 parable official (as specified by the Secretary)
23 of such provider or supplier, that all such infor-
24 mation is complete and accurate.

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

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

13 “(A) may be similar to any template made
14 available by the Centers for Medicare & Med-
15 icaid Services (as described in subsection
16 (a)(2)(C)(ii));

17 “(B) shall meet such standards as deter-
18 mined appropriate by the Secretary in order to
19 ensure the accessibility and usability of such in-
20 formation; and

21 “(C) shall be updated as determined ap-
22 propriate by the Secretary, in consultation with
23 stakeholders.

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

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

3 “(5) ENFORCEMENT.—

4 “(A) IN GENERAL.—In the case that the
5 Secretary determines that a provider of services
6 or supplier is not in compliance with paragraph
7 (1)—

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

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

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

1 such submission), the Secretary may im-
2 pose a civil monetary penalty in an amount
3 not to exceed \$300 for each day (beginning
4 with the day on which the Secretary first
5 determined that such provider or supplier
6 was failing to comply with such paragraph)
7 during which such failure to comply or fail-
8 ure to submit is ongoing.

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

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

23 “(D) AUTHORITY TO WAIVE OR REDUCE
24 PENALTY.—

1 “(i) IN GENERAL.—Subject to clause
2 (ii), the Secretary may waive or reduce any
3 penalty otherwise applicable with respect to
4 a provider of services or supplier under
5 this subparagraph if the Secretary deter-
6 mines that imposition of such penalty
7 would result in an immediate threat to ac-
8 cess to care for individuals in the service
9 area of such provider or supplier.

10 “(ii) LIMITATION.—The Secretary
11 may not elect to waive or reduce a penalty
12 under clause (i) with respect to a specific
13 provider of services or supplier more than
14 3 times in a 10 year period.

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

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

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

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

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

8 (2) by inserting after subsection (c) the fol-
9 lowing new subsection:

10 “(d) AMBULATORY SURGICAL CENTER PRICE
11 TRANSPARENCY.—

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

17 “(2) REQUIREMENT DESCRIBED.—

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

23 “(i) in accordance with a method and
24 format established by the Secretary under
25 subparagraph (C), compile and make pub-
26 lic (without subscription and free of

1 charge), and update not less frequently
2 than annually (or at such greater fre-
3 quency as may be specified by the Sec-
4 retary)—

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

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

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

7 “(ii) in accordance with a method and
8 format established by the Secretary, com-
9 pile and make public (on an annual
10 basis)—

11 “(I) the legal business name, tax
12 status, business structure, type of or-
13 ganization, and business address of
14 each entity that, with respect to the
15 ambulatory surgical center—

16 “(aa) has directly or indi-
17 rectly an ownership interest of 5
18 percent or more in the ambula-
19 tory surgical center;

20 “(bb) has a partnership in-
21 terest of 5 percent or more in the
22 ambulatory surgical center;

23 “(cc) has managing control
24 of 5 percent or more of the am-
25 bulatory surgical center;

1 “(dd) has a mortgage inter-
2 est of 5 percent or more in the
3 ambulatory surgical center; or

4 “(ee) has a security interest
5 of 5 percent or more in the am-
6 bulatory surgical center; and

7 “(II) such information as the
8 Secretary may require with respect to
9 any changes in ownership, mergers,
10 acquisitions, or consolidations with re-
11 spect to the ambulatory surgical cen-
12 ter in the preceding 1-year period;
13 and

14 “(iii) submit to the Secretary on an
15 annual basis an attestation, signed by the
16 chief executive officer, chief financial offi-
17 cer, or other comparable official (as speci-
18 fied by the Secretary) of such center, that
19 all information made public pursuant to
20 this subparagraph is complete and accu-
21 rate.

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

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

3 “(i) A plain language description (as
4 specified by the Secretary) of each item or
5 service, accompanied by, as applicable,
6 commonly recognized billing code sets, in-
7 cluding the Healthcare Common Procedure
8 Coding System code, the national drug
9 code, or other applicable identifier deter-
10 mined appropriate by the Secretary.

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

14 “(iii) For each such item or service—

15 “(I) the discounted cash price, as
16 applicable, expressed as a dollar
17 amount; or

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

1 “(iv) Any other additional information
2 the Secretary may require (in consultation
3 with stakeholders) for the purpose of im-
4 proving the accuracy of, or enabling con-
5 sumers to easily understand and compare,
6 standard charges and prices for an item or
7 service, except information that is duplica-
8 tive of any other reporting requirement
9 under this subsection.

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

19 “(i) shall, in the case of—

20 “(I) standard charges made pub-
21 lic by an ambulatory surgical center
22 under subparagraph (A)(i)(I), ensure
23 that such charges are made available
24 in a machine-readable format (or suc-
25 cessor technology); and

1 “(II) prices made public by an
2 ambulatory surgical center under sub-
3 paragraph (A)(i)(II), ensure that such
4 prices are made available in a con-
5 sumer-friendly format (as specified by
6 the Secretary);

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

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

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

18 “(3) MONITORING COMPLIANCE.—The Sec-
19 retary shall establish processes to monitor and as-
20 sess ambulatory surgical centers’ compliance with
21 this subsection. Such processes shall include proc-
22 esses relating to the following:

23 “(A) The evaluation and analysis of com-
24 plaints made by individuals or other entities re-

1 lating to such centers’ compliance with this sub-
2 section.

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

5 “(C) The obtaining of additional informa-
6 tion from such centers to determine such cen-
7 ters’ compliance with this subsection (as deter-
8 mined appropriate by the Secretary).

9 “(4) ENFORCEMENT.—

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

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

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

24 “(B) CIVIL MONETARY PENALTY.—

1 “(i) IN GENERAL.—In addition to any
2 other enforcement actions or penalties that
3 may apply under another provision of Fed-
4 eral law, an ambulatory surgical center
5 that has received a notification under sub-
6 paragraph (A)(i) and fails to comply with
7 the requirements of this subsection by the
8 date that is 90 days after such notification
9 (or, in the case of an ambulatory surgical
10 center that has submitted a corrective ac-
11 tion plan described in subparagraph (A)(ii)
12 in response to a request so described and
13 has failed to comply with such require-
14 ments by the date that is 90 days after
15 such submission) shall be subject to a civil
16 monetary penalty of an amount specified
17 by the Secretary for each day (beginning
18 with the day on which the Secretary first
19 determined that such center was not com-
20 plying with such requirements) during
21 which such failure is ongoing (not to ex-
22 ceed \$300 per day).

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

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

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

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

17 “(I) CENTERS LOCATED IN
18 RURAL OR UNDERSERVED AREAS.—

19 “(aa) IN GENERAL.—Sub-
20 ject to item (bb), the Secretary
21 may waive any penalty, or reduce
22 any penalty by not more than 75
23 percent, otherwise applicable
24 under this subparagraph with re-
25 spect to an ambulatory surgical

1 center located in a rural or un-
2 derserved area if the Secretary
3 certifies that imposition of such
4 penalty would result in an imme-
5 diate threat to access to care for
6 individuals in the service area of
7 such center.

8 “(bb) LIMITATION ON AP-
9 PPLICATION.—The Secretary may
10 not elect to waive a penalty
11 under item (aa) with respect to
12 an ambulatory surgical center
13 more than once in a 6-year pe-
14 riod and may not elect to reduce
15 such a penalty with respect to
16 such a center more than once in
17 such a period. Nothing in the
18 preceding sentence shall be con-
19 strued as prohibiting the Sec-
20 retary from both waiving and re-
21 ducing a penalty with respect to
22 an ambulatory surgical center
23 during a 6-year period.

24 “(II) REDUCTION IF HEARING
25 WAIVED.—The Secretary may reduce

1 any penalty otherwise applicable
2 under this subparagraph (as reduced,
3 if applicable, under subclause (I)) by
4 not more than 35 percent if the am-
5 bulatory surgical center that is the
6 subject of such penalty agrees to
7 waive any right of such center to a
8 hearing before an administrative law
9 judge with respect to the imposition of
10 such penalty.

11 “(5) PROVISION OF TECHNICAL ASSISTANCE.—
12 The Secretary shall, to the extent practicable, pro-
13 vide technical assistance relating to compliance with
14 the provisions of this subsection to ambulatory sur-
15 gical centers requesting such assistance.”.

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

17 (a) PRICE TRANSPARENCY REQUIREMENTS.—

18 (1) IRC.—

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

21 (i) in the header, by striking “**MAIN-**
22 **TENANCE OF PRICE COMPARISON**
23 **TOOL**” and inserting “**TRANSPARENCY**
24 **IN COVERAGE**”;

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

3 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
4 FOR PLAN YEARS BEFORE 2028.—

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

6 (iii) in subsection (a), as inserted by
7 clause (ii), by adding at the end the fol-
8 lowing new paragraph:

9 “(2) SUNSET.—Paragraph (1) shall not apply
10 with respect to plan years beginning on or after Jan-
11 uary 1, 2028.”; and

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

14 “(b) TRANSPARENCY.—

15 “(1) IN GENERAL.—For plan years beginning
16 on or after January 1, 2028, a group health plan
17 shall provide a participant or beneficiary, in a timely
18 manner upon request of the participant or bene-
19 ficiary, information on the amount of cost-sharing
20 (including deductibles, copayments, and coinsurance)
21 under the participant or beneficiary’s plan that the
22 participant or beneficiary would be responsible for
23 paying with respect to the furnishing of a specific
24 item or service by a provider. At a minimum, such
25 information shall include the information specified in

1 paragraph (2) and shall be made available to such
2 participant or beneficiary through a self-service tool
3 that meets the requirements of paragraph (3) or, at
4 the option of such participant or beneficiary,
5 through a paper disclosure or phone or other elec-
6 tronic disclosure (as selected by such participant or
7 beneficiary and provided at no cost to such partici-
8 pant or beneficiary) that meets such requirements as
9 the Secretary may specify.

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

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

19 “(B) If such provider is not a participating
20 provider with respect to such item or service,
21 the maximum allowed amount or other dollar
22 amount that such plan will recognize as pay-
23 ment for such item or service, along with a no-
24 tice that such participant or beneficiary may be
25 liable for additional charges.

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

10 “(D) The amount the participant or bene-
11 ficiary has already accumulated with respect to
12 any deductible or out of pocket maximum under
13 the plan (broken down, in the case separate
14 deductibles or maximums apply to a participant
15 and such participant’s beneficiaries enrolled in
16 the plan, by such separate deductibles or maxi-
17 mums, in addition to any cumulative deductible
18 or maximum).

19 “(E) In the case such plan imposes any
20 frequency or volume limitations with respect to
21 such item or service (excluding medical neces-
22 sity determinations), the amount that such par-
23 ticipant or beneficiary has accrued towards such
24 limitation with respect to such item or service.

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

5 “(G) Any financial incentives (such as any
6 credit, payment, or other benefit provided by
7 such plan) available to the participant or bene-
8 ficiary with respect to such item or service fur-
9 nished by such provider known at the time such
10 request is made.

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

14 “(i) a specification that such item or
15 service is such an applicable spread price
16 drug;

17 “(ii) the amount of the difference (if
18 any) between the specified payment
19 amount for such drug so dispensed by such
20 pharmacy and the specified reimbursement
21 amount for such drug so dispensed by such
22 pharmacy;

23 “(iii) a plain language statement spec-
24 ified by the Secretary that explains the
25 concept of spread pricing and how such

1 item's status as such an applicable spread
2 price drug may impact the amount such
3 plan pays for such drug and cost sharing
4 amounts for such drug described in sub-
5 paragraph (C); and

6 “(iv) a plain language statement spec-
7 ified by the Secretary informing the partic-
8 ipant or beneficiary of the participant's or
9 beneficiary's ability to obtain a summary
10 document relating to drug pricing informa-
11 tion described in section 9826(b)(2)(B)(ii).

12 “(I) Any other information determined ap-
13 propriate by the Secretary.

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

18 “(A) is based on an Internet website (or
19 successor technology specified by the Sec-
20 retary);

21 “(B) is made available in plain language at
22 no cost;

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

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

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

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

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

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

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

22 “(G) meets any other requirement deter-
23 mined appropriate by the Secretary, including
24 requirements to ensure the accessibility and

1 usability of information provided through such
2 tool.

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

8 “(c) RATE AND PAYMENT INFORMATION.—

9 “(1) IN GENERAL.—For plan years beginning
10 on or after January 1, 2028, each group health plan
11 (other than a grandfathered health plan (as defined
12 in section 1251(e) of the Patient Protection and Af-
13 fordable Care Act)) shall make available to the pub-
14 lic the rate and payment information described in
15 paragraph (2) in accordance with paragraph (3).

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

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

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

1 which such information is made public
2 with each provider that is a participating
3 provider with respect to such item or serv-
4 ice (other than, in the case that such plan
5 provides benefits for such item or service
6 only when furnished by a specific type of
7 provider, such a participating provider who
8 is not such type of provider (referred to in
9 this subparagraph as an ‘excluded pro-
10 vider’)); and

11 “(ii) with respect to each such pro-
12 vider (other than a provider that is an ex-
13 cluded provider with respect to such item
14 or service), an indication of whether, dur-
15 ing the 1-year period beginning 18 months
16 before the date such information is made
17 public, such provider submitted a claim for
18 such item or service to such plan for which
19 payment was made (in whole or in part)
20 under such plan.

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

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

1 day of the month in which such informa-
2 tion is made public with each provider that
3 is a participating provider with respect to
4 such drug;

5 “(ii) the average amount paid by such
6 plan (accounting for, in a manner deter-
7 mined appropriate by the Secretary, re-
8 bates, discounts, price concessions, and
9 any other remuneration specified by the
10 Secretary) for such drug dispensed or ad-
11 ministered during the 90-day period begin-
12 ning 180 days before such date of publica-
13 tion to each provider that was a partici-
14 pating provider with respect to such drug,
15 broken down by each such provider, unless
16 fewer than 20 claims for such drug were
17 submitted to such plan during such period;
18 and

19 “(iii) in the case such drug is an ap-
20 plicable spread price drug dispensed by a
21 pharmacy—

22 “(I) a specification that such
23 drug is such an applicable spread
24 price drug; and

1 “(II) for each pharmacy that has
2 a contractual relationship for dis-
3 pensing such drug under such plan, a
4 specification of the difference (if any)
5 between the specified payment amount
6 for such drug so dispensed by such
7 pharmacy and the specified reim-
8 bursement amount for such drug so
9 dispensed by such pharmacy.

10 “(C) With respect to each item or service
11 for which benefits are available under such
12 plan, the amount billed, and the amount al-
13 lowed by the plan, for each such item or service
14 furnished during the 6-month period beginning
15 9 months before the date such information is
16 made public (or such other period as may be
17 specified by the Secretary) by a provider that
18 was not a participating provider with respect to
19 such item or service, broken down by each such
20 provider, other than such an amount with re-
21 spect to an item or service furnished by a pro-
22 vider that, during such period, submitted fewer
23 than 11 claims for such item or service to such
24 plan.

25 “(3) MANNER OF PUBLICATION.—

1 “(A) IN GENERAL.—Rate and payment in-
2 formation required to be made available under
3 this subsection shall be so made available in
4 dollar amounts through separate machine-read-
5 able files (and any successor technology, as ap-
6 plicable, such as application programming inter-
7 face technology, determined appropriate by the
8 Secretary) corresponding to the information de-
9 scribed in each of subparagraphs (A) through
10 (C) of paragraph (2) that meet such require-
11 ments as specified by the Secretary (which may
12 be so specified through subregulatory guid-
13 ance). Such requirements shall ensure that such
14 files are limited to an appropriate size, do not
15 include disclosure of unnecessary duplicative in-
16 formation contained in other files made avail-
17 able under this subsection, are made available
18 in a widely available format through a publicly
19 available website that allows for information
20 contained in such files to be compared across
21 group health plans and group or individual
22 health insurance coverage, and are accessible to
23 individuals at no cost and without the need to
24 establish a user account or provide other cre-

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

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

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

15 “(5) SUMMARY.—For each plan year beginning
16 on or after January 1, 2028, each group health plan
17 shall make public a data file, in a manner that en-
18 sures that such file may be easily downloaded and
19 read by standard spreadsheet software and that
20 meets such requirements as established by the Sec-
21 retary, containing a summary of all rate and pay-
22 ment information made public by such plan with re-
23 spect to such plan during such plan year. Such file
24 shall include the following:

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

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

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

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

24 “(i) a description of the formulae,
25 pricing methodologies, or other information

1 used to calculate the payment rate for such
2 rate; and

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

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

11 “(d) OWNERSHIP INFORMATION.—

12 “(1) IN GENERAL.—For plan years beginning
13 on or after January 1, 2028, each group health plan
14 (other than a grandfathered health plan (as defined
15 in section 1251(e) of the Patient Protection and Af-
16 fordable Care Act)) shall make available to the pub-
17 lic (on an annual basis), in accordance with a meth-
18 od and format established by the Secretary, the own-
19 ership information described in paragraph (2).

20 “(2) OWNERSHIP INFORMATION DESCRIBED.—

21 For purposes of paragraph (1), the rate and pay-
22 ment information described in this paragraph is,
23 with respect to a group health plan—

24 “(A) the legal business name, tax status,
25 business structure, type of organization, and

1 business address of each entity that, with re-
2 spect to the group health plan—

3 “(i) has directly or indirectly an own-
4 ership interest of 5 percent or more in the
5 group health plan;

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

8 “(iii) has managing control of 5 per-
9 cent or more of the group health plan;

10 “(iv) has a mortgage interest of 5 per-
11 cent or more in the group health plan; or

12 “(v) has a security interest of 5 per-
13 cent or more in the group health plan; and

14 “(B) such information as the Secretary
15 may require with respect to any changes in
16 ownership, mergers, acquisitions, or consolida-
17 tions with respect to the group health plan in
18 the preceding 1-year period.

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

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

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

12 “(g) PBM DISCLOSURE OF APPLICABLE SPREAD
13 PRICE DRUGS.—An entity providing pharmacy benefit
14 management services on behalf of a group health plan
15 shall disclose to such plan, at such time and in such man-
16 ner as specified by the Secretary to ensure that informa-
17 tion provided under subsection (b) and rate and payment
18 information made public under subsection (c) is timely
19 and accurate—

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

23 “(2) with respect to each drug included on such
24 list and each pharmacy with a contractual relation-
25 ship for furnishing such drug under such plan, a

1 specification of the difference (if any) between the
2 specified payment amount for such drug so dis-
3 pensed by such pharmacy and the specified reim-
4 bursement amount for such drug so dispensed by
5 such pharmacy.

6 “(h) DEFINITIONS.—In this section:

7 “(1) APPLICABLE SPREAD PRICE DRUG.—The
8 term ‘applicable spread price drug’ means, with re-
9 spect to a group health plan, a drug for which bene-
10 fits are available under such plan and with respect
11 to which, at the time a disclosure described in sub-
12 section (g) is required to be made by an entity pro-
13 viding pharmacy benefit management services on be-
14 half of such plan—

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

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

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

1 plan and item or service, the contracted rate (re-
2 flected as a dollar amount) in effect between such
3 plan and such provider for such item or service, re-
4 gardless of whether such rate is calculated based on
5 a set amount, a fee schedule, or an amount derived
6 from another amount, or a formula, or other meth-
7 od.

8 “(3) PARTICIPATING PROVIDER.—The term
9 ‘participating provider’ means, with respect to an
10 item or service and a group health plan, a physician
11 or other health care provider (as defined in para-
12 graph (4)) who is acting within the scope of practice
13 of that provider’s license or certification under appli-
14 cable State law and who has a contractual relation-
15 ship with the plan for furnishing such item or serv-
16 ice under the plan.

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

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

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

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

1 (B) CLERICAL AMENDMENT.—The item re-
2 lating to section 9819 of the table of sections
3 for subchapter B of chapter 100 of the Internal
4 Revenue Code of 1986 is amended to read as
5 follows:

“Sec. 9819. Transparency in coverage.”.

6 (2) PHSA.—

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

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

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

16 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
17 FOR PLAN YEARS BEFORE 2028.—

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

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

22 “(2) SUNSET.—Paragraph (1) shall not apply
23 with respect to plan years beginning on or after Jan-
24 uary 1, 2028.”; and

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

3 “(b) TRANSPARENCY.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2028, a group health plan
6 and a health insurance issuer offering group or indi-
7 vidual health insurance coverage shall provide a par-
8 ticipant, beneficiary, or enrollee, in a timely manner
9 upon request of the participant, beneficiary, or en-
10 rollee, information on the amount of cost-sharing
11 (including deductibles, copayments, and coinsurance)
12 under the participant, beneficiary, or enrollee’s plan
13 or coverage that the participant, beneficiary, or en-
14 rollee would be responsible for paying with respect
15 to the furnishing of a specific item or service by a
16 provider. At a minimum, such information shall in-
17 clude the information specified in paragraph (2) and
18 shall be made available to such participant, bene-
19 ficiary, or enrollee through a self-service tool that
20 meets the requirements of paragraph (3) or, at the
21 option of such participant, beneficiary, or enrollee,
22 through a paper disclosure or phone or other elec-
23 tronic disclosure (as selected by such individual and
24 provided at no cost to such individual) that meets
25 such requirements as the Secretary may specify.

1 “(2) SPECIFIED INFORMATION.—For purposes
2 of paragraph (1), the information specified in this
3 paragraph is, with respect to an item or service for
4 which benefits are available under a group health
5 plan or group or individual health insurance cov-
6 erage furnished by a health care provider to an indi-
7 vidual enrolled under such plan or coverage, the fol-
8 lowing:

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

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

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

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

3 “(D) The amount the individual has al-
4 ready accumulated with respect to any deduct-
5 ible or out of pocket maximum under the plan
6 or coverage (broken down, in the case separate
7 deductibles or maximums apply to individuals
8 enrolled in the plan or coverage, by such sepa-
9 rate deductibles or maximums, in addition to
10 any cumulative deductible or maximum).

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

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

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

1 by such provider known at the time such re-
2 quest is made.

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

6 “(i) a specification that such item or
7 service is such an applicable spread price
8 drug;

9 “(ii) the amount of the difference (if
10 any) between the specified payment
11 amount for such drug so dispensed by such
12 pharmacy and the specified reimbursement
13 amount for such drug so dispensed by such
14 pharmacy;

15 “(iii) a plain language statement spec-
16 ified by the Secretary that explains the
17 concept of spread pricing and how such
18 item’s status as such an applicable spread
19 price drug may impact the amount such
20 plan or coverage pays for such drug and
21 cost sharing amounts for such drug de-
22 scribed in subparagraph (C); and

23 “(iv) except in the case of individual
24 health insurance coverage, a plain lan-
25 guage statement specified by the Secretary

1 informing the participant or beneficiary of
2 the participant's or beneficiary's ability to
3 obtain a summary document relating to
4 drug pricing information described in sec-
5 tion 2799A-11(b)(2)(B)(ii).

6 “(I) Any other information determined ap-
7 propriate by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

1 “(c) RATE AND PAYMENT INFORMATION.—

2 “(1) IN GENERAL.—For plan years beginning
3 on or after January 1, 2028, each group health plan
4 and health insurance issuer offering group or indi-
5 vidual health insurance coverage (other than a
6 grandfathered health plan (as defined in section
7 1251(e) of the Patient Protection and Affordable
8 Care Act)) shall make available to the public the
9 rate and payment information described in para-
10 graph (2) in accordance with paragraph (3).

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

17 “(A) With respect to each item or service
18 (other than a drug) for which benefits are avail-
19 able under such plan or coverage,—

20 “(i) the in-network rate (expressed as
21 a dollar amount) in effect as of the date on
22 which such information is made public
23 with each provider that is a participating
24 provider with respect to such item or serv-
25 ice (other than, in the case that such plan

1 or coverage provides benefits for such item
2 or service only when furnished by a specific
3 type of provider, such a participating pro-
4 vider who is not such type of provider (re-
5 ferred to in this subparagraph as an ‘ex-
6 cluded provider’)); and

7 “(ii) with respect to each such pro-
8 vider (other than a provider that is an ex-
9 cluded provider with respect to such item
10 or service), an indication of whether, dur-
11 ing the 1-year period beginning 18 months
12 before the date such information is made
13 public, such provider submitted a claim for
14 such item or service to such plan or cov-
15 erage for which payment was made (in
16 whole or in part) under such plan or cov-
17 erage.

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

21 “(i) the in-network rate (expressed as
22 a dollar amount) in effect as of the first
23 day of the month in which such informa-
24 tion is made public with each provider that

1 is a participating provider with respect to
2 such drug;

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

17 “(iii) in the case such drug is an ap-
18 plicable spread price drug dispensed by a
19 pharmacy—

20 “(I) a specification that such
21 drug is such an applicable spread
22 price drug; and

23 “(II) for each pharmacy that has
24 a contractual relationship for dis-
25 pensing such drug under such plan or

1 coverage, a specification of the dif-
2 ference (if any) between the specified
3 payment amount for such drug so dis-
4 pensed by such pharmacy and the
5 specified reimbursement amount for
6 such drug so dispensed by such phar-
7 macy.

8 “(C) With respect to each item or service
9 for which benefits are available under such plan
10 or coverage, the amount billed, and the amount
11 allowed by the plan, for each such item or serv-
12 ice furnished during the 6-month period begin-
13 ning 9 months before the date such information
14 is made public (or such other period as may be
15 specified by the Secretary) by a provider that
16 was not a participating provider with respect to
17 such item or service, broken down by each such
18 provider, other than such an amount with re-
19 spect to an item or service furnished by a pro-
20 vider that, during such period, submitted fewer
21 than 11 claims for such item or service to such
22 plan or coverage.

23 “(3) MANNER OF PUBLICATION.—

24 “(A) IN GENERAL.—Rate and payment in-
25 formation required to be made available under

1 this subsection shall be so made available in
2 dollar amounts through separate machine-read-
3 able files (and any successor technology, as ap-
4 plicable, such as application programming inter-
5 face technology, determined appropriate by the
6 Secretary) corresponding to the information de-
7 scribed in each of subparagraphs (A) through
8 (C) of paragraph (2) that meet such require-
9 ments as specified by the Secretary (which may
10 be so specified through subregulatory guid-
11 ance). Such requirements shall ensure that such
12 files are limited to an appropriate size, do not
13 include disclosure of unnecessary duplicative in-
14 formation contained in other files made avail-
15 able under this subsection, are made available
16 in a widely-available format through a publicly-
17 available website that allows for information
18 contained in such files to be compared across
19 group health plans and group or individual
20 health insurance coverage, and are accessible to
21 individuals at no cost and without the need to
22 establish a user account or provide other cre-
23 dentials or undertake other steps as may be
24 specified by the Secretary.

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

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

15 “(5) SUMMARY.—For each plan year beginning
16 on or after January 1, 2028, each group health plan
17 and health insurance issuer offering group or indi-
18 vidual health insurance coverage shall make public a
19 data file, in a manner that ensures that such file
20 may be easily downloaded and read by standard
21 spreadsheet software and that meets such require-
22 ments as established by the Secretary, containing a
23 summary of all rate and payment information made
24 public by such plan or issuer with respect to such

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

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

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

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

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

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

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

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

15 “(d) OWNERSHIP INFORMATION.—

16 “(1) IN GENERAL.—For plan years beginning
17 on or after January 1, 2028, each group health plan
18 and health insurance issuer offering group or indi-
19 vidual health insurance coverage (other than a
20 grandfathered health plan (as defined in section
21 1251(e) of the Patient Protection and Affordable
22 Care Act)) shall make available to the public (on an
23 annual basis), in accordance with a method and for-
24 mat established by the Secretary, the ownership in-
25 formation described in paragraph (2).

1 “(2) OWNERSHIP INFORMATION DESCRIBED.—

2 For purposes of paragraph (1), the rate and pay-
3 ment information described in this paragraph is,
4 with respect to a group health plan or a health in-
5 surance issuer offering group or individual health in-
6 surance coverage—

7 “(A) the legal business name, tax status,
8 business structure, type of organization, and
9 business address of each entity that, with re-
10 spect to the plan or issuer—

11 “(i) has directly or indirectly an own-
12 ership interest of 5 percent or more in the
13 plan or issuer;

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

16 “(iii) has managing control of 5 per-
17 cent or more of the plan or issuer;

18 “(iv) has a mortgage interest of 5 per-
19 cent or more in the plan or issuer; or

20 “(v) has a security interest of 5 per-
21 cent or more in the plan or issuer; and

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

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

3 “(e) ATTESTATION.—Each group health plan and
4 health insurance issuer offering group or individual health
5 insurance coverage shall annually submit to the Secretary
6 an attestation, signed by the chief executive officer, chief
7 financial officer, or other comparable official (as specified
8 by the Secretary) of such plan or issuer, of such plan’s
9 or coverage’s compliance with the provisions of this sec-
10 tion. Such attestation shall include a link to the website
11 (or other successor technology) where rate and payment
12 information required to be made public under subsection
13 (c) may be accessed.

14 “(f) ACCESSIBILITY.—A group health plan and a
15 health insurance issuer offering group or individual health
16 insurance coverage shall take reasonable steps (as speci-
17 fied by the Secretary) to ensure that information provided
18 in response to a request described in subsection (b), and
19 rate and payment information made public under sub-
20 section (c), is provided in plain, easily understandable lan-
21 guage and that interpretation, translations, and assistive
22 services are provided to those with limited English pro-
23 ficiency and those with disabilities.

24 “(g) PBM DISCLOSURE OF APPLICABLE SPREAD
25 PRICE DRUGS.—

1 “(1) IN GENERAL.—An entity providing phar-
2 macy benefit management services on behalf of a
3 group health plan or health insurance issuer offering
4 group or individual health insurance coverage shall
5 disclose to such plan or coverage, at such time and
6 in such manner as specified by the Secretary to en-
7 sure that information provided under subsection (b)
8 and rate and payment information made public
9 under subsection (c) is timely and accurate—

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

14 “(B) with respect to each drug included on
15 such list and each pharmacy with a contractual
16 relationship for furnishing such drug under
17 such plan or coverage, a specification of the dif-
18 ference (if any) between the specified payment
19 amount for such drug so dispensed by such
20 pharmacy and the specified reimbursement
21 amount for such drug so dispensed by such
22 pharmacy.

23 “(2) ENFORCEMENT.—

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

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

9 “(B) FALSE INFORMATION.— An entity
10 providing pharmacy benefit management serv-
11 ices on behalf of a specified group health plan
12 or health insurance issuer offering specified
13 group or individual health insurance coverage
14 that knowingly provides false information under
15 this subsection with respect to such plan or cov-
16 erage shall be subject to a civil monetary pen-
17 alty in an amount not to exceed \$100,000 for
18 each item of false information. Such civil mone-
19 tary penalty shall be in addition to other pen-
20 alties as may be prescribed by law.

21 “(C) PROCEDURE.—The provisions of sec-
22 tion 1128A of the Social Security Act, other
23 than subsections (a) and (b) and the first sen-
24 tence of subsection (c)(1) of such section shall
25 apply to civil monetary penalties under this sub-

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

4 “(D) DEFINITIONS.—In this paragraph,
5 the terms ‘specified group health plan’ and
6 ‘specified group or individual health insurance
7 coverage’ mean a group health plan or group or
8 individual health insurance coverage (as appli-
9 cable) to which the requirements of subparts I
10 and II of part A and this part apply in accord-
11 ance with section 2722.

12 “(h) DEFINITIONS.—In this section:

13 “(1) APPLICABLE SPREAD PRICE DRUG.—The
14 term ‘applicable spread price drug’ means, with re-
15 spect to a group health plan or group or individual
16 health insurance coverage, a drug for which benefits
17 are available under such plan or coverage and with
18 respect to which, at the time a disclosure described
19 in subsection (g) is required to be made by an entity
20 providing pharmacy benefit management services on
21 behalf of such plan or coverage—

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

1 “(B) the specified payment amount for
2 such drug so dispensed is less than the specified
3 reimbursement amount for such drug so dis-
4 pensed.

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

17 “(3) PARTICIPATING PROVIDER.—The term
18 ‘participating provider’ means, with respect to an
19 item or service and a group health plan or health in-
20 surance issuer offering group or individual health in-
21 surance coverage, a physician or other health care
22 provider (as defined in paragraph (4)) who is acting
23 within the scope of practice of that provider’s license
24 or certification under applicable State law and who
25 has a contractual relationship with the plan or

1 issuer, respectively, for furnishing such item or serv-
2 ice under the plan or coverage, respectively.

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

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

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

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

16 (B) CONFORMING AMENDMENTS.—Section
17 2723 of the Public Health Service Act (42
18 U.S.C. 300gg–22) is amended by striking
19 “(other than section 2799A–11)” each place it
20 appears and inserting “(other than sections
21 2799A–4(f) and 2799A–11)” in each such
22 place.

23 (3) ERISA.—

1 (A) IN GENERAL.—Section 719 of the Em-
2 ployee Retirement Income Security Act of 1974
3 (29 U.S.C. 1185h) is amended—

4 (i) in the header, by striking “**MAIN-**
5 **TENANCE OF PRICE COMPARISON**
6 **TOOL**” and inserting “**TRANSPARENCY**
7 **IN COVERAGE**”;

8 (ii) by striking “A group health plan”
9 and inserting the following:
10 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
11 FOR PLAN YEARS BEFORE 2028.—

12 “(1) IN GENERAL.—A group health plan”;
13 (iii) in subsection (a), as inserted by
14 clause (ii), by adding at the end the fol-
15 lowing new paragraph:

16 “(2) SUNSET.—Paragraph (1) shall not apply
17 with respect to plan years beginning on or after Jan-
18 uary 1, 2028.”; and

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

21 “(b) TRANSPARENCY.—

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

1 beneficiary, in a timely manner upon request of the
2 participant or beneficiary, information on the
3 amount of cost-sharing (including deductibles, co-
4 payments, and coinsurance) under the participant or
5 beneficiary's plan or coverage that the participant or
6 beneficiary would be responsible for paying with re-
7 spect to the furnishing of a specific item or service
8 by a provider. At a minimum, such information shall
9 include the information specified in paragraph (2)
10 and shall be made available to such participant or
11 beneficiary through a self-service tool that meets the
12 requirements of paragraph (3) or, at the option of
13 such participant or beneficiary, through a paper dis-
14 closure or phone or other electronic disclosure (as
15 selected by such participant or beneficiary and pro-
16 vided at no cost to such participant or beneficiary)
17 that meets such requirements as the Secretary may
18 specify.

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

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

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

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

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

1 enrolled in the plan or coverage, by such sepa-
2 rate deductibles or maximums, in addition to
3 any cumulative deductible or maximum).

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

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

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

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

23 “(i) a specification that such item or
24 service is such an applicable spread price
25 drug;

1 “(ii) the amount of the difference (if
2 any) between the specified payment
3 amount for such drug so dispensed by such
4 pharmacy and the specified reimbursement
5 amount for such drug so dispensed by such
6 pharmacy;

7 “(iii) a plain language statement spec-
8 ified by the Secretary that explains the
9 concept of spread pricing and how such
10 item’s status as such an applicable spread
11 price drug may impact the amount such
12 plan or coverage pays for such drug and
13 cost sharing amounts for such drug de-
14 scribed in subparagraph (C); and

15 “(iv) a plain language statement spec-
16 ified by the Secretary informing the partic-
17 ipant or beneficiary of the participant’s or
18 beneficiary’s ability to obtain a summary
19 document relating to drug pricing informa-
20 tion described in section 726(b)(2)(B)(ii).

21 “(I) Any other information determined ap-
22 propriate by the Secretary.

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

1 group health insurance coverage meets the require-
2 ments of this paragraph if such tool—

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

6 “(B) is made available in plain language at
7 no cost;

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

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

13 “(E) allows such a request to be made
14 with respect to an item or service furnished
15 by—

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

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

22 “(iii) nonspecific providers located in
23 a relevant geographic region that are not
24 participating providers with respect to such
25 item or service;;

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

6 “(G) meets any other requirement deter-
7 mined appropriate by the Secretary, including
8 requirements to ensure the accessibility and
9 usability of information provided through such
10 tool.

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

16 “(c) RATE AND PAYMENT INFORMATION.—

17 “(1) IN GENERAL.—For plan years beginning
18 on or after January 1, 2028, each group health plan
19 and health insurance issuer offering group health in-
20 surance coverage (other than a grandfathered health
21 plan (as defined in section 1251(e) of the Patient
22 Protection and Affordable Care Act)) shall make
23 available to the public the rate and payment infor-
24 mation described in paragraph (2) in accordance
25 with paragraph (3).

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

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

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

21 “(ii) with respect to each such pro-
22 vider (other than a provider that is an ex-
23 cluded provider with respect to such item
24 or service), an indication of whether, dur-
25 ing the 1-year period beginning 18 months

1 before the date such information is made
2 public, such provider submitted a claim for
3 such item or service to such plan or cov-
4 erage for which payment was made (in
5 whole or in part) under such plan or cov-
6 erage.

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

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

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

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

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

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

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

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

1 ning 9 months before the date such information
2 is made public (or such other period as may be
3 specified by the Secretary) by a provider that
4 was not a participating provider with respect to
5 such item or service, broken down by each such
6 provider, other than such an amount with re-
7 spect to an item or service furnished by a pro-
8 vider that, during such period, submitted fewer
9 than 11 claims for such item or service to such
10 plan or coverage.

11 “(3) MANNER OF PUBLICATION.—

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

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

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

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

1 “(5) SUMMARY.—For each plan year beginning
2 on or after January 1, 2028, each group health plan
3 and health insurance issuer offering group health in-
4 surance coverage shall make public a data file, in a
5 manner that ensures that such file may be easily
6 downloaded and read by standard spreadsheet soft-
7 ware and that meets such requirements as estab-
8 lished by the Secretary, containing a summary of all
9 rate and payment information made public by such
10 plan or issuer with respect to such plan or coverage
11 during such plan year. Such file shall include the fol-
12 lowing:

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

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

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

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

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

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

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

25 “(d) OWNERSHIP INFORMATION.—

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

11 “(2) OWNERSHIP INFORMATION DESCRIBED.—
12 For purposes of paragraph (1), the rate and pay-
13 ment information described in this paragraph is,
14 with respect to a group health plan or a health in-
15 surance issuer offering group health insurance cov-
16 erage—

17 “(A) the legal business name, tax status,
18 business structure, type of organization, and
19 business address of each entity that, with re-
20 spect to the plan or issuer—

21 “(i) has directly or indirectly an own-
22 ership interest of 5 percent or more in the
23 plan or issuer;

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

1 “(iii) has managing control of 5 per-
2 cent or more of the plan or issuer;

3 “(iv) has a mortgage interest of 5 per-
4 cent or more in the plan or issuer; or

5 “(v) has a security interest of 5 per-
6 cent or more in the plan or issuer; and

7 “(B) such information as the Secretary
8 may require with respect to any changes in
9 ownership, mergers, acquisitions, or consolida-
10 tions with respect to the plan or issuer in the
11 preceding 1-year period.

12 “(e) ATTESTATION.—Each group health plan and
13 health insurance issuer offering group health insurance
14 coverage shall annually submit to the Secretary an attesta-
15 tion, signed by the chief executive officer, chief financial
16 officer, or other comparable official (as specified by the
17 Secretary) of such plan or issuer, of such plan’s or cov-
18 erage’s compliance with the provisions of this section.
19 Such attestation shall include a link to the website (or
20 other successor technology) where rate and payment infor-
21 mation required to be made public under subsection (c)
22 may be accessed.

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

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

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

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

19 “(2) with respect to each drug included on such
20 list and each pharmacy with a contractual relation-
21 ship for furnishing such drug under such plan or
22 coverage, a specification of the difference (if any) be-
23 tween the specified payment amount for such drug
24 so dispensed by such pharmacy and the specified re-

1 imbursement amount for such drug so dispensed by
2 such pharmacy.

3 “(h) DEFINITIONS.—In this section:

4 “(1) APPLICABLE SPREAD PRICE DRUG.—The
5 term ‘applicable spread price drug’ means, with re-
6 spect to a group health plan or group health insur-
7 ance coverage, a drug for which benefits are avail-
8 able under such plan or coverage and with respect
9 to which, at the time a disclosure described in sub-
10 section (g) is required to be made by an entity pro-
11 viding pharmacy benefit management services on be-
12 half of such plan or coverage—

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

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

20 “(2) IN-NETWORK RATE.—The term ‘in-net-
21 work rate’ means, with respect to a group health
22 plan or group health insurance coverage and an item
23 or service furnished by a provider that is a partici-
24 pating provider with respect to such plan or cov-
25 erage and item or service, the contracted rate (re-

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

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

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

20 “(5) SPECIFIED PAYMENT AMOUNT.—The term
21 ‘specified payment amount’ means, with respect to a
22 drug to be dispensed by a pharmacy to a participant
23 or beneficiary of a group health plan or group health
24 insurance coverage where such pharmacy has in ef-
25 fect a contract with an entity providing pharmacy

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

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

1 compensation structure specified by the Secretary),
2 taking into account any cost sharing requirement
3 applicable to such drug and participant or bene-
4 ficiary.”.

5 (B) CLERICAL AMENDMENT.—The table of
6 contents in section 1 of the Employee Retire-
7 ment Income Security Act of 1974 is amended
8 by striking the item relating to section 719 and
9 inserting the following new item:

“Sec. 719. Transparency in coverage.”.

10 (b) APPLICATION PROGRAMMING INTERFACE RE-
11 PORT.—Not later than January 1, 2028, and annually
12 thereafter, the Secretary of Health and Human Services
13 shall, in consultation with the Office of the National Coor-
14 dinator for Health Information Technology, Department
15 of Labor, the Department of the Treasury, and stake-
16 holders, submit to the House Committees on Education
17 and the Workforce, Energy and Commerce, and Ways and
18 Means, and the Senate Committees on Finance and
19 Health, Education, Labor, and Pensions a report on the
20 use of standards-based application programming inter-
21 faces (in this subsection referred to as “APIs”) to facili-
22 tate access to health care price transparency information
23 and the interoperability of other medical information.
24 Such report shall include an evaluation of the capacity of
25 the Department of Health and Human Services, the De-

1 partment of Labor, and the Department of the Treasury
2 to regulate and implement standards related to APIs and
3 recommendations for improving such capacity. Such re-
4 port shall include the following:

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

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

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

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

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

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

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

11 (7) An analysis of the cost of API standards
12 implementation on issuers, employers, and other pri-
13 vate-sector entities.

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

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

21 (c) PROVIDER TOOL REPORT.—

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

1 icaid Services, shall, in consultation with stake-
2 holders, conduct a study and submit to the House
3 Committees on Education and the Workforce, En-
4 ergy and Commerce, and Ways and Means, and the
5 Senate Committees on Finance and Health, Edu-
6 cation, Labor, and Pensions a report on the useful-
7 ness and feasibility of the establishment of a pro-
8 vider tool by a group health plan, or a health insur-
9 ance issuer offering group or individual health insur-
10 ance coverage, in facilitating the provision of infor-
11 mation made available pursuant to the amendments
12 made by subsection (a). Such report shall include
13 the following:

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

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

1 vider under other Federal requirements in place
2 or under consideration.

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

8 (D) A description of the usability and ex-
9 pected utilization of such tool among providers,
10 including among different provider types.

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

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

- 15 (i) patients' out-of-pocket spending;
- 16 (ii) plan design, including impacts on
- 17 cost-sharing requirements;
- 18 (iii) care coordination and quality;
- 19 (iv) plan premiums;
- 20 (v) overall health care spending and
- 21 utilization; and
- 22 (vi) health care access in rural areas.

23 (G) An analysis of the feasibility of a pro-
24 vider tool to include additional functionality to
25 facilitate and improve the administration of the

1 requirements on providers to submit notifica-
2 tions to such plan or coverage under section
3 2799B–6 of the Public Health Service Act and
4 the requirements on such plan or coverage to
5 provide an advanced explanation of benefits to
6 individuals under section 2799A–1(f) of such
7 Act.

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

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

14 (J) An analysis of the burden and cost of
15 the creation of a provider tool by plans and cov-
16 erage on providers, issuers, employers, and
17 other private-sector entities.

18 (K) An analysis of the ability of state reg-
19 ulators to enforce provider tool standards and
20 the costs to the Department and states to regu-
21 late and enforce provider tool standards.

22 (2) DEFINITION.—The term “provider tool”
23 means a tool designed to facilitate the provision of
24 information made available pursuant to the amend-
25 ments made by subsection (a) and established by a

1 group health plan or a health insurance issuer offer-
2 ing group or individual health insurance coverage
3 that allows providers to access the information such
4 plan or coverage must provide through the self-serv-
5 ice tool described in such amendments to an indi-
6 vidual with whom the provider is actively treating at
7 the time of such request, upon the request of the
8 provider, and with the consent of such individual.

9 (d) REPORTS.—

10 (1) COMPLIANCE.—Not later than January 1,
11 2029, the Comptroller General of the United States
12 shall submit to Congress a report containing—

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

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

18 (C) recommendations relating to improving
19 such enforcement; and

20 (D) recommendations relating to improving
21 public disclosure, and public awareness, of in-
22 formation required to be made available by
23 group health plans and health insurance issuers
24 pursuant to such amendments.

1 (2) PRICES.—Not later than January 1, 2029,
2 and biennially thereafter, the Secretaries of Health
3 and Human Services, Labor, and the Treasury shall
4 jointly submit to Congress a report containing an as-
5 sessment of differences in negotiated prices (and any
6 trends in such prices) in the private market be-
7 tween—

8 (A) rural and urban areas;

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

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

14 (D) nonprofit and for-profit hospitals;

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

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

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

1 made by subsection (a). Such report shall include rec-
2 ommendations for legislative and regulatory actions to
3 identify appropriate metrics for assessing and comparing
4 quality of care.

5 (f) CONTINUED APPLICABILITY OF RULES FOR PRE-
6 VIOUS YEARS.—Nothing in the amendments made by sub-
7 section (a) may be construed as affecting the applicability
8 of the rule entitled “Transparency in Coverage” published
9 by the Department of the Treasury, the Department of
10 Labor, and the Department of Health and Human Serv-
11 ices on November 12, 2020 (85 Fed. Reg. 72158), for any
12 plan year beginning before January 1, 2028.

13 **SEC. 106. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
14 **VIDERS.**

15 (a) ERISA AMENDMENTS.—

16 (1) IN GENERAL.—Subpart B of part 7 of sub-
17 title B of the Employee Retirement Income Security
18 Act of 1974 (29 U.S.C. 1021 et seq.), as amended
19 by section 6701(b) of the Consolidated Appropria-
20 tions Act, 2026, is amended by adding at the end
21 the following:

22 **“SEC. 727. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
23 **VIDERS.**

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

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

19 “(b) REQUIRED DISCLOSURES.—

20 “(1) CONTENTS AND FREQUENCY.—With re-
21 spect to plan years beginning on or after the date
22 that is 2 years after the date of enactment of this
23 section, not less frequently than once every 6
24 months, a health plan service provider shall provide
25 to the group health plan or health insurance issuer

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

3 “(A) The information described in section
4 724(a)(1)(B).

5 “(B) Any contractual and subcontractual
6 calculation methodologies, pricing or fee sched-
7 ules, or other formulae used to determine reim-
8 bursement amounts to providers and sub-
9 contractors, including methodologies, schedules,
10 fee structures, and any applied adjustments or
11 modifiers, with such information provided in a
12 manner sufficiently detailed to enable the group
13 health plan or health insurance issuer to accu-
14 rately assess, verify, and ensure compliance
15 with the terms of any contractual and sub-
16 contractual agreement governing the reimburse-
17 ment amounts.

18 “(C) The total amount received or ex-
19 pected to be received by the health plan service
20 provider or its subcontractors in provider or
21 supplier rebates, fees, alternative discounts, and
22 all other remuneration including amounts held
23 in escrow or variance accounts that has been
24 paid or is to be paid for claims incurred and

1 administrative services including data sales or
2 network payments.

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

8 “(E) All payment data and reconciliation
9 information related to alternative compensation
10 arrangements including accountable care orga-
11 nizations, value-based programs, shared savings
12 programs, incentive compensation, bundled pay-
13 ments, capitation arrangements, performance
14 payments, and any other reimbursement or pay-
15 ment models, where the group health plan or
16 health insurance issuer paid fees, incurred obli-
17 gations, or made payments in connection with
18 the group health plan related to such arrange-
19 ments.

20 “(2) MANNER OF PROVIDING INFORMATION OR
21 DATA.—

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

1 section 13402(a) of the Health Information
2 Technology for Economic and Clinical Health
3 Act (42 U.S.C. 17932(a)) and consistent with
4 the privacy regulations promulgated under the
5 Health Insurance Portability and Accountability
6 Act of 1996 in part 160 and subparts A and E
7 of part 164 of title 45, Code of Federal Regula-
8 tions (or successor regulations) (referred to in
9 this paragraph as the ‘HIPAA privacy regula-
10 tions’) and shall restrict the use and disclosure
11 of such information according to such privacy
12 regulations and such HIPAA privacy regula-
13 tions.

14 “(B) ADDITIONAL REQUIREMENTS.—

15 “(i) IN GENERAL.—A health plan
16 service provider that submits information
17 or data under this subsection shall ensure
18 that such information or data contains
19 only summary health information, as de-
20 fined in section 164.504(a) of title 45,
21 Code of Federal Regulations (or successor
22 regulations).

23 “(ii) RESTRICTIONS.—In carrying out
24 this subsection, a health plan service pro-
25 vider shall comply with section 164.504(f)

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

3 “(C) RULE OF CONSTRUCTION.—

4 “(i) IN GENERAL.—Nothing in this
5 subsection shall be construed to modify the
6 requirements for the creation, receipt,
7 maintenance, or transmission of protected
8 health information under the HIPAA pri-
9 vacy regulations.

10 “(ii) CIVIL RIGHTS LAWS.—Nothing
11 in this subsection shall be construed to af-
12 fect the application of any Federal or State
13 privacy or civil rights law, including the
14 HIPAA privacy regulations, the Genetic
15 Information Nondiscrimination Act of
16 2008 (Public Law 110–233) (including the
17 amendments made by such Act), the Amer-
18 icans with Disabilities Act of 1990 (42
19 U.S.C. 12101 et seq.), section 504 of the
20 Rehabilitation Act of 1973 (29 U.S.C.
21 794), section 1557 of the Patient Protec-
22 tion and Affordable Care Act (42 U.S.C.
23 18116), title VI of the Civil Rights Act of
24 1964 (42 U.S.C. 2000d), and title VII of

1 the Civil Rights Act of 1964 (42 U.S.C.
2 2000e).

3 “(D) WRITTEN NOTICE.—Each plan year,
4 a health plan service provider shall provide to
5 each participant or beneficiary written notice
6 informing the participant or beneficiary of the
7 requirement for health plan service providers to
8 submit information or data under paragraph
9 (1), as applicable, which may include incor-
10 porating such notification in plan documents
11 provided to the participant or beneficiary, or
12 providing individual notification.

13 “(E) LIMITATION TO BUSINESS ASSOCI-
14 ATES.—A health plan service provider receiving
15 data or information under paragraph (1) may
16 disclose such information only to the entity
17 from which the information or data was re-
18 ceived or to that entity’s business associates as
19 defined in section 160.103 of title 45, Code of
20 Federal Regulations (or successor regulations)
21 or as permitted by the HIPAA privacy regula-
22 tions.

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

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

8 “(G) LIMITATION.—This paragraph shall
9 not be construed to abridge or limit the disclo-
10 sure requirements under this subsection or to
11 impose additional privacy or security require-
12 ments on health plan service providers or plan
13 sponsors.

14 “(3) DISCLOSURE AND REDISCLOSURE.—

15 “(A) IN GENERAL.—A group health plan
16 receiving information under paragraph (1) may
17 disclose such information only—

18 “(i) to the entity from which the in-
19 formation was received or to that entity’s
20 business associates or to the group health
21 plan’s business associates as defined in
22 section 160.103 of title 45, Code of Fed-
23 eral Regulations (or successor regulations);
24 or

1 “(ii) as permitted by the HIPAA Pri-
2 vacy Rule (45 C.F.R. parts 160 and 164
3 (subparts A and E)).

4 “(B) AVAILABILITY OF INFORMATION.—To
5 the extent the information required by this sub-
6 section is made available to the health insur-
7 ance issuer offering group health insurance cov-
8 erage, the health insurance issuer shall make
9 such information available, at the same time, in
10 the same format, and at no cost, to the group
11 health plan.

12 “(C) FAILURE TO PROVIDE INFORMA-
13 TION.—The obligation to provide information
14 pursuant to this subsection shall exist notwith-
15 standing the presence of any formal data-shar-
16 ing agreement between the parties. Failure to
17 provide the required information as specified
18 shall constitute a violation of this Act and the
19 Secretary shall initiate enforcement action
20 under section 502 within 90 days of becoming
21 aware of a violation of this section, except that
22 nothing in this section shall be construed to
23 limit the Secretary’s existing authority under
24 the Act.

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

4 “(A) All claims from a healthcare provider
5 shall be made to the group health plan in ac-
6 cordance with transactions standards adopted
7 under HIPAA, as follows:

8 “(i) Institutional, professional, and
9 dental claims and adjustments to these
10 claims shall be in ASC X12N 837 format,
11 as transmitted by the provider, or, in the
12 case of paper claims, converted to the ASC
13 X12N 837 electronic format (or successor
14 formats).

15 “(ii) Prescription drug claims shall be
16 in the National Council for Prescription
17 Drug Programs (NCPDP) format, as
18 transmitted by the provider, or in the case
19 of paper claims, converted to the NCPDP
20 electronic format.

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

23 “(B) All claim payment (or EFT, elec-
24 tronic funds transfer) and electronic remittance
25 advice (ERA) information sent by a health plan

1 service provider shall be provided to the group
2 health plan or health insurance issuer in the
3 ASC X12N 835 format in accordance with
4 transaction standards adopted under HIPAA,
5 unmodified from the form in which it was
6 transmitted to the healthcare provider. Such in-
7 formation shall be provided at no cost to the
8 group health plan or health insurance issuer.

9 “(C) The Secretary may modify the stand-
10 ards set forth in this paragraph as necessary to
11 align with any changes adopted by the Sec-
12 retary of Health and Human Services pursuant
13 to the authority provided under section 1173 of
14 the Social Security Act (42 U.S.C. 1320d–2).

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

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

3 “(d) PENALTIES FOR NON-COMPLIANCE.—Any fail-
4 ure by a health plan service provider to comply with the
5 requirements of this section shall result in the imposition
6 of a civil penalty of \$100,000 for each day the violation
7 continues, in addition to any other penalties prescribed by
8 law.

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

15 (2) PENALTY.—

16 (A) IN GENERAL.—Section 502(c) of the
17 Employee Retirement Income Security Act of
18 1974 (29 U.S.C. 1132(c)) is amended by add-
19 ing at the end the following new paragraph:

20 “(14) The Secretary may assess a civil penalty
21 against any person of \$100,000 per day for each vio-
22 lation by any person of section 727.”.

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

1 1132(a)) is amended by striking “or (9)” and
2 inserting it with the phrase “(9), (13), or
3 (14)”.

4 (b) PHSA AMENDMENTS.—

5 (1) IN GENERAL.—Part D of title XXVII of the
6 Public Health Service Act (42 U.S.C. 300gg–111 et
7 seq.), as amended by section 6701(a) of the Consoli-
8 dated Appropriations Act, 2026, is amended by add-
9 ing at the end the following:

10 **“SEC. 2799A–12. OVERSIGHT OF ADMINISTRATIVE SERVICE**
11 **PROVIDERS.**

12 “(a) IN GENERAL.—For plan years beginning on
13 January 1 of the year that begins on or after the date
14 that is 1 year after the date of enactment of this section,
15 no agreement between a group health plan that is a self-
16 funded, non-Federal governmental plan, as defined in sec-
17 tion 2791(d)(8)(C) (42 U.S.C. 300gg–91(d)(8)(C)) or
18 health insurance issuer offering individual or group health
19 coverage, a health insurance issuer that is operating as
20 a third party administrator, and a health care provider,
21 network or association of providers, third-party adminis-
22 trator, service provider offering access to a network of pro-
23 viders, pharmacy benefit managers, or any other third
24 party (each referred to in this section as a ‘health plan
25 service provider’) is permissible if such agreement limits

1 (or delays beyond the applicable reporting period described
2 in subsection (b)(1)) the disclosure of information to such
3 group health plans and health insurance issuers in a man-
4 ner that prevents any health plan service provider from
5 providing the information described in subsection (b)).

6 “(b) REQUIRED DISCLOSURES.—

7 “(1) CONTENTS AND FREQUENCY.—With re-
8 spect to plan years beginning on or after the date
9 that is 1 year after the date of enactment of this
10 section, not less frequently than once every 6
11 months, a health plan service provider shall provide
12 to the group health plan that is a self-funded, non-
13 Federal governmental plan or the health insurance
14 issuer the following information at no cost to the
15 plan or issuer:

16 “(A) The information described in section
17 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
18 119(a)(1)(B)).

19 “(B) Any contractual and subcontractual
20 calculation methodologies, pricing or fee sched-
21 ules, or other formulae used to determine reim-
22 bursement amounts to providers and sub-
23 contractors, including methodologies, schedules,
24 fee structures, and any applied adjustments or
25 modifiers, with such information provided in a

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

6 “(C) The total amount received or ex-
7 pected to be received by the health plan service
8 provider or its subcontractors in provider or
9 supplier rebates, fees, alternative discounts, and
10 all other remuneration including amounts held
11 in escrow or variance accounts that has been
12 paid or is to be paid for claims incurred and
13 administrative services including data sales or
14 network payments.

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

20 “(E) All payment data, calculation meth-
21 odologies, and reconciliation information related
22 to alternative compensation arrangements, in-
23 cluding accountable care organizations, value-
24 based programs, shared savings programs, in-
25 centive compensation, bundled payments, capi-

1 tation arrangements, performance payments,
2 and any other reimbursement or payment mod-
3 els, where the group health plan paid fees, in-
4 curred obligations, or made payments in con-
5 nection with the group health plan or issuer re-
6 lated to such arrangements.

7 “(2) MANNER OF PROVIDING INFORMATION OR
8 DATA.—

9 “(A) IN GENERAL.—A health plan service
10 provider shall provide information or data
11 under paragraph (1) in a manner consistent
12 with the privacy regulations promulgated under
13 section 13402(a) of the Health Information
14 Technology for Economic and Clinical Health
15 Act (42 U.S.C. 17932(a)) and consistent with
16 the privacy regulations promulgated under the
17 Health Insurance Portability and Accountability
18 Act of 1996 in part 160 and subparts A and E
19 of part 164 of title 45, Code of Federal Regula-
20 tions (or successor regulations) (referred to in
21 this paragraph as the ‘HIPAA privacy regula-
22 tions’) and shall restrict the use and disclosure
23 of such information according to such privacy
24 regulations and such HIPAA privacy regula-
25 tions.

1 “(B) ADDITIONAL REQUIREMENTS.—

2 “(i) IN GENERAL.—A health plan
3 service provider that submits information
4 or data under this subsection shall ensure
5 that such information or data contains
6 only summary health information, as de-
7 fined in section 164.504(a) of title 45,
8 Code of Federal Regulations (or successor
9 regulations).

10 “(ii) RESTRICTIONS.—In carrying out
11 this subsection, a health plan service pro-
12 vider shall comply with section 164.504(f)
13 of title 45, Code of Federal Regulations (or
14 a successor regulation).

15 “(C) RULE OF CONSTRUCTION.—

16 “(i) IN GENERAL.—Nothing in this
17 subsection shall be construed to modify the
18 requirements for the creation, receipt,
19 maintenance, or transmission of protected
20 health information under the HIPAA pri-
21 vacy regulations.

22 “(ii) CIVIL RIGHTS LAWS.—Nothing
23 in this subsection shall be construed to af-
24 fect the application of any Federal or State
25 privacy or civil rights law, including the

1 HIPAA privacy regulations, the Genetic
2 Information Nondiscrimination Act of
3 2008 (Public Law 110–233) (including the
4 amendments made by such Act), the Amer-
5 icans with Disabilities Act of 1990 (42
6 U.S.C. 12101 et seq.), section 504 of the
7 Rehabilitation Act of 1973 (29 U.S.C.
8 794), section 1557 of the Patient Protec-
9 tion and Affordable Care Act (42 U.S.C.
10 18116), title VI of the Civil Rights Act of
11 1964 (42 U.S.C. 2000d), and title VII of
12 the Civil Rights Act of 1964 (42 U.S.C.
13 2000e).

14 “(D) WRITTEN NOTICE.—Each plan year,
15 a health plan service provider shall provide to
16 each participant or beneficiary written notice
17 informing the participant or beneficiary of the
18 requirement for health plan service providers to
19 submit information or data under paragraph
20 (1), as applicable, which may include incor-
21 porating such notification in plan documents
22 provided to the participant or beneficiary, or
23 providing individual notification.

24 “(E) LIMITATION TO BUSINESS ASSOCI-
25 ATES.—A health plan service provider receiving

1 data or information under paragraph (1) may
2 disclose such information only to the entity
3 from which the information or data was re-
4 ceived or to that entity's business associates as
5 defined in section 160.103 of title 45, Code of
6 Federal Regulations (or successor regulations)
7 or as permitted by the HIPAA privacy regula-
8 tions.

9 “(F) CLARIFICATION REGARDING PUBLIC
10 DISCLOSURE OF INFORMATION.—Nothing in
11 this subsection shall prevent a health plan serv-
12 ice provider from placing reasonable restrictions
13 on the public disclosure of the information or
14 data described in paragraph (1), except that
15 such provider may not restrict disclosure of
16 such report to the Department of Health and
17 Human Services, the Department of Labor, or
18 the Department of the Treasury.

19 “(G) LIMITATION.—This paragraph shall
20 not be construed to abridge or limit the disclo-
21 sure requirements under this subsection or to
22 impose additional privacy or security require-
23 ments on health plan service providers or plan
24 sponsors.

25 “(3) DISCLOSURE AND REDISCLOSURE.—

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

5 “(i) to the entity from which the in-
6 formation was received or to that entity’s
7 business associates as defined in section
8 160.103 of title 45, Code of Federal Regu-
9 lations (or successor regulations); or

10 “(ii) as permitted by the HIPAA Pri-
11 vacy Rule (45 C.F.R. part 160 and sub-
12 parts A and E of part 164).

13 “(B) AVAILABILITY OF INFORMATION.—To
14 the extent the information required by this sub-
15 section is made available to the health insur-
16 ance issuer offering group health insurance cov-
17 erage, the health insurance issuer shall make
18 such information available, at the same time, in
19 the same format, and at no cost, to the group
20 health plan.

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

1 to such a plan, from placing reasonable restric-
2 tions on the public disclosure of the information
3 described in paragraph (1), except that such
4 plan or entity may not restrict disclosure of
5 such information to the Department of Health
6 and Human Services, the Department of Labor,
7 the Department of the Treasury, or the Comp-
8 troller General of the United States.

9 “(D) FAILURE TO PROVIDE.—The obliga-
10 tion to provide information pursuant to this
11 subsection shall exist notwithstanding the pres-
12 ence of any formal data-sharing agreement be-
13 tween the parties. Failure to provide the re-
14 quired information as specified shall constitute
15 a violation of this Act and the Secretary shall
16 initiate enforcement action under section
17 2723(b) (42 U.S.C. 300gg–22(b)) within 90
18 days of becoming aware of a violation of this
19 section, except that nothing in this section shall
20 be construed to limit the Secretary’s existing
21 authority under this Act.

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

1 “(A) All claims from a healthcare provider
2 shall be made to the group health plan in ac-
3 cordance with standards adopted under HIPAA
4 as described in subpart K of part 162 of title
5 45, Code of Federal Regulations, as follows:

6 “(i) Institutional, professional, and
7 dental claims and adjustments to these
8 claims shall be provided to the group
9 health plan that is a self-funded, non-Fed-
10 eral governmental plan in the ASC X12N
11 837 format.

12 “(ii) Prescription drug claims shall be
13 in the National Council for Prescription
14 Drug Programs (NCPDP) format.

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

22 “(B) All claim payment (or EFT, elec-
23 tronic funds transfer) and electronic remittance
24 advice (ERA) information sent by a health plan
25 service provider shall be provided to the group

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

9 “(C) The Secretary may modify the stand-
10 ards set forth in this paragraph as necessary to
11 align with any changes adopted by the Sec-
12 retary pursuant to the authority provided under
13 section 1173 of the Social Security Act (42
14 U.S.C. 1320d–2).

15 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
16 provision in an agreement that unduly delays or limits a
17 group health plan that is a self-funded, non-Federal gov-
18 ernmental plan’s access to information described in this
19 section or that restricts the format or timing of the provi-
20 sion of such information in a manner that is inconsistent
21 with the requirements of this section shall be prohibited
22 and, if a self-funded, non-Federal governmental plan en-
23 ters into such agreement, shall be deemed void as against
24 public policy.

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

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

8 “(4) ENFORCEMENT AUTHORITY RELATING TO
9 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
10 standing any provisions to the contrary, the Sec-
11 retary may assess a penalty against a health plan
12 service provider, as defined in section 2799A–12(a)
13 (42 U.S.C. 300gg–121(a)), of \$100,000 per day for
14 each violation of such section, pursuant to substan-
15 tially similar processes and procedures as those set
16 forth in section 2723(b)(2)(D) through (G) (42
17 U.S.C. 300gg–121(b)(2)(D) through (G)).”.

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

21 **“SEC. 9826. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
22 **VIDERS.**

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

1 no agreement between a group health plan that is a self-
2 funded, non-Federal governmental plan, as defined in sec-
3 tion 2791(d)(8)(C) of the Public Health Service Act, and
4 a health care provider, network or association of providers,
5 third-party administrator, service provider offering access
6 to a network of providers, pharmacy benefit managers, or
7 any other third party (each referred to in this section as
8 a ‘health plan service provider’) is permissible if such
9 agreement limits (or delays beyond the applicable report-
10 ing period described in subsection (b)(1)) the disclosure
11 of information to such group health plans in a manner
12 that prevents any plan or entity from providing the infor-
13 mation described in subsection (b).

14 “(b) REQUIRED DISCLOSURES.—

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

23 “(A) The information described in section
24 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
25 119(a)(1)(B)).

1 “(B) Any contractual and subcontractual
2 calculation methodologies, pricing or fee sched-
3 ules, or other formulae used to determine reim-
4 bursement amounts to providers and sub-
5 contractors, including methodologies, schedules,
6 fee structures, and any applied adjustments or
7 modifiers, with such information provided in a
8 manner sufficiently detailed to enable the group
9 health plan to accurately assess, verify, and en-
10 sure compliance with the terms of any contrac-
11 tual and subcontractual agreement governing
12 the reimbursement amounts.

13 “(C) The total amount received or ex-
14 pected to be received by the health plan service
15 provider or its subcontractors in provider or
16 supplier rebates, fees, alternative discounts, and
17 all other remuneration including amounts held
18 in escrow or variance accounts that has been
19 paid or is to be paid for claims incurred and
20 administrative services including data sales or
21 network payments.

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

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

3 “(E) All payment data, calculation meth-
4 odologies and reconciliation information related
5 to alternative compensation arrangements in-
6 cluding accountable care organizations, value-
7 based programs, shared savings programs, in-
8 centive compensation, bundled payments, capi-
9 tation arrangements, performance payments,
10 and any other reimbursement or payment mod-
11 els, where the group health plan paid fees, in-
12 curred obligations, or made payments in con-
13 nection with the group health plan related to
14 such arrangements.

15 “(2) MANNER OF PROVIDING INFORMATION OR
16 DATA.—

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

1 Act of 1996 in part 160 and subparts A and E
2 of part 164 of title 45, Code of Federal Regula-
3 tions (or successor regulations) (referred to in
4 this paragraph as the ‘HIPAA privacy regula-
5 tions’) and shall restrict the use and disclosure
6 of such information according to such privacy
7 regulations and such HIPAA privacy regula-
8 tions.

9 “(B) ADDITIONAL REQUIREMENTS.—

10 “(i) IN GENERAL.—A health plan
11 service provider that submits information
12 or data under this subsection shall ensure
13 that such information or data contains
14 only summary health information, as de-
15 fined in section 164.504(a) of title 45,
16 Code of Federal Regulations (or successor
17 regulations).

18 “(ii) RESTRICTIONS.—In carrying out
19 this subsection, a health plan service pro-
20 vider shall comply with section 164.504(f)
21 of title 45, Code of Federal Regulations (or
22 a successor regulation).

23 “(C) RULE OF CONSTRUCTION.—

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

1 requirements for the creation, receipt,
2 maintenance, or transmission of protected
3 health information under the HIPAA pri-
4 vacy regulations.

5 “(ii) CIVIL RIGHTS LAWS.—Nothing
6 in this subsection shall be construed to af-
7 fect the application of any Federal or State
8 privacy or civil rights law, including the
9 HIPAA privacy regulations, the Genetic
10 Information Nondiscrimination Act of
11 2008 (Public Law 110–233) (including the
12 amendments made by such Act), the Amer-
13 icans with Disabilities Act of 1990 (42
14 U.S.C. 12101 et seq.), section 504 of the
15 Rehabilitation Act of 1973 (29 U.S.C.
16 794), section 1557 of the Patient Protec-
17 tion and Affordable Care Act (42 U.S.C.
18 18116), title VI of the Civil Rights Act of
19 1964 (42 U.S.C. 2000d), and title VII of
20 the Civil Rights Act of 1964 (42 U.S.C.
21 2000e).

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

1 requirement for health plan service providers to
2 submit information or data under paragraph
3 (1), as applicable, which may include incor-
4 porating such notification in plan documents
5 provided to the participant or beneficiary, or
6 providing individual notification.

7 “(E) LIMITATION TO BUSINESS ASSOCI-
8 ATES.—A health plan service provider receiving
9 data or information under paragraph (1) may
10 disclose such information only to the entity
11 from which the information or data was re-
12 ceived or to that entity’s business associates as
13 defined in section 160.103 of title 45, Code of
14 Federal Regulations (or successor regulations)
15 or as permitted by the HIPAA privacy regula-
16 tions.

17 “(F) CLARIFICATION REGARDING PUBLIC
18 DISCLOSURE OF INFORMATION.—Nothing in
19 this subsection shall prevent a health plan serv-
20 ice provider from placing reasonable restrictions
21 on the public disclosure of the information or
22 data described in paragraph (1), except that
23 such provider may not restrict disclosure of
24 such report to the Department of Health and

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

3 “(G) LIMITATION.—This paragraph shall
4 not be construed to abridge or limit the disclo-
5 sure requirements under this subsection or to
6 impose additional privacy or security require-
7 ments on health plan service providers or plan
8 sponsors.

9 “(3) DISCLOSURE AND REDISCLOSURE.—

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

14 “(i) to the entity from which the in-
15 formation was received or to that entity’s
16 business associates as defined in section
17 160.103 of title 45, Code of Federal Regu-
18 lations (or successor regulations); or

19 “(ii) as permitted by the HIPAA Pri-
20 vacy Rule (45 C.F.R. part 160 and sub-
21 parts A and E of part 164).

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

1 service provider providing services with respect
2 to such a plan, from placing reasonable restric-
3 tions on the public disclosure of the information
4 described in paragraph (1), except that such
5 plan or entity may not restrict disclosure of
6 such information to the Department of Health
7 and Human Services, the Department of Labor,
8 the Department of the Treasury, or the Comp-
9 troller General of the United States.

10 “(C) FAILURE TO PROVIDE.—The obliga-
11 tion to provide information pursuant to this
12 subsection shall exist notwithstanding the pres-
13 ence of any formal data-sharing agreement be-
14 tween the parties. Failure to provide the re-
15 quired information as specified shall constitute
16 a violation of this Act and the Secretary shall
17 initiate enforcement action under section
18 2723(b) (42 U.S.C. 300gg–22(b)) within 90
19 days of becoming aware of a violation of this
20 section, except that nothing in this section shall
21 be construed to limit the Secretary’s existing
22 authority under this Act.

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

1 “(A) All claims from a healthcare provider
2 shall be made to the group health plan in ac-
3 cordance with standards adopted under HIPAA
4 as described in subpart K of part 162 of title
5 45, Code of Federal Regulations, as follows:

6 “(i) Institutional, professional, and
7 dental claims and adjustments to these
8 claims shall be provided to the group
9 health plan that is a self-funded, non-Fed-
10 eral governmental plan in the ASC X12N
11 837 format.

12 “(ii) Prescription drug claims shall be
13 in the National Council for Prescription
14 Drug Programs (NCPDP) format.

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

22 “(B) All claim payment (or EFT, elec-
23 tronic funds transfer) and electronic remittance
24 advice (ERA) information sent by a health plan
25 service provider shall be provided to the group

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

9 “(C) The Secretary may modify the stand-
10 ards set forth in this paragraph as necessary to
11 align with any changes adopted by the Sec-
12 retary pursuant to the authority provided under
13 section 1173 of the Social Security Act (42
14 U.S.C. 1320d–2).

15 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
16 provision in an agreement that unduly delays or limits a
17 group health plan that is a self-funded, non-Federal gov-
18 ernmental plan’s access to information described in this
19 section or that restricts the format or timing of the provi-
20 sion of such information in a manner that is inconsistent
21 with the requirements of this section shall be prohibited
22 and, if a self-funded, non-Federal governmental plan en-
23 ters into such agreement, shall be deemed void as against
24 public policy.

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

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

6 (a) IN GENERAL.—Not later than December 31,
7 2029, and annually thereafter through December 31,
8 2033, the Secretary shall post on a publicly available
9 website of the Department of Health and Human Services
10 a report on the ownership of specified entities during the
11 previous 1-year period. Such report shall include the fol-
12 lowing:

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

15 (2) With respect to each such specified entity—

16 (A) the business structure of such specified
17 entity (as determined in accordance with sub-
18 section (b));

19 (B) the type of organization of such speci-
20 fied entity (as determined in accordance with
21 subsection (c));

22 (C) the number of owners of such specified
23 entity;

24 (D) any change in ownership of such speci-
25 fied entity during such period;

1 (E) any change in the tax status of such
2 specified entity during such period; and

3 (F) as applicable, the name, address, and
4 business structure of the parent company of
5 such specified entity (including the business
6 type of such parent company, as determined
7 under subsection (b), and the tax status of such
8 parent company).

9 (3) An analysis of trends in horizontal and
10 vertical consolidation of specified entities,
11 disaggregated by business structure and provider
12 type.

13 (b) BUSINESS STRUCTURE.—For purposes of sub-
14 section (a)(2), the Secretary shall determine which of the
15 following business structures apply to a specified entity
16 (or the parent company of such specified entity), and shall
17 identify such structures as privately held or publicly trad-
18 ed:

- 19 (1) Corporation.
- 20 (2) Limited liability company.
- 21 (3) General partnership.
- 22 (4) Limited partnership.
- 23 (5) Individual.
- 24 (6) Federal Government.
- 25 (7) State government.

1 (c) TYPES OF ORGANIZATION.—For purposes of sub-
2 section (a)(2), the Secretary shall determine which of the
3 following types of organization apply to a specified entity
4 (or the parent company of such specified entity), and shall
5 identify such organizations as privately held or publicly
6 traded:

7 (1) Bank or other financial institution.

8 (2) Consulting firm.

9 (3) Holding company.

10 (4) Investment firm (other than a private eq-
11 uity company).

12 (5) Management services company.

13 (6) Medical provider or supplier.

14 (7) Medical staffing company.

15 (8) Private equity company.

16 (9) Real estate investment trust.

17 (d) SPECIFIED ENTITY DEFINED.—In this section,
18 the term “specified entity” means—

19 (1) a hospital;

20 (2) a clinical laboratory;

21 (3) a provider or supplier of imaging services;

22 (4) an ambulatory surgical center;

23 (5) a physician-owned physician practice with
24 more than 25 physicians for a year; and

1 (6) a physician practice that is not physician-
2 owned.

3 **SEC. 108. FUNDING.**

4 There are appropriated, out of any monies in the
5 Treasury not otherwise obligated, \$20,000,000 for fiscal
6 year 2026 for purposes of carrying out the provisions of,
7 and the amendments made by, this title, to remain avail-
8 able until expended.

9 **TITLE II—INSURANCE**
10 **ACCOUNTABILITY**

11 **SEC. 201. DISPLAYING PRIOR AUTHORIZATION RATES.**

12 (a) PHSA.—Part D of title XXVII of the Public
13 Health Service Act (42 U.S.C. 300gg–111 et seq.), as
14 amended by section 106(b), is further amended by adding
15 at the end the following new section:

16 **“SEC. 2799A–13. PRIOR AUTHORIZATION TRANSPARENCY**
17 **REQUIREMENTS.**

18 “(a) IN GENERAL.—In the case of a group health
19 plan or health insurance issuer offering group or indi-
20 vidual health insurance coverage that imposes any prior
21 authorization requirement with respect to an item or serv-
22 ice furnished under such plan or coverage during a plan
23 year beginning on or after January 1, 2028, such plan
24 or issuer shall, at a time and in a manner specified by
25 the Secretary (but not less frequently than annually), sub-

1 mit to the Secretary and make available on a public
2 website of the plan or issuer the following information:

3 “(1) A list of all items and services that were
4 subject to a prior authorization requirement under
5 the plan or coverage during such plan year.

6 “(2) The percentage and number of prior au-
7 thorization requests approved during such plan year
8 by the plan or issuer in an initial determination and
9 the percentage and number of prior authorization re-
10 quests denied during such plan year by such plan or
11 issuer in an initial determination (both in the aggre-
12 gate and categorized by each item and service).

13 “(3) The percentage and number of prior au-
14 thorization requests that were denied during such
15 plan year by the plan or issuer in an initial deter-
16 mination and that were subsequently appealed (both
17 in the aggregate and categorized by each item and
18 service).

19 “(4) The percentage and number of resolved
20 appeals of such requests that resulted in approval of
21 coverage of the item or service that was the subject
22 of such request, categorized by each item and service
23 and categorized by each level of appeal (including ju-
24 dicial review).

1 “(5) The percentage and number of prior au-
2 thorization requests that were denied, and the per-
3 centage and number of prior authorization requests
4 that were approved, by the plan or issuer during
5 such plan year solely through the utilization of deci-
6 sion support technology, artificial intelligence tech-
7 nology, machine-learning technology, clinical deci-
8 sion-making technology, or any other technology
9 specified by the Secretary (both in the aggregate
10 and categorized by each item and service).

11 “(6) The average and the median amount of
12 time (in hours) that elapsed during such plan year
13 between the submission of a prior authorization re-
14 quest to the plan or issuer and a determination by
15 the plan or issuer with respect to such request for
16 each such item and service (excluding any such re-
17 quests that were not submitted with the medical or
18 other documentation required to be submitted by the
19 plan or issuer), broken out by prior authorization re-
20 quests that were expedited because the application of
21 the normal time frame for making a determination
22 could seriously jeopardize the life or health of the in-
23 dividual or the individual’s ability to regain max-
24 imum function and such requests that were not so
25 expedited.

1 “(7) The percentage and number of prior au-
2 thorization requests that were excluded from each
3 calculation described in paragraph (6) based on the
4 plan or issuer’s determination that such requests
5 were not submitted with the medical or other docu-
6 mentation required to be submitted by the plan or
7 issuer.

8 “(8) The percentage and number of occasions
9 in which, during a surgical or medical procedure in-
10 volving the furnishing of an item or service with re-
11 spect to which the plan or issuer had approved a
12 prior authorization request, the provider furnishing
13 such item or service determined that a different or
14 additional item or service was medically necessary,
15 and a specification of whether such plan or issuer
16 subsequently approved the furnishing of such dif-
17 ferent or additional item or service.

18 “(9) A disclosure and description of any tech-
19 nology described in paragraph (5) that the plan or
20 issuer utilized during such plan year in making de-
21 terminations with respect to prior authorization re-
22 quests.

23 “(10) The number of complaints received by
24 such plan or issuer that were related to a prior au-
25 thorization requirement.

1 “(11) Such other information as the Secretary
2 determines appropriate.

3 “(b) MANNER OF PUBLICATION.—Information sub-
4 mitted and published by a group health plan or health in-
5 surance issuer offering group or individual health insur-
6 ance coverage under subsection (a) shall be so submitted
7 and published on the plan or coverage level (as applicable)
8 and shall in addition, if determined appropriate by the
9 Secretary, be so submitted and published in the aggregate
10 in such manner as specified by the Secretary (such as
11 across all group health plans of the sponsor of such plan
12 or all health insurance coverage offered by such issuer that
13 are offered within the same insurance market). For pur-
14 poses of the preceding sentence, the term ‘insurance mar-
15 ket’ means the individual market, the small group market,
16 and the large group market.”.

17 (b) ERISA.—

18 (1) IN GENERAL.—Subpart B of part 7 of sub-
19 title B of title I of the Employee Retirement Income
20 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
21 amended by section 106(a), is further amended by
22 adding at the end the following new section:

1 **“SEC. 728. PRIOR AUTHORIZATION TRANSPARENCY RE-**
2 **QUIREMENTS.**

3 “(a) IN GENERAL.—In the case of a group health
4 plan or health insurance issuer offering group health in-
5 surance coverage that imposes any prior authorization re-
6 quirement with respect to an item or service furnished
7 under such plan or coverage during a plan year beginning
8 on or after January 1, 2028, such plan or issuer shall,
9 at a time and in a manner specified by the Secretary (but
10 not less frequently than annually), submit to the Secretary
11 and make available on a public website of the plan or
12 issuer the following information:

13 “(1) A list of all items and services that were
14 subject to a prior authorization requirement under
15 the plan or coverage during such plan year.

16 “(2) The percentage and number of prior au-
17 thorization requests approved during such plan year
18 by the plan or issuer in an initial determination and
19 the percentage and number of prior authorization re-
20 quests denied during such plan year by such plan or
21 issuer in an initial determination (both in the aggre-
22 gate and categorized by each item and service).

23 “(3) The percentage and number of prior au-
24 thorization requests that were denied during such
25 plan year by the plan or issuer in an initial deter-
26 mination and that were subsequently appealed (both

1 in the aggregate and categorized by each item and
2 service).

3 “(4) The percentage and number of resolved
4 appeals of such requests that resulted in approval of
5 coverage of the item or service that was the subject
6 of such request, categorized by each item and service
7 and categorized by each level of appeal (including ju-
8 dicial review).

9 “(5) The percentage and number of prior au-
10 thorization requests that were denied, and the per-
11 centage and number of prior authorization requests
12 that were approved, by the plan or issuer during
13 such plan year solely through the utilization of deci-
14 sion support technology, artificial intelligence tech-
15 nology, machine-learning technology, clinical deci-
16 sion-making technology, or any other technology
17 specified by the Secretary (both in the aggregate
18 and categorized by each item and service).

19 “(6) The average and the median amount of
20 time (in hours) that elapsed during such plan year
21 between the submission of a prior authorization re-
22 quest to the plan or issuer and a determination by
23 the plan or issuer with respect to such request for
24 each such item and service (excluding any such re-
25 quests that were not submitted with the medical or

1 other documentation required to be submitted by the
2 plan or issuer), broken out by prior authorization re-
3 quests that were expedited because the application of
4 the normal time frame for making a determination
5 could seriously jeopardize the life or health of the in-
6 dividual or the individual's ability to regain max-
7 imum function and such requests that were not so
8 expedited.

9 “(7) The percentage and number of prior au-
10 thorization requests that were excluded from each
11 calculation described in paragraph (6) based on the
12 plan or issuer's determination that such requests
13 were not submitted with the medical or other docu-
14 mentation required to be submitted by the plan or
15 issuer.

16 “(8) The percentage and number of occasions
17 in which, during a surgical or medical procedure in-
18 volving the furnishing of an item or service with re-
19 spect to which the plan or issuer had approved a
20 prior authorization request, the provider furnishing
21 such item or service determined that a different or
22 additional item or service was medically necessary,
23 and a specification of whether such plan or issuer
24 subsequently approved the furnishing of such dif-
25 ferent or additional item or service.

1 “(9) A disclosure and description of any tech-
2 nology described in paragraph (5) that the plan or
3 issuer utilized during such plan year in making de-
4 terminations with respect to prior authorization re-
5 quests.

6 “(10) The number of complaints received by
7 such plan or issuer that were related to a prior au-
8 thorization requirement.

9 “(11) Such other information as the Secretary
10 determines appropriate.

11 “(b) MANNER OF PUBLICATION.—Information sub-
12 mitted and published by a group health plan or health in-
13 surance issuer offering group health insurance coverage
14 under subsection (a) shall be so submitted and published
15 on the plan or coverage level (as applicable) and shall in
16 addition, if determined appropriate by the Secretary, be
17 so submitted and published in the aggregate in such man-
18 ner as specified by the Secretary (such as across all group
19 health plans of the sponsor of such plan or all health in-
20 surance coverage offered by such issuer that are offered
21 within the same insurance market). For purposes of the
22 preceding sentence, the term ‘insurance market’ means
23 the individual market, the small group market, and the
24 large group market.”.

1 (2) CLERICAL AMENDMENT.—The table of con-
2 tents in section 1 of the Employee Retirement In-
3 come Security Act of 1974 (29 U.S.C. 1001 note) is
4 amended by inserting after the item relating to sec-
5 tion 726 the following new item:

“Sec. 728. Prior authorization transparency requirements.”.

6 (c) IRC.—

7 (1) IN GENERAL.—Subchapter B of chapter
8 100 of the Internal Revenue Code of 1986, as
9 amended by section 106(c), is further amended by
10 adding at the end the following new section:

11 **“SEC. 9828. PRIOR AUTHORIZATION TRANSPARENCY RE-**
12 **QUIREMENTS.**

13 “(a) IN GENERAL.—In the case of a group health
14 plan that imposes any prior authorization requirement
15 with respect to an item or service furnished under such
16 plan during a plan year beginning on or after January
17 1, 2028, such plan shall, at a time and in a manner speci-
18 fied by the Secretary (but not less frequently than annu-
19 ally), submit to the Secretary and make available on a
20 public website of the plan the following information:

21 “(1) A list of all items and services that were
22 subject to a prior authorization requirement under
23 the plan during such plan year.

24 “(2) The percentage and number of prior au-
25 thorization requests approved during such plan year

1 by the plan in an initial determination and the per-
2 centage and number of prior authorization requests
3 denied during such plan year by such plan in an ini-
4 tial determination (both in the aggregate and cat-
5 egorized by each item and service).

6 “(3) The percentage and number of prior au-
7 thorization requests that were denied during such
8 plan year by the plan or issuer in an initial deter-
9 mination and that were subsequently appealed (both
10 in the aggregate and categorized by each item and
11 service).

12 “(4) The percentage and number of resolved
13 appeals of such requests that resulted in approval of
14 coverage of the item or service that was the subject
15 of such request, categorized by each item and service
16 and categorized by each level of appeal (including ju-
17 dicial review).

18 “(5) The percentage and number of prior au-
19 thorization requests that were denied, and the per-
20 centage and number of prior authorization requests
21 that were approved, by the plan during such plan
22 year solely through the utilization of decision sup-
23 port technology, artificial intelligence technology,
24 machine-learning technology, clinical decision-mak-
25 ing technology, or any other technology specified by

1 the Secretary (both in the aggregate and categorized
2 by each item and service).

3 “(6) The average and the median amount of
4 time (in hours) that elapsed during such plan year
5 between the submission of a prior authorization re-
6 quest to the plan and a determination by the plan
7 with respect to such request for each such item and
8 service (excluding any such requests that were not
9 submitted with the medical or other documentation
10 required to be submitted by the plan), broken out by
11 prior authorization requests that were expedited be-
12 cause the application of the normal time frame for
13 making a determination could seriously jeopardize
14 the life or health of the individual or the individual’s
15 ability to regain maximum function and such re-
16 quests that were not so expedited.

17 “(7) The percentage and number of prior au-
18 thorization requests that were excluded from each
19 calculation described in paragraph (6) based on the
20 plan’s determination that such requests were not
21 submitted with the medical or other documentation
22 required to be submitted by the plan.

23 “(8) The percentage and number of occasions
24 in which, during a surgical or medical procedure in-
25 volving the furnishing of an item or service with re-

1 spect to which the plan had approved a prior author-
2 ization request, the provider furnishing such item or
3 service determined that a different or additional
4 item or service was medically necessary, and a speci-
5 fication of whether such plan or issuer subsequently
6 approved the furnishing of such different or addi-
7 tional item or service.

8 “(9) A disclosure and description of any tech-
9 nology described in paragraph (5) that the plan or
10 issuer utilized during such plan year in making de-
11 terminations with respect to prior authorization re-
12 quests.

13 “(10) The number of complaints received by
14 such plan that were related to a prior authorization
15 requirement.

16 “(11) Such other information as the Secretary
17 determines appropriate.

18 “(b) MANNER OF PUBLICATION.—Information sub-
19 mitted and published by a group health plan under sub-
20 section (a) shall be so submitted and published on the plan
21 or coverage level (as applicable) and shall in addition, if
22 determined appropriate by the Secretary, be so submitted
23 and published in the aggregate in such manner as speci-
24 fied by the Secretary (such as across all group health
25 plans of the sponsor of such plan). For purposes of the

1 preceding sentence, the term ‘insurance market’ means
2 the small group market and the large group market.”.

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

“Sec. 9828. Prior authorization transparency requirements.”.

7 **SEC. 202. ENSURING HEALTH INSURER ACCOUNTABILITY**
8 **THROUGH PUBLISHING OF OVERHEAD COSTS**
9 **AND CLAIM PAYMENTS.**

10 (a) IN GENERAL.—Section 2718(a) of the Public
11 Health Service Act (42 U.S.C. 300gg–18(a)) is amend-
12 ed—

13 (1) by redesignating paragraphs (1) through
14 (3) as subparagraphs (A) through (C), and adjust-
15 ing the margins accordingly;

16 (2) by striking “A health insurance issuer” and
17 inserting the following:

18 “(1) IN GENERAL.—A health insurance issuer”;
19 and

20 (3) by adding at the end the following new
21 paragraph:

22 “(2) OVERHEAD COSTS AND CLAIM PAYMENT
23 INFORMATION.—

24 “(A) IN GENERAL.—A health insurance
25 issuer offering group or individual health insur-

1 ance coverage (including a grandfathered health
2 plan) shall, with respect to each plan year be-
3 ginning on or after January 1, 2028, submit to
4 the Secretary and publish on the public website
5 of such issuer the following information in a
6 consumer-friendly format and in such form and
7 manner as the Secretary shall specify:

8 “(i) The percentage of total premium
9 revenue expended for each category de-
10 scribed in subparagraphs (A) through (C)
11 of paragraph (1).

12 “(ii) The explanation described in
13 paragraph (1)(C).

14 “(iii) The percentage of total premium
15 revenue expended on Federal and State
16 taxes and licensing or regulatory fees.

17 “(iv) The percentage of total premium
18 revenue not expended and retained by such
19 issuer.

20 “(B) MANNER OF PUBLICATION.—Infor-
21 mation submitted and published by a health in-
22 surance issuer under subparagraph (A) shall be
23 so submitted and published at the issuer level
24 and shall in addition, if determined appropriate
25 by the Secretary, be so submitted and published

1 in the aggregate in such manner as specified by
2 the Secretary (such as across all such coverage
3 offered by such issuer that are offered within
4 the same State or the same insurance market
5 (individual, small group, or large group)).”.

6 (b) MEDICARE ADVANTAGE.—Section 1857(e) of the
7 Social Security Act (42 U.S.C. 1395w–27(e)) is amended
8 by adding at the end the following new paragraph:

9 “(7) OVERHEAD COSTS AND CLAIM PAYMENT
10 INFORMATION.—

11 “(A) IN GENERAL.—Beginning with plan
12 years beginning on or after January 1, 2028, a
13 contract under this section with an MA organi-
14 zation shall require the organization, with re-
15 spect to each MA plan offered by such organi-
16 zation during such plan year, to submit to the
17 Secretary and publish on the public website of
18 such organization the following information in a
19 consumer-friendly format specified by the Sec-
20 retary:

21 “(i) The amount of total revenue (as
22 determined in accordance with section
23 422.2420(c) of title 42, Code of Federal
24 Regulations (or a successor regulation)) of
25 such plan.

1 “(ii) The amount and percentage of
2 such revenue expended on incurred claims
3 (as determined in accordance with para-
4 graphs (2) through (4) of section
5 422.2420(b) of title 42, Code of Federal
6 Regulations (or a successor regulation)).

7 “(iii) The amount and percentage of
8 such revenue expended on non-claims costs
9 (as defined in section 422.2401 of title 42,
10 Code of Federal Regulations (or a suc-
11 cessor regulation)).

12 “(iv) The amount of the difference be-
13 tween the MLR numerator (as determined
14 in accordance with paragraph (b) of sec-
15 tion 422.2420 of title 42, Code of Federal
16 Regulations (or a successor regulation) and
17 the MLR denominator (as determined in
18 accordance with paragraph (c) of such sec-
19 tion (or a successor regulation)).

20 “(v) The amount described in clause
21 (iv), expressed as a percentage of such rev-
22 enue.

23 “(B) MANNER OF PUBLICATION.—Infor-
24 mation submitted and published by an MA or-
25 ganization under subparagraph (A) shall be so

1 submitted and published at the MA plan level
2 and shall in addition, if determined appropriate
3 by the Secretary, be so submitted and published
4 in the aggregate in such manner as specified by
5 the Secretary (such as across all MA plans of-
6 fered by such organization).”.

7 **SEC. 203. PROMOTING COMPARABILITY OF QUALIFIED**
8 **HEALTH PLANS OFFERED THROUGH AN EX-**
9 **CHANGE.**

10 Section 1311(d)(4)(C) of the Patient Protection and
11 Affordable Care Act (42 U.S.C. 18031(d)(4)(C)) is
12 amended—

13 (1) by striking “website through which” and in-
14 serting the following: “website—

15 “(i) through which”;

16 (2) in clause (i), as so inserted, by striking the
17 semicolon and inserting “; and”; and

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

20 “(ii) that includes, as part of such
21 comparative information for enrollments
22 for plan years beginning on or after Janu-
23 ary 1, 2029, in the case a qualified health
24 plan offered through such Exchange for
25 such plan year was offered through such

1 Exchange for a previous plan year, the
2 most recent information submitted to such
3 Exchange with respect to such plan by the
4 health insurance issuer of such plan under
5 sections 2718(a)(2) and 2799A–13 of the
6 Public Health Service Act;”.

7 **SEC. 204. GUIDANCE ON PROVISION OF CERTAIN INSUR-**
8 **ANCE INFORMATION IN STANDARDIZED,**
9 **PLAIN LANGUAGE FORMAT.**

10 (a) IN GENERAL.—Not later than January 1, 2028,
11 the Secretary shall update guidance implementing section
12 2715 of the Public Health Service Act (42 U.S.C. 300gg–
13 15) and section 1852(c) of the Social Security Act (42
14 U.S.C. 1395w–22(c)) as necessary to ensure that such
15 guidance includes standards for group health plans, health
16 insurance issuers offering group or individual health in-
17 surance coverage, and MA organizations offering MA
18 plans (including MA–PD plans) to provide information on
19 the benefits and coverage available under the applicable
20 plan or coverage in a standardized, plain language format
21 with respect to the following aspects of the plan or cov-
22 erage (to the extent applicable):

- 23 (1) Any monthly premium.
24 (2) Any annual deductible.
25 (3) Any out-of-pocket limit.

1 (4) The plan or coverage type (such as health
2 maintenance organization or preferred provider or-
3 ganization).

4 (5) The plan or coverage share of the total al-
5 lowed costs of benefits provided under the plan or
6 coverage.

7 (6) The standard cost-sharing amounts for in-
8 network care, including for the following types of
9 care:

10 (A) Primary care.

11 (B) Specialist care.

12 (C) Urgent care.

13 (D) Emergency department care.

14 (E) Imaging.

15 (F) Inpatient hospital care.

16 (G) Outpatient facility care.

17 (H) Laboratory, diagnostic, and X-ray
18 services.

19 (I) Preferred brand name drugs.

20 (J) Generic drugs.

21 (7) Additional features of the plan or coverage,
22 including the following:

23 (A) Specialist referral policies.

24 (B) The availability of wellness programs.

1 (C) The availability of disease management
2 programs.

3 (D) Whether an individual enrolled in such
4 plan or coverage is an eligible individual for
5 purposes of section 223 of the Internal Revenue
6 Code of 1986 (relating to health savings ac-
7 counts).

8 (E) Coverage of preventive care services.

9 (8) Such other aspects of the plan or coverage
10 as the Secretary may specify.

11 (b) CONSULTATION.—In updating guidance described
12 in subsection (a) with respect to section 2715 of the Public
13 Health Service Act (42 U.S.C. 300gg–15), the Secretary
14 shall consult with the Secretary of Labor and the Sec-
15 retary of the Treasury.

16 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
17 tion shall be construed as requiring a group health plan,
18 a health insurance issuer offering group or individual
19 health insurance coverage, or an MA organization offering
20 an MA plan to offer any of the plan features described
21 in subsection (a).

22 (d) DEFINITIONS.—In this section:

23 (1) MEDICARE ADVANTAGE TERMS.—The terms
24 “MA organization” and “MA plan” have the mean-
25 ings given each such term for purposes of part C of

1 title XVIII of the Social Security Act (42 U.S.C.
2 1395w–21 et seq.).

3 (2) PRIVATE HEALTH INSURANCE TERMS.—The
4 terms “group health plan”, “health insurance cov-
5 erage”, “health insurance issuer”, “group health in-
6 surance coverage”, and “individual health insurance
7 coverage” have the meanings given each such term
8 in section 2791 of the Public Health Service Act (42
9 U.S.C. 300gg–91).

10 (3) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 **SEC. 205. ESTABLISHING REQUIREMENTS WITH RESPECT**
13 **TO THE USE OF PRIOR AUTHORIZATION**
14 **UNDER MEDICARE ADVANTAGE PLANS.**

15 Section 1852 of the Social Security Act (42 U.S.C.
16 1395w–22) is amended by adding at the end the following
17 new subsection:

18 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

19 “(1) IN GENERAL.—In the case of an MA plan
20 that imposes any prior authorization requirement
21 with respect to any applicable item or service (as de-
22 fined in paragraph (5)) during a plan year beginning
23 on or after January 1, 2029, such plan shall—

24 “(A) establish the electronic prior author-
25 ization program described in paragraph (2);

1 “(B) meet the transparency requirements
2 specified in paragraph (3); and

3 “(C) meet the enrollee protection stand-
4 ards specified pursuant to paragraph (4).

5 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
6 GRAM.—

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

12 “(i) a prior authorization request
13 from a provider to an MA plan with re-
14 spect to an applicable item or service to be
15 furnished to an individual and a response,
16 in accordance with this paragraph, from
17 such plan to such provider; and

18 “(ii) any supporting documentation
19 relating to such request or response.

20 “(B) ELECTRONIC TRANSMISSION.—

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

1 transmission described in subparagraph
2 (A).

3 “(ii) STANDARDS.—An electronic
4 transmission described in subparagraph
5 (A) shall comply with applicable technical
6 standards and other requirements to pro-
7 mote the standardization and streamlining
8 of electronic transactions adopted by the
9 Secretary.

10 “(3) TRANSPARENCY REQUIREMENTS.—

11 “(A) IN GENERAL.—For purposes of para-
12 graph (1)(B), the transparency requirements
13 specified in this paragraph are, with respect to
14 an MA plan and a plan year, the following:

15 “(i) The plan, at a time and in a
16 manner specified by the Secretary, shall
17 submit to the Secretary and post on the
18 public website of such plan the following
19 information with respect to such plan year:

20 “(I) A list of all applicable items
21 and services that were subject to a
22 prior authorization requirement under
23 the plan.

24 “(II) The percentage and number
25 of specified requests (as defined in

1 subparagraph (F)) approved by the
2 plan in an initial determination and
3 the percentage and number of speci-
4 fied requests denied by such plan in
5 an initial determination (both in the
6 aggregate and categorized by each
7 item and service).

8 “(III) The percentage and num-
9 ber of specified requests that were de-
10 nied by the plan in an initial deter-
11 mination and that were subsequently
12 appealed.

13 “(IV) The percentage and num-
14 ber of appeals of specified requests re-
15 solved, and the percentage and num-
16 ber of such resolved appeals that re-
17 sulted in approval of the furnishing of
18 the item or service that was the sub-
19 ject of such request, categorized by
20 each applicable item and service and
21 categorized by each level of appeal
22 (including judicial review).

23 “(V) The percentage and number
24 of specified requests that were denied,
25 and the percentage and number of

1 specified requests that were approved,
2 by the plan through the utilization of
3 decision support technology, artificial
4 intelligence technology, machine-learning
5 technology, clinical decision-making
6 technology, or any other technology
7 specified by the Secretary.

8 “(VI) The average and the median
9 amount of time (in hours) that
10 elapsed between the submission of a
11 specified request to the plan and a determination
12 by the plan with respect
13 to such request for each such item
14 and service (excluding any such requests
15 that were not submitted with
16 the medical or other documentation
17 required to be submitted by the plan),
18 categorized by such requests that were
19 for expedited determinations (as described
20 in subsection (g)(3)) and such
21 requests that were not for expedited
22 determinations.

23 “(VII) The percentage and number
24 of specified requests that were excluded
25 from the calculation described

1 in subclause (VI) based on the plan's
2 determination that such requests were
3 not submitted with the medical or
4 other documentation required to be
5 submitted by the plan.

6 “(VIII) The percentage and
7 number of instances in which, during
8 a surgical or medical procedure involv-
9 ing the furnishing of an applicable
10 item or service with respect to which
11 such plan had approved a prior au-
12 thorization request, the provider fur-
13 nishing such item or service deter-
14 mined that a different or additional
15 item or service was medically nec-
16 essary, and a specification of whether
17 such plan subsequently approved the
18 furnishing of such different or addi-
19 tional item or service.

20 “(IX) A disclosure and descrip-
21 tion of any technology described in
22 subclause (V) that the plan utilized in
23 making determinations with respect to
24 specified requests.

1 “(X) The number of grievances
2 (as described in subsection (f)) re-
3 ceived by such plan that were related
4 to a prior authorization requirement.

5 “(XI) Such other information as
6 the Secretary determines appropriate.

7 “(ii) The plan shall provide—

8 “(I) to each provider that seeks
9 to enter into a contract with such
10 plan to furnish applicable items and
11 services under such plan, the list de-
12 scribed in clause (i)(I) and any poli-
13 cies or procedures used by the plan
14 for making determinations with re-
15 spect to prior authorization requests;

16 “(II) to each such provider that
17 enters into such a contract, access to
18 the criteria used by the plan for mak-
19 ing such determinations and an
20 itemization of the medical or other
21 documentation required to be sub-
22 mitted by a provider with respect to
23 such a request; and

24 “(III) to an enrollee of the plan,
25 upon request, access to such criteria.

1 “(B) OPTION FOR PLAN TO PROVIDE CER-
2 TAIN ADDITIONAL INFORMATION.—As part of
3 the information described in subparagraph
4 (A)(i) submitted to the Secretary with respect
5 to a plan year, an MA plan may elect to include
6 information regarding the percentage and num-
7 ber of specified requests made with respect to
8 an item or service that were denied by the plan
9 in an initial determination based on such re-
10 quests failing to demonstrate that individuals
11 requesting to receive such item or service met
12 the clinical criteria used by such plan to receive
13 such item or service.

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

18 “(i) access to criteria described in
19 subparagraph (A)(ii)(II) to providers in ac-
20 cordance with such subparagraph; and

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

24 “(D) PUBLICATION OF INFORMATION.—
25 The Secretary shall publish information de-

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

8 “(E) MEDPAC REPORT.—Not later than
9 the first June 15 occurring after the date that
10 is 2 years after the date information submitted
11 under subparagraph (A)(i) is made available to
12 the Medicare Payment Advisory Commission,
13 the Commission shall submit to Congress a re-
14 port on such information that includes a de-
15 scriptive analysis of the use of prior authoriza-
16 tion. As appropriate, the Commission should re-
17 port on statistics including the frequency of ap-
18 peals and overturned decisions. The Commis-
19 sion shall provide recommendations, as appro-
20 priate, on any improvement that should be
21 made to the electronic prior authorization pro-
22 grams of MA plans.

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

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

3 “(4) ENROLLEE PROTECTION STANDARDS.—
4 For purposes of paragraph (1)(C), with respect to
5 the use of prior authorization by MA plans for appli-
6 cable items and services, the enrollee protection
7 standards specified in this paragraph are—

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

13 “(B) allowing for the waiver or modifica-
14 tion of prior authorization requirements based
15 on the performance of such providers in dem-
16 onstrating compliance with such requirements,
17 such as adherence to evidence-based medical
18 guidelines and other quality criteria; and

19 “(C) conducting annual reviews of such
20 items and services for which prior authorization
21 requirements are imposed under such plans
22 through a process that takes into account input
23 from physicians who meet such criteria as may
24 be specified by the Secretary and other stake-
25 holders (including enrollees and providers with

1 such contracts in effect) and is based on consid-
2 eration of prior authorization data from pre-
3 vious plan years and analyses of current cov-
4 erage criteria.

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

11 “(6) REPORTS TO CONGRESS.—

12 “(A) GAO.—Not later than January 1,
13 2032, the Comptroller General of the United
14 States shall submit to Congress a report con-
15 taining an evaluation of the implementation of
16 the requirements of this subsection and an
17 analysis of issues in implementing such require-
18 ments faced by MA plans.

19 “(B) HHS.—

20 “(i) THE SECRETARY.—Not later than
21 the end of the fifth plan year beginning
22 after the date of the enactment of this sub-
23 section, and again not later than the end
24 of the seventh plan year after such date of
25 enactment and the ninth plan year after

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

5 “(I) in the case of the first such
6 report, the fourth plan year beginning
7 after the date of the enactment of this
8 subsection; and

9 “(II) in the case of a subsequent
10 report, the 2 plan years preceding the
11 year of the submission of such report.

12 “(ii) CMS.—Not later than January
13 1, 2032, the Centers for Medicare & Med-
14 icaid Services and the Office of National
15 Coordinator for Health Information Tech-
16 nology shall submit to Congress and pub-
17 lish on the internet website of the Centers
18 for Medicare & Medicaid Services a report
19 that—

20 “(I) defines the term ‘real-time
21 decision’ and details how the defini-
22 tion for such term may be updated
23 based on any technological advances;

24 “(II) using the data submitted to
25 the Secretary under paragraph

1 (3)(A)(i), details a process for real-
2 time decisions for routinely approved
3 items and services for purposes of the
4 electronic prior authorization program
5 described in paragraph (2) (which the
6 Secretary may, if determined appro-
7 priate by the Secretary, require to be
8 implemented by MA plans as part of
9 such program pursuant to subsection
10 (g)); and

11 “(III) includes an analysis of—

12 “(aa) items and services
13 that are routinely approved;

14 “(bb) items and services
15 identified in item (aa) that could
16 be subject to real-time decisions;

17 “(cc) whether requiring real-
18 time decisions for such items and
19 services could—

20 “(AA) improve enrollee
21 access to benefits covered
22 under the original medicare
23 fee-for-service program
24 under parts A and B;

1 “(BB) produce oper-
2 ational efficiencies for pro-
3 viders and MA plans; and

4 “(CC) reduce health
5 disparities for enrollees of
6 MA plans in rural and low-
7 income communities; and

8 “(dd) how determinations of
9 routinely approved items and
10 services made solely through au-
11 tomation and artificial intel-
12 ligence by MA plans impact pa-
13 tient access, including disparities
14 in access for rural and low-in-
15 come enrollees of MA plans.”.

16 **SEC. 206. REQUIRING THE INCLUSION OF CERTAIN INFOR-**
17 **MATION IN ENCOUNTER DATA.**

18 Section 1859 of the Social Security Act (42 U.S.C.
19 1395w–28) is amended by adding at the end the following
20 new subsection:

21 “(j) INCLUSION OF CERTAIN INFORMATION IN EN-
22 COUNTER DATA.—

23 “(1) IN GENERAL.—In the case of any encoun-
24 ter data submitted by an MA organization with re-
25 spect to an item or service furnished to an individual

1 under an MA plan offered by such organization dur-
2 ing a plan year beginning on or after January 1,
3 2028, the Secretary shall require that such data in-
4 clude—

5 “(A) the allowed amount for such item or
6 service or, in the case such item or service is
7 furnished under a payment arrangement other
8 than a fee-for-service arrangement (such as a
9 capitated or value-based payment arrangement),
10 an amount that accounts for any payment made
11 for such item or service under such payment ar-
12 rangement, calculated using an allocation meth-
13 od specified by the Secretary;

14 “(B) the amount of cost sharing (including
15 deductibles, copayments, and coinsurance) im-
16 posed for such item or service;

17 “(C) in the case such individual was fur-
18 nished, during such plan year before such item
19 or service was so furnished, an in-home health
20 risk assessment from a specified assessment en-
21 tity, an indicator that such individual was so
22 furnished such an assessment by such an entity;
23 and

24 “(D) in the case such individual was fur-
25 nished, during such plan year before such item

1 or service was so furnished, an in-home health
2 risk assessment from an assessment entity not
3 described in subparagraph (C), an indicator
4 (distinct from the indicator described in such
5 subparagraph) that such individual was so fur-
6 nished such an assessment by such an entity.

7 “(2) INCLUSION OF DATA IN WAREHOUSE.—

8 The Secretary shall include any data required to be
9 included as part of encounter data under paragraph
10 (1) in the Chronic Conditions Data Warehouse (or
11 a successor data warehouse) maintained by the Cen-
12 ters for Medicare & Medicaid Services.

13 “(3) DEFINITIONS.—In this subsection:

14 “(A) ASSESSMENT ENTITY.—The term ‘as-
15 sessment entity’ means an entity with a focus
16 on furnishing in-home health risk assessments,
17 as specified by the Secretary.

18 “(B) SPECIFIED ASSESSMENT ENTITY.—

19 The term ‘specified assessment entity’ means,
20 with respect to an MA organization and a plan
21 year, an assessment entity with respect to
22 which such organization (or any person with an
23 ownership or control interest (as defined in sec-
24 tion 1124(a)(3)) in such organization) is a per-

1 son with an ownership or control interest (as so
2 defined).”.

3 **SEC. 207. INCREASING DATA TRANSPARENCY FOR SUPPLE-**
4 **MENTAL BENEFITS UNDER MEDICARE AD-**
5 **VANTAGE.**

6 (a) IN GENERAL.—Section 1857(e) of the Social Se-
7 curity Act (42 U.S.C. 1395w–27(e)), as amended by sec-
8 tion 202(b), is further amended by adding at the end the
9 following new paragraph:

10 “(8) REPORTING OF ENROLLEE-LEVEL DATA
11 ON SUPPLEMENTAL BENEFITS.—

12 “(A) IN GENERAL.—Beginning with plan
13 years beginning on or after January 1, 2029, a
14 contract under this section with an MA organi-
15 zation shall require the organization to submit
16 to the Secretary, for each MA plan offered by
17 the organization, enrollee-level data on supple-
18 mental benefits (by item or service, or category
19 of item or service, as determined appropriate by
20 the Secretary, and National Provider Identifier
21 (if applicable)), including eligibility for such
22 benefits, the benefit category applicable with re-
23 spect to each such benefit, and data on utiliza-
24 tion of and payments for such benefits (includ-
25 ing the total amount spent by the plan for each

1 enrollee who utilized such benefits and the total
2 out-of-pocket cost per utilization for each en-
3 rollee).

4 “(B) DATA ACCESS.—

5 “(i) IN GENERAL.—Not later than
6 January 1 of the year that is two years
7 after the beginning of a plan year for
8 which data is submitted under subpara-
9 graph (A), the Secretary shall—

10 “(I) upon request, make such
11 data available to individuals and enti-
12 ties for the purpose of conducting—

13 “(aa) evaluations and other
14 analyses to support the program
15 under this title; and

16 “(bb) other health care re-
17 lated research; and

18 “(II) make available on the inter-
19 net website of the Centers for Medi-
20 care & Medicaid Services a public use
21 data file containing such data in de-
22 identified form.

23 “(ii) CONFIDENTIALITY.—In making
24 data available under clause (i)(I), the Sec-
25 retary shall have in place procedures to

1 safeguard the privacy and security of any
2 individually identifiable enrollee informa-
3 tion.”.

4 (b) RULE OF CONSTRUCTION.—Nothing in the
5 amendments made by this section shall affect the collec-
6 tion of information as proposed, or so finalized, pursuant
7 to—

8 (1) the notice entitled “Agency Information
9 Collection Activities: Proposed Collection; Comment
10 Request”, published in the Federal Register on
11 March 14, 2023 (88 Fed. Reg. 15726); or

12 (2) the notice entitled “Agency Information
13 Collection Activities: Submission for OMB Review;
14 Comment Request”, published in the Federal Reg-
15 ister on September 25, 2023 (88 Fed. Reg. 65689).

16 **SEC. 208. IMPLEMENTATION FUNDING.**

17 There are appropriated, out of any monies in the
18 Treasury not otherwise obligated, \$40,000,000 for fiscal
19 year 2026 for purposes of carrying out the provisions of,
20 and the amendments made by, this title, to remain avail-
21 able until expended.

22 **SEC. 209. MEDICARE IMPROVEMENT FUND.**

23 Section 1898(b)(1) of the Social Security Act (42
24 U.S.C. 1395iii(b)(1)) is amended by striking
25 “\$2,062,000,000” and inserting “\$2,014,000,000”.

1 **TITLE III—LOWERING DRUG**
2 **PRICES**

3 **SEC. 301. BIOSIMILAR BIOLOGICAL PRODUCTS.**

4 (a) IN GENERAL.—Section 351(k) of the Public
5 Health Service Act (42 U.S.C. 262(k)) is amended—

6 (1) in the subsection heading, by striking “OR
7 INTERCHANGEABLE”;

8 (2) in paragraph (2)—

9 (A) by striking subparagraph (B);

10 (B) by redesignating clauses (ii) and (iii)
11 of subparagraph (A) as subparagraphs (B) and
12 (C), respectively, and adjusting the margins ac-
13 cordingly;

14 (C) in subparagraph (A)—

15 (i) in clause (i), by redesignating sub-
16 clauses (I) through (V) as clauses (i)
17 through (v), respectively, and adjusting the
18 margins accordingly;

19 (ii) in clause (i), as so redesignated by
20 clause (i) of this subparagraph, by redesign-
21 ating items (aa) through (cc) as sub-
22 clauses (I) through (III), respectively, and
23 adjusting the margins accordingly;

24 (iii) in subclause (II) of clause (i), as
25 so redesignated by clause (ii) of this sub-

1 paragraph, by striking “item (aa) or (cc)”
2 and inserting “subclause (I) or (III)”; and
3 (iv) by striking “(A) IN GENERAL” and
4 all that follows through “An application
5 submitted under this subsection shall in-
6 clude information” and inserting the fol-
7 lowing:

8 “(A) IN GENERAL.—An application sub-
9 mitted under this subsection shall include infor-
10 mation”;

11 (D) in subparagraph (B), as so redesign-
12 nated by subparagraph (B) of this paragraph,
13 by striking “clause (i)(I)” and inserting “sub-
14 paragraph (A)(i)”; and

15 (E) in subparagraph (C), as so redesign-
16 nated by subparagraph (B) of this paragraph,
17 by redesignating subclauses (I) through (III) as
18 clauses (i) through (iii), respectively, and by ad-
19 justing the margins accordingly;

20 (3) by amending subparagraph (A) of para-
21 graph (3) to read as follows:

22 “(A) the Secretary determines that the in-
23 formation submitted in the application (or the
24 supplement) is sufficient to show that the bio-

1 logical product is biosimilar to the reference
2 product; and”;

3 (4) by amending paragraph (4) to read as fol-
4 lows:

5 “(4) INTERCHANGEABILITY.—

6 “(A) IN GENERAL.—A biological product
7 licensed under this subsection shall be deemed
8 to be interchangeable with the reference prod-
9 uct, subject to subparagraph (B).

10 “(B) TIMING OF DEEMED INTERCHANGE-
11 ABILITY.—

12 “(i) LICENSURE ON OR AFTER DATE
13 OF ENACTMENT.—A biological product li-
14 censed under this subsection on or after
15 the date of enactment of the Lower Costs,
16 More Transparency Act of 2026 (referred
17 to in this clause as the ‘applicable biologi-
18 cal product’) shall be deemed to be inter-
19 changeable with the reference product
20 upon such licensure, unless the applicable
21 biological product relied on the same ref-
22 erence product as another biological prod-
23 uct for which—

24 “(I) licensure under this sub-
25 section was in effect on the day before

1 the date of enactment of the such Act;
2 and

3 “(II) a first interchangeable ex-
4 clusivity period under paragraph (6)
5 (as in effect on the day before the
6 date of enactment of such Act) is in
7 effect on the date of licensure of the
8 applicable biological product,
9 in which case the applicable biological
10 product shall be deemed interchangeable
11 with the reference product under this para-
12 graph on the date on which the exclusivity
13 period described in subclause (II) ends.

14 “(ii) LICENSURE PRIOR TO DATE OF
15 ENACTMENT.—A biological product li-
16 censed under this subsection prior to the
17 date of enactment of the Lower Costs,
18 More Transparency Act of 2026 (referred
19 to in this clause as the ‘applicable biologi-
20 cal product’) shall be deemed to be inter-
21 changeable with the reference product on
22 such date, unless the applicable biological
23 product relied on the same reference prod-
24 uct as another biological product for
25 which—

1 “(I) licensure under this sub-
2 section was in effect on the day before
3 the date of enactment of such Act;
4 and

5 “(II) a first interchangeable ex-
6 clusivity period under paragraph (6)
7 (as in effect on the day before the
8 date of enactment of such Act) is in
9 effect on the date of enactment of
10 such Act,

11 in which case the applicable biological
12 product shall be deemed interchangeable
13 with the reference product under this para-
14 graph on the date on which the exclusivity
15 period described in subclause (II) ends.”;

16 (5) by amending paragraph (6) to read as fol-
17 lows:

18 “(6) PRESERVING FIRST INTERCHANGEABLE
19 EXCLUSIVITY WITH RESPECT TO CERTAIN BIOLOGI-
20 CAL PRODUCTS.—With respect to a biological prod-
21 uct licensed under this subsection before the date of
22 enactment of the Lower Costs, More Transparency
23 Act of 2026, for which there was an unexpired pe-
24 riod of first interchangeable exclusivity under this
25 subsection (as then in effect), such unexpired exclu-

1 sivity period shall remain in effect for the duration
2 of such period.”; and

3 (6) in paragraph (8)(D)—

4 (A) in clause (i), by striking “class; and”
5 and inserting “class.”;

6 (B) by striking clause (ii); and

7 (C) by striking “description of—” and all
8 that follows through “criteria that the Sec-
9 retary” and inserting “description of the cri-
10 teria that the Secretary”.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 351(i)(3) of the Public Health Serv-
13 ice Act (42 U.S.C. 262(i)(3)) is amended by striking
14 “that is shown to meet the standards described in
15 subsection (k)(4)” and inserting “licensed under
16 subsection (k)”.

17 (2) Section 352A of the Public Health Service
18 Act (42 U.S.C. 263–1) is amended by striking “and
19 interchangeable biosimilar biological products” each
20 place it appears.

21 (3) Section 744G(14) of the Federal Food,
22 Drug, and Cosmetic Act (21 U.S.C. 379j–51(14)) is
23 amended by striking “, including a supplement re-
24 questing that the Secretary determine that the bio-
25 similar biological product meets the standards for

1 interchangeability described in section 351(k)(4) of
2 the Public Health Service Act”.

3 (4) Section 505B(l) of the Federal Food, Drug,
4 and Cosmetic Act (21 U.S.C. 355c(l)) to read as fol-
5 lows:

6 “(l) BIOSIMILAR BIOLOGICAL PRODUCTS.—A biologi-
7 cal product for which an application is submitted under
8 section 351(k) of the Public Health Service Act shall not
9 be considered to have a new active ingredient for purposes
10 of this section, unless—

11 “(1) the application seeks licensure for a
12 claimed indication that has been approved for the
13 reference product in a relevant pediatric population
14 or for which there is a deferral of the pediatric as-
15 sessment under paragraph (4) for the reference
16 product; and

17 “(2) a pediatric assessment or investigation
18 under this section would not involve the development
19 of a biological product with a strength, dosage form,
20 route of administration, or condition of use that
21 could not be licensed under section 351(k) of the
22 Public Health Service Act.”.

23 (c) GUIDANCE.—The Secretary shall—

24 (1) not later than 18 months after the date of
25 enactment of this Act, update existing draft and

1 final guidance, as appropriate, to reflect the amend-
2 ments made by this Act, including by revising or re-
3 voking the guidance document titled “Considerations
4 in Demonstrating Interchangeability With a Ref-
5 erence Product” (May 2019) and “Considerations in
6 Demonstrating Interchangeability With a Reference
7 Product: Update” (June 2024);

8 (2) not later than 18 months after the date of
9 enactment of this Act, issue or revise guidance, as
10 appropriate, on review and approval of biosimilar bi-
11 ological products under section 351(k) of the Public
12 Health Service Act (42 U.S.C. 262(k)) relating to
13 the data and information that an applicant is re-
14 quired to submit to support a determination that a
15 biosimilar biological product that is the subject of an
16 application under such section is biosimilar to the
17 reference product (as defined in section 351(i) of
18 such Act (42 U.S.C. 262(i))); and

19 (3) not later than 18 months after the comment
20 period closes on the guidance under paragraphs (1)
21 and (2), issue revised draft or final versions of such
22 guidances.

1 **SEC. 302. ASSESSMENT OF PHARMACODYNAMICS OR EFFI-**
2 **CACY IN CLINICAL STUDIES REQUIRED FOR**
3 **LICENSURE OF BIOLOGICAL PRODUCTS AS**
4 **BIOSIMILAR.**

5 (a) IN GENERAL.—Section 351(k)(2) of the Public
6 Health Service Act (42 U.S.C. 262(k)(2)), as amended by
7 section 301, is further amended—

8 (1) in subparagraph (A)(i), as redesignated by
9 section 301(a)(2)(C)—

10 (A) in subclause (II), as so redesignated—

11 (i) by striking “subclause (I) or (III)”

12 and inserting “subclause (I), (II), or

13 (III)”;

14 (ii) by striking “and” at the end; and

15 (B) by striking subclause (III), as redesign-

16 nated by section 301(a)(2)(C), and inserting

17 the following:

18 “(III) an assessment of phar-

19 macokinetics and immunogenicity

20 (which may rely on, or consist of, a

21 clinical pharmacokinetics study or

22 studies or a study or studies described

23 in subclause (I) or (IV), as appro-

24 priate); and

25 “(IV) a clinical study or studies

26 required by the Secretary pursuant to

1 subparagraph (D) to support a dem-
2 onstration that no clinically meaning-
3 ful differences exist between the bio-
4 logical product and reference product
5 with respect to safety, purity, and po-
6 tenency;” and

7 (2) by adding at the end the following:

8 “(D) LIMITATION ON REQUIRING ADDI-
9 TIONAL CLINICAL STUDY OR STUDIES.—

10 “(i) IN GENERAL.—The Secretary
11 may only require an additional clinical
12 study or studies described in subparagraph
13 (A)(i)(IV), including a study or studies
14 that include an assessment of
15 pharmacodynamics or efficacy, if the Sec-
16 retary determines that such study or stud-
17 ies are necessary, in combination with the
18 other studies described in subparagraph
19 (A)(i), to demonstrate biosimilarity and
20 provides written notice of such determina-
21 tion to the sponsor of the proposed bio-
22 similar biological product.

23 “(ii) TIMING OF ISSUANCE OF WRIT-
24 TEN NOTICE.—Written notice under clause
25 (i) shall be provided not later than—

1 “(I) in the case of the Secretary
2 granting a request for a biosimilar bi-
3 ological product development meeting
4 and the sponsor of the biosimilar bio-
5 logical product involved requesting at
6 such meeting that the Secretary deter-
7 mine whether such additional clinical
8 study or studies are necessary, the
9 date on which the Secretary issues
10 meeting minutes for such meeting,
11 unless the Secretary describes in the
12 meeting minutes why an assessment
13 of the need for such study or studies
14 cannot be made at that time; or

15 “(II) in the case that no such re-
16 quest is made or if the Secretary was
17 unable to make the assessment under
18 subclause (I), the date that is 60 days
19 after the date of the submission of an
20 application under this subsection.

21 “(iii) DETERMINATION RELATING TO
22 PROPOSED BIOSIMILAR BIOLOGICAL PROD-
23 UCTS.—At the written request of the spon-
24 sor of a proposed biosimilar biological
25 product, the Secretary shall determine that

1 a study or studies described in subpara-
2 graph (A)(i)(IV) that includes the assess-
3 ment of pharmacodynamics, or efficacy are
4 unnecessary to support a determination
5 that the biological product is biosimilar to
6 the reference product, unless the Secretary
7 provides a written response, within an
8 agreed upon period after receipt of the
9 written request, that includes a written
10 justification as to why such study or stud-
11 ies are necessary or why an assessment of
12 the need for such study or studies cannot
13 be made at that time.”.

14 (b) REPEAL OF REQUIREMENT RELATING TO CON-
15 DUCT OF REVIEWS.—Section 351(k)(5) of the Public
16 Health Service Act (42 U.S.C. 262(k)(5)) is amended—

17 (1) by striking subparagraph (B); and
18 (2) by redesignating subparagraph (C) as sub-
19 paragraph (B).

20 (c) APPLICABILITY.—The amendments made by sub-
21 section (a) shall apply with respect to—

22 (1) a biosimilar product development meeting
23 request submitted on or after the date of enactment
24 of this Act; and

1 (2) an application submitted under section
2 351(k) of the Public Health Service Act (42 U.S.C.
3 262(k)) on or after the date of enactment of this
4 Act.

5 **SEC. 303. DENIAL OF PETITIONS WHOSE PRIMARY PUR-**
6 **POSE IS TO DELAY APPROVAL OF CERTAIN**
7 **APPLICATIONS.**

8 (a) IN GENERAL.—Section 505(q)(1) of the Federal
9 Food, Drug, and Cosmetic Act (21 U.S.C. 355(q)(1))—
10 (1) in subparagraph (A), by amending clause (i)
11 to read as follows:

12 “(i) the request is—

13 “(I) in writing;

14 “(II) a petition submitted to the
15 Secretary pursuant to section 10.30,
16 10.31, or 10.35 of title 21, Code of
17 Federal Regulations (or any successor
18 regulations); and

19 “(III) submitted not later than
20 the date that is 60 days after the in-
21 formation upon which the petition is
22 based first became known to, or rea-
23 sonably should have been known by,
24 the party on whose behalf the petition
25 is submitted; and”;

1 (2) by amending subparagraph (E) to read as
2 follows:

3 “(E) DENIAL BASED ON INTENT TO
4 DELAY.—

5 “(i) IN GENERAL.—If the Secretary
6 determines that a petition or a supplement
7 to the petition was submitted with the pri-
8 mary purpose of delaying the approval of
9 an application or the petition does not on
10 its face raise valid scientific or regulatory
11 issues, the Secretary may deny the petition
12 at any point based on such determination.

13 “(ii) FACTORS.—The Secretary may
14 issue guidance to describe the factors that
15 will be used to determine under this sub-
16 paragraph whether a petition is submitted
17 with the primary purpose of delaying the
18 approval of an application. Such factors
19 shall include the following:

20 “(I) Submission of a petition
21 where it appears, based on the date
22 that relevant information relied upon
23 in the petition became known to the
24 petitioner (or reasonably should have
25 been known to the petitioner), that

1 the petitioner has taken an unreason-
2 able length of time to submit the peti-
3 tion.

4 “(II) Submission of multiple or
5 serial petitions raising issues that rea-
6 sonably could have been known to the
7 petitioner at the time of submission of
8 the earlier petition or petitions.

9 “(III) Submission of a petition
10 close in time to a known, first date
11 upon which an application under sub-
12 section (b)(2) or (j) of this section or
13 under section 351(k) of the Public
14 Health Service Act could be approved
15 (such as submission close in time to
16 the expiration of a blocking patent or
17 exclusivity).

18 “(IV) Submission of a petition
19 without any data or information in
20 support of the scientific positions set
21 forth in the petition.

22 “(V) Submission of a petition
23 raising the same or substantially simi-
24 lar issues as a prior petition to which
25 the Food and Drug Administration

1 has already substantively responded,
2 particularly where the subsequent sub-
3 mission closely follows in time the ear-
4 lier response.

5 “(VI) Submission of a petition
6 concerning standards for approval of
7 a drug product for which—

8 “(aa) the Food and Drug
9 Administration has provided an
10 opportunity for public input
11 (such as when the Food and
12 Drug Administration has issued
13 draft or final product-specific
14 guidance applicable to the drug
15 product); and

16 “(bb) the petitioner has not
17 provided comment other than
18 through the petition.

19 “(VII) Submission of a petition
20 requesting that other applicants must
21 meet standards for testing, data, or
22 labeling for their products that are
23 more onerous or rigorous than the
24 standards applicable to the applicable
25 listed drug, reference product, or the

1 petitioner’s version of the same drug
2 or product.

3 “(VIII) Other relevant consider-
4 ations, including the history of the pe-
5 titioner with the Food and Drug Ad-
6 ministration (such as whether the pe-
7 titioner has a history of submitting
8 petitions which the Food and Drug
9 Administration has determined were
10 submitted with the primary purpose of
11 delay).”;

12 (3) by striking subparagraph (F);

13 (4) by redesignating subparagraphs (G)
14 through (I) as subparagraphs (F) through (H), re-
15 spectively; and

16 (5) in subparagraph (H), as so redesignated, by
17 striking “‘submission of this petition’” and insert-
18 ing “‘submission of this document’”.

19 (b) EXHAUSTION OF ADMINISTRATIVE REMEDIES.—
20 Section 505(q)(2) of the Federal Food, Drug, and Cos-
21 metic Act (21 U.S.C. 355(q)(2)) is amended—

22 (1) in subparagraph (A)—

23 (A) in the heading, by striking “WITHIN
24 150 DAYS”;

1 (B) in clause (i), by striking “during the
2 150-day period referred to in paragraph
3 (1)(F),”; and

4 (C) by amending clause (ii) to read as fol-
5 lows:

6 “(ii) on or after the date that is 151
7 days after the date of submission of the
8 petition, the Secretary approves or has ap-
9 proved the application that is the subject
10 of the petition without having made such a
11 final decision.”; and

12 (2) by amending subparagraph (B) to read as
13 follows:

14 “(B) DISMISSAL OF CERTAIN CIVIL AC-
15 TIONS.—

16 “(i) PETITION.—If a person files a
17 civil action against the Secretary in which
18 a person seeks to set aside, delay, rescind,
19 withdraw, or prevent submission, review, or
20 approval of an application submitted under
21 subsection (b)(2) or (j) of this section or
22 section 351(k) of the Public Health Service
23 Act without first submitting a petition to
24 the Secretary under paragraph (1) that de-
25 scribes all information and arguments that

1 form the basis of the relief requested in
2 such civil action, the court shall dismiss
3 without prejudice the action for failure to
4 exhaust administrative remedies.

5 “(ii) TIMELINESS.—If a person files a
6 civil action against the Secretary in which
7 a person seeks to set aside, delay, rescind,
8 withdraw, or prevent submission, review, or
9 approval of an application submitted under
10 subsection (b)(2) or (j) of this section or
11 section 351(k) of the Public Health Service
12 Act after the date described in paragraph
13 (1)(A)(i), the court shall dismiss with prej-
14 udice the action for failure to timely file a
15 petition.

16 “(iii) FINAL RESPONSE.—If a civil ac-
17 tion is filed against the Secretary with re-
18 spect to any issue raised in a petition time-
19 ly filed under paragraph (1) in which the
20 petitioner requests that the Secretary take
21 any form of action that could, if taken, set
22 aside, delay, rescind, withdraw, or prevent
23 submission, review, or approval of an appli-
24 cation submitted under subsection (b)(2)
25 or (j) of this section or section 351(k) of

1 the Public Health Service Act before the
2 Secretary has taken final agency action on
3 the petition within the meaning of sub-
4 paragraph (A), the court shall dismiss
5 without prejudice the action for failure to
6 exhaust administrative remedies.”.

7 (c) REMOVAL OF BIOLOGICAL PRODUCTS FROM EX-
8 CEPTIONS.—Section 505(q)(4) of the Federal Food, Drug,
9 and Cosmetic Act (21 U.S.C. 355(q)(4)) is amended—

10 (1) by striking subparagraph (B);

11 (2) in subparagraph (A)—

12 (A) by redesignating clauses (i) and (ii) as
13 subparagraphs (A) and (B), respectively, and
14 adjusting the margins accordingly; and

15 (B) by striking “; and” at the end and in-
16 serting a period; and

17 (3) by striking “(4) EXCEPTIONS” and all that
18 follows through “This subsection does not” and in-
19 serting the following:

20 “(4) EXCEPTIONS.—This subsection does not”.

21 **SEC. 304. PRIORITY NONPRESCRIPTION DRUGS.**

22 (a) IN GENERAL.—The Federal Food, Drug, and
23 Cosmetic Act is amended by inserting after section 506L
24 (21 U.S.C. 356l) the following:

1 **“SEC. 506M. PRIORITY NONPRESCRIPTION DRUGS.**

2 “(a) IN GENERAL.—

3 “(1) DESIGNATION.—The Secretary may, at the
4 request of the sponsor of a nonprescription drug,
5 designate as a priority nonprescription drug under
6 this section a drug intended for nonprescription use
7 that is subject to an application submitted (or to be
8 submitted) under section 505(b), if the Secretary de-
9 termines that the drug meets the criteria specified in
10 subsection (d).

11 “(2) NONPRESCRIPTION DEFINED.—In this sec-
12 tion, the term ‘nonprescription’ means, with respect
13 to a drug, that such drug is not subject to section
14 503(b)(1).

15 “(b) REQUEST FOR DESIGNATION.—The sponsor of
16 a drug subject to a pending application under section
17 505(b) for nonprescription use may request that the Sec-
18 retary designate the drug as a priority nonprescription
19 drug.

20 “(c) DESIGNATION.—Not later than 60 calendar days
21 after the receipt of a request under subsection (b), the
22 Secretary shall determine whether a drug meets the cri-
23 teria for designation as a priority nonprescription drug
24 under this section, and if so, make such designation.

25 “(d) CRITERIA.—

1 “(1) ELIGIBILITY.—Except as provided in para-
2 graph (2), a drug described in subsection (a) is eligi-
3 ble for designation as a priority nonprescription
4 drug if—

5 “(A) the drug is intended for a novel non-
6 prescription indication that could provide a
7 meaningful public health benefit;

8 “(B) the drug is a new molecular entity; or

9 “(C) the drug contains an active ingredient
10 that has never been available in a nonprescrip-
11 tion drug.

12 “(2) EXCLUSION.—A drug is not eligible for
13 designation as a priority nonprescription drug if the
14 drug is subject to a risk evaluation and mitigation
15 strategy under section 505–1 or if the drug is a con-
16 trolled substance (as defined in section 102 of the
17 Controlled Substances Act).

18 “(e) ACTIONS.—If the Secretary designates a drug
19 as a priority nonprescription drug, the Secretary shall take
20 such actions as are appropriate to facilitate the develop-
21 ment of, and expedite the review of, an application or sup-
22 plement to an application for such drug, which may in-
23 clude—

1 “(1) holding meetings with the sponsor and the
2 review team throughout the development of the
3 drug;

4 “(2) providing timely advice to, and interactive
5 communication with, the sponsor regarding the de-
6 velopment of the drug to ensure that the develop-
7 ment program to gather the nonclinical and clinical
8 data necessary to demonstrate the inapplicability of
9 the criteria described in section 503(b)(1) is as effi-
10 cient as practicable;

11 “(3) involving senior managers and experienced
12 review staff, as appropriate, in a collaborative, cross-
13 disciplinary review;

14 “(4) assigning a cross-disciplinary project lead
15 for the Food and Drug Administration team to fa-
16 cilitate an efficient review of the development pro-
17 gram and to serve as a scientific liaison between the
18 review team and the sponsor; and

19 “(5) taking steps to ensure that the design of
20 any necessary nonclinical or clinical trials is as effi-
21 cient as practicable, when scientifically appropriate,
22 including reliance on real world evidence.

23 “(f) LIST OF CONDITIONS.—

24 “(1) ESTABLISHMENT.—Not later than 18
25 months after the date of enactment of this section,

1 the Secretary shall publish in the Federal Register
2 a list of conditions for which a nonprescription drug,
3 if developed for the condition, could provide mean-
4 ingful public health benefit.

5 “(2) PUBLIC COMMENT.—The Secretary shall
6 provide a period of not less than 30 days for public
7 comment on—

8 “(A) the list under paragraph (1); and

9 “(B) any updates to such list.”.

10 (b) RULE OF CONSTRUCTION.—The amendment
11 made by subsection (a) shall not be construed to alter the
12 evidentiary standards or the information required for ap-
13 proval of a nonprescription drug under section 505 of the
14 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355).

15 (c) REPORT TO CONGRESS.—Not later than 4 years
16 after the date of enactment of this Act, the Secretary of
17 Health and Human Services shall submit to Congress a
18 report containing—

19 (1) the number of nonprescription drugs for
20 which a sponsor requested that the Secretary des-
21 ignate such a drug as a priority nonprescription
22 drug under section 506M of the Federal Food,
23 Drug, and Cosmetic Act, as added by subsection (a);

24 (2) the number of nonprescription drugs for
25 which the Secretary approved such request;

1 (3) the number of priority nonprescription
2 drugs (as designated under such section) for which
3 the Secretary approved an application under section
4 505 of the Federal Food, Drug, and Cosmetic Act
5 (21 U.S.C. 355);

6 (4) an overview of the resources used to imple-
7 ment such section; and

8 (5) any recommendation on further improve-
9 ment on increasing over-the-counter drug approvals
10 using a framework similar to the designation frame-
11 work established in such section.

12 (d) SUNSET DATE.—The authority provided to the
13 Secretary of Health and Human Services under section
14 506M of the Federal Food, Drug, and Cosmetic Act, as
15 added by subsection (a), shall cease to be effective Sep-
16 tember 30, 2032.

17 **TITLE IV—EXPANDING ACCESS** 18 **TO CARE**

19 **SECTION 401. REQUIRED PRIMARY HEALTH SERVICES OF** 20 **COMMUNITY HEALTH CENTERS.**

21 (a) INCLUSION OF BEHAVIORAL AND MENTAL
22 HEALTH AND SUBSTANCE USE DISORDER SERVICES.—
23 Section 330(b)(1)(A)(i) of the Public Health Service Act
24 (42 U.S.C. 254b(b)(1)(A)(i)) is amended—

1 (1) in subclause (IV), by striking “and” at the
2 end;

3 (2) in subclause (V), by striking the semicolon
4 at the end and inserting “; and”; and

5 (3) by adding at the end the following:

6 “(VI) behavioral and mental
7 health and substance use disorder
8 services;”.

9 (b) CONFORMING AMENDMENT.—Section 330(b)(2)
10 of the Public Health Service Act (42 U.S.C. 254b(b)(2))
11 is amended—

12 (1) by striking subparagraph (A); and

13 (2) by redesignating subparagraphs (B), (C),
14 and (D) as subparagraphs (A), (B), and (C), respec-
15 tively.

16 **SEC. 402. NUTRITION EDUCATION AND CHRONIC DISEASE**
17 **PREVENTION AT FEDERALLY QUALIFIED**
18 **HEALTH CENTERS.**

19 Section 330 of the Public Health Service Act (42
20 U.S.C. 254b) is amended—

21 (1) by redesignating subsection (r) as sub-
22 section (s); and

23 (2) by inserting after subsection (q) the fol-
24 lowing:

1 “(r) NUTRITION EDUCATION AND CHRONIC DISEASE
2 PREVENTION INITIATIVE.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Administrator of the Health Resources
5 and Services Administration, shall support health
6 centers in integrating and expanding evidence-based
7 nutrition education and counseling into primary care
8 delivery and workforce training.

9 “(2) USE OF FUNDS.—In carrying out para-
10 graph (1), the Secretary may utilize funding, made
11 available under section 10503(b)(4) of the Patient
12 Protection and Affordable Care Act, to award a
13 grant, contract, or cooperative agreement, and may
14 provide technical assistance, to a health center for—

15 “(A) patient-centered nutrition education
16 and counseling services;

17 “(B) integration of nutrition assessment
18 and dietary counseling into chronic disease
19 management;

20 “(C) training and continuing education in
21 nutrition science and dietary counseling for
22 health center providers in health centers;

23 “(D) establishing and maintaining inter-
24 disciplinary models of care that incorporate reg-

1 istered dietitians, community health workers,
2 and other appropriate professionals;

3 “(E) developing culturally and linguis-
4 tically appropriate nutrition education mate-
5 rials; and

6 “(F) evaluating clinical and cost outcomes
7 associated with nutrition interventions.

8 “(3) PARTICIPATION OF AFFILIATED ENTI-
9 TIES.—A health center may affiliate with an aca-
10 demic medical center or medical school in carrying
11 out activities receiving assistance under this sub-
12 section.

13 “(4) PRIORITY.—In making awards under this
14 subsection, the Secretary shall prioritize health cen-
15 ters serving populations with high rates of diet-re-
16 lated chronic disease, food insecurity, or other nutri-
17 tion-related health disparities.

18 “(5) SUPPLEMENT, NOT SUPPLANT.—Funds
19 made available to carry out this subsection shall
20 supplement, and not supplant, other Federal, State,
21 local, or private funding used for similar purposes.

22 “(6) REPORT TO CONGRESS.—Not later than 2
23 years after the date of enactment of this subsection,
24 the Secretary shall submit to Congress a report
25 that—

1 “(A) describes the use of funds under this
2 subsection;

3 “(B) evaluates improvements in patient
4 outcomes related to chronic disease indicators
5 attributable to activities receiving assistance
6 under this subsection;

7 “(C) assesses improvements in workforce
8 training participation and competency develop-
9 ment attributable to activities receiving assist-
10 ance under this subsection; and

11 “(D) estimates potential cost savings to
12 Federal health care programs attributable to
13 nutrition interventions receiving assistance
14 under this subsection.”.

15 **SEC. 403. FUNDING.**

16 Section 10503(b) of the Patient Protection and Af-
17 fordable Care Act (42 U.S.C. 254b–2(b)) is amended—

18 (1) in paragraph (1)(K), by striking “and” at
19 the end;

20 (2) in paragraph (2)(L), by striking the period
21 at the end and inserting a semicolon; and

22 (3) by adding at the end the following:

23 “(3) to be transferred to the Secretary of
24 Health and Human Services to provide enhanced
25 funding to provide the services specified in subclause

1 (VI) of section 330(b)(1)(A)(i) of the Public Health
2 Service Act, \$250,000,000 for each of fiscal years
3 2027 and 2028; and
4 “(4) to be transferred to the Secretary of
5 Health and Human Services to provide enhanced
6 funding to provide the services specified in section
7 330(r) of the Public Health Service Act,
8 \$125,000,000 for each of fiscal years 2027 and
9 2028.”.

