

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 3281
OFFERED BY M . _____**

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Transparent Prices
3 Required to Inform Consumers and Employers Act” or the
4 “Transparent PRICE Act”.

5 **TITLE I—INCREASING PRICE**
6 **TRANSPARENCY TO LOWER**
7 **COSTS**

8 **SEC. 101. PRICE TRANSPARENCY REQUIREMENTS.**

9 (a) IN GENERAL.—Section 2718(e) of the Public
10 Health Service Act (42 U.S.C. 300gg–18(e)) is amend-
11 ed—

12 (1) by striking “Each hospital” and inserting
13 the following:

14 “(1) IN GENERAL.—Each hospital”;

15 (2) by inserting “, without subscription and
16 free of charge, in a single machine-readable file,”
17 after “a list”;

1 (3) by inserting “and a list, in plain language
2 and without subscription and free of charge, in a
3 consumer-friendly format, of the hospital’s standard
4 charges for as many of the 70 Centers for Medicare
5 & Medicaid Services-specified shoppable services that
6 are provided by the hospital, and as many additional
7 hospital-selected shoppable services (or all such addi-
8 tional services, if such hospital provides fewer than
9 300 shoppable services) as may be necessary for a
10 combined total of at least 300 shoppable services”
11 after “Social Security Act”; and

12 (4) by adding at the end the following: “Such
13 lists shall be updated not less frequently than annu-
14 ally. Beginning January 1, 2024, each hospital shall
15 include in its lists of standard charges, along with
16 such additional information as the Secretary may re-
17 quire with respect to such charges for purposes of
18 promoting public awareness of hospital pricing in
19 advance of receiving a hospital item or service, the
20 following:

21 “(A) A plain language description of each
22 item or service included on such list, including,
23 as applicable, the Healthcare Common Proce-
24 dure Coding System (HCPCS) code, the Diag-
25 nosis Related Group (DRG), the National Drug

1 Code (NDC), or other payer identifier used or
2 approved by the Centers for Medicare & Med-
3 icaid Services for such item or service.

4 “(B) The gross charge, expressed as a dol-
5 lar amount, for each such item or service, when
6 provided in, as applicable, the hospital inpatient
7 setting and outpatient department setting.

8 “(C) Any current payer-specific negotiated
9 charges, clearly associated with the name of the
10 third party payer and plan and expressed as a
11 dollar amount, that applies to each such item or
12 service when provided in, as applicable, the hos-
13 pital inpatient setting and outpatient depart-
14 ment setting.

15 “(D) The de-identified maximum and min-
16 imum negotiated charges for each such item or
17 service.

18 “(E) The discounted cash price, expressed
19 as a dollar amount, for each such item or serv-
20 ice when provided in, as applicable, the hospital
21 inpatient setting and outpatient department
22 setting. If the discounted cash price is a per-
23 centage of another value provided, the cal-
24 culated value must be entered as a dollar
25 amount. If the discounted cash price equates to

1 the gross charge, the gross charge shall be re-
2 entered to indicate that no cash discount is
3 available.

4 “(2) DEEMED COMPLIANCE WITH SHOPPABLE
5 SERVICES REQUIREMENT FOR CERTAIN YEARS.—
6 With respect to a year before 2025, a hospital shall
7 be deemed to meet the requirement of paragraph (1)
8 that such hospital make available a list of standard
9 charges for shoppable services if the hospital main-
10 tains an internet-based price estimator tool that
11 meets the following requirements:

12 “(A) The tool provides estimates for as
13 many of the 70 Centers for Medicare & Med-
14 icaid Services specified shoppable services that
15 are provided by the hospital, and as many addi-
16 tional hospital-selected shoppable services (or
17 all such additional services, if such hospital pro-
18 vides fewer than 300 shoppable services) as
19 may be necessary for a combined total of at
20 least 300 shoppable services.

21 “(B) The tool allows health care con-
22 sumers to, at the time they use the tool, obtain
23 an estimate of the amount they will be obligated
24 to pay the hospital for the shoppable service.

1 “(C) The tool is prominently displayed on
2 the hospital’s website and easily accessible to
3 the public, without subscription, fee, or having
4 to submit personal identifying information, and
5 searchable by service description, billing code,
6 and payer.

7 The Secretary may not deem the establishment of an
8 internet-based price estimator tool that meets the re-
9 quirements of this paragraph to constitute compli-
10 ance with the requirement of paragraph (1) that
11 such hospital make available a list of standard
12 charges for shoppable services for 2025 or a subse-
13 quent year.

14 “(3) UNIFORM METHOD AND FORMAT.—Not
15 later than January 1, 2025, the Secretary shall im-
16 plement a standard, uniform method and format for
17 hospitals to use in order to satisfy the requirements
18 of this subsection for disclosing directly to the public
19 charge and price information. Such method and for-
20 mat may be similar to any template established by
21 the Centers for Medicare & Medicaid Services as of
22 the date of the enactment of this paragraph for re-
23 porting such information under this subsection and
24 shall meet such standards as determined appropriate
25 by the Secretary.

1 “(4) MONITORING OF PRICING INFORMATION.—
2 The Secretary, in consultation with the Inspector
3 General of the Department of Health and Human
4 Services, shall, through notice and comment rule-
5 making, establish a process to regularly monitor the
6 accuracy and validity of pricing information dis-
7 played by each hospital pursuant to paragraph (1).

8 “(5) DEFINITIONS.—Notwithstanding any other
9 provision of law, for the purpose of paragraphs (1)
10 and (2):

11 “(A) DE-IDENTIFIED MAXIMUM NEGO-
12 TIATED CHARGE.—The term ‘de-identified max-
13 imum negotiated charge’ means the highest
14 charge that a hospital has negotiated with all
15 third party payers for an item or service.

16 “(B) DE-IDENTIFIED MINIMUM NEGO-
17 TIATED CHARGE.—The term ‘de-identified min-
18 imum negotiated charge’ means the lowest
19 charge that a hospital has negotiated with all
20 third party payers for an item or service.

21 “(C) DISCOUNTED CASH PRICE.—The
22 term ‘discounted cash price’ means the charge
23 that applies to an individual who pays cash, or
24 cash equivalent, for a hospital item or service.
25 Hospitals that do not offer self-pay discounts

1 may display the hospital’s undiscounted gross
2 charges as found in the hospital chargemaster.

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

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

12 “(F) SHOPPABLE SERVICE.—The term
13 ‘shoppable service’ means a service that can be
14 scheduled by a health care consumer in ad-
15 vance.

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

21 “(6) ENFORCEMENT.—

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

24 “(i) the Secretary shall notify such
25 hospital of such failure not later than 30

1 days after the date on which the Secretary
2 determines such failure exists; and

3 “(ii) not later than 45 days after the
4 date of such notification, the hospital shall
5 complete a corrective action plan to comply
6 with such requirements.

7 “(B) CIVIL MONETARY PENALTY.—

8 “(i) IN GENERAL.—In addition to any
9 other enforcement actions or penalties that
10 may apply under subsection (b)(3) or an-
11 other provision of law, a hospital that has
12 received a notification under subparagraph
13 (A)(i) and fails to satisfy the requirement
14 under subparagraph (A)(ii) or otherwise
15 comply with the requirements of this sub-
16 section by the date that is 90 days after
17 such notification shall be subject to a civil
18 monetary penalty of an amount—

19 “(I) in the case the hospital pro-
20 vides not more than 30 beds (as de-
21 termined under section
22 180.90(c)(2)(ii)(D) of title 45, Code
23 of Federal Regulations, as in effect on
24 the date of the enactment of this
25 paragraph), not to exceed \$300 per

1 day that the violation is ongoing as
2 determined by the Secretary; and

3 “(II) in the case the hospital pro-
4 vides more than 30 beds (as so deter-
5 mined), equal to—

6 “(aa) subject to item (bb),
7 \$10 per bed per day that the vio-
8 lation is ongoing as determined
9 by the Secretary, but for viola-
10 tions occurring before January 1,
11 2024, not to exceed \$5,500 per
12 each such day; or

13 “(bb) in the case such hos-
14 pital has failed to satisfy the re-
15 quirement under subparagraph
16 (A)(ii) or otherwise comply with
17 the requirements of this sub-
18 section for any continuous 1-year
19 period beginning on or after Jan-
20 uary 1, 2024, and the amount
21 otherwise imposed under item
22 (aa) for such failure for such pe-
23 riod would be less than
24 \$5,000,000, an amount not less
25 than \$5,000,000.

1 “(ii) INCREASE AUTHORITY.—In ap-
2 plying this subparagraph with respect to
3 violations occurring in 2025 or a subse-
4 quent year, the Secretary may through no-
5 tice and comment rulemaking increase any
6 dollar amount applied under this subpara-
7 graph by an amount specified by the Sec-
8 retary.

9 “(iii) APPLICATION OF CERTAIN PRO-
10 VISIONS.—The provisions of section 1128A
11 of the Social Security Act (other than sub-
12 sections (a) and (b) of such section) shall
13 apply to a civil monetary penalty imposed
14 under clause (i) in the same manner as
15 such provisions apply to a civil monetary
16 penalty imposed under subsection (a) of
17 such section.”.

18 (b) PUBLICATION OF LIST OF HOSPITALS.—

19 (1) LIST OF HOSPITALS.—Beginning not later
20 than 90 days after the date of enactment of this
21 Act, the Secretary of Health and Human Services
22 (referred to in this section as the “Secretary”) shall
23 establish and maintain a publicly available list on
24 the website of the Centers for Medicare & Medicaid
25 Services of each hospital with respect to which the

1 Secretary has conducted a review of such hospital's
2 compliance with the provisions of section 2718(e) of
3 the Public Health Service Act (42 U.S.C. 300gg-
4 18(e)). Such list shall include, with respect to each
5 such hospital that was noncompliant with such pro-
6 visions, a specification as to whether such hospital—

7 (A) has been issued a civil monetary pen-
8 alty;

9 (B) has received a warning notice; or

10 (C) has submitted a corrective action plan.

11 (2) ADDITIONS AND UPDATES.—In the case of
12 a hospital not included on the list described in para-
13 graph (1) as of the date of the establishment of such
14 list and that is subject to a review of such hospital's
15 compliance with the provisions described in such
16 paragraph after such date, the Secretary shall add
17 such hospital to such list, along with the specifica-
18 tions described in such paragraph, not later than 1
19 business day after such review occurs. The Secretary
20 shall update such specifications with respect to any
21 hospital included on such list—

22 (A) not later than 1 business day after any
23 subsequent review of such hospital's compliance
24 with such provisions; and

1 (B) not later than 1 business day after any
2 penalty, notice, or request described in para-
3 graph (1) is made with respect to such hospital.

4 (3) FOIA REQUESTS.—Any penalty, notice, or
5 request described in paragraph (1) shall be subject
6 to public disclosure, in full and without redaction,
7 under section 552 of title 21, United States Code,
8 notwithstanding any exemptions or exclusions other-
9 wise available under such section 552.

10 (4) REPORTS TO CONGRESS.—Not later than 1
11 year after the date of enactment of this Act and
12 each year thereafter, the Secretary of Health and
13 Human Services shall submit to Congress, and make
14 publicly available, a report that contains information
15 regarding complaints of alleged violations of law and
16 enforcement activities by the Secretary under the
17 hospital price transparency rule implementing sec-
18 tion 2718(e) of the Public Health Service Act (42
19 U.S.C. 300gg–18(e)). Such report shall be made
20 available to the public on the website of the Centers
21 for Medicare & Medicaid Services. Each such report
22 shall include, with respect to the year involved—

23 (A) the number of compliance and enforce-
24 ment inquiries opened by the Secretary pursu-
25 ant to such section;

1 (B) the number of notices of noncompli-
2 ance issued by the Secretary based on such in-
3 quiries;

4 (C) the identity of each hospital entity that
5 received a notice of noncompliance and the na-
6 ture of the failure giving rise to the Secretary's
7 determination of noncompliance;

8 (D) the amount of civil monetary penalty
9 assessed against the hospital entity;

10 (E) whether the hospital entity subse-
11 quently corrected the noncompliance; and

12 (F) an analysis of factors contributing to
13 increasing health care costs.

14 (5) GAO REPORT.—Not later than 1 year after
15 the date of enactment of this Act, the Comptroller
16 General of the United States shall submit to the
17 Committee on Energy and Commerce of the House
18 of Representatives and the Committee on Health,
19 Education, Labor, and Pensions of the Senate a re-
20 port on the compliance and enforcement with the
21 hospital price transparency rule implementing sec-
22 tion 2718(e) of the Public Health Service Act (42
23 U.S.C. 300gg–18(e)). The report shall include rec-
24 ommendations related to—

1 (A) improving price transparency to pa-
2 tients, employers, and the public; and

3 (B) increased civil monetary penalty
4 amounts to ensure compliance.

5 (6) REQUEST FOR INFORMATION.—Not later
6 than January 1, 2025, the Secretary of Health and
7 Human Services shall issue a public request for in-
8 formation as to the best method through which hos-
9 pitals may be required to publish quality data (such
10 as data required to be reported under the Medicare
11 Hospital Compare program) alongside data required
12 to be reported under section 2718(e) of the Public
13 Health Service Act (42 U.S.C. 300gg–18(e)).

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

1 **SEC. 102. STRENGTHENING HEALTH INSURER TRANS-**
2 **PARENCY REQUIREMENTS.**

3 (a) **TRANSPARENCY IN COVERAGE.**—Section
4 1311(e)(3)(C) of the Patient Protection and Affordable
5 Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

6 (1) by striking “The Exchange” and inserting
7 the following:

8 “(i) **IN GENERAL.**—The Exchange”;

9 (2) in clause (i), as inserted by paragraph (1)—

10 (A) by striking “participating provider”
11 and inserting “provider”;

12 (B) by inserting “shall include the infor-
13 mation specified in clause (ii) and” after “such
14 information”;

15 (C) by striking “an Internet website” and
16 inserting “a self-service tool that meets the re-
17 quirements of clause (iii)”; and

18 (D) by striking “and such other” and all
19 that follows through the period and inserting
20 “or, at the option such individual, through a
21 paper or phone disclosure (as selected by such
22 individual and provided at no cost to such indi-
23 vidual) that meets such requirements as the
24 Secretary may specify.”; and

25 (3) by adding at the end the following new
26 clauses:

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

7 “(I) If such provider is a partici-
8 pating provider with respect to such
9 item or service, the in-network rate
10 (as defined in subparagraph (F)) for
11 such item or service.

12 “(II) If such provider is not de-
13 scribed in subclause (I), the maximum
14 allowed amount for such item or serv-
15 ice.

16 “(III) The amount of cost shar-
17 ing (including deductibles, copay-
18 ments, and coinsurance) that the indi-
19 vidual will incur for such item or serv-
20 ice (which, in the case such item or
21 service is to be furnished by a pro-
22 vider described in subclause (II), shall
23 be calculated using the maximum
24 amount described in such subclause).

1 “(IV) The amount the individual
2 has already accumulated with respect
3 to any deductible or out of pocket
4 maximum under the plan (broken
5 down, in the case separate deductibles
6 or maximums apply to separate indi-
7 viduals enrolled in the plan, by such
8 separate deductibles or maximums, in
9 addition to any cumulative deductible
10 or maximum).

11 “(V) In the case such plan im-
12 poses any frequency or volume limita-
13 tions with respect to such item or
14 service (excluding medical necessity
15 determinations), the amount that such
16 individual has accrued towards such
17 limitation with respect to such item or
18 service.

19 “(VI) Any prior authorization,
20 concurrent review, step therapy, fail
21 first, or similar requirements applica-
22 ble to coverage of such item or service
23 under such plan.

24 “(iii) SELF-SERVICE TOOL.—For pur-
25 poses of clause (i), a self-service tool estab-

1 lished by a health plan meets the require-
2 ments of this clause if such tool—

3 “(I) is based on an Internet
4 website;

5 “(II) provides for real-time re-
6 sponses to requests described in such
7 clause;

8 “(III) is updated in a manner
9 such that information provided
10 through such tool is timely and accu-
11 rate;

12 “(IV) allows such a request to be
13 made with respect to an item or serv-
14 ice furnished by—

15 “(aa) a specific provider
16 that is a participating provider
17 with respect to such item or serv-
18 ice;

19 “(bb) all providers that are
20 participating providers with re-
21 spect to such plan and such item
22 or service; or

23 “(cc) a provider that is not
24 described in item (bb); and

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

7 The Secretary may require such tool, as a
8 condition of complying with subclause (V),
9 to link multiple billing codes to a single de-
10 scriptive term if the Secretary determines
11 that the billing codes to be so linked cor-
12 respond to items and services.”.

13 (b) DISCLOSURE OF ADDITIONAL INFORMATION.—
14 Section 1311(e)(3) of the Patient Protection and Afford-
15 able Care Act (42 U.S.C. 18031(e)(3)) is amended by add-
16 ing at the end the following new subparagraphs:

17 “(E) RATE AND PAYMENT INFORMA-
18 TION.—

19 “(i) IN GENERAL.—Not later than
20 January 1, 2025, and every 3 months
21 thereafter, each health plan shall submit to
22 the Exchange, the Secretary, the State in-
23 surance commissioner, and make available
24 to the public, the rate and payment infor-

1 mation described in clause (ii) in accord-
2 ance with clause (iii).

3 “(ii) RATE AND PAYMENT INFORMA-
4 TION DESCRIBED.—For purposes of clause
5 (i), the rate and payment information de-
6 scribed in this clause is, with respect to a
7 health plan, the following:

8 “(I) With respect to each item or
9 service for which benefits are available
10 under such plan, the in-network rate
11 in effect as of the date of the submis-
12 sion of such information with each
13 provider (identified by national pro-
14 vider identifier) that is a participating
15 provider with respect to such item or
16 service, other than such a rate in ef-
17 fect with a provider that, during the
18 1-year period ending on such date,
19 submitted fewer than 10 claims for
20 such item or service to such plan.

21 “(II) With respect to each drug
22 (identified by national drug code) for
23 which benefits are available under
24 such plan, the average amount paid
25 by such plan (net of rebates, dis-

1 counts, and price concessions) for
2 such drug dispensed or administered
3 during the 90-day period beginning
4 180 days before such date of submis-
5 sion to each provider that was a par-
6 ticipating provider with respect to
7 such drug, broken down by each such
8 provider (identified by national pro-
9 vider identifier), other than such an
10 amount paid to a provider that, dur-
11 ing such period, submitted fewer than
12 20 claims for such drug to such plan.

13 “(III) With respect to each item
14 or service for which benefits are avail-
15 able under such plan, the amount
16 billed, and the amount allowed by the
17 plan, for each such item or service
18 furnished during the 90-day period
19 specified in subclause (II) by a pro-
20 vider that was not a participating pro-
21 vider with respect to such item or
22 service, broken down by each such
23 provider (identified by national pro-
24 vider identifier), other than items and
25 services with respect to which fewer

1 than 20 claims for such item or serv-
2 ice were submitted to such plan dur-
3 ing such period.

4 “(iii) MANNER OF SUBMISSION.—Rate
5 and payment information required to be
6 submitted and made available under this
7 subparagraph shall be so submitted and so
8 made available in 3 separate machine-read-
9 able files corresponding to the information
10 described in each of subclauses (I) through
11 (III) of clause (ii) that meet such require-
12 ments as specified by the Secretary
13 through rulemaking. Such requirements
14 shall ensure that such files are limited to
15 an appropriate size, are made available in
16 a widely-available format that allows for
17 information contained in such files to be
18 compared across health plans, and are ac-
19 cessible to individuals at no cost and with-
20 out the need to establish a user account or
21 provider other credentials.

22 “(iv) USER GUIDE.—Each health plan
23 shall make available to the public instruc-
24 tions written in plain language explaining
25 how individuals may search for information

1 described in clause (ii) in files submitted in
2 accordance with clause (iii).

3 “(F) DEFINITIONS.—In this paragraph:

4 “(i) PARTICIPATING PROVIDER.—The
5 term ‘participating provider’ has the mean-
6 ing given the term ‘in-network provider’ in

7 “(ii) IN-NETWORK RATE.—The term
8 ‘in-network rate’ means, with respect to a
9 health plan and an item or service fur-
10 nished by a provider that is a participating
11 provider with respect to such plan and
12 item or service, the contracted rate in ef-
13 fect between such plan and such provider
14 for such item or service.”.

15 (c) REPORTS.—

16 (1) COMPLIANCE.—Not later than January 1,
17 2025, the Comptroller General of the United States
18 shall submit to Congress a report containing—

19 (A) an analysis of health plan compliance
20 with the amendments made by this section;

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

24 (C) recommendations relating to improving
25 such enforcement; and

1 (D) recommendations relating to improving
2 public disclosure, and public awareness, of in-
3 formation required to be made available by such
4 plans pursuant to such amendments.

5 (2) PRICES.—Not later than January 1, 2028,
6 the Comptroller General of the United States shall
7 submit to Congress a report containing an assess-
8 ment of differences in negotiated prices (and any
9 trends in such prices) in the private market be-
10 tween—

11 (A) rural and urban areas;

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

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

17 (D) nonprofit and for-profit hospitals;

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

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

22 (d) ENSURING ACCESSIBILITY THROUGH IMPLEMEN-
23 TATION.—In implementing the amendments made by this
24 section, the Secretary shall through rulemaking ensure
25 that any entity making available information pursuant to

1 such amendments takes reasonable steps (as specified by
2 the Secretary) to ensure the accessibility of such to indi-
3 viduals with limited English proficiency. Such steps may
4 include the entity's provision of interpretation services or
5 of translations of such information.

6 (e) EFFECTIVE DATE.—

7 (1) IN GENERAL.—The amendments made by
8 subsection (a) shall apply beginning January 1,
9 2025.

10 (2) CONTINUED APPLICABILITY OF RULES FOR
11 PREVIOUS YEARS.—Nothing in the amendments
12 made by this section may be construed as affecting
13 the applicability of the rule entitled “Transparency
14 in Coverage” published by the Department of the
15 Treasury, the Department of Labor, and the De-
16 partment of Health and Human Services on Novem-
17 ber 12, 2020 (85 Fed. Reg. 72158) before January
18 1, 2025.

19 **SEC. 103. REQUIRING A SEPARATE IDENTIFICATION NUM-**
20 **BER AND AN ATTESTATION FOR EACH OFF-**
21 **CAMPUS OUTPATIENT DEPARTMENT OF A**
22 **PROVIDER.**

23 Section 1833(t) of the Social Security Act (42 U.S.C.
24 1395l(t)) is amended by adding at the end the following
25 new paragraph:

1 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;
2 ATTESTATION.—

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

10 “(i) such department has obtained,
11 and such items and services are billed
12 under, a standard unique health identifier
13 for health care providers (as described in
14 section 1173(b)) that is separate from
15 such identifier for such provider; and

16 “(ii) such provider has submitted to
17 the Secretary, during the 2-year period
18 ending on the date such items and services
19 are so furnished, an attestation that such
20 department is compliant with the require-
21 ments described in section 413.65 of title
22 42, Code of Federal Regulations (or a suc-
23 cessor regulation).

24 “(B) PROCESS FOR SUBMISSION AND RE-
25 VIEW.—Not later than 1 year after the date of

1 enactment of this paragraph, the Secretary
2 shall, through notice and comment rulemaking,
3 establish a process for each provider with an
4 off-campus outpatient department of a provider
5 to submit an attestation pursuant to subpara-
6 graph (A)(ii), and for the Secretary to review
7 each such attestation and determine, through
8 site visits or through remote audits (as deter-
9 mined appropriate by the Secretary), whether
10 such department is compliant with the require-
11 ments described in such subparagraph.

12 “(C) OFF-CAMPUS OUTPATIENT DEPART-
13 MENT OF A PROVIDER DEFINED.—For purposes
14 of this paragraph, the term ‘off-campus out-
15 patient department of a provider’ means a de-
16 partment of a provider (as defined in section
17 413.65 of title 42, Code of Federal Regulations,
18 or any successor regulation) that is not lo-
19 cated—

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

22 “(ii) within the distance (described in
23 such definition of campus) from a remote
24 location of a hospital facility (as defined in
25 such section).”.

1 **SEC. 104. MANDATORY REPORTING WITH RESPECT TO CER-**
2 **TAIN HEALTH-RELATED OWNERSHIP INFOR-**
3 **MATION.**

4 Part A of title XI of the Social Security Act (42
5 U.S.C. 1301 et seq.) is amended by adding at the end
6 the following new section:

7 **“SEC. 1150D. MANDATORY REPORTING WITH RESPECT TO**
8 **CERTAIN HEALTH-RELATED OWNERSHIP IN-**
9 **FORMATION.**

10 **“(a) MANDATORY REPORTING WITH RESPECT CER-**
11 **TAIN HEALTH-RELATED OWNERSHIP INFORMATION.—**

12 **“(1) INITIAL REPORT.—**Not later than January
13 1, 2025 (or in the case of a specified entity formed
14 after January 1, 2025, within 60 days of becoming
15 a specified entity), each specified entity (as defined
16 in subsection (f)(5)) shall submit to the Secretary,
17 in a form and manner specified by the Secretary, a
18 report containing the following information:

19 **“(A)** Data on mergers, acquisitions, and
20 changes in ownership with respect to such spec-
21 ified entity for the previous 1-year period.

22 **“(B)** In the case that a specified entity is,
23 or includes, a hospital, the additional informa-
24 tion described in subsection (b).

25 **“(C)** As applicable, the name, address, and
26 business structure of the parent company of

1 such specified entity (including the tax status of
2 such parent company), as of the date of the
3 submission of this report.

4 “(D) Any other information with respect to
5 ownership of a specified entity, as determined
6 by the Secretary.

7 “(2) SUBSEQUENT REPORTS.—Not later than 1
8 year after submitting the report under paragraph
9 (1), and annually thereafter, each specified entity
10 shall submit to the Secretary an updated report, in-
11 cluding—

12 “(A)(i) data on mergers, acquisitions, and
13 changes in ownership with respect to such enti-
14 ties for the previous 1-year period; and

15 “(ii) any other information with re-
16 spect to ownership of a specified entity, as
17 determined by the Secretary; and

18 “(B) in the case that a specified entity is,
19 or includes, a hospital, the additional informa-
20 tion described in subsection (b).

21 “(b) ADDITIONAL INFORMATION SUBMITTED BY
22 CERTAIN SPECIFIED ENTITIES.—For purposes of para-
23 graphs (1)(B) and (2)(B) of subsection (a), with respect
24 to a specified entity that is, or includes, a hospital, the

1 information described in this subsection is the following
2 information with respect to the previous 1-year period:

3 “(1) The business structure of the specified en-
4 tity, including the business type and the tax status
5 of such entity.

6 “(2) The average debt-to-earnings ratio of the
7 specified entity.

8 “(3) The average amount of debt incurred—

9 “(A) by the hospital; and

10 “(B) by the entire specified entity.

11 “(4) Information with respect to real estate
12 leases and purchases for property used, or intended
13 to be used, to furnish or otherwise support the provi-
14 sion of health care services.

15 “(5) In the case of a non-profit hospital, a sub-
16 sidiary of a non-profit hospital, or a 501(c)(3) entity
17 that shares common ownership with a non-profit
18 hospital, capital gains investments (disaggregated by
19 the type of investment) and any taxes paid on such
20 gains from such investments.

21 “(6) As applicable, information with respect to
22 the parent company of such specified entity.

23 “(c) PUBLIC REPORTING.—Not later than January
24 1, 2027, and annually thereafter, the Secretary shall post
25 on a publicly available website of the Department of

1 Health and Human Services a report with respect to the
2 previous 1-year period, including—

3 “(1) the number of specified entities reporting
4 for such year, disaggregated by the business struc-
5 ture of each specified entity;

6 “(2) the number of owners of each specified en-
7 tity;

8 “(3) any change in ownership for each specified
9 entity;

10 “(4) any change in the tax status of a specified
11 entity;

12 “(5) an analysis of trends in horizontal and
13 vertical consolidation, disaggregated by business
14 structure and provider type; and

15 “(6) as applicable, the name, address, and busi-
16 ness structure of the parent company of such speci-
17 fied entity (including the business type and the tax
18 status of such parent company).

19 “(d) AUDITS.—The Secretary shall conduct an an-
20 nual audit consisting of a random sample of specified enti-
21 ties to verify compliance with the requirements of this sec-
22 tion and the accuracy of information submitted pursuant
23 to this section.

24 “(e) PENALTY FOR FAILURE TO REPORT.—If a spec-
25 ified entity fails to provide a complete report under sub-

1 section (a), or submits a report containing false informa-
2 tion, such entity shall be subject to a civil monetary pen-
3 alty of not more than \$5,000,000 for each such report
4 not provided or containing false information. Such penalty
5 shall be imposed and collected in the same manner as civil
6 money penalties under subsection (a) of section 1128A are
7 imposed and collected under that section.

8 “(f) INAPPLICABILITY OF PAPERWORK REDUCTION
9 ACT.—Chapter 35 of title 44, United States Code, shall
10 not apply to collections of information made under this
11 section.

12 “(g) DEFINITIONS.—In this section:

13 “(1) HEALTH PLAN.—The term ‘health plan’
14 has the meaning given such term in section
15 1128C(c).

16 “(2) HOSPITAL.—The term ‘hospital’ has the
17 meaning given such term in section 1861(e).

18 “(3) INDEPENDENT FREESTANDING EMER-
19 GENCY DEPARTMENT.—The term ‘independent free-
20 standing emergency department’ has the meaning
21 given such term in section 2799A–1(a)(3)(D) of the
22 Public Health Service Act.

23 “(4) PRIVATE EQUITY COMPANY.—The term
24 ‘private equity company’ means a publicly-traded or
25 non-publicly traded company that collects capital in-

1 vestments from individuals or entities and purchases
2 an ownership share of a provider of services (as de-
3 fined in section 1861(u)).

4 “(5) SPECIFIED ENTITY.—The term ‘specified
5 entity’ means—

6 “(A) a hospital;

7 “(B) a physician-owned physician practice
8 with more than 25 physicians for a year;

9 “(C) a physician practice owned by a hos-
10 pital, a health plan, a private equity company,
11 or a venture capital firm;

12 “(D) an ambulatory surgical center meet-
13 ing the standards specified under section
14 1832(a)(2)(F)(i); or

15 “(E) an independent freestanding emer-
16 gency department.

17 “(6) VENTURE CAPITAL FUND.—The term ‘ven-
18 ture capital fund’ has the meaning given such term
19 in section 275.203(l)–1of title 17, Code of Federal
20 Regulations.”.

21 **SEC. 105. INCREASING PRICE TRANSPARENCY OF CLINICAL**
22 **DIAGNOSTIC LABORATORY TESTS UNDER**
23 **THE MEDICARE PROGRAM.**

24 Section 1846 of the Social Security Act (42 U.S.C.
25 1395w–2) is amended—

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

4 (2) by adding at the end the following new sub-
5 section:

6 “(c) PRICE TRANSPARENCY REQUIREMENT.—

7 “(1) IN GENERAL.—Beginning January 1,
8 2025, each provider of services or supplier that is
9 available to furnish any specified clinical diagnostic
10 laboratory test under this title shall—

11 “(A) make publicly available on an Inter-
12 net website the information described in para-
13 graph (2) with respect to each such specified
14 clinical diagnostic laboratory test that such pro-
15 vider or supplier is so available to furnish; and

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

18 “(2) INFORMATION DESCRIBED.—For purposes
19 of paragraph (1), the information described in this
20 paragraph is, with respect to a provider of services
21 or supplier and a specified clinical diagnostic labora-
22 tory test, the following:

23 “(A) The discounted cash price for such
24 test (or, if no such price exists, the gross
25 charge for such test).

1 “(B) The deidentified minimum negotiated
2 rate in effect between such provider or supplier
3 and any group health plan or group or indi-
4 vidual health insurance coverage for such test.

5 “(C) The deidentified maximum negotiated
6 rate in effect between such provider or supplier
7 and any such plan or coverage for such test.

8 “(3) INCLUSION OF ANCILLARY SERVICES.—
9 Any price or rate for a specified clinical diagnostic
10 laboratory test available to be furnished by a pro-
11 vider of services or supplier made publicly available
12 in accordance with paragraph (1) shall include the
13 price or rate (as applicable) for any ancillary item
14 or service (such as specimen collection services) that
15 would normally be furnished by such provider or
16 supplier as part of such test, as specified by the Sec-
17 retary.

18 “(4) ENFORCEMENT.—

19 “(A) IN GENERAL.—In the case that the
20 Secretary determines that a provider of services
21 or supplier is not in compliance with paragraph
22 (1)—

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

1 such provider or supplier of such deter-
2 mination;

3 “(ii) not later than 90 days after such
4 notification is sent, such provider or sup-
5 plier shall complete a corrective action plan
6 to comply with such paragraph and submit
7 such plan to the Secretary; and

8 “(iii) if such provider or supplier con-
9 tinues to fail to comply with such para-
10 graph after the date that is 90 days after
11 such notification is sent, the Secretary may
12 impose a civil monetary penalty in an
13 amount not to exceed \$300 for each day
14 (beginning with the date that is 91 days
15 after such notification was sent) during
16 which such failure is ongoing.

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

25 “(5) DEFINITIONS.—In this subsection:

1 “(A) GROUP HEALTH PLAN; GROUP
2 HEALTH INSURANCE COVERAGE; INDIVIDUAL
3 HEALTH INSURANCE COVERAGE.—The terms
4 ‘group health plan’, ‘group health insurance
5 coverage’, and ‘individual health insurance cov-
6 erage’ have the meaning given such terms in
7 section 2791 of the Public Health Service Act.

8 “(B) SPECIFIED CLINICAL DIAGNOSTIC
9 LABORATORY TEST.—the term ‘specified clinical
10 diagnostic laboratory test’ means a clinical di-
11 agnostic laboratory test that is included on the
12 list of shoppable services specified by the Cen-
13 ters for Medicare & Medicaid Services (as de-
14 scribed in section 180.60 of title 42, Code of
15 Federal Regulations (or a successor regula-
16 tion)).”.

17 **SEC. 106. PROMOTING TRANSPARENCY OF COMMON OWN-**
18 **ERSHIP INTERESTS UNDER PARTS C AND D**
19 **OF THE MEDICARE PROGRAM.**

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

23 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-
24 FORMATION RELATING TO HEALTH CARE PROVIDER
25 OWNERSHIP.—

1 “(A) IN GENERAL.—For plan years begin-
2 ning on or after January 1, 2025, a contract
3 under this section with an MA organization
4 shall require the organization to report to the
5 Secretary, not later than 1 year after the last
6 day of such plan year, the information de-
7 scribed in subparagraph (B) with respect to
8 such plan year.

9 “(B) INFORMATION DESCRIBED.—For pur-
10 poses of subparagraph (A), the information de-
11 scribed in this subparagraph is, with respect to
12 an MA organization and a plan year, the fol-
13 lowing:

14 “(i) The number of items and services
15 furnished during such plan year by each
16 specified provider (as defined in subpara-
17 graph (C)) for which payment was made
18 by such organization.

19 “(ii) The number of items and serv-
20 ices furnished during such plan year by
21 providers of services or suppliers not de-
22 scribed in clause (i) for which payment was
23 made by such organization.

24 “(iii) The average per-enrollee number
25 of qualifying diagnoses (as defined in sub-

1 paragraph (C)) made during such plan
2 year by specified providers (including
3 through chart reviews and health risk as-
4 sessments) with respect to individuals en-
5 rolled under an MA plan offered by such
6 organization, broken down by site of serv-
7 ice of such providers, as specified by the
8 Secretary.

9 “(iv) The average per-enrollee number
10 of qualifying diagnoses made during such
11 plan year by providers of services and sup-
12 pliers not described in clause (iii) (includ-
13 ing through such reviews and assessments)
14 with respect to such individuals, broken
15 down by site of service of such providers.

16 “(v) The average risk score (as cal-
17 culated under the methodology described in
18 subparagraph (C)(i)) for such an indi-
19 vidual for such plan year who received
20 items and services from a specified pro-
21 vider during such plan year.

22 “(vi) The average risk score for such
23 an individual for such plan year who did
24 not receive items and services from a speci-
25 fied provider during such plan year.

1 “(vii) The average risk score for such
2 an individual for such plan year who re-
3 ceived a health risk assessment from an
4 assessment entity that was a specified as-
5 sessment entity during such plan year.

6 “(viii) The average risk score for such
7 an individual for such plan year who re-
8 ceived a health risk assessment from an
9 assessment entity that was not a specified
10 assessment entity during such plan year.

11 “(ix) The number of prior authoriza-
12 tion requests for an item or service sub-
13 mitted to such organization during such
14 plan year, the number of such requests
15 that were approved, the number of such re-
16 quests that were denied, and the number
17 of such denied requests that were subse-
18 quently appealed and then approved, bro-
19 ken down by whether the entity proposing
20 to furnish such item or service was a speci-
21 fied provider or not a specified provider.

22 “(x) The total amount of incentive-
23 based payments made to, and the total
24 amount of shared losses recoupments col-

1 lected from, specified providers during
2 such plan year.

3 “(xi) The total amount of incentive-
4 based payments made to, and the total
5 amount of shared losses recoupments col-
6 lected from, providers of services and sup-
7 pliers not described in clause (x) during
8 such plan year.

9 “(xii) The allowed amount, and the
10 amount of cost sharing imposed, with re-
11 spect to each item and service furnished
12 during such plan year by specified pro-
13 viders paid by such organization.

14 “(xiii) The allowed amount, and the
15 amount of cost sharing imposed, with re-
16 spect to each item and service furnished
17 during such plan year by providers of serv-
18 ices and suppliers not described in clause
19 (xii) paid by such organization.

20 “(xiv) For each MA plan offered by
21 such organization during such plan year—

22 “(I) the total amount of pay-
23 ments made under section 1853(a)(1)
24 to such organization for coverage of
25 individuals under such plan, and the

1 total amount of payments made by
2 such individuals to such organization
3 for coverage under such plan;

4 “(II) the total amount expended
5 under such plan as payment for items
6 and services furnished by each speci-
7 fied provider during such year;

8 “(III) the total amount expended
9 under such plan as payment for items
10 and services furnished by providers of
11 services or suppliers not described in
12 subclause (II) during such year;

13 “(IV) the medical loss ratio
14 under such plan with respect to indi-
15 viduals furnished an item or service
16 from a specified provider during such
17 year; and

18 “(V) the medical loss ratio under
19 such plan with respect to individuals
20 not described in subclause (IV).

21 “(C) DEFINITIONS.—In this paragraph:

22 “(i) ASSESSMENT ENTITY.—The term
23 ‘assessment entity’ means an entity with a
24 focus on furnishing in-home medical as-
25 sessments, as specified by the Secretary.

1 “(ii) QUALIFYING DIAGNOSIS.—The
2 term ‘qualifying diagnosis’ means, with re-
3 spect to an individual, a diagnosis that is
4 taken into account in calculating a risk
5 score for such individual under the risk ad-
6 justment methodology established by the
7 Secretary pursuant to section 1853(a)(3).

8 “(iii) SPECIFIED ASSESSMENT ENTI-
9 TY.—The term ‘specified assessment enti-
10 ty’ means, with respect to an MA organiza-
11 tion and a plan year, an assessment entity
12 with respect to which such organization (or
13 any person with an ownership or control
14 interest (as defined in section 1124(a)(3))
15 in such organization) is a person with an
16 ownership or control interest (as so de-
17 fined).

18 “(iv) SPECIFIED PROVIDER.—The
19 term ‘specified provider’ means, with re-
20 spect to an MA organization and a plan
21 year, a provider of services or supplier with
22 respect to which such organization (or any
23 person with an ownership or control inter-
24 est (as defined in section 1124(a)(3)) in
25 such organization) is a person with an

1 ownership or control interest (as so de-
2 fined).

3 “(D) NONAPPLICATION OF PAPERWORK
4 REDUCTION ACT.—Chapter 35 of title 44,
5 United States Code, shall not apply to informa-
6 tion collected under this paragraph.”.

7 (b) PHARMACY BENEFIT MANAGER AND PHARMACY
8 INFORMATION.—Section 1860D–12(b) of the Social Secu-
9 rity Act (42 U.S.C. 1395w–112(b)) is amended by adding
10 at the end the following new paragraphs:

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

13 “(A) IN GENERAL.—For plan years begin-
14 ning on or after January 1, 2025, a contract
15 entered into under this part with a PDP spon-
16 sor shall require the sponsor to report to the
17 Secretary, not later than 1 year after the last
18 day of such plan year, the information de-
19 scribed in subparagraph (B) with respect to
20 such plan year.

21 “(B) INFORMATION DESCRIBED.—For pur-
22 poses of subparagraph (A), the information de-
23 scribed in this subparagraph is, for each pre-
24 scription drug plan offered by a PDP sponsor
25 for a plan year, the following:

1 “(i) The negotiated price for each cov-
2 ered part D drug for which benefits are
3 available under such plan for each network
4 pharmacy (including an identification of
5 whether each such pharmacy is a specified
6 pharmacy).

7 “(ii) The average per-drug amount of
8 direct and indirect remuneration paid by
9 specified pharmacies for such covered part
10 D drugs dispensed during such plan year
11 under such plan.

12 “(iii) The average per-drug amount of
13 direct and indirect remuneration paid by
14 pharmacies not described in clause (ii) for
15 such covered part D drugs dispensed dur-
16 ing such plan year under such plan.

17 “(C) DEFINITIONS.—In this paragraph:

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

24 “(ii) NETWORK PHARMACY.—The
25 term ‘network pharmacy’ has the meaning

1 given such term in section 423.100 of title
2 42, Code of Federal Regulations (or any
3 successor regulation).

4 “(iii) NEGOTIATED PRICE.—The ‘ne-
5 gotiated price’ for a covered part D drug
6 shall take into account all negotiated price
7 concessions, such as discounts, direct or in-
8 direct subsidies, rebates, and direct or indi-
9 rect remunerations, for such drug, and in-
10 clude any dispensing fee for such drug.

11 “(iv) SPECIFIED PHARMACY.—The
12 term ‘specified pharmacy’ means, with re-
13 spect to an PDP sponsor and a plan year,
14 a pharmacy with respect to which such
15 sponsor (or any person with an ownership
16 or control interest (as defined in section
17 1124(a)(3)) in such sponsor) is a person
18 with an ownership or control interest (as
19 so defined).

20 “(D) NONAPPLICATION OF PAPERWORK
21 REDUCTION ACT.—Chapter 35 of title 44,
22 United States Code, shall not apply to informa-
23 tion collected under this paragraph.

24 “(10) PROVISION OF INFORMATION BY PHAR-
25 MACY BENEFIT MANAGERS.—

1 “(A) IN GENERAL.—For plan years begin-
2 ning on or after January 1, 2025, a contract
3 entered into under this part with a PDP spon-
4 sor shall prohibit such sponsor from entering
5 into a contract with a specified pharmacy ben-
6 efit manager for purposes of performing any
7 service with respect to covered part D drugs
8 dispensed under any prescription drug plan of-
9 fered by such sponsor for such plan year unless
10 such manager agrees to report to the Secretary,
11 not later than 1 year after the last day of such
12 plan year, the information described in subpara-
13 graph (B) with respect to each prescription
14 drug plan for which such manager is providing
15 any such service during such plan year, regard-
16 less of the sponsor of such plan.

17 “(B) INFORMATION DESCRIBED.—For pur-
18 poses of subparagraph (A), the information de-
19 scribed in this subparagraph is, with respect to
20 a pharmacy benefit manager performing serv-
21 ices under a prescription drug plan for a plan
22 year, the following:

23 “(i) With respect to the total amount
24 of pharmacy and manufacturer rebates col-
25 lected by such manager (or collected on be-

1 half of such plan by any other entity with
2 a contract in effect with such manager for
3 such collection) for all covered part D
4 drugs dispensed under such plan during
5 such plan year—

6 “(I) the total amount of such re-
7 bates passed through to the PDP
8 sponsor of such plan; and

9 “(II) the total amount of such re-
10 bates retained by such manager or
11 such other entities.

12 “(ii) The total amount paid by such
13 manager to pharmacies for drugs furnished
14 under such plan during such plan year.

15 “(iii) The total amount of payments
16 made by such sponsor to such manager as
17 reimbursement for such manager’s pay-
18 ments described in clause (ii).

19 “(iv) The total amount of payments
20 made by such sponsor to such manager as
21 fees for services furnished by such man-
22 ager with respect to such plan for such
23 plan year (not including payments de-
24 scribed in clause (iii)).

1 “(v) The total amount of administra-
2 tive costs incurred by such manager for
3 furnishing such services under such plan
4 for such plan year.

5 “(vi) A specification as to whether
6 such manager is a specified pharmacy ben-
7 efit manager with respect to the PDP
8 sponsor of such plan.

9 “(C) DEFINITION.—In this paragraph, the
10 term ‘specified pharmacy benefit manager’
11 means, with respect to an PDP sponsor and a
12 plan year, a pharmacy benefit manager with re-
13 spect to which such sponsor (or any person with
14 an ownership or control interest (as defined in
15 section 1124(a)(3)) in such sponsor) is a person
16 with an ownership or control interest (as so de-
17 fined).”.

18 (c) ENCOUNTER DATA.—Section 1859 of the Social
19 Security Act (42 U.S.C. 1395w–28) is amended by adding
20 at the end the following 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 a Medicare Advantage plan
25 with respect to an item or service furnished to an in-

1 dividual under such plan during a plan year begin-
2 ning on or after January 1, 2025, the Secretary
3 shall require that such data include—

4 “(A) the allowed amount for such item or
5 service;

6 “(B) the amount of cost sharing (including
7 deductibles, copayments, and coinsurance) im-
8 posed for such item or service;

9 “(C) in the case such individual was fur-
10 nished, during such plan year before such item
11 or service was so furnished, an at-home health
12 risk assessment from a specified assessment en-
13 tity, an indicator that such individual was so
14 furnished such an assessment by such an entity;
15 and

16 “(D) in the case such individual was fur-
17 nished, during such plan year before such item
18 or service was so furnished, an at-home health
19 risk assessment from an assessment entity not
20 described in subparagraph (C), an indicator
21 (distinct from the indicator described in such
22 subparagraph) that such individual was so fur-
23 nished such an assessment by such an entity.

24 “(2) DEFINITIONS.—For purposes of this sub-
25 section, the terms ‘assessment entity’ and ‘specified

1 assessment entity' have the meaning given such
2 terms in section 1857(e)(6).”.

3 (d) MEDPAC REPORT.—Not later than December
4 31, 2027, and every 2 years thereafter, the Medicare Pay-
5 ment Advisory Commission shall submit to Congress a re-
6 port on the effects of vertical integration in the health care
7 sector on the Medicare program. Such report shall include
8 an analysis of the effects of entities such as health care
9 providers, pharmacies, PDP sponsors, Medicare Advan-
10 tage organizations, and pharmacy benefit managers that
11 were previously under separate ownership from one an-
12 other coming under common ownership.

13 (e) PUBLICATION.—Not later than January 1, 2027,
14 the Secretary of Health and Human Services shall estab-
15 lish a process under which information submitted to the
16 Secretary pursuant to the amendments made by sub-
17 sections (a) and (b) is publicly disclosed. Such process
18 shall ensure that any information so disclosed does not
19 identify a specific drug manufacturer, provider of services
20 or supplier, pharmacy, pharmacy benefit manager, or any
21 price charged with respect to a particular drug.

22 **SEC. 107. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
23 **SERVICES.**

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

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

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

5 “(a) IN GENERAL.—For plan years beginning on or
6 after January 1, 2025, a group health plan or health in-
7 surance issuer offering group health insurance coverage
8 or an entity or subsidiary providing pharmacy benefits
9 management services on behalf of such a plan or issuer
10 shall not enter into a contract with a drug manufacturer,
11 distributor, wholesaler, subcontractor, rebate aggregator,
12 or any associated third party that limits the disclosure of
13 information to plan sponsors in such a manner that pre-
14 vents the plan or issuer, or an entity or subsidiary pro-
15 viding pharmacy benefits management services on behalf
16 of a plan or issuer, from making the reports described in
17 subsection (b).

18 “(b) REPORTS.—

19 “(1) IN GENERAL.—For plan years beginning
20 on or after January 1, 2025, not less frequently
21 than annually, a health insurance issuer offering
22 group health insurance coverage or an entity pro-
23 viding pharmacy benefits management services on
24 behalf of a group health plan or an issuer providing
25 group health insurance coverage shall submit to the

1 plan sponsor (as defined in section 3(16)(B) of the
2 Employee Retirement Income Security Act of 1974)
3 of such group health plan or health insurance cov-
4 erage a report in accordance with this subsection
5 and make such report available to the plan sponsor
6 in a machine-readable format. Each such report
7 shall include, with respect to the applicable group
8 health plan or health insurance coverage—

9 “(A) as applicable, information collected
10 from drug manufacturers by such issuer or en-
11 tity on the total amount of copayment assist-
12 ance dollars paid, or copayment cards applied,
13 that were funded by the drug manufacturer
14 with respect to the participants and bene-
15 ficiaries in such plan or coverage;

16 “(B) a list of each drug covered by such
17 plan, issuer, or entity providing pharmacy bene-
18 fits management services that was dispensed
19 during the reporting period, including, with re-
20 spect to each such drug during the reporting
21 period—

22 “(i) the brand name, chemical entity,
23 and National Drug Code;

24 “(ii) the number of participants and
25 beneficiaries for whom the drug was filled

1 during the plan year, the total number of
2 prescription fills for the drug (including
3 original prescriptions and refills), and the
4 total number of dosage units of the drug
5 dispensed across the plan year, including
6 whether the dispensing channel was by re-
7 tail, mail order, or specialty pharmacy;

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

12 “(iv) the total out-of-pocket spending
13 by participants and beneficiaries on such
14 drug, including participant and beneficiary
15 spending through copayments, coinsurance,
16 and deductibles; and

17 “(v) for any drug for which gross
18 spending of the group health plan or
19 health insurance coverage exceeded
20 \$10,000 during the reporting period—

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

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

3 “(II) the rationale for preferred
4 formulary placement of such drug in
5 that therapeutic category or class, if
6 applicable;

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

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

16 “(ii) the number of participants and
17 beneficiaries who filled a prescription for a
18 drug in that category or class;

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

24 “(iv) the total out-of-pocket spending
25 by participants and beneficiaries, including

1 participant and beneficiary spending
2 through copayments, coinsurance, and
3 deductibles; and

4 “(v) for each therapeutic category or
5 class under which 3 or more drugs are in-
6 cluded on the formulary of such plan or
7 coverage—

8 “(I) the amount received, or ex-
9 pected to be received, from drug man-
10 ufacturers in rebates, fees, alternative
11 discounts, or other remuneration—

12 “(aa) that has been paid, or
13 is to be paid, by drug manufac-
14 turers for claims incurred during
15 the reporting period; or

16 “(bb) that is related to utili-
17 zation of drugs, in such thera-
18 peutic category or class;

19 “(II) the total net spending, after
20 deducting rebates, price concessions,
21 alternative discounts or other remu-
22 neration from drug manufacturers, by
23 the health plan or health insurance
24 coverage on that category or class of
25 drugs; and

1 “(III) the net price per course of
2 treatment or single fill, such as a 30-
3 day supply or 90-day supply, incurred
4 by the health plan or health insurance
5 coverage and its participants and
6 beneficiaries, after manufacturer re-
7 bates, fees, and other remuneration
8 for drugs dispensed within such thera-
9 peutic category or class during the re-
10 porting period;

11 “(D) total gross spending on prescription
12 drugs by the plan or coverage during the re-
13 porting period, before rebates and other manu-
14 facturer fees or remuneration;

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

1 “(F) the total net spending on prescription
2 drugs by the health plan or health insurance
3 coverage during the reporting period; and

4 “(G) amounts paid directly or indirectly in
5 rebates, fees, or any other type of remuneration
6 to brokers, consultants, advisors, or any other
7 individual or firm who referred the group health
8 plan’s or health insurance issuer’s business to
9 the pharmacy benefits manager.

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

21 “(3) DISCLOSURE AND REDISCLOSURE.—

22 “(A) LIMITATION TO BUSINESS ASSOCI-
23 ATES.—A group health plan receiving a report
24 under paragraph (1) may disclose such informa-
25 tion only to business associates of such plan as

1 defined in section 160.103 of title 45, Code of
2 Federal Regulations (or successor regulations).

3 “(B) CLARIFICATION REGARDING PUBLIC
4 DISCLOSURE OF INFORMATION.—Nothing in
5 this section prevents a health insurance issuer
6 offering group health insurance coverage or an
7 entity providing pharmacy benefits management
8 services on behalf of a group health plan from
9 placing reasonable restrictions on the public dis-
10 closure of the information contained in a report
11 described in paragraph (1), except that such
12 issuer or entity may not restrict disclosure of
13 such report to the Department of Health and
14 Human Services, the Department of Labor, the
15 Department of the Treasury, the Comptroller
16 General of the United States, or applicable
17 State agencies.

18 “(C) LIMITED FORM OF REPORT.—The
19 Secretary shall define through rulemaking a
20 limited form of the report under paragraph (1)
21 required of plan sponsors who are drug manu-
22 facturers, drug wholesalers, or other direct par-
23 ticipants in the drug supply chain, in order to
24 prevent anti-competitive behavior.

1 “(4) REPORT TO GAO.—A health insurance
2 issuer offering group health insurance coverage or
3 an entity providing pharmacy benefits management
4 services on behalf of a group health plan shall sub-
5 mit to the Comptroller General of the United States
6 each of the first 4 reports submitted to a plan spon-
7 sor under paragraph (1) with respect to such cov-
8 erage or plan, and other such reports as requested,
9 in accordance with the privacy requirements under
10 paragraph (2), the disclosure and redisclosure stand-
11 ards under paragraph (3), the standards specified
12 pursuant to paragraph (5), and such other informa-
13 tion that the Comptroller General determines nec-
14 essary to carry out the study under section 2(d) of
15 the Pharmacy Benefits Manager Accountability Act.

16 “(5) STANDARD FORMAT.—Not later than June
17 1, 2023, the Secretary shall specify through rule-
18 making standards for health insurance issuers and
19 entities required to submit reports under paragraph
20 (4) to submit such reports in a standard format.

21 “(c) ENFORCEMENT.—

22 “(1) IN GENERAL.—The Secretary, in consulta-
23 tion with the Secretary of Labor and the Secretary
24 of the Treasury, shall enforce this section.

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

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

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

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

7 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
8 tion shall be construed to permit a health insurance issuer,
9 group health plan, or other entity to restrict disclosure to,
10 or otherwise limit the access of, the Department of Health
11 and Human Services to a report described in subsection
12 (b)(1) or information related to compliance with sub-
13 section (a) by such issuer, plan, or entity.

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

17 (2) in section 2723 (42 U.S.C. 300gg–22)—

18 (A) in subsection (a)—

19 (i) in paragraph (1), by inserting
20 “(other than subsections (a) and (b) of
21 section 2799A–11)” after “part D”; and

22 (ii) in paragraph (2), by inserting
23 “(other than subsections (a) and (b) of
24 section 2799A–11)” after “part D”; and

25 (B) in subsection (b)—

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

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

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

10 (b) ERISA.—

11 (1) IN GENERAL.—Subtitle B of title I of the
12 Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1021 et seq.) is amended—

14 (A) in subpart B of part 7 (29 U.S.C.
15 1185 et seq.), by adding at the end the fol-
16 lowing:

17 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
18 **SERVICES.**

19 “(a) IN GENERAL.—For plan years beginning on or
20 after January 1, 2025, a group health plan (or health in-
21 surance issuer offering group health insurance coverage
22 in connection with such a plan) or an entity or subsidiary
23 providing pharmacy benefits management services on be-
24 half of such a plan or issuer shall not enter into a contract
25 with a drug manufacturer, distributor, wholesaler, subcon-

1 tractor, rebate aggregator, or any associated third party
2 that limits the disclosure of information to plan sponsors
3 in such a manner that prevents the plan or issuer, or an
4 entity or subsidiary providing pharmacy benefits manage-
5 ment services on behalf of a plan or issuer, from making
6 the reports described in subsection (b).

7 “(b) REPORTS.—

8 “(1) IN GENERAL.—For plan years beginning
9 on or after January 1, 2025, not less frequently
10 than annually, a health insurance issuer offering
11 group health insurance coverage or an entity pro-
12 viding pharmacy benefits management services on
13 behalf of a group health plan or an issuer providing
14 group health insurance coverage shall submit to the
15 plan sponsor (as defined in section 3(16)(B)) of
16 such group health plan or group health insurance
17 coverage a report in accordance with this subsection
18 and make such report available to the plan sponsor
19 in a machine-readable format. Each such report
20 shall include, with respect to the applicable group
21 health plan or health insurance coverage—

22 “(A) as applicable, information collected
23 from drug manufacturers by such issuer or en-
24 tity on the total amount of copayment assist-
25 ance dollars paid, or copayment cards applied,

1 that were funded by the drug manufacturer
2 with respect to the participants and bene-
3 ficiaries in such plan or coverage;

4 “(B) a list of each drug covered by such
5 plan, issuer, or entity providing pharmacy bene-
6 fits management services that was dispensed
7 during the reporting period, including, with re-
8 spect to each such drug during the reporting
9 period—

10 “(i) the brand name, chemical entity,
11 and National Drug Code;

12 “(ii) the number of participants and
13 beneficiaries for whom the drug was filled
14 during the plan year, the total number of
15 prescription fills for the drug (including
16 original prescriptions and refills), and the
17 total number of dosage units of the drug
18 dispensed across the plan year, including
19 whether the dispensing channel was by re-
20 tail, mail order, or specialty pharmacy;

21 “(iii) the wholesale acquisition cost,
22 listed as cost per days supply and cost per
23 pill, or in the case of a drug in another
24 form, per dose;

1 “(iv) the total out-of-pocket spending
2 by participants and beneficiaries on such
3 drug, including participant and beneficiary
4 spending through copayments, coinsurance,
5 and deductibles; and

6 “(v) for any drug for which gross
7 spending of the group health plan or
8 health insurance coverage exceeded
9 \$10,000 during the reporting period—

10 “(I) a list of all other drugs in
11 the same therapeutic category or
12 class, including brand name drugs
13 and biological products and generic
14 drugs or biosimilar biological products
15 that are in the same therapeutic cat-
16 egory or class as such drug; and

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

21 “(C) a list of each therapeutic category or
22 class of drugs that were dispensed under the
23 health plan or health insurance coverage during
24 the reporting period, and, with respect to each

1 such therapeutic category or class of drugs,
2 during the reporting period—

3 “(i) total gross spending by the plan,
4 before manufacturer rebates, fees, or other
5 manufacturer remuneration;

6 “(ii) the number of participants and
7 beneficiaries who filled a prescription for a
8 drug in that category or class;

9 “(iii) if applicable to that category or
10 class, a description of the formulary tiers
11 and utilization mechanisms (such as prior
12 authorization or step therapy) employed
13 for drugs in that category or class;

14 “(iv) the total out-of-pocket spending
15 by participants and beneficiaries, including
16 participant and beneficiary spending
17 through copayments, coinsurance, and
18 deductibles; and

19 “(v) for each therapeutic category or
20 class under which 3 or more drugs are in-
21 cluded on the formulary of such plan or
22 coverage—

23 “(I) the amount received, or ex-
24 pected to be received, from drug man-

1 manufacturers in rebates, fees, alternative
2 discounts, or other remuneration—
3 “(aa) that has been paid, or
4 is to be paid, by drug manufac-
5 turers for claims incurred during
6 the reporting period; or
7 “(bb) that is related to utili-
8 zation of drugs, in such thera-
9 peutic category or class;
10 “(II) the total net spending, after
11 deducting rebates, price concessions,
12 alternative discounts or other remu-
13 nation from drug manufacturers, by
14 the health plan or health insurance
15 coverage on that category or class of
16 drugs; and
17 “(III) the net price per course of
18 treatment or single fill, such as a 30-
19 day supply or 90-day supply, incurred
20 by the health plan or health insurance
21 coverage and its participants and
22 beneficiaries, after manufacturer re-
23 bates, fees, and other remuneration
24 for drugs dispensed within such thera-

1 peutic category or class during the re-
2 porting period;

3 “(D) total gross spending on prescription
4 drugs by the plan or coverage during the re-
5 porting period, before rebates and other manu-
6 facturer fees or remuneration;

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

16 “(F) the total net spending on prescription
17 drugs by the health plan or health insurance
18 coverage during the reporting period; and

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

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

12 “(3) DISCLOSURE AND REDISCLOSURE.—

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

19 “(B) CLARIFICATION REGARDING PUBLIC
20 DISCLOSURE OF INFORMATION.—Nothing in
21 this section prevents a health insurance issuer
22 offering group health insurance coverage or an
23 entity providing pharmacy benefits management
24 services on behalf of a group health plan from
25 placing reasonable restrictions on the public dis-

1 closure of the information contained in a report
2 described in paragraph (1), except that such
3 issuer or entity may not restrict disclosure of
4 such report to the Department of Health and
5 Human Services, the Department of Labor, the
6 Department of the Treasury, the Comptroller
7 General of the United States, or applicable
8 State agencies.

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

16 “(4) REPORT TO GAO.—A health insurance
17 issuer offering group health insurance coverage or
18 an entity providing pharmacy benefits management
19 services on behalf of a group health plan shall sub-
20 mit to the Comptroller General of the United States
21 each of the first 4 reports submitted to a plan spon-
22 sor under paragraph (1) with respect to such cov-
23 erage or plan, and other such reports as requested,
24 in accordance with the privacy requirements under
25 paragraph (2), the disclosure and redisclosure stand-

1 ards under paragraph (3), the standards specified
2 pursuant to paragraph (5), and such other informa-
3 tion that the Comptroller General determines nec-
4 essary to carry out the study under section 2(d) of
5 the Pharmacy Benefits Manager Accountability Act.

6 “(5) STANDARD FORMAT.—Not later than June
7 1, 2023, the Secretary shall specify through rule-
8 making standards for health insurance issuers and
9 entities required to submit reports under paragraph
10 (4) to submit such reports in a standard format.

11 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed to permit a health insurance issuer,
13 group health plan, or other entity to restrict disclosure to,
14 or otherwise limit the access of, the Department of Labor
15 to a report described in subsection (b)(1) or information
16 related to compliance with subsection (a) by such issuer,
17 plan, or entity.

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

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

22 (i) in subsection (a)—

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

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

3 (III) in paragraph (11), at the
4 end by striking the period and insert-
5 ing “; or”; and

6 (IV) by adding at the end the fol-
7 lowing new paragraph:

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

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

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

16 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
17 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
18 MANAGER SERVICES.—

19 “(A) FAILURE TO PROVIDE TIMELY INFOR-
20 MATION.—The Secretary, in consultation with
21 the Secretary of Health and Human Services
22 and the Secretary of the Treasury, may impose
23 a penalty against any health insurance issuer or
24 entity providing pharmacy benefits management
25 services that violates section 726(a) or fails to

1 provide information required under section
2 726(b) in the amount of \$10,000 for each day
3 during which such violation continues or such
4 information is not disclosed or reported.

5 “(B) FALSE INFORMATION.—The Sec-
6 retary, in consultation with the Secretary of
7 Health and Human Services and the Secretary
8 of the Treasury, may impose a penalty against
9 a health insurance issuer or entity providing
10 pharmacy benefits management services that
11 knowingly provides false information under sec-
12 tion 726 in an amount not to exceed \$100,000
13 for each item of false information. Such penalty
14 shall be in addition to other penalties as may
15 be prescribed by law.

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

22 (2) CLERICAL AMENDMENT.—The table of con-
23 tents in section 1 of the Employee Retirement In-
24 come Security Act of 1974 (29 U.S.C. 1001 et seq.)

1 is amended by inserting after the item relating to
2 section 725 the following new item:

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

3 (c) IRC.—

4 (1) IN GENERAL.—Subchapter B of chapter
5 100 of the Internal Revenue Code of 1986 is amend-
6 ed by adding at the end the following:

7 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-
8 AGER SERVICES.**

9 “(a) IN GENERAL.—For plan years beginning on or
10 after January 1, 2025, a group health plan or an entity
11 or subsidiary providing pharmacy benefits management
12 services on behalf of such a plan shall not enter into a
13 contract with a drug manufacturer, distributor, whole-
14 saler, subcontractor, rebate aggregator, or any associated
15 third party that limits the disclosure of information to
16 plan sponsors in such a manner that prevents the plan,
17 or an entity or subsidiary providing pharmacy benefits
18 management services on behalf of a plan, from making
19 the reports described in subsection (b).

20 “(b) REPORTS.—

21 “(1) IN GENERAL.—For plan years beginning
22 on or after January 1, 2025, not less frequently
23 than annually, an entity providing pharmacy benefits
24 management services on behalf of a group health
25 plan shall submit to the plan sponsor (as defined in

1 section 3(16)(B) of the Employee Retirement In-
2 come Security Act of 1974) of such group health
3 plan a report in accordance with this subsection and
4 make such report available to the plan sponsor in a
5 machine-readable format. Each such report shall in-
6 clude, with respect to the applicable group health
7 plan—

8 “(A) as applicable, information collected
9 from drug manufacturers by such entity on the
10 total amount of copayment assistance dollars
11 paid, or copayment cards applied, that were
12 funded by the drug manufacturer with respect
13 to the participants and beneficiaries in such
14 plan;

15 “(B) a list of each drug covered by such
16 plan or entity providing pharmacy benefits
17 management services that was dispensed during
18 the reporting period, including, with respect to
19 each such drug during the reporting period—

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

22 “(ii) the number of participants and
23 beneficiaries for whom the drug was filled
24 during the plan year, the total number of
25 prescription fills for the drug (including

1 original prescriptions and refills), and the
2 total number of dosage units of the drug
3 dispensed across the plan year, including
4 whether the dispensing channel was by re-
5 tail, mail order, or specialty pharmacy;

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

10 “(iv) the total out-of-pocket spending
11 by participants and beneficiaries on such
12 drug, including participant and beneficiary
13 spending through copayments, coinsurance,
14 and deductibles; and

15 “(v) for any drug for which gross
16 spending of the group health plan exceeded
17 \$10,000 during the reporting period—

18 “(I) a list of all other drugs in
19 the same therapeutic category or
20 class, including brand name drugs
21 and biological products and generic
22 drugs or biosimilar biological products
23 that are in the same therapeutic cat-
24 egory or class as such drug; and

1 “(II) the rationale for preferred
2 formulary placement of such drug in
3 that therapeutic category or class, if
4 applicable;

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

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

13 “(ii) the number of participants and
14 beneficiaries who filled a prescription for a
15 drug in that category or class;

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

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

1 “(v) for each therapeutic category or
2 class under which 3 or more drugs are in-
3 cluded on the formulary of such plan—

4 “(I) the amount received, or ex-
5 pected to be received, from drug man-
6 ufacturers in rebates, fees, alternative
7 discounts, or other remuneration—

8 “(aa) that has been paid, or
9 is to be paid, by drug manufac-
10 turers for claims incurred during
11 the reporting period; or

12 “(bb) that is related to utili-
13 zation of drugs, in such thera-
14 peutic category or class;

15 “(II) the total net spending, after
16 deducting rebates, price concessions,
17 alternative discounts or other remu-
18 neration from drug manufacturers, by
19 the health plan on that category or
20 class of drugs; and

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

1 rebates, fees, and other remuneration
2 for drugs dispensed within such thera-
3 peutic category or class during the re-
4 porting period;

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

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

17 “(F) the total net spending on prescription
18 drugs by the health plan during the reporting
19 period; and

20 “(G) amounts paid directly or indirectly in
21 rebates, fees, or any other type of remuneration
22 to brokers, consultants, advisors, or any other
23 individual or firm who referred the group health
24 plan’s business to the pharmacy benefits man-
25 ager.

1 “(2) PRIVACY REQUIREMENTS.—Entities pro-
2 viding pharmacy benefits management services on
3 behalf of a group health plan shall provide informa-
4 tion under paragraph (1) in a manner consistent
5 with the privacy, security, and breach notification
6 regulations promulgated under section 264(c) of the
7 Health Insurance Portability and Accountability Act
8 of 1996, and shall restrict the use and disclosure of
9 such information according to such privacy regula-
10 tions.

11 “(3) DISCLOSURE AND REDISCLOSURE.—

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

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

1 strict disclosure of such report to the Depart-
2 ment of Health and Human Services, the De-
3 partment of Labor, the Department of the
4 Treasury, the Comptroller General of the
5 United States, or applicable State agencies.

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

13 “(4) REPORT TO GAO.—An entity providing
14 pharmacy benefits management services on behalf of
15 a group health plan shall submit to the Comptroller
16 General of the United States each of the first 4 re-
17 ports submitted to a plan sponsor under paragraph
18 (1) with respect to such plan, and other such reports
19 as requested, in accordance with the privacy require-
20 ments under paragraph (2), the disclosure and re-
21 disclosure standards under paragraph (3), the stand-
22 ards specified pursuant to paragraph (5), and such
23 other information that the Comptroller General de-
24 termines necessary to carry out the study under sec-

1 tion 2(d) of the Pharmacy Benefits Manager Ac-
2 countability Act.

3 “(5) STANDARD FORMAT.—Not later than June
4 1, 2023, the Secretary shall specify through rule-
5 making standards for entities required to submit re-
6 ports under paragraph (4) to submit such reports in
7 a standard format.

8 “(c) ENFORCEMENT.—

9 “(1) IN GENERAL.—The Secretary, in consulta-
10 tion with the Secretary of Labor and the Secretary
11 of Health and Human Services, shall enforce this
12 section.

13 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
14 TION.—An entity providing pharmacy benefits man-
15 agement services that violates subsection (a) or fails
16 to provide information required under subsection (b)
17 shall be subject to a civil monetary penalty in the
18 amount of \$10,000 for each day during which such
19 violation continues or such information is not dis-
20 closed or reported.

21 “(3) FALSE INFORMATION.—An entity pro-
22 viding pharmacy benefits management services that
23 knowingly provides false information under this sec-
24 tion shall be subject to a civil money penalty in an
25 amount not to exceed \$100,000 for each item of

1 false information. Such civil money penalty shall be
2 in addition to other penalties as may be prescribed
3 by law.

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

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

18 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
19 tion shall be construed to permit a group health plan or
20 other entity to restrict disclosure to, or otherwise limit the
21 access of, the Department of the Treasury to a report de-
22 scribed in subsection (b)(1) or information related to com-
23 pliance with subsection (a) by such plan or entity.

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

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

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

8 (d) GAO STUDY.—

9 (1) IN GENERAL.—Not later than 3 years after
10 the date of enactment of this Act, the Comptroller
11 General of the United States shall submit to Con-
12 gress a report on—

13 (A) pharmacy networks of group health
14 plans, health insurance issuers, and entities
15 providing pharmacy benefits management serv-
16 ices under such group health plan or group or
17 individual health insurance coverage, including
18 networks that have pharmacies that are under
19 common ownership (in whole or part) with
20 group health plans, health insurance issuers, or
21 entities providing pharmacy benefits manage-
22 ment services or pharmacy benefits administra-
23 tive services under group health plan or group
24 or individual health insurance coverage;

1 (B) as it relates to pharmacy networks
2 that include pharmacies under common owner-
3 ship described in subparagraph (A)—

4 (i) whether such networks are de-
5 signed to encourage enrollees of a plan or
6 coverage to use such pharmacies over other
7 network pharmacies for specific services or
8 drugs, and if so, the reasons the networks
9 give for encouraging use of such phar-
10 macies; and

11 (ii) whether such pharmacies are used
12 by enrollees disproportionately more in the
13 aggregate or for specific services or drugs
14 compared to other network pharmacies;

15 (C) whether group health plans and health
16 insurance issuers offering group or individual
17 health insurance coverage have options to elect
18 different network pricing arrangements in the
19 marketplace with entities that provide phar-
20 macy benefits management services, the preva-
21 lence of electing such different network pricing
22 arrangements;

23 (D) pharmacy network design parameters
24 that encourage enrollees in the plan or coverage
25 to fill prescriptions at mail order, specialty, or

1 retail pharmacies that are wholly or partially-
2 owned by that issuer or entity; and

3 (E) the degree to which mail order, spe-
4 cialty, or retail pharmacies that dispense pre-
5 scription drugs to an enrollee in a group health
6 plan or health insurance coverage that are
7 under common ownership (in whole or part)
8 with group health plans, health insurance
9 issuers, or entities providing pharmacy benefits
10 management services or pharmacy benefits ad-
11 ministrative services under group health plan or
12 group or individual health insurance coverage
13 receive reimbursement that is greater than the
14 median price charged to the group health plan
15 or health insurance issuer when the same drug
16 is dispensed to enrollees in the plan or coverage
17 by other pharmacies included in the pharmacy
18 network of that plan, issuer, or entity that are
19 not wholly or partially owned by the health in-
20 surance issuer or entity providing pharmacy
21 benefits management services.

22 (2) REQUIREMENT.—The Comptroller General
23 of the United States shall ensure that the report
24 under paragraph (1) does not contain information
25 that would allow a reader to identify a specific plan

1 or entity providing pharmacy benefits management
2 services or otherwise contain commercial or financial
3 information that is privileged or confidential.

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

9 **TITLE II—SUPPORTING PA-**
10 **TIENTS, HEALTH CARE WORK-**
11 **ERS, COMMUNITY HEALTH**
12 **CENTERS, AND HOSPITALS**

13 **SEC. 201. EXTENSION FOR COMMUNITY HEALTH CENTERS,**
14 **THE NATIONAL HEALTH SERVICE CORPS,**
15 **AND TEACHING HEALTH CENTERS THAT OP-**
16 **ERATE GME PROGRAMS.**

17 (a) TEACHING HEALTH CENTERS THAT OPERATE
18 GRADUATE MEDICAL EDUCATION PROGRAMS.—Section
19 340H(g) of the Public Health Service Act (42 U.S.C.
20 256h(g)) is amended—

21 (1) by amending paragraph (1) to read as fol-
22 lows:

23 “(1) IN GENERAL.—To carry out this section,
24 there are appropriated such sums as may be nec-
25 essary, not to exceed—

1 “(A) \$230,000,000, for the period of fiscal
2 years 2011 through 2015;

3 “(B) \$60,000,000 for each of fiscal years
4 2016 and 2017;

5 “(C) \$126,500,000 for each of fiscal years
6 2018 through 2023;

7 “(D) \$175,000,000 for each of fiscal years
8 2024 and 2025;

9 “(E) \$225,000,000 for each of fiscal years
10 2026 and 2027; and

11 “(F) \$275,000,000 for each of fiscal years
12 2028 and 2029.”; and

13 (2) by adding at the end the following:

14 “(3) AVAILABILITY.—The amounts made avail-
15 able under paragraph (1) shall remain available until
16 expended.”.

17 (b) EXTENSION FOR COMMUNITY HEALTH CEN-
18 TERS.—Section 10503(b)(1)(F) of the Patient Protection
19 and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is
20 amended—

21 (1) by striking “and” before “\$4,000,000,000”
22 and inserting a comma; and

23 (2) by inserting “, and \$4,200,000,000 for each
24 of fiscal years 2024 and 2025” before the semicolon.

1 (c) EXTENSION FOR THE NATIONAL HEALTH SERV-
2 ICE CORPS.—Section 10503(b)(2) of the Patient Protec-
3 tion and Affordable Care Act (42 U.S.C. 254b–2(b)(2))
4 is amended—

5 (1) in subparagraph (G), by striking “and” at
6 the end;

7 (2) in subparagraph (H), by striking the period
8 at the end and inserting “; and”; and

9 (3) by adding at the end the following:

10 “(I) \$350,000,000 for each of fiscal years
11 2024 and 2025.”

12 (d) APPLICATION OF PROVISIONS.—Amounts appro-
13 priated pursuant to the amendments made by this section
14 shall be subject to the requirements contained in Public
15 Law 117–328 for funds for programs authorized under
16 sections 330 through 340 of the Public Health Service
17 Act.

18 (e) CONFORMING AMENDMENT.—Paragraph (4) of
19 section 3014(h) of title 18, United States Code, is amend-
20 ed by striking “and section 301(d) of division BB of the
21 Consolidated Appropriations Act, 2021.” and inserting
22 “section 301(d) of division BB of the Consolidated Appro-
23 priations Act, 2021, and section 201(d) of the Trans-
24 parent PRICE Act of 2023”.

1 **SEC. 202. EXTENSION OF SPECIAL DIABETES PROGRAMS.**

2 (a) EXTENSION OF SPECIAL DIABETES PROGRAMS
3 FOR TYPE I DIABETES.—Section 330B(b)(2) of the Pub-
4 lic Health Service Act (42 U.S.C. 254e–2(b)(2)) is amend-
5 ed—

6 (1) in subparagraph (C), by striking “and” at
7 the end;

8 (2) in subparagraph (D), by striking the period
9 and inserting “; and”; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(E) \$170,000,000 for each of fiscal years
13 2024 and 2025.”.

14 (b) EXTENDING FUNDING FOR SPECIAL DIABETES
15 PROGRAMS FOR INDIANS.—Section 330C(c)(2) of the
16 Public Health Service Act (42 U.S.C. 254e–3(c)(2)) is
17 amended—

18 (1) in subparagraph (C), by striking “and” at
19 the end;

20 (2) in subparagraph (D), by striking the period
21 and inserting “; and”; and

22 (3) by adding at the end the following new sub-
23 paragraph:

24 “(E) \$170,000,000 for each of fiscal years
25 2024 and 2025.”.

1 **SEC. 203. DELAYING CERTAIN DISPROPORTIONATE SHARE**
2 **HOSPITAL PAYMENT REDUCTIONS UNDER**
3 **THE MEDICAID PROGRAM.**

4 Section 1923(f)(7)(A) of the Social Security Act (42
5 U.S.C.1396r-4(f)(7)(A)) is amended—

6 (1) in clause (i), in the matter preceding sub-
7 clause (I), by striking “2024” and inserting “2026”;
8 and

9 (2) in clause (ii), by striking “2024” and in-
10 sserting “2026”.

11 **SEC. 204. MEDICAID IMPROVEMENT FUND.**

12 Section 1941(b)(3)(A) of the Social Security Act (42
13 U.S.C. 1396w-1(b)(3)(A)) is amended by striking
14 “\$7,000,000,000” and inserting “\$0”.

15 **TITLE III—REDUCING HEALTH**
16 **CARE COSTS**

17 **SEC. 301. INCREASING TRANSPARENCY IN GENERIC DRUG**
18 **APPLICATIONS.**

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

22 “(H)(i) Upon request (in controlled correspondence
23 or an analogous process) by a person that has submitted
24 or intends to submit an abbreviated application under this
25 subsection for a drug that is required by regulation to con-
26 tain one or more of the same inactive ingredients in the

1 same concentrations as the listed drug referred to, or for
2 which the Secretary determines there is a scientific jus-
3 tification for an approach that is in vitro in whole or in
4 part to be used to demonstrate bioequivalence for a drug
5 if such a drug contains one or more of the same inactive
6 ingredients in the same concentrations as the listed drug,
7 the Secretary shall inform the person whether such drug
8 is qualitatively and quantitatively the same as the listed
9 drug. The Secretary may also provide such information
10 to such a person on the Secretary's own initiative during
11 the review of an abbreviated application under this sub-
12 section for such drug.

13 “(ii) Notwithstanding section 301(j), if the Secretary
14 determines that such drug is not qualitatively or quan-
15 titatively the same as the listed drug, the Secretary shall
16 identify and disclose to the person—

17 “(I) the ingredient or ingredients that cause
18 such drug not to be qualitatively or quantitatively
19 the same as the listed drug; and

20 “(II) for any ingredient for which there is an
21 identified quantitative deviation, whether the quan-
22 tity or proportion of any ingredient in such drug is
23 greater than or less than the quantity or proportion
24 of such ingredient in the listed drug.

1 “(iii) If the Secretary determines that such drug is
2 qualitatively and quantitatively the same as the listed
3 drug, the Secretary shall not change or rescind such deter-
4 mination after the submission of an abbreviated applica-
5 tion for such drug under this subsection unless—

6 “(I) the formulation of the listed drug has been
7 changed and the Secretary has determined that the
8 prior listed drug formulation was withdrawn for rea-
9 sons of safety or effectiveness; or

10 “(II) the Secretary makes a written determina-
11 tion that the prior determination must be changed
12 because an error has been identified.

13 “(iv) If the Secretary makes a written determination
14 described in clause (iii)(II), the Secretary shall provide no-
15 tice and a copy of the written determination to the person
16 making the request under clause (i).

17 “(v) The disclosures required by this subparagraph
18 are disclosures authorized by law, including for purposes
19 of section 1905 of title 18, United States Code.”.

20 (b) GUIDANCE.—

21 (1) IN GENERAL.—Not later than one year
22 after the date of enactment of this Act, the Sec-
23 retary of Health and Human Services shall issue
24 draft guidance, or update guidance, describing how
25 the Secretary will determine whether a drug is quali-

1 tatively and quantitatively the same as the listed
2 drug (as such terms are used in section
3 505(j)(3)(H) of the Federal Food, Drug, and Cos-
4 metic Act, as added by subsection (a)), including
5 with respect to assessing pH adjusters.

6 (2) PROCESS.—In issuing guidance under this
7 subsection, the Secretary of Health and Human
8 Services shall—

9 (A) publish draft guidance;

10 (B) provide a period of at least 60 days for
11 comment on the draft guidance; and

12 (C) after considering any comments re-
13 ceived and not later than one year after the
14 close of the comment period on the draft guid-
15 ance, publish final guidance.

16 (c) APPLICABILITY.—Section 505(j)(3)(H) of the
17 Federal Food, Drug, and Cosmetic Act, as added by sub-
18 section (a), applies beginning on the date of enactment
19 of this Act, irrespective of the date on which the guidance
20 required by subsection (b) is finalized.

1 **SEC. 302. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**
2 **OUTPATIENT DEPARTMENT SERVICES FUR-**
3 **NISHED OFF-CAMPUS.**

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

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

11 “(i) IN GENERAL.—Subject to clause
12 (iii), in the case of specified OPD services
13 (as defined in clause (iv)) that are fur-
14 nished during 2025 or a subsequent year
15 by an off-campus outpatient department of
16 a provider (as defined in clause (iv)), there
17 shall be substituted for the amount other-
18 wise determined under this subsection for
19 such service and year an amount equal to
20 the payment amount that would have been
21 payable under the applicable payment sys-
22 tem under this part (other than under this
23 subsection) had such services been fur-
24 nished by such a department subject to
25 such payment system pursuant to para-
26 graph (21)(C).

1 “(ii) NOT BUDGET NEUTRAL IMPLE-
2 MENTATION.—In making any budget neu-
3 trality adjustments under this subsection
4 for 2025 or a subsequent year, the Sec-
5 retary shall not take into account the re-
6 duced expenditures that result from the
7 application of this subparagraph.

8 “(iii) TRANSITION.—The Secretary
9 shall provide for a 4-year phase-in of the
10 application of clause (i), with clause (i)
11 being fully applicable for specified OPD
12 services beginning with 2028.

13 “(iv) DEFINITIONS.—For purposes of
14 this subparagraph:

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

22 “(II) SPECIFIED OPD SERVICES
23 DEFINED.—The term ‘specified OPD
24 services’ means covered OPD services

1 included in a designated ambulatory
2 payment classification group.

3 “(III) OFF-CAMPUS OUTPATIENT
4 DEPARTMENT OF A PROVIDER DE-
5 FINED.—The term ‘off-campus out-
6 patient department of a provider’
7 means a department of a provider (as
8 defined in section 413.65(a)(2) of title
9 42, Code of Federal Regulations) that
10 is not located—

11 “(aa) on the campus (as
12 such term is defined in such sec-
13 tion 413.65(a)(2)) of such pro-
14 vider; or

15 “(bb) within the distance
16 (described in such definition of
17 campus) from a remote location
18 of a hospital facility (as defined
19 in such section 413.65(a)(2)).”.

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

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

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

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

5 “(F) the determination of any payment
6 amount under paragraph (16)(H), including the
7 transition under clause (iii) of such para-
8 graph.”.

9 **SEC. 303. IMPROVING TRANSPARENCY AND PREVENTING**
10 **THE USE OF ABUSIVE SPREAD PRICING AND**
11 **RELATED PRACTICES IN MEDICAID.**

12 (a) PHARMACY PRICE REIMBURSEMENT REQUIRE-
13 MENTS.—

14 (1) IN GENERAL.—Section 1927(e) of the So-
15 cial Security Act (42 U.S.C. 1396r–8(e)) is amended
16 by adding at the end the following:

17 “(6) PHARMACY PRICE REIMBURSEMENT RE-
18 QUIRED.—A contract between the State and a man-
19 aged care entity (or subcontractor of a managed
20 care entity that manages the pharmacy benefit for
21 such entity (in this section referred to as a ‘PBM’),
22 or other specified entity (as such terms are defined
23 in section 1903(m)(9)(D)) that includes provisions
24 making the managed care entity responsible for cov-
25 erage of covered outpatient drugs dispensed to indi-

1 viduals enrolled with the entity, shall require that
2 payment for such drugs and related administrative
3 services (as applicable), including payments made by
4 a PBM on behalf of the State or entity, is based on
5 a pass-through pricing model under which—

6 “(A) any payment made by the entity or
7 the PBM (as applicable) for such a drug—

8 “(i) is limited to—

9 “(I) ingredient cost; and

10 “(II) a professional dispensing
11 fee that is not less than the profes-
12 sional dispensing fee that the State
13 plan or waiver would pay if the plan
14 or waiver was making the payment di-
15 rectly;

16 “(ii) is passed through in its entirety
17 by the entity or PBM to the pharmacy or
18 provider that dispenses the drug; and

19 “(iii) is made in a manner that is con-
20 sistent with sections 447.502, 447.512,
21 447.514, and 447.518 of title 42, Code of
22 Federal Regulations (or any successor reg-
23 ulation) as if such requirements applied di-
24 rectly to the entity or the PBM;

1 “(B) payment to the entity or the PBM
2 (as applicable) for administrative services per-
3 formed by the entity or PBM is limited to an
4 administrative fee that covers the reasonable
5 cost of providing such services;

6 “(C) the entity or the PBM (as applicable)
7 shall make available to the State, and the Sec-
8 retary upon request, all costs and payments re-
9 lated to covered outpatient drugs and accom-
10 panying administrative services incurred, re-
11 ceived, or made by the entity or the PBM, in-
12 cluding ingredient costs, professional dispensing
13 fees, administrative fees, post-sale and post-in-
14 voice fees, discounts, or related adjustments
15 such as direct and indirect remuneration fees,
16 and any and all other remuneration; and

17 “(D) any form of spread pricing whereby
18 any amount charged or claimed by the entity or
19 the PBM (as applicable) is in excess of the
20 amount paid to the pharmacies on behalf of the
21 entity, including any post-sale or post-invoice
22 fees, discounts, or related adjustments such as
23 direct and indirect remuneration fees or assess-
24 ments (after allowing for a reasonable adminis-
25 trative fee as described in subparagraph (B)) is

1 not allowable for purposes of claiming Federal
2 matching payments under this title.”.

3 (2) CONFORMING AMENDMENTS.—Section
4 1903(m)(2)(A)(xiii) of such Act (42 U.S.C.
5 1396b(m)(2)(A)(xiii)) is amended—

6 (A) by striking “and (III)” and inserting
7 “(III)”;

8 (B) by inserting before the period at the
9 end the following: “, and (IV) the pharmacy
10 benefit provided by the entity (or pharmacy
11 benefit manager on behalf of the entity under
12 a contract), the other specified entity (as de-
13 fined in paragraph (9)(D)), or by another ar-
14 rangement between the entity and the phar-
15 macy benefit manager, shall comply with the re-
16 quirements of section 1927(e)(6)”;

17 (C) by moving the left margin 2 ems to the
18 left.

19 (3) EFFECTIVE DATE.—The amendments made
20 by this subsection apply to contracts between States
21 and managed care entities, or other specified enti-
22 ties, that have an initial effective date or are re-
23 newed on or after the date that is 18 months after
24 the date of enactment of this Act.

1 (b) ENSURING ACCURATE PAYMENTS TO PHAR-
2 MACIES UNDER MEDICAID.—

3 (1) IN GENERAL.—Section 1927(f) of the Social
4 Security Act (42 U.S.C. 1396r–8(f)) is amended—

5 (A) by striking “and” after the semicolon
6 at the end of paragraph (1)(A)(i) and all that
7 precedes it through “(1)” and inserting the fol-
8 lowing:

9 “(1) DETERMINING PHARMACY ACTUAL ACQUI-
10 SITION COSTS.—The Secretary shall conduct a sur-
11 vey of retail community pharmacy drug prices to de-
12 termine the national average drug acquisition cost as
13 follows:

14 “(A) USE OF VENDOR.—The Secretary
15 may contract services for—

16 “(i) with respect to retail community
17 pharmacies, the determination of retail
18 survey prices of the national average drug
19 acquisition cost for covered outpatient
20 drugs based on a monthly survey of such
21 pharmacies; and”;

22 (B) by adding at the end of paragraph (1)
23 the following:

24 “(F) SURVEY REPORTING.—A State shall
25 require that any retail community pharmacy in

1 the State that receives any payment, reimburse-
2 ment, administrative fee, discount, or rebate re-
3 lated to the dispensing of covered outpatient
4 drugs to individuals receiving benefits under
5 this title, regardless of whether such payment,
6 reimbursement, administrative fee, discount, or
7 rebate is received from the State or a managed
8 care entity directly or from a pharmacy benefit
9 manager or other specified entity (as defined in
10 section 1903(m)(9)(D)) that has a contract
11 with the State or a managed care entity, shall
12 respond to surveys of retail prices conducted
13 under this subsection.

14 “(G) SURVEY INFORMATION.—Information
15 on national drug acquisition prices obtained
16 under this paragraph shall be made publicly
17 available in a timely manner following the col-
18 lection of such information and shall include at
19 least the following:

20 “(i) The monthly response rate to the
21 survey including a list of pharmacies not in
22 compliance with subparagraph (F).

23 “(ii) The sampling frame and number
24 of pharmacies sampled monthly.

1 “(iii) Information on price concessions
2 to the pharmacy, including discounts, re-
3 bates, and other price concessions, to the
4 extent that such information is available
5 during the survey period.

6 “(H) REPORT ON SPECIALTY PHAR-
7 MACIES.—Not later than 1 year after the date
8 that this subparagraph takes effect, the Sec-
9 retary shall submit to Congress a report exam-
10 ining specialty drug coverage and reimburse-
11 ment under this title, including—

12 “(i) a description of how State Med-
13 icaid programs define specialty drugs and
14 specialty pharmacies;

15 “(ii) the amount State Medicaid pro-
16 grams pay for specialty drugs;

17 “(iii) how States and managed care
18 entities determine payment for specialty
19 drugs;

20 “(iv) the settings in which specialty
21 drugs are dispensed to individuals receiv-
22 ing benefits under this title (such as retail
23 community pharmacies or specialty phar-
24 macies);

1 “(v) the extent to which speciality
2 drugs (as defined by the respective States)
3 are captured in the national average drug
4 acquisition cost survey (or through another
5 process);

6 “(vi) examples of specialty drug dis-
7 pensing fees to support the services associ-
8 ated with dispensing such specialty drugs;
9 and

10 “(vii) recommendations as to whether
11 specialty pharmacies should be included in
12 the survey of retail prices to ensure na-
13 tional average drug acquisition costs cap-
14 ture drugs sold at specialty pharmacies,
15 and how such specialty pharmacies should
16 be defined.

17 “(I) ENFORCEMENT.—At the discretion of
18 the Secretary, the Secretary may enforce non-
19 compliance with this paragraph by a pharmacy
20 through the establishment of penalties or the
21 suspension of payments under this title, in full
22 or in part, until compliance with this paragraph
23 has been completed.”; and

24 (C) in paragraph (2)—

1 (i) in subparagraph (A), by inserting
2 “(including payment rates under Medicaid
3 managed care plans)” after “under this
4 title”; and

5 (ii) in subparagraph (B), by inserting
6 “, and the basis for such dispensing fees”
7 before the semicolon at the end.

8 (2) EFFECTIVE DATE.—The amendments made
9 by this subsection take effect on the first day of the
10 first quarter that begins on or after the date that is
11 18 months after the date of enactment of this Act.

