

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

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

118TH CONGRESS
1ST SESSION

H. R. 5378

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 8, 2023

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

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Lower Costs, More
5 Transparency Act”.

1 SEC. 2. TABLE OF CONTENTS.

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

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

TITLE I—IMPROVING HEALTH CARE TRANSPARENCY

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

TITLE II—REDUCING HEALTH CARE COSTS FOR PATIENTS

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

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

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

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

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

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

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

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

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

8 “(a) **TRANSPARENCY REQUIREMENT.**—

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

14 “(2) **REQUIREMENT DESCRIBED.**—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(4) ENFORCEMENT.—

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

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

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

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

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

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

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

17 “(B) CIVIL MONETARY PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (b) PHSA.—

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

12 “(f) HOSPITAL TRANSPARENCY REQUIREMENT.—

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

17 “(2) REQUIREMENT DESCRIBED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(4) ENFORCEMENT.—

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

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

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

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

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

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

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

17 “(B) CIVIL MONETARY PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(i) the number of reviews of compli-
22 ance with this subsection undertaken by
23 the Secretary;

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

4 “(iii) the identity of each hospital that
5 was sent such a notification and a descrip-
6 tion of the nature of such hospital’s non-
7 compliance with this subsection;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 “(5) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(b) IMAGING SERVICES PRICE TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(5) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 “(2) REQUIREMENT DESCRIBED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(4) ENFORCEMENT.—

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

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

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

12 “(B) CIVIL MONETARY PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (a) PRICE TRANSPARENCY REQUIREMENTS.—

15 (1) IRC.—

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

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

20 “(a) COST-SHARING TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(b) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

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

21 “(C) With respect to each item or service
22 for which benefits are available under such
23 plan, the amount billed, and the amount al-
24 lowed by the plan, for each such item or service
25 furnished during the 90-day period specified in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(d) DEFINITIONS.—In this section:

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

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

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

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

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

“Sec. 9819. Transparency in coverage.”.

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

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

25 “(a) COST-SHARING TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(b) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 “(d) DEFINITIONS.—In this section:

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

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

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

15 (3) ERISA.—

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

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

21 “(a) COST-SHARING TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(b) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(d) DEFINITIONS.—In this section:

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

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

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

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

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

“Sec. 719. Transparency in coverage.”.

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

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

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

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

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

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

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

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

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

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

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

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

24 (c) PROVIDER TOOL REPORT.—

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

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

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

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

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

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

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

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

1 (vi) health care access in rural areas.

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

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

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

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

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

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

13 (d) REPORTS.—

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

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

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

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

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

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

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

11 (A) rural and urban areas;

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

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

17 (D) nonprofit and for-profit hospitals;

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

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

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

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

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

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

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

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

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

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

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

11 “(b) REPORTS.—

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

1 and shall include the information described in para-
2 graph (2).

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

9 “(A) in the case of such a plan offered by
10 a specified large employer (or such coverage of-
11 fered in connection with such a plan offered by
12 a specified large employer)—

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

16 “(I) the brand name, chemical
17 entity, and National Drug Code;

18 “(II) the type of dispensing chan-
19 nel used to furnish such drug, includ-
20 ing retail, mail order, or specialty
21 pharmacy;

22 “(III) with respect to each drug
23 dispensed under each type of dis-
24 pensing channel (including retail, mail
25 order, or specialty pharmacy)—

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

4 “(AA) in the case of a
5 brand name drug, the whole-
6 sale acquisition cost, listed
7 as cost per days supply and
8 cost per dosage unit, on the
9 date such drug was dis-
10 pensed; and

11 “(BB) in the case of a
12 generic drug, the average
13 wholesale price, listed as
14 cost per days supply and
15 cost per dosage unit, on the
16 date such drug was dis-
17 pensed; and

18 “(bb) the total number of—

19 “(AA) prescription
20 claims (including original
21 prescriptions and refills);

22 “(BB) participants,
23 beneficiaries, and enrollees
24 for whom a claim for such
25 drug was filed;

1 “(CC) dosage units per
2 fill of such drug; and

3 “(DD) days supply of
4 such drug per fill;

5 “(IV) the net price per course of
6 treatment or single fill, such as a 30-
7 day supply or 90-day supply to the
8 plan or coverage after manufacturer
9 rebates, fees, and other remuneration
10 or adjustments;

11 “(V) the total amount of out-of-
12 pocket spending by participants, bene-
13 ficiaries, and enrollees on such drug,
14 including spending through copay-
15 ments, coinsurance, and deductibles;

16 “(VI) the total net spending by
17 the plan or coverage during the re-
18 porting period;

19 “(VII) the total amount received,
20 or expected to be received, by the plan
21 or coverage from any entity in drug
22 manufacturer rebates, fees, alternative
23 discounts, and all other remuneration
24 received from an entity or any third
25 party (including group purchasing or-

1 organizations) other than the plan spon-
2 sor;
3 “(VIII) the total amount re-
4 ceived, or expected to be received by
5 the plan or issuer, from drug manu-
6 facturers 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; and
12 “(bb) that is related to utili-
13 zation rebates for such drug; and
14 “(IX) to the extent feasible, in-
15 formation on the total amount of re-
16 muneration, including copayment as-
17 sistance dollars paid, copayment cards
18 applied, or other discounts provided
19 by each drug manufacturer (or entity
20 administering copay assistance on be-
21 half of such drug manufacturer) to
22 the participants, beneficiaries, and en-
23 rollees enrolled in such plan or cov-
24 erage for such drug;

1 “(ii) for each category or class of
2 drugs for which a claim was filed, a break-
3 down of the total gross spending on drugs
4 in such category or class before rebates,
5 price concessions, alternative discounts, or
6 other remuneration from drug manufactur-
7 ers, and the net spending after such re-
8 bates, price concessions, alternative dis-
9 counts, or other remuneration from drug
10 manufacturers, including—

11 “(I) the number of participants,
12 beneficiaries, and enrollees who filled
13 a prescription for a drug in such cat-
14 egory or class, including the National
15 Drug Code for each such drug;

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

21 “(III) the total out-of-pocket
22 spending under the plan or coverage
23 by participants, beneficiaries, and en-
24 rollees, including spending through co-

1 payments, coinsurance, and
2 deductibles;

3 “(iii) in the case of a drug for which
4 gross spending by such plan, coverage, or
5 entity exceeded \$10,000 during the report-
6 ing period—

7 “(I) a list of all other drugs in
8 the same therapeutic category or
9 class; and

10 “(II) the rationale for the for-
11 mulary placement of such drug in that
12 therapeutic category or class, if appli-
13 cable; and

14 “(iv) in the case such plan or coverage
15 (or an entity providing pharmacy benefits
16 management services on behalf of such
17 plan or coverage) has an affiliated phar-
18 macy or pharmacy under common owner-
19 ship—

20 “(I) the percentage of total pre-
21 scriptions dispensed by such phar-
22 macies to individuals enrolled in such
23 plan or coverage;

24 “(II) a list of all drugs dispensed
25 by such pharmacies to individuals en-

1 rolled in such plan or coverage, and,
2 with respect to each drug dispensed—

3 “(aa) the amount charged,
4 per dosage unit, per 30-day sup-
5 ply, or per 90-day supply (as ap-
6 plicable) to the plan or issuer,
7 and to participants, beneficiaries,
8 and enrollees enrolled in such
9 plan or coverage;

10 “(bb) the median amount
11 charged to such plan or issuer,
12 and the interquartile range of the
13 costs, per dosage unit, per 30-
14 day supply, and per 90-day sup-
15 ply, including amounts paid by
16 the participants, beneficiaries,
17 and enrollees, when the same
18 drug is dispensed by other phar-
19 macies that are not affiliated
20 with or under common ownership
21 with the entity and that are in-
22 cluded in the pharmacy network
23 of such plan or coverage;

24 “(cc) the lowest cost per
25 dosage unit, per 30-day supply

1 and per 90-day supply, for each
2 such drug, including amounts
3 charged to the plan and partici-
4 pants, beneficiaries, and enroll-
5 ees, that is available from any
6 pharmacy included in the net-
7 work of such plan or coverage;
8 and

9 “(dd) the net acquisition
10 cost per dosage unit, per 30-day
11 supply, and per 90-day supply, if
12 such drug is subject to a max-
13 imum price discount;

14 “(B) in the case of a plan or coverage not
15 described in subparagraph (A)—

16 “(i) the total net spending by the plan
17 or coverage for all drugs covered by such
18 plan or coverage during such reporting pe-
19 riod;

20 “(ii) the total amount received, or ex-
21 pected to be received, by the plan or cov-
22 erage from any entity in drug manufac-
23 turer rebates, fees, alternative discounts,
24 and all other remuneration received from
25 an entity or any third party (including

1 group purchasing organizations) other
2 than the plan sponsor for all such drugs;
3 and

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

14 “(C) amounts paid directly or indirectly in
15 rebates, fees, or any other type of compensation
16 (as defined in section 408(b)(2)(B)(ii)(dd)(AA)
17 of the Employee Retirement Income Security
18 Act) to brokers, consultants, advisors, or any
19 other individual or firm, for the referral of the
20 group health plan’s or health insurance issuer’s
21 business to an entity providing pharmacy bene-
22 fits management services, including the identity
23 of the recipient of such amounts;

24 “(D) an explanation of any benefit design
25 parameters that encourage or require partici-

1 pants, beneficiaries, and enrollees in such plan
2 or coverage to fill prescriptions at mail order,
3 specialty, or retail pharmacies that are affili-
4 ated with or under common ownership with the
5 entity providing pharmacy benefit management
6 services under such plan or coverage, including
7 mandatory mail and specialty home delivery
8 programs, retail and mail auto-refill programs,
9 and cost-sharing assistance incentives directly
10 or indirectly funded by such entity; and

11 “(E) total gross spending on all drugs dur-
12 ing the reporting period.

13 “(3) PRIVACY REQUIREMENTS.—

14 “(A) IN GENERAL.—Health insurance
15 issuers offering group health insurance coverage
16 and entities providing pharmacy benefits man-
17 agement services on behalf of a group health
18 plan shall provide information under paragraph
19 (1) in a manner consistent with the privacy, se-
20 curity, and breach notification regulations pro-
21 mulgated under section 13402(a) of the Health
22 Information Technology for Clinical Health Act
23 and consistent with the HIPAA privacy regula-
24 tions (as defined in section 1180(b)(3) of the
25 Social Security Act) and shall restrict the use

1 and disclosure of such information according to
2 such privacy, security, and breach notification
3 regulations and such HIPAA privacy regula-
4 tions.

5 “(B) ADDITIONAL REQUIREMENTS.—

6 “(i) IN GENERAL.—An entity pro-
7 viding pharmacy benefits management
8 services on behalf of a group health plan or
9 health insurance issuer offering group
10 health insurance coverage that submits a
11 report under paragraph (1) shall ensure
12 that such report contains only summary
13 health information, as defined in section
14 164.504(a) of title 45, Code of Federal
15 Regulations (or successor regulations).

16 “(ii) RESTRICTIONS.—A group health
17 plan shall comply with section 164.504(f)
18 of title 45, Code of Federal Regulations (or
19 a successor regulation) and a plan sponsor
20 shall act in accordance with the terms of
21 the agreement described in such section.

22 “(C) RULE OF CONSTRUCTION.—Nothing
23 in this section shall be construed to modify the
24 requirements for the creation, receipt, mainte-
25 nance, or transmission of protected health in-

1 formation under the HIPAA privacy regulations
2 (as defined in section 1180(b)(3) of the Social
3 Security Act).

4 “(4) DISCLOSURE AND REDISCLOSURE.—

5 “(A) LIMITATION TO BUSINESS ASSOCI-
6 ATES.—A group health plan receiving a report
7 under paragraph (1) may disclose such informa-
8 tion only to the entity from which the report
9 was received or to that entity’s business associ-
10 ates as defined in section 160.103 of title 45,
11 Code of Federal Regulations (or successor regu-
12 lations) or as permitted by the HIPAA Privacy
13 Rule (45 CFR parts 160 and 164, subparts A
14 and E).

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

1 to the Department of Health and Human Serv-
2 ices, the Department of Labor, the Department
3 of the Treasury, or the Comptroller General of
4 the United States.

5 “(C) LIMITED FORM OF REPORT.—The
6 Secretary shall define through rulemaking a
7 limited form of the report under paragraph (1)
8 required with respect to group health plans
9 where the plan sponsors of such plans are drug
10 manufacturers, drug wholesalers, or other direct
11 participants in the drug supply chain, in order
12 to prevent anti-competitive behavior.

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

1 out the study under section 106(d) of the Lower
2 Costs, More Transparency Act.

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

12 “(c) ENFORCEMENT.—

13 “(1) IN GENERAL.—The Secretary shall enforce
14 this section.

15 “(2) FAILURE TO PROVIDE INFORMATION.—A
16 health insurance issuer or an entity providing phar-
17 macy benefits management services on behalf of
18 such plan or coverage that violates sub-section (a) or
19 fails to provide the information required under sub-
20 section (b) shall be subject to a civil monetary pen-
21 alty in the amount of \$10,000 for each day during
22 which such violation continues or such information is
23 not disclosed or reported.

24 “(3) FALSE INFORMATION.—A health insurance
25 issuer or an entity providing pharmacy benefits

1 management services on behalf of such a plan or
2 coverage that knowingly provides false information
3 under this section shall be subject to a civil money
4 penalty in an amount not to exceed \$100,000 for
5 each item of false information. Such civil money
6 penalty shall be in addition to other penalties as
7 may be prescribed by law.

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

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

21 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
22 tion shall be construed to permit a group health plan,
23 health insurance issuer, or entity providing pharmacy ben-
24 efits management services on behalf of such plan or cov-
25 erage, to restrict disclosure to, or otherwise limit the ac-

1 cess of, the Department of Health and Human Services
2 to a report described in subsection (b)(1) or information
3 related to compliance with subsection (a) or (b) by entities
4 subject to such subsection.

5 “(e) DEFINITIONS.—In this section:

6 “(1) SPECIFIED LARGE EMPLOYER.—The term
7 ‘specified large employer’ means, in connection with
8 a group health plan with respect to a calendar year
9 and a plan year, an employer who employed an aver-
10 age of at least 50 employees on business days during
11 the preceding calendar year and who employs at
12 least 1 employee on the first day of the plan year.

13 “(2) WHOLESALE ACQUISITION COST.—The
14 term ‘wholesale acquisition cost’ has the meaning
15 given such term in section 1847A(c)(6)(B) of the
16 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 BENEFIT MANAGER**
18 **SERVICES.**

19 “(a) IN GENERAL.—For plan years beginning on or
20 after the date that is 2 years after the date of enactment
21 of this section, a group health plan or a health insurance
22 issuer offering group health insurance coverage, or an en-
23 tity or subsidiary providing pharmacy benefits manage-
24 ment services on behalf of such a plan or issuer, shall not
25 enter into a contract with a drug manufacturer, dis-

1 tributor, wholesaler, subcontractor, rebate aggregator, or
2 any other third party that limits (or delays beyond the
3 applicable reporting period described in subsection (b)(1))
4 the disclosure of information to group health plans in such
5 a manner that prevents such plan, issuer, or entity from
6 making the reports described in subsection (b).

7 “(b) REPORTS.—

8 “(1) IN GENERAL.—With respect to plan years
9 beginning on or after the date that is 2 years after
10 the date of enactment of this section, not less fre-
11 quently than every 6 months (or at the request of
12 a group health plan, not less frequently than quar-
13 terly, but under the same conditions, terms, and cost
14 of the semiannual report under this subsection), a
15 group health plan or health insurance issuer offering
16 group health insurance coverage, or an entity pro-
17 viding pharmacy benefits management services on
18 behalf of such a plan or issuer, shall submit to the
19 group health plan a report in accordance with this
20 section. Each such report shall be made available to
21 such group health plan in a machine-readable format
22 and shall include the information described in para-
23 graph (2).

24 “(2) INFORMATION DESCRIBED.—For purposes
25 of paragraph (1), the information described in this

1 paragraph is, with respect to drugs covered by a
2 group health plan or health insurance issuer offering
3 group health insurance coverage during each report-
4 ing period—

5 “(A) in the case of such a plan offered by
6 a specified large employer (or such coverage of-
7 fered in connection with such a plan offered by
8 a specified large employer)—

9 “(i) a list of drugs for which a claim
10 was filed and, with respect to each such
11 drug on such list—

12 “(I) the brand name, chemical
13 entity, and National Drug Code;

14 “(II) the type of dispensing chan-
15 nel used to furnish such drug, includ-
16 ing retail, mail order, or specialty
17 pharmacy;

18 “(III) with respect to each drug
19 dispensed under each type of dis-
20 pensing channel (including retail, mail
21 order, or specialty pharmacy)—

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

1 “(AA) in the case of a
2 brand name drug, the whole-
3 sale acquisition cost, listed
4 as cost per days supply and
5 cost per dosage unit, on the
6 date such drug was dis-
7 pensed; and

8 “(BB) in the case of a
9 generic drug, the average
10 wholesale price, listed as
11 cost per days supply and
12 cost per dosage unit, on the
13 date such drug was dis-
14 pensed; and

15 “(bb) the total number of—

16 “(AA) prescription
17 claims (including original
18 prescriptions and refills);

19 “(BB) participants and
20 beneficiaries for whom a
21 claim for such drug was
22 filed;

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

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

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

9 “(V) the total amount of out-of-
10 pocket spending by participants, bene-
11 ficiaries, and enrollees on such drug,
12 including spending through copay-
13 ments, coinsurance, and deductibles;

14 “(VI) the total net spending by
15 the plan or coverage during the re-
16 porting period;

17 “(VII) the total amount received,
18 or expected to be received, by the plan
19 or coverage from any entity in drug
20 manufacturer rebates, fees, alternative
21 discounts, and all other remuneration
22 received from an entity or any third
23 party (including group purchasing or-
24 ganizations) other than the plan spon-
25 sor;

1 “(VIII) the total amount re-
2 ceived, or expected to be received by
3 the plan or issuer, from drug manu-
4 facturers in rebates, fees, alternative
5 discounts, or other remuneration—

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

10 “(bb) that is related to utili-
11 zation rebates for such drug; and

12 “(IX) to the extent feasible, in-
13 formation on the total amount of re-
14 muneration, including copayment as-
15 sistance dollars paid, copayment cards
16 applied, or other discounts provided
17 by each drug manufacturer (or entity
18 administering copay assistance on be-
19 half of such drug manufacturer) to
20 the participants, beneficiaries, and en-
21 rollees enrolled in such plan or cov-
22 erage for such drug;

23 “(ii) for each category or class of
24 drugs for which a claim was filed, a break-
25 down of the total gross spending on drugs

1 in such category or class before rebates,
2 price concessions, alternative discounts, or
3 other remuneration from drug manufactur-
4 ers, and the net spending after such re-
5 bates, price concessions, alternative dis-
6 counts, or other remuneration from drug
7 manufacturers, including—

8 “(I) the number of participants,
9 beneficiaries, and enrollees who filled
10 a prescription for a drug in such cat-
11 egory or class, including the National
12 Drug Code for each such drug;

13 “(II) if applicable, a description
14 of the formulary tiers and utilization
15 mechanisms (such as prior authoriza-
16 tion or step therapy) employed for
17 drugs in that category or class; and

18 “(III) the total out-of-pocket
19 spending under the plan or coverage
20 by participants, beneficiaries, and en-
21 rollees, including spending through co-
22 payments, coinsurance, and
23 deductibles;

24 “(iii) in the case of a drug for which
25 gross spending by such plan, coverage, or

1 entity exceeded \$10,000 during the report-
2 ing period—

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

6 “(II) the rationale for the for-
7 mulary placement of such drug in that
8 therapeutic category or class, if appli-
9 cable; and

10 “(iv) in the case such plan or coverage
11 (or an entity providing pharmacy benefits
12 management services on behalf of such
13 plan or coverage) has an affiliated phar-
14 macy or pharmacy under common owner-
15 ship—

16 “(I) the percentage of total pre-
17 scriptions dispensed by such phar-
18 macies to individuals enrolled in such
19 plan or coverage;

20 “(II) a list of all drugs dispensed
21 by such pharmacies to individuals en-
22 rolled in such plan or coverage, and,
23 with respect to each drug dispensed—

24 “(aa) the amount charged,
25 per dosage unit, per 30-day sup-

1 ply, or per 90-day supply (as ap-
2 plicable) to the plan or issuer,
3 and to participants, beneficiaries,
4 and enrollees enrolled in such
5 plan or coverage;

6 “(bb) the median amount
7 charged to such plan or issuer,
8 and the interquartile range of the
9 costs, per dosage unit, per 30-
10 day supply, and per 90-day sup-
11 ply, including amounts paid by
12 the participants, beneficiaries,
13 and enrollees, when the same
14 drug is dispensed by other phar-
15 macies that are not affiliated
16 with or under common ownership
17 with the entity and that are in-
18 cluded in the pharmacy network
19 of such plan or coverage;

20 “(cc) the lowest cost per
21 dosage unit, per 30-day supply
22 and per 90-day supply, for each
23 such drug, including amounts
24 charged to the plan and partici-
25 pants, beneficiaries, and enroll-

1 ees, that is available from any
2 pharmacy included in the net-
3 work of such plan or coverage;
4 and

5 “*(dd)* the net acquisition
6 cost per dosage unit, per 30-day
7 supply, and per 90-day supply, if
8 such drug is subject to a max-
9 imum price discount;

10 “*(B)* in the case of a plan or coverage not
11 described in subparagraph *(A)*—

12 “*(i)* the total net spending by the plan
13 or coverage for all drugs covered by such
14 plan or coverage during such reporting pe-
15 riod;

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

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

11 “(C) amounts paid directly or indirectly in
12 rebates, fees, or any other type of compensation
13 (as defined in section 408(b)(2)(B)(ii)(dd)(AA))
14 to brokers, consultants, advisors, or any other
15 individual or firm, for the referral of the group
16 health plan’s or health insurance issuer’s busi-
17 ness to an entity providing pharmacy benefits
18 management services, including the identity of
19 the recipient of such amounts;

20 “(D) an explanation of any benefit design
21 parameters that encourage or require partici-
22 pants, beneficiaries, and enrollees in such plan
23 or coverage to fill prescriptions at mail order,
24 specialty, or retail pharmacies that are affili-
25 ated with or under common ownership with the

1 entity providing pharmacy benefit management
2 services under such plan or coverage, including
3 mandatory mail and specialty home delivery
4 programs, retail and mail auto-refill programs,
5 and cost-sharing assistance incentives directly
6 or indirectly funded by such entity; and

7 “(E) total gross spending on all drugs dur-
8 ing the reporting period.

9 “(3) PRIVACY REQUIREMENTS.—

10 “(A) IN GENERAL.—Health insurance
11 issuers offering group health insurance coverage
12 and entities providing pharmacy benefits man-
13 agement services on behalf of a group health
14 plan shall provide information under paragraph
15 (1) in a manner consistent with the privacy, se-
16 curity, and breach notification regulations pro-
17 mulgated under section 13402(a) of the Health
18 Information Technology for Clinical Health Act
19 and consistent with the HIPAA privacy regula-
20 tions (as defined in section 1180(b)(3) of the
21 Social Security Act) and shall restrict the use
22 and disclosure of such information according to
23 such privacy, security, and breach notification
24 regulations and such HIPAA privacy regula-
25 tions.

1 “(B) ADDITIONAL REQUIREMENTS.—

2 “(i) IN GENERAL.—An entity pro-
3 viding pharmacy benefits management
4 services on behalf of a group health plan or
5 health insurance issuer offering group
6 health insurance coverage that submits a
7 report under paragraph (1) shall ensure
8 that such report contains only summary
9 health information, as defined in section
10 164.504(a) of title 45, Code of Federal
11 Regulations (or successor regulations).

12 “(ii) RESTRICTIONS.—A group health
13 plan shall comply with section 164.504(f)
14 of title 45, Code of Federal Regulations (or
15 a successor regulation) and a plan sponsor
16 shall act in accordance with the terms of
17 the agreement described in such section.

18 “(C) RULE OF CONSTRUCTION.—Nothing
19 in this section shall be construed to modify the
20 requirements for the creation, receipt, mainte-
21 nance, or transmission of protected health in-
22 formation under the HIPAA privacy regulations
23 (as defined in section 1180(b)(3) of the Social
24 Security Act).

25 “(4) DISCLOSURE AND REDISCLOSURE.—

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

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

1 “(C) LIMITED FORM OF REPORT.—The
2 Secretary shall define through rulemaking a
3 limited form of the report under paragraph (1)
4 required with respect to group health plans
5 where the plan sponsors of such plans are drug
6 manufacturers, drug wholesalers, or other direct
7 participants in the drug supply chain, in order
8 to prevent anti-competitive behavior.

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

24 “(6) STANDARD FORMAT.—Not later than 1
25 year after the date of enactment of this section, the

1 Secretary shall specify through rulemaking stand-
2 ards for group health plans, health insurance issuers
3 offering group health insurance coverage, and enti-
4 ties providing pharmacy benefits management serv-
5 ices on behalf of such plans or coverage, required to
6 submit reports under paragraph (1) to submit such
7 reports in a standard format.

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

17 “(d) DEFINITIONS.—In this section:

18 “(1) SPECIFIED LARGE EMPLOYER.—The term
19 ‘specified large employer’ means, in connection with
20 a group health plan with respect to a calendar year
21 and a plan year, an employer who employed an aver-
22 age of at least 50 employees on business days during
23 the preceding calendar year and who employs at
24 least 1 employee on the first day of the plan year.

1 “(2) WHOLESALE ACQUISITION COST.—The
2 term ‘wholesale acquisition cost’ has the meaning
3 given such term in section 1847A(c)(6)(B) of the
4 Social Security Act.”.

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

6 (i) in subsection (b)(3), by striking
7 “under subsection (c)(9))” and inserting
8 “under paragraphs (9) and (13) of sub-
9 section (c))”; and

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

12 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
13 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
14 MANAGER SERVICES.—

15 “(A) FAILURE TO PROVIDE INFORMA-
16 TION.—The Secretary may impose a penalty
17 against any health insurance issuer or entity
18 providing pharmacy benefits management serv-
19 ices that violates section 726(a) or fails to pro-
20 vide information required under section 726(b)
21 in the amount of \$10,000 for each day during
22 which such violation continues or such informa-
23 tion is not disclosed or reported.

24 “(B) FALSE INFORMATION.—The Sec-
25 retary may impose a penalty against a health

1 insurance issuer or entity providing pharmacy
2 benefits management services that knowingly
3 provides false information under section 726 in
4 an amount not to exceed \$100,000 for each
5 item of false information. Such penalty shall be
6 in addition to other penalties as may be pre-
7 scribed by law.

8 “(C) WAIVERS.—The Secretary may waive
9 penalties under subparagraph (A), or extend
10 the period of time for compliance with a re-
11 quirement of section 726, for an entity in viola-
12 tion of such section that has made a good-faith
13 effort to comply with such section.”.

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

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

19 (c) IRC.—

20 (1) IN GENERAL.—Subchapter B of chapter
21 100 of the Internal Revenue Code of 1986 is amend-
22 ed by adding at the end the following:

1 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER**
2 **SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or
4 after the date that is 2 years after the date of enactment
5 of this section, a group health plan, or an entity or sub-
6 sidiary providing pharmacy benefits management services
7 on behalf of such a plan, shall not enter into a contract
8 with a drug manufacturer, distributor, wholesaler, subcon-
9 tractor, rebate aggregator, or any other third party that
10 limits (or delays beyond the applicable reporting period de-
11 scribed in subsection (b)(1)) the disclosure of information
12 to group health plans in such a manner that prevents such
13 plan or entity from making the reports described in sub-
14 section (b).

15 “(b) REPORTS.—

16 “(1) IN GENERAL.—With respect to plan years
17 beginning on or after the date that is 2 years after
18 the date of enactment of this section, not less fre-
19 quently than every 6 months (or at the request of
20 a group health plan, not less frequently than quar-
21 terly, but under the same conditions, terms, and cost
22 of the semiannual report under this subsection), a
23 group health plan, or an entity providing pharmacy
24 benefits management services on behalf of such a
25 plan, shall submit to the group health plan a report
26 in accordance with this section. Each such report

1 shall be made available to such group health plan in
2 a machine-readable format and shall include the in-
3 formation described in paragraph (2).

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

8 “(A) in the case of such a plan offered by
9 a specified large employer—

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

13 “(I) the brand name, chemical
14 entity, and National Drug Code;

15 “(II) the type of dispensing chan-
16 nel used to furnish such drug, includ-
17 ing retail, mail order, or specialty
18 pharmacy;

19 “(III) with respect to each drug
20 dispensed under each type of dis-
21 pensing channel (including retail, mail
22 order, or specialty pharmacy)—

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

1 “(AA) in the case of a
2 brand name drug, the whole-
3 sale acquisition cost, listed
4 as cost per days supply and
5 cost per dosage unit, on the
6 date such drug was dis-
7 pensed; and

8 “(BB) in the case of a
9 generic drug, the average
10 wholesale price, listed as
11 cost per days supply and
12 cost per dosage unit, on the
13 date such drug was dis-
14 pensed; and

15 “(bb) the total number of—

16 “(AA) prescription
17 claims (including original
18 prescriptions and refills);

19 “(BB) participants,
20 beneficiaries, and enrollees
21 for whom a claim for such
22 drug was filed;

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

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

3 “(IV) the net price per course of
4 treatment or single fill, such as a 30-
5 day supply or 90-day supply to the
6 plan after manufacturer rebates, fees,
7 and other remuneration or adjust-
8 ments;

9 “(V) the total amount of out-of-
10 pocket spending by participants, bene-
11 ficiaries, and enrollees on such drug,
12 including spending through copay-
13 ments, coinsurance, and deductibles;

14 “(VI) the total net spending by
15 the plan during the reporting period;

16 “(VII) the total amount received,
17 or expected to be received, by the plan
18 from any entity in drug manufacturer
19 rebates, fees, alternative discounts,
20 and all other remuneration received
21 from an entity or any third party (in-
22 cluding group purchasing organiza-
23 tions) other than the plan sponsor;

24 “(VIII) the total amount re-
25 ceived, or expected to be received by

1 the plan, from drug manufacturers in
2 rebates, fees, alternative discounts, or
3 other remuneration—

4 “(aa) that has been paid, or
5 is to be paid, by drug manufac-
6 turers for claims incurred during
7 the reporting period; and

8 “(bb) that is related to utili-
9 zation rebates for such drug; and

10 “(IX) to the extent feasible, in-
11 formation on the total amount of re-
12 munerations, including copayment as-
13 sistance dollars paid, copayment cards
14 applied, or other discounts provided
15 by each drug manufacturer (or entity
16 administering copay assistance on be-
17 half of such drug manufacturer) to
18 the participants, beneficiaries, and en-
19 rollees enrolled in such plan for such
20 drug;

21 “(ii) for each category or class of
22 drugs for which a claim was filed, a break-
23 down of the total gross spending on drugs
24 in such category or class before rebates,
25 price concessions, alternative discounts, or

1 other remuneration from drug manufactur-
2 ers, and the net spending after such re-
3 bates, price concessions, alternative dis-
4 counts, or other remuneration from drug
5 manufacturers, including—

6 “(I) the number of participants,
7 beneficiaries, and enrollees who filled
8 a prescription for a drug in such cat-
9 egory or class, including the National
10 Drug Code for each such drug;

11 “(II) if applicable, a description
12 of the formulary tiers and utilization
13 mechanisms (such as prior authoriza-
14 tion or step therapy) employed for
15 drugs in that category or class;

16 “(III) the total out-of-pocket
17 spending under the plan by partici-
18 pants, beneficiaries, and enrollees, in-
19 cluding spending through copayments,
20 coinsurance, and deductibles; and

21 “(iii) in the case of a drug for which
22 gross spending by such plan or entity ex-
23 ceeded \$10,000 during the reporting pe-
24 riod—

1 “(I) a list of all other drugs in
2 the same therapeutic category or
3 class; and

4 “(II) the rationale for the for-
5 mulary placement of such drug in that
6 therapeutic category or class, if appli-
7 cable; and

8 “(iv) in the case such plan (or an en-
9 tity providing pharmacy benefits manage-
10 ment services on behalf of such plan) that
11 has an affiliated pharmacy or pharmacy
12 under common ownership—

13 “(I) the percentage of total pre-
14 scriptions dispensed by such phar-
15 macies to individuals enrolled in such
16 plan;

17 “(II) a list of all drugs dispensed
18 by such pharmacies to individuals en-
19 rolled in such plan, and, with respect
20 to each drug dispensed—

21 “(aa) the amount charged,
22 per dosage unit, per 30-day sup-
23 ply, or per 90-day supply (as ap-
24 plicable) to the plan, and to par-

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participants, beneficiaries, and enrollees enrolled in such plan;

“(bb) the median amount charged to such plan, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants, beneficiaries, and enrollees, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

“(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan and participants, beneficiaries, and enrollees, that is available from any pharmacy included in the network of such plan; and

1 “(dd) the net acquisition
2 cost per dosage unit, per 30-day
3 supply, and per 90-day supply, if
4 such drug is subject to a max-
5 imum price discount;

6 “(B) in the case of a plan not described in
7 subparagraph (A)—

8 “(i) the total net spending by the plan
9 for all drugs covered by such plan during
10 such reporting period;

11 “(ii) the total amount received, or ex-
12 pected to be received, by the plan from any
13 entity in drug manufacturer rebates, fees,
14 alternative discounts, and all other remu-
15 neration received from an entity or any
16 third party (including group purchasing or-
17 ganizations) other than the plan sponsor
18 for all such drugs; and

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

1 to the participants, beneficiaries, and en-
2 rollees enrolled in such plan for such
3 drugs;

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

14 “(D) an explanation of any benefit design
15 parameters that encourage or require partici-
16 pants, beneficiaries, and enrollees in such plan
17 to fill prescriptions at mail order, specialty, or
18 retail pharmacies that are affiliated with or
19 under common ownership with the entity pro-
20 viding pharmacy benefit management services
21 under such plan, including mandatory mail and
22 specialty home delivery programs, retail and
23 mail auto-refill programs, and cost-sharing as-
24 sistance incentives directly or indirectly funded
25 by such entity; and

1 “(E) total gross spending on all drugs dur-
2 ing the reporting period.

3 “(3) PRIVACY REQUIREMENTS.—

4 “(A) IN GENERAL.—Entities providing
5 pharmacy benefits management services on be-
6 half of a group health plan shall provide infor-
7 mation under paragraph (1) in a manner con-
8 sistent with the privacy, security, and breach
9 notification regulations promulgated under sec-
10 tion 13402(a) of the Health Information Tech-
11 nology for Clinical Health Act and consistent
12 with the HIPAA privacy regulations (as defined
13 in section 1180(b)(3) of the Social Security
14 Act) and shall restrict the use and disclosure of
15 such information according to such privacy, se-
16 curity, and breach notification regulations and
17 such HIPAA privacy regulations.

18 “(B) ADDITIONAL REQUIREMENTS.—

19 “(i) IN GENERAL.—An entity pro-
20 viding pharmacy benefits management
21 services on behalf of a group health plan
22 that submits a report under paragraph (1)
23 shall ensure that such report contains only
24 summary health information, as defined in
25 section 164.504(a) of title 45, Code of

1 Federal Regulations (or successor regula-
2 tions).

3 “(ii) RESTRICTIONS.—A group health
4 plan shall comply with section 164.504(f)
5 of title 45, Code of Federal Regulations (or
6 a successor regulation) and a plan sponsor
7 shall act in accordance with the terms of
8 the agreement described in such section.

9 “(C) RULE OF CONSTRUCTION.—Nothing
10 in this section shall be construed to modify the
11 requirements for the creation, receipt, mainte-
12 nance, or transmission of protected health in-
13 formation under the HIPAA privacy regulations
14 (as defined in section 1180(b)(3) of the Social
15 Security Act).

16 “(4) DISCLOSURE AND REDISCLOSURE.—

17 “(A) LIMITATION TO BUSINESS ASSOCI-
18 ATES.—A group health plan receiving a report
19 under paragraph (1) may disclose such informa-
20 tion only to the entity from which the report
21 was received or to that entity’s business associ-
22 ates as defined in section 160.103 of title 45,
23 Code of Federal Regulations (or successor regu-
24 lations) or as permitted by the HIPAA Privacy

1 Rule (45 CFR parts 160 and 164, subparts A
2 and E).

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

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 with respect to group health plans
22 where the plan sponsors of such plans are drug
23 manufacturers, drug wholesalers, or other direct
24 participants in the drug supply chain, in order
25 to prevent anti-competitive behavior.

1 “(5) REPORT TO GAO.—A group health plan, or
2 an entity providing pharmacy benefits management
3 services on behalf of such plan, shall submit to the
4 Comptroller General of the United States each of
5 the first 4 reports submitted to a group health plan
6 under paragraph (1) and other such reports as re-
7 quested, in accordance with the privacy requirements
8 under paragraph (3), the disclosure and redisclosure
9 standards under paragraph (4), the standards speci-
10 fied pursuant to paragraph (6), and such other in-
11 formation that the Comptroller General determines
12 necessary to carry out the study under section
13 106(d) of the Lower Costs, More Transparency Act.

14 “(6) STANDARD FORMAT.—Not later than 1
15 year after the date of enactment of this section, the
16 Secretary shall specify through rulemaking stand-
17 ards for group health plans, and entities providing
18 pharmacy benefits management services on behalf of
19 such plans, required to submit reports under para-
20 graph (1) to submit such reports in a standard for-
21 mat.

22 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
23 tion shall be construed to permit a group health plan or
24 entity providing pharmacy benefits management services
25 on behalf of such plan, to restrict disclosure to, or other-

1 wise limit the access of, the Secretary of Health and
2 Human Services to a report described in subsection (b)(1)
3 or information related to compliance with subsections (a)
4 or (b) by entities subject to such subsection.

5 “(d) DEFINITIONS.—In this section:

6 “(1) SPECIFIED LARGE EMPLOYER.—The term
7 ‘specified large employer’ means, in connection with
8 a group health plan with respect to a calendar year
9 and a plan year, an employer who employed an aver-
10 age of at least 50 employees on business days during
11 the preceding calendar year and who employs at
12 least 1 employee on the first day of the plan year.

13 “(2) WHOLESALE ACQUISITION COST.—The
14 term ‘wholesale acquisition cost’ has the meaning
15 given such term in section 1847A(c)(6)(B) of the
16 Social Security Act.”.

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

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

21 (d) GAO REPORTS.—

22 (1) REPORT ON PHARMACY NETWORK DE-
23 SIGN.—

24 (A) IN GENERAL.—Not later than 3 years
25 after the date of enactment of this Act, the

1 Comptroller General of the United States shall
2 submit to Congress a report on—

3 (i) pharmacy networks that have con-
4 tracted with group health plans, health in-
5 surance issuers offering group health in-
6 surance coverage, or entities providing
7 pharmacy benefits management services on
8 behalf of such plans or issuers, including
9 networks with pharmacies that are under
10 common ownership (in whole or part) with
11 such plans, issuers, or entities (including
12 entities that provide pharmacy benefits ad-
13 ministrative services on behalf of such
14 plans or issuers);

15 (ii) pharmacy network design param-
16 eters that encourage individuals enrolled in
17 such plans or coverage to fill prescriptions
18 at mail order, specialty, or retail phar-
19 macies that are wholly or partially owned
20 by a plan, issuer, or entity;

21 (iii) whether such plans and issuers
22 have options to elect different network
23 pricing arrangements in the marketplace
24 with entities that provide pharmacy bene-
25 fits management services and the preva-

1 lence of electing such different network
2 pricing arrangements;

3 (iv) with respect to pharmacy net-
4 works that include pharmacies under com-
5 mon ownership described in clause (i)—

6 (I) whether such networks are
7 designed to encourage individuals en-
8 rolled in a group health plan or health
9 insurance coverage to use such phar-
10 macies over other network pharmacies
11 for specific services or drugs, and if
12 so, the reasons the networks give for
13 encouraging use of such pharmacies;
14 and

15 (II) whether such pharmacies are
16 used by enrollees disproportionately
17 more in the aggregate or for specific
18 services or drugs compared to other
19 network pharmacies;

20 (v) the degree to which mail order,
21 specialty, or retail pharmacies that dis-
22 pense prescription drugs to an enrollee in
23 a plan or coverage that are under common
24 ownership (in whole or part) with plans,
25 issuers, or entities providing pharmacy

1 benefits management services or pharmacy
2 benefits administrative services on behalf
3 of such plan or coverage receive reimburse-
4 ment that is greater than the median price
5 charged to the plan or issuer when the
6 same drug is dispensed to enrollees in the
7 plan or coverage by other pharmacies in-
8 cluded in the pharmacy network of that
9 plan, issuer, or entity that are not wholly
10 or partially owned by the plan or issuer, or
11 entity providing pharmacy benefits man-
12 agement services on behalf of such plan or
13 issuer.

14 (B) REQUIREMENT.—The Comptroller
15 General of the United States shall ensure that
16 the report under subparagraph (A) does not
17 contain information that would identify a spe-
18 cific group health plan or health insurance
19 issuer (or an entity providing pharmacy benefits
20 management services on behalf of such plan or
21 issuer), or otherwise contain commercial or fi-
22 nancial information that is privileged or con-
23 fidential.

24 (C) DEFINITIONS.—In this paragraph, the
25 terms “group health plan”, “health insurance

1 coverage”, and “health insurance issuer” have
2 the meanings given such terms in section 2791
3 of the Public Health Service Act (42 U.S.C.
4 300gg-91).

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

14 (A) a description of copay assistance pro-
15 grams, including—

16 (i) the types of programs available
17 and the methods of providing copay assist-
18 ance through such programs, including
19 cash discounts, copay cards, or drugs pro-
20 vided to an individual at no cost;

21 (ii) how such programs are funded;

22 (iii) the types of entities that own, op-
23 erate, or otherwise conduct such programs,
24 the types of information such entities col-
25 lect, and the direct and indirect contrac-

1 tual relationships between the entities in
2 the drug supply chain that interact with
3 such programs, such as a drug manufac-
4 turer, pharmacy, wholesaler, switch, rebate
5 aggregator, pharmacy benefit manager,
6 and other entities in the drug supply chain;

7 (iv) the effect of such programs on
8 patient out-of-pocket spending, including
9 for stop-loss insurance, and drug utiliza-
10 tion, including drug adherence; and

11 (v) patient eligibility criteria for such
12 programs; and

13 (B) an analysis of—

14 (i) the sources of funding for such
15 programs; and

16 (ii) the effects of such programs on
17 Federal health care programs and the indi-
18 viduals enrolled in such Federal health
19 care programs.

20 **SEC. 107. REPORTS ON HEALTH CARE TRANSPARENCY**
21 **TOOLS AND DATA.**

22 (a) INITIAL REPORT.—Not later than December 31,
23 2024, the Comptroller General of the United States shall
24 submit to the Committees (as defined in subsection (d))
25 an initial report that—

1 (1) identifies and describes health care trans-
2 parency tools and Federal health care reporting re-
3 quirements (as described in subsection (d)) that are
4 in effect as of the date of the submission of such ini-
5 tial report, including the frequency of reports with
6 respect to each such requirement and whether any
7 such requirements are duplicative;

8 (2) reviews how such reporting requirements
9 are enforced;

10 (3) analyzes whether the public availability of
11 health care transparency tools, and the publication
12 of data pursuant to such reporting requirements,
13 has—

14 (A) been utilized and valued by consumers,
15 including reasons for such utilization (or lack
16 thereof); and

17 (B) assisted health insurance plan spon-
18 sors and fiduciaries improve benefits, lower
19 health care costs for plan participants, and
20 meet fiduciary requirements;

21 (4) includes recommendations to the Commit-
22 tees, the Secretary of Health and Human Services,
23 the Secretary of Labor, and the Secretary of the
24 Treasury to—

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

3 (B) streamline Federal health care report-
4 ing requirements to eliminate duplicative re-
5 quirements and reduce the burden on entities
6 required to submit reports pursuant to such
7 provisions;

8 (C) improve the accuracy and efficiency of
9 such reports while maintaining the integrity
10 and usability of the data provided by such re-
11 ports;

12 (D) address any gaps in data provided by
13 such reports; and

14 (E) ensure that the data and information
15 reported is comparable and usable to con-
16 sumers, including patients, plan sponsors, and
17 policy makers.

18 (b) FINAL REPORT.—Not later than December 31,
19 2028, the Comptroller General of the United States shall
20 submit to the Committees a report that includes—

21 (1) the information provided in the initial re-
22 port, along with any updates to such information;
23 and

24 (2) any new information with respect to health
25 care transparency tools that have been released fol-

1 lowing the submission of such initial report, or new
2 reporting requirements in effect as of the date of the
3 submission of the final report.

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

14 (d) DEFINITIONS.—In this section:

15 (1) COMMITTEES.—The term “Committees”
16 means the Committee on Ways and Means, the
17 Committee on Energy and Commerce, and the Com-
18 mittee on Education and the Workforce of the
19 House of Representatives, and the Committee on Fi-
20 nance and the Committee on Health, Education,
21 Labor, and Pensions of the Senate.

22 (2) FEDERAL HEALTH CARE REPORTING RE-
23 QUIREMENTS.—The term “Federal health care re-
24 porting requirements” includes regulatory and statu-
25 tory requirements with respect to the reporting and

1 publication of health care price, cost access, and
2 quality data, including requirements established by
3 the Consolidated Appropriations Act of 2021 (Public
4 Law 116–260), this Act, and other reporting and
5 publication requirements with respect to trans-
6 parency in health care as identified by the Comp-
7 troller General of the United States.

8 (3) SHOPPABLE SERVICE.—The term
9 “shoppable service” means a service that can be
10 scheduled by a health care consumer in advance and
11 includes all ancillary items and services customarily
12 furnished as part of such service.

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

14 (a) REQUIRED MA AND PDP REPORTING.—

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

18 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-
19 FORMATION RELATING TO HEALTH CARE PROVIDER
20 OWNERSHIP.—

21 “(A) IN GENERAL.—For plan year 2025
22 and for every third plan year thereafter, each
23 applicable MA organization offering an MA
24 plan under this part during such plan year shall

1 submit to the Secretary, at a time and in a
2 manner specified by the Secretary—

3 “(i) the taxpayer identification num-
4 ber for each health care provider that was
5 a specified health care provider with re-
6 spect to such organization during such
7 year;

8 “(ii) the total amount of incentive-
9 based payments made to, and the total
10 amount of shared losses recoupments col-
11 lected from, such specified health care pro-
12 viders during such plan year; and

13 “(iii) the total amount of incentive-
14 based payments made to, and the total
15 amount of shared losses recoupments col-
16 lected from, providers of services and sup-
17 pliers not described in clause (ii) during
18 such plan year.

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

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

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

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

14 (2) PRESCRIPTION DRUG PLANS.—Section
15 1860D–12(b) of the Social Security Act (42 U.S.C.
16 1395w–112(b)) is amended by adding at the end the
17 following new paragraph:

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

20 “(A) IN GENERAL.—For plan year 2025
21 and for every third plan year thereafter, each
22 PDP sponsor offering a prescription drug plan
23 under this part during such plan year shall sub-
24 mit to the Secretary, at a time and in a manner
25 specified by the Secretary, the taxpayer identi-

1 fication number and National Provider Identifi-
2 fier for each pharmacy that was a specified
3 pharmacy with respect to such sponsor during
4 such year.

5 “(B) DEFINITION.—For purposes of this
6 paragraph, the term ‘specified pharmacy’
7 means, with respect to an PDP sponsor offering
8 a prescription drug plan and a plan year, a
9 pharmacy with respect to which—

10 “(i) such sponsor (or any person with
11 an ownership or control interest (as de-
12 fined in section 1124(a)(3)) in such spon-
13 sor) is a person with an ownership or con-
14 trol interest (as so defined); or

15 “(ii) a pharmacy benefit manager of-
16 fering services under such plan (or any
17 person with an ownership or control inter-
18 est (as so defined) in such sponsor) is a
19 person with an ownership or control inter-
20 est (as so defined).”.

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

1 **“SEC. 1899D. REPORTS ON VERTICAL INTEGRATION UNDER**
2 **MEDICARE.**

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

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

14 “(2) with respect to prescription drug plans,
15 pharmacy benefit managers, and pharmacies, the
16 comparisons and evaluations described in subsection
17 (c);

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

22 “(4) the identifications described in subsection
23 (e); and

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

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

7 “(1) the average number of qualifying diag-
8 noses made during such year with respect to enroll-
9 ees of a Medicare Advantage plan offered by such
10 organization who, during such year, received a
11 health risk assessment from a specified health care
12 provider;

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

15 “(3) any relationship between such risk scores
16 for such enrollees receiving such an assessment from
17 such a provider during such year and incentive pay-
18 ments made to such providers;

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

22 “(5) any relationship between the risk scores of
23 enrollees under such plan and whether the enrollees
24 have received any item or service from a specified
25 provider; and

1 “(6) any relationship between the risk scores of
2 enrollees under such plan that have received any
3 item or service from a specified provider and incen-
4 tive payments made under the plan to specified pro-
5 viders.

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

10 “(1) For each covered part D drug for which
11 benefits are available under such a plan, a compari-
12 son of the average negotiated rate in effect with
13 specified pharmacies with such rates in effect for in-
14 network pharmacies that are not specified phar-
15 macies.

16 “(2) Comparisons of the following:

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

22 “(B) The total amount paid by such spon-
23 sors to specified pharmacy benefit managers as
24 reimbursement for covered part D drugs and
25 the total amount so paid to pharmacy benefit

1 managers that are not specified pharmacy ben-
2 efit managers as such reimbursement.

3 “(C) Fees paid under by plan to specified
4 pharmacy benefit managers compared to such
5 fees paid to pharmacy benefit managers that
6 are not specified pharmacy benefit managers.

7 “(3) An evaluation of the total amount of direct
8 and indirect remuneration for covered part D drugs
9 passed through to prescription drug plan sponsors
10 and the total amount retained by pharmacy benefit
11 managers (including entities under contract with
12 such a manager).

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

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

21 “(1) With respect to each such plan, an identi-
22 fication of each drug for which benefits were avail-
23 able under such plan only when administered by a
24 health care provider that acquired such drug from
25 an affiliated pharmacy.

1 “(2) An evaluation of the difference between
2 the total number of drugs administered by a health
3 care provider that were acquired from affiliated
4 pharmacies compared to the number of such drugs
5 so administered that were acquired from pharmacies
6 other than affiliated pharmacies, and an evaluation
7 of the difference in payments for such drugs so ad-
8 ministered when acquired from a specified pharmacy
9 and when acquired from a pharmacy that is not a
10 specified pharmacy.

11 “(3) An evaluation of the dollar value of all
12 such drugs that were not so administered because of
13 a delay attributable to an affiliated pharmacy com-
14 pared to the dollar value of all such drugs that were
15 not so administered because of a delay attributable
16 to pharmacy that is not an affiliated pharmacy.

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

20 “(5) The number of enrollees furnished such a
21 drug that was acquired from a pharmacy that is not
22 an affiliated pharmacy.

23 “(e) IDENTIFICATIONS.—For purposes of subsection
24 (a)(4), the identifications described in this subsection are,
25 with respect to an applicable year, identifications of each

1 health care entity participating under the Medicare pro-
2 gram with respect to which another health care entity so
3 participating is a person with an ownership or control in-
4 terest (as defined in section 1124(a)(3)).

5 “(f) DEFINITIONS.—In this section:

6 “(1) AFFILIATED PHARMACY.—The term ‘affili-
7 ated pharmacy’ means, with respect to a Medicare
8 Advantage plan offered by a Medicare Advantage or-
9 ganization, a pharmacy with respect to which such
10 organization (or any person with an ownership or
11 control interest (as defined in section 1124(a)(3)) in
12 such organization) is a person with an ownership or
13 control interest (as so defined).

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

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

22 “(4) DIRECT AND INDIRECT REMUNERATION.—
23 The term ‘direct and indirect remuneration’ has the
24 meaning given such term in section 423.308 of title

1 42, Code of Federal Regulations (or any successor
2 regulation).

3 “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-
4 fying diagnosis’ means, with respect to an enrollee of
5 a Medicare Advantage plan, a diagnosis that is
6 taken into account in calculating a risk score for
7 such enrollee under the risk adjustment methodology
8 established by the Secretary pursuant to section
9 1853(a)(3).

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

14 “(7) PHYSICIAN-ADMINISTERED DRUG.—The
15 term ‘physician-administered drug’ means a drug
16 furnished to an individual that, had such individual
17 been enrolled under part B and not enrolled under
18 part C, would have been payable under section
19 1842(o).

20 “(8) SPECIFIED HEALTH CARE PROVIDER.—
21 The term ‘specified health care provider’ means,
22 with respect to a Medicare Advantage plan offered
23 by a Medicare Advantage organization, a health care
24 provider with respect to which such organization (or
25 any person with an ownership or control interest (as

1 defined in section 1124(a)(3)) in such organization)
2 is a person with an ownership or control interest (as
3 so defined).

4 “(9) SPECIFIED PHARMACY.—The term ‘speci-
5 fied pharmacy’ means, with respect to a prescription
6 drug plan offered by a prescription drug plan spon-
7 sor, a pharmacy with respect to which—

8 “(A) such sponsor (or any person with an
9 ownership or control interest (as defined in sec-
10 tion 1124(a)(3)) in such sponsor) is a person
11 with an ownership or control interest (as so de-
12 fined); or

13 “(B) a pharmacy benefit manager offering
14 services under such plan (or any person with an
15 ownership or control interest (as so defined) in
16 such sponsor) is a person with an ownership or
17 control interest (as so defined).

18 “(10) SPECIFIED PHARMACY BENEFIT MAN-
19 AGER.—The term ‘specified pharmacy benefit man-
20 ager’ means, with respect to a prescription drug
21 plan offered by a prescription drug plan sponsor, a
22 pharmacy benefit manager with respect to which
23 such sponsor (or any person with an ownership or
24 control interest (as defined in section 1124(a)(3)) in

1 such sponsor) is a person with an ownership or con-
2 trol interest (as so defined).”.

3 **SEC. 109. ADVISORY COMMITTEE.**

4 (a) IN GENERAL.—Not later than January 1, 2025,
5 the Secretary of Labor, the Secretary of Health and
6 Human Services, and the Secretary of the Treasury shall
7 jointly convene an advisory committee (in this section re-
8 ferred to as the “committee”) consisting of 9 members to
9 advise the Secretaries on how to improve the usefulness,
10 accessibility, and usability of information made available
11 in accordance the amendments made by sections 105 and
12 106, and by section 204 of division BB of the Consolidated
13 Appropriation Act, 2021 (Public Law 116–260), stream-
14 line the reporting of such information, and ensure that—

15 (1) such information is accurate, accessible, and
16 is delivered in a form and manner consistent with
17 the requirements of such section;

18 (2) the form and manner in which such infor-
19 mation is delivered is routinely updated in accord-
20 ance with widely-used practices in order to ensure
21 accessibility; and

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

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

6 (c) TERMINATION.—The committee shall terminate
7 on January 1, 2028.

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

11 **SEC. 110. REPORT ON IMPACT OF MEDICARE REGULATIONS**
12 **ON PROVIDER AND PAYER CONSOLIDATION.**

13 (a) ANNUAL REPORT ON THE IMPACT OF CERTAIN
14 MEDICARE REGULATIONS ON PROVIDER AND PAYER
15 CONSOLIDATION; PUBLIC COMMENT ON PROVIDER AND
16 PAYER CONSOLIDATION FOR CERTAIN PROPOSED
17 RULES.—

18 (1) ANNUAL REPORT.—Not later than Decem-
19 ber 30, 2026, and annually thereafter, the Secretary
20 of Health and Human Services (in this section re-
21 ferred to as the “Secretary”) shall submit to Con-
22 gress a report on the impact in the aggregate on
23 provider and payer consolidation with respect to reg-
24 ulations for parts A, B, C, and D of title XVIII of
25 the Social Security Act (42 U.S.C. 1395 et seq.) im-

1 plemented in the calendar year immediately prior to
2 such report. Such report shall include regulations
3 that—

4 (A) implement a change to an applicable
5 payment system, a rate schedule, or another
6 payment system under part A, B, C, or D of
7 such title; or

8 (B) result in a significant rule effecting
9 provider or payer consolidation.

10 (2) PUBLIC COMMENT ON IMPACT TO PROVIDER
11 AND PAYER CONSOLIDATION.—Beginning for 2025,
12 as part of any notice and comment rulemaking pro-
13 cess that will result in a significant rule effecting pro-
14 vider or payer consolidation with respect to a pro-
15 posed rule for parts A, B, C, and D of title XVIII
16 of the Social Security Act (42 U.S.C. 1395j et seq.),
17 the Secretary shall seek public comment on the pro-
18 jected impact of such proposed rule on provider and
19 payer consolidation in the aggregate.

20 (3) DEFINITIONS.—In this section:

21 (A) PROVIDER AND PAYER CONSOLIDA-
22 TION.—The term “provider and payer consoli-
23 dation” includes the vertical or horizontal inte-
24 gration among providers of services (as defined
25 in subsection (u) of section 1861 of the Social

1 Security Act (42 U.S.C. 1395x)), suppliers (as
2 defined in subsection (d) of such section), ac-
3 countable care organizations under section 1899
4 of the Social Security Act (42 U.S.C. 1395jjj),
5 Medicare Advantage organizations, PDP spon-
6 sors, pharmacy benefit managers, pharmacies,
7 and integrated delivery systems.

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

10 (i) with respect to outpatient hospital
11 services, the prospective payment system
12 for covered OPD services established under
13 section 1833(t) of such Act (42 U.S.C.
14 1395(l)); and

15 (ii) with respect to physicians’ serv-
16 ices, the physician fee schedules established
17 under section 1848 of such Act (42 U.S.C.
18 1395w-4).

19 (b) CONSIDERATION OF EFFECTS ON PROVIDER AND
20 PAYER CONSOLIDATION WITH RESPECT TO CMI MOD-
21 ELS.—

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

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

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

5 (C) by adding at the end the following new
6 clause:

7 “(iii) the extent to which, and how,
8 the model has effected and could effect
9 provider and payer consolidation, which in-
10 cludes the vertical or horizontal integration
11 among providers of services (as defined in
12 subsection (u) of section 1861), suppliers
13 (as defined in subsection (d) of such sec-
14 tion), and accountable care organizations
15 under section 1899.”.

16 (2) **EFFECTIVE DATE.**—The amendments made
17 by paragraph (1) shall apply with respect to models
18 tested on or after January 1, 2025.

19 **SEC. 111. IMPLEMENTATION FUNDING.**

20 (a) **IN GENERAL.**—For the purposes described in
21 subsection (b), there are appropriated, in addition to
22 amounts otherwise available, out of amounts in the Treas-
23 ury not otherwise appropriated, to the Secretary of Health
24 and Human Services and the Secretary of the Treasury,

1 \$65,000,000 for fiscal year 2024, to remain available
2 through fiscal year 2029.

3 (b) PERMITTED PURPOSES.—The purposes described
4 in this subsection are the following purposes, insofar as
5 such purposes are to carry out the provisions of, including
6 the amendments made by, this title:

7 (1) Preparing, drafting, and issuing proposed
8 and final regulations or interim regulations.

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

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

12 (4) Enforcement of such provisions.

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

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

16 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—
17 Each Secretary described in subsection (a) shall annually
18 submit, no later than September 1st of each year, to the
19 Committees on Energy and Commerce, on Ways and
20 Means, on Education and Workforce, and on Appropria-
21 tions of the House of Representatives and on the Commit-
22 tees on Health, Education, Labor, and Pensions and on
23 Appropriations of the Senate a report on funds expended
24 pursuant to funds appropriated under this section.

1 **TITLE II—REDUCING HEALTH**
2 **CARE COSTS FOR PATIENTS**

3 **SEC. 201. INCREASING TRANSPARENCY IN GENERIC DRUG**
4 **APPLICATIONS.**

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

8 “(H)(i) Upon request (in controlled correspondence
9 or an analogous process) by a person that has submitted
10 or intends to submit an abbreviated application under this
11 subsection for a drug that is required by regulation to con-
12 tain one or more of the same inactive ingredients in the
13 same concentrations as the listed drug referred to, or for
14 which the Secretary determines there is a scientific jus-
15 tification for an approach that is in vitro in whole or in
16 part to be used to demonstrate bioequivalence for a drug
17 if such a drug contains one or more of the same inactive
18 ingredients in the same concentrations as the listed drug,
19 the Secretary shall inform the person whether such drug
20 is qualitatively and quantitatively the same as the listed
21 drug. The Secretary may also provide such information
22 to such a person on the Secretary’s own initiative during
23 the review of an abbreviated application under this sub-
24 section for such drug.

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

5 “(I) the ingredient or ingredients that cause
6 such drug not to be qualitatively or quantitatively
7 the same as the listed drug; and

8 “(II) for any ingredient for which there is an
9 identified quantitative deviation, the amount of such
10 deviation.

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

16 “(I) the formulation of the listed drug has been
17 changed and the Secretary has determined that the
18 prior listed drug formulation was withdrawn for rea-
19 sons of safety or effectiveness; or

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

23 “(iv) If the Secretary makes a written determination
24 described in clause (iii)(II), the Secretary shall provide no-

1 tice and a copy of the written determination to the person
2 making the request under clause (i).

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

6 (b) GUIDANCE.—

7 (1) IN GENERAL.—Not later than one year
8 after the date of enactment of this Act, the Sec-
9 retary of Health and Human Services shall issue
10 draft guidance, or update guidance, describing how
11 the Secretary will determine whether a drug is quali-
12 tatively and quantitatively the same as the listed
13 drug (as such terms are used in section
14 505(j)(3)(H) of the Federal Food, Drug, and Cos-
15 metic Act, as added by subsection (a)), including
16 with respect to assessing pH adjusters.

17 (2) PROCESS.—In issuing guidance under this
18 subsection, the Secretary of Health and Human
19 Services shall—

20 (A) publish draft guidance;

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

23 (C) after considering any comments re-
24 ceived and not later than one year after the

1 close of the comment period on the draft guid-
2 ance, publish final guidance.

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

8 **SEC. 202. IMPROVING TRANSPARENCY AND PREVENTING**
9 **THE USE OF ABUSIVE SPREAD PRICING AND**
10 **RELATED PRACTICES IN MEDICAID.**

11 (a) SPREAD PRICING.—

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

15 “(6) PHARMACY PRICE REIMBURSEMENT RE-
16 QUIRED.—

17 “(A) IN GENERAL.—A contract between
18 the State and a pharmacy benefit manager (in
19 this paragraph referred to as a ‘PBM’), or a
20 contract between the State and a designated en-
21 tity (as defined in subparagraph (C)) that in-
22 cludes provisions making the designated entity
23 responsible for the administration of medical
24 assistance consisting of covered outpatient
25 drugs for individuals enrolled with the des-

1 ignated entity, shall require that payment for
2 such drugs and related administrative services
3 (as applicable), including payments made by a
4 PBM on behalf of the State or designated enti-
5 ty, is based on a pharmacy price reimbursement
6 model under which—

7 “(i) any payment made by the des-
8 ignated entity or the PBM (as applicable)
9 for such a drug—

10 “(I) is limited to—

11 “(aa) ingredient cost; and

12 “(bb) a professional dis-
13 pensing fee that is not less than
14 the professional dispensing fee
15 that the State plan or waiver
16 would pay if the plan or waiver
17 was making the payment directly;

18 “(II) is passed through in its en-
19 tirety by the designated entity or
20 PBM to the pharmacy or provider
21 that dispenses the drug and is not
22 retroactively denied or reduced except
23 as permitted or required under Fed-
24 eral or State law or regulation; and

1 “(III) is made in a manner that
2 is consistent with sections 447.502,
3 447.512, 447.514, and 447.518 of
4 title 42, Code of Federal Regulations
5 (or any successor regulation) as if
6 such requirements applied directly to
7 the designated entity or the PBM, ex-
8 cept that any payment by the des-
9 ignated entity or the PBM for the in-
10 gredient cost of such a drug pur-
11 chased by a covered entity (as defined
12 in subsection (a)(5)(B)) may exceed
13 the actual acquisition cost (as defined
14 in section 447.502 of title 42, Code of
15 Federal Regulations (or any successor
16 regulation)) for such drug if—

17 “(aa) such drug was subject
18 to an agreement under section
19 340B of the Public Health Serv-
20 ice Act;

21 “(bb) such payment for such
22 cost of such drug does not exceed
23 the maximum payment that
24 would have been made by the
25 designated entity or the PBM for

1 the ingredient cost of such drug
2 had such drug not been pur-
3 chased by such a covered entity;
4 and

5 “(cc) such covered entity re-
6 ports to the Secretary, on an an-
7 nual basis (in a form and manner
8 specified by the Secretary) and
9 with respect to payments for
10 such costs of such drugs so pur-
11 chased by such covered entity
12 that are in excess of the actual
13 acquisition costs for such drugs,
14 the aggregate amount of such ex-
15 cess;

16 “(ii) payment to the designated entity
17 or the PBM (as applicable) for administra-
18 tive services performed by the designated
19 entity or PBM is limited to an administra-
20 tive fee that reflects the fair market value
21 of providing such services;

22 “(iii) the designated entity or the
23 PBM (as applicable) makes available to
24 the State, and the Secretary upon request,
25 all costs and payments related to covered

1 outpatient drugs and accompanying admin-
2 istrative services incurred, received, or
3 made by the designated entity or the PBM,
4 including ingredient costs, professional dis-
5 pensing fees, administrative fees, post-sale
6 and post-invoice fees, discounts, or related
7 adjustments such as direct and indirect re-
8 muneration fees, and any and all other re-
9 muneration; and

10 “(iv) any form of spread pricing
11 whereby any amount charged or claimed by
12 the designated entity or the PBM (as ap-
13 plicable) is in excess of the amount paid to
14 the pharmacies by the designated entity or
15 the PBM, including any post-sale or post-
16 invoice fees, discounts, or related adjust-
17 ments such as direct and indirect remu-
18 neration fees or assessments (after allow-
19 ing for a fair market administrative fee as
20 described in clause (ii)), is not allowable
21 for purposes of claiming Federal matching
22 payments under this title.

23 “(B) MAKING CERTAIN INFORMATION
24 AVAILABLE.—The Secretary shall publish, not
25 less frequently than on an annual basis, infor-

1 mation received by the Secretary pursuant to
2 subparagraph (A)(i)(III)(cc). Such information
3 shall be so published in an electronic and
4 searchable format, such as through the 340B
5 Office of Pharmacy Affairs Information System
6 (or a successor system).

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

8 “(i) DESIGNATED ENTITY.—The term
9 ‘designated entity’ means a managed care
10 entity or other specified entity.

11 “(ii) MANAGED CARE ENTITY; OTHER
12 SPECIFIED ENTITY.—The terms ‘managed
13 care entity’ and ‘other specified entity’
14 have the meaning given such terms in sec-
15 tion 1903(m)(9)(D).”.

16 (2) CONFORMING AMENDMENTS.—Section
17 1903(m) of such Act (42 U.S.C. 1396b(m)) is
18 amended—

19 (A) in paragraph (2)(A)(xiii)—

20 (i) by striking “and (III)” and insert-
21 ing “(III)”;

22 (ii) by inserting before the period at
23 the end the following: “, and (IV) with re-
24 spect to covered outpatient drugs and re-
25 lated administrative services (as applicable)

1 provided by the entity (or by a pharmacy
2 benefit manager on behalf of the entity
3 under a contract or other arrangement
4 with the entity), that payment for such
5 drugs and related administrative services is
6 based on a pharmacy price reimbursement
7 model described in section 1927(e)(6)(A)”;
8 and

9 (iii) by moving the margin 2 ems to
10 the left; and

11 (B) by adding at the end the following new
12 paragraph:

13 “(10) No payment shall be made under this title to
14 a State with respect to expenditures incurred by it for pay-
15 ment for services provided by an other specified entity (as
16 defined in paragraph (9)(D)) unless the contract between
17 the State and the entity for the provision of such services
18 provides, with respect to covered outpatient drugs and re-
19 lated administrative services (as applicable) provided by
20 the entity (or by a pharmacy benefit manager on behalf
21 of the entity under a contract or other arrangement with
22 the entity), that payment for such drugs and related ad-
23 ministrative services is based on a pharmacy price reim-
24 bursement model described in section 1927(e)(6)(A).”.

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection apply to contracts between States
3 and pharmacy benefit managers and designated enti-
4 ties (as defined in section 1927(e)(6) of the Social
5 Security Act, as added by paragraph (1)) that have
6 an effective date beginning on or after the date that
7 is 18 months after the date of enactment of this Act.

8 (b) ENSURING ACCURATE PAYMENTS TO PHAR-
9 MACIES UNDER MEDICAID.—

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

12 (A) by striking “and” after the semicolon
13 at the end of paragraph (1)(A)(i) and all that
14 precedes it through “(1)” and inserting the fol-
15 lowing:

16 “(1) DETERMINING PHARMACY ACTUAL ACQUI-
17 SITION COSTS.—The Secretary shall conduct a sur-
18 vey of retail community pharmacy drug prices to de-
19 termine the national average drug acquisition cost as
20 follows:

21 “(A) USE OF VENDOR.—The Secretary
22 may contract services for—

23 “(i) with respect to retail community
24 pharmacies, the determination of retail
25 survey prices of the national average drug

1 acquisition cost for covered outpatient
2 drugs based on a monthly survey of such
3 pharmacies; and”;

4 (B) by adding at the end of paragraph (1)
5 the following:

6 “(F) SURVEY REPORTING.—A State shall
7 require that any retail community pharmacy in
8 the State that receives any payment, reimburse-
9 ment, administrative fee, discount, or rebate re-
10 lated to the dispensing of covered outpatient
11 drugs to individuals receiving benefits under
12 this title, regardless of whether such payment,
13 reimbursement, administrative fee, discount, or
14 rebate is received from the State or a des-
15 ignated entity (as defined in subsection
16 (e)(6)(C)) directly or from a pharmacy benefit
17 manager that has a contract with the State or
18 a designated entity, shall respond to surveys of
19 retail prices conducted under this subsection.

20 “(G) SURVEY INFORMATION.—Information
21 on national drug acquisition prices obtained
22 under this paragraph shall be made publicly
23 available in a timely manner following the col-
24 lection of such information and shall include at
25 least the following:

1 “(i) The monthly response rate to the
2 survey including a list of pharmacies not in
3 compliance with subparagraph (F).

4 “(ii) The sampling frame and number
5 of pharmacies sampled monthly.

6 “(iii) Information on price concessions
7 to the pharmacy, including discounts, re-
8 bates, and other price concessions, to the
9 extent that such information may be pub-
10 licly released and is available during the
11 survey period.

12 “(H) REPORT ON SPECIALTY PHAR-
13 MACIES.—Not later than 1 year after the date
14 that this subparagraph takes effect, the Sec-
15 retary shall submit to Congress a report exam-
16 ining specialty drug coverage and reimburse-
17 ment under this title, including—

18 “(i) a description of how State Med-
19 icaid programs define specialty drugs and
20 specialty pharmacies;

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

23 “(iii) how States and designated enti-
24 ties (as defined in subsection (e)(6)(C)) de-
25 termine payment for specialty drugs;

1 “(iv) the settings in which specialty
2 drugs are dispensed to individuals receiv-
3 ing benefits under this title (such as retail
4 community pharmacies or specialty phar-
5 macies);

6 “(v) the extent to which specialty
7 drugs (as defined by the respective States)
8 are captured in the national average drug
9 acquisition cost survey (or through another
10 process);

11 “(vi) examples of specialty drug dis-
12 pensing fees to support the services associ-
13 ated with dispensing such specialty drugs;
14 and

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

22 “(I) ENFORCEMENT.—At the discretion of
23 the Secretary, the Secretary (acting through the
24 Inspector General and in collaboration with the
25 Administrator of the Centers for Medicare &

1 Medicaid Services) may enforce non-compliance
2 with this paragraph by a pharmacy through the
3 establishment of penalties until compliance with
4 this paragraph has been completed.”; and

5 (C) in paragraph (2)—

6 (i) in subparagraph (A), by inserting
7 “(including payment rates under managed
8 care organization as defined in section
9 1932(a)(1)(B)(i) and PIHPs and PAHPs
10 as defined in section 1903(m)(9)(D)(iii)(I
11 and (II), respectively)” after “under this
12 title”; and

13 (ii) in subparagraph (B), by inserting
14 “, and the basis for such dispensing fees”
15 before the semicolon at the end.

16 (2) EFFECTIVE DATE.—The amendments made
17 by this subsection shall take effect on the first day
18 of the first quarter that begins on or after the date
19 that is 18 months after the date of enactment of
20 this Act.

1 **SEC. 203. 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 (v)) 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)) (or,
17 in the case of an off-campus outpatient de-
18 partment of a provider that is a hospital
19 described in section 1886(d)(1)(B)(v), or is
20 located in a rural area or a health profes-
21 sional shortage area, such services that are
22 furnished during 2026 or a subsequent
23 year), there shall be substituted for the
24 amount otherwise determined under this
25 subsection for such service and year an
26 amount equal to the payment amount that

1 would have been payable under the applica-
2 ble payment system under this part (other
3 than under this subsection) had such serv-
4 ices been furnished by such a department
5 subject to such payment system pursuant
6 to paragraph (21)(C).

7 “(ii) NOT BUDGET NEUTRAL IMPLE-
8 MENTATION.—In making any budget neu-
9 trality adjustments under this subsection
10 for 2025 or a subsequent year, the Sec-
11 retary shall not take into account the re-
12 duced expenditures that result from the
13 application of this subparagraph.

14 “(iii) TRANSITION.—The Secretary
15 shall provide for a 4-year phase-in of the
16 application of clause (i), with clause (i)
17 being fully applicable for specified OPD
18 services beginning with 2028 (or in the
19 case of an off-campus outpatient depart-
20 ment of a provider that is a hospital de-
21 scribed in section 1886(d)(1)(B)(v), or is
22 located in a rural area or a health profes-
23 sional shortage area, beginning with 2029).

24 “(iv) OFF-CAMPUS DEPARTMENT OF A
25 PROVIDER.—For purposes of this subpara-

1 graph, the term ‘off-campus outpatient de-
2 partment of a provider’ means a depart-
3 ment of a provider (as defined in section
4 413.65(a)(2) of title 42, Code of Federal
5 Regulations) that is not located—

6 “(I) on the campus (as such term
7 is defined in such section) of such
8 provider; or

9 “(II) within the distance (de-
10 scribed in such definition of campus)
11 from a remote location of a hospital
12 facility (as defined in such section).

13 “(v) OTHER DEFINITIONS.—For pur-
14 poses of 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) HEALTH PROFESSIONAL
23 SHORTAGE AREA.—The term ‘health
24 professional shortage area’ has the
25 meaning given such term in section

1 332(a)(1)(A) of the Public Health
2 Service Act.

3 “(III) RURAL AREA.—The term
4 ‘rural area’ has the meaning given
5 such term in section 1886(d)(2)(D).

6 “(IV) SPECIFIED OPD SERV-
7 ICES.—The term ‘specified OPD serv-
8 ices’ means covered OPD services as-
9 signed to a designated ambulatory
10 payment classification group.”.

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

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

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

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

20 “(F) the determination of any payment
21 amount under paragraph (16)(H), including the
22 transition under clause (iii) of such para-
23 graph.”.

1 **SEC. 204. REQUIRING A SEPARATE IDENTIFICATION NUM-**
2 **BER AND AN ATTESTATION FOR EACH OFF-**
3 **CAMPUS OUTPATIENT DEPARTMENT OF A**
4 **PROVIDER.**

5 (a) IN GENERAL.—Section 1833(t) of the Social Se-
6 curity Act (42 U.S.C. 1395l(t)) is amended by adding at
7 the end the following new paragraph:

8 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;
9 ATTESTATION.—

10 “(A) IN GENERAL.—No payment may be
11 made under this subsection (or under an appli-
12 cable payment system pursuant to paragraph
13 (21)) for items and services furnished on or
14 after January 1, 2026, by an off-campus out-
15 patient department of a provider (as defined in
16 subparagraph (C)) unless—

17 “(i) such department has obtained,
18 and such items and services are billed
19 under, a standard unique health identifier
20 for health care providers (as described in
21 section 1173(b)) that is separate from
22 such identifier for such provider; and

23 “(ii) such provider has submitted to
24 the Secretary, during the 2-year period
25 ending on the date such items and services
26 are so furnished, an attestation that such

1 department is compliant with the require-
2 ments described in section 413.65 of title
3 42, Code of Federal Regulations (or a suc-
4 cessor regulation).

5 “(B) PROCESS FOR SUBMISSION AND RE-
6 VIEW.—Not later than 1 year after the date of
7 enactment of this paragraph, the Secretary
8 shall, through notice and comment rulemaking,
9 establish a process for each provider with an
10 off-campus outpatient department of a provider
11 to submit an attestation pursuant to subpara-
12 graph (A)(ii), and for the Secretary to review
13 each such attestation and determine, through
14 site visits, remote audits, or other means (as
15 determined appropriate by the Secretary),
16 whether such department is compliant with the
17 requirements described in such subparagraph.

18 “(C) OFF-CAMPUS OUTPATIENT DEPART-
19 MENT OF A PROVIDER DEFINED.—For purposes
20 of this paragraph, the term ‘off-campus out-
21 patient department of a provider’ means a de-
22 partment of a provider (as defined in section
23 413.65 of title 42, Code of Federal Regulations,
24 or any successor regulation) that is not lo-
25 cated—

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

3 “(ii) within the distance (described in
4 such definition of campus) from a remote
5 location of a hospital facility (as defined in
6 such section).”.

7 (b) HHS OIG ANALYSIS.—Not later than January
8 1, 2030, the Inspector General of the Department of
9 Health and Human Services shall submit to Congress—

10 (1) an analysis of the process established by the
11 Secretary of Health and Human Services to conduct
12 the reviews and determinations described in section
13 1833(t)(23)(B) of the Social Security Act, as added
14 by subsection (a) of this section; and

15 (2) recommendations based on such analysis, as
16 the Inspector General determines appropriate.

1 **TITLE III—SUPPORTING PA-**
2 **TIENTS, HEALTH CARE WORK-**
3 **ERS, COMMUNITY HEALTH**
4 **CENTERS, AND HOSPITALS**

5 **SEC. 301. EXTENSION FOR COMMUNITY HEALTH CENTERS,**
6 **THE NATIONAL HEALTH SERVICE CORPS,**
7 **AND TEACHING HEALTH CENTERS THAT OP-**
8 **ERATE GME PROGRAMS.**

9 (a) TEACHING HEALTH CENTERS THAT OPERATE
10 GRADUATE MEDICAL EDUCATION PROGRAMS.—

11 (1) ADDITION TO CAPPED AMOUNTS FOR FIS-
12 CAL YEARS 2024 AND 2025.—Paragraph (2) of section
13 340H(b) of the Public Health Service Act (42
14 U.S.C. 256h(b)) is amended by adding at the end
15 the following:

16 “(C) ADDITION.—Notwithstanding any
17 provision of this section, for each of fiscal years
18 2024 and 2025, the Secretary may use any
19 amounts made available in any fiscal year to
20 carry out this section (including amounts re-
21 couped under subsection (f)) to make payments
22 described in paragraphs (1)(A) and (1)(B), in
23 addition to the total amount of funds appro-
24 priated under subsection (g).”.

1 (2) RECONCILIATION.—Section 340H(f) of the
2 Public Health Service Act (42 U.S.C. 256h(f)) is
3 amended—

4 (A) by striking “The Secretary shall deter-
5 mine” and inserting the following:

6 “(1) DETERMINATION.—The Secretary shall de-
7 termine”; and

8 (B) by adding at the end the following:

9 “(2) ANNUAL REPORT TO CONGRESS.—For
10 each fiscal year, the Secretary shall submit to the
11 Committee on Energy and Commerce of the House
12 of Representatives and the Committee on Health,
13 Education, Labor, and Pensions of the Senate a re-
14 port specifying—

15 “(A) the total amount of funds recouped
16 under paragraph (1);

17 “(B) the rationale for the funds being re-
18 couped; and

19 “(C) in the case of the reports for each of
20 fiscal years 2024 and 2025, the total amount of
21 funds recouped under paragraph (1) that were
22 used pursuant to subsection (b)(2)(C) to adjust
23 total payment amounts above the total amounts
24 appropriated under subsection (g).”.

1 (3) FUNDING.—Section 340H(g) of the Public
2 Health Service Act (42 U.S.C. 256h(g)) is amend-
3 ed—

4 (A) by amending paragraph (1) to read as
5 follows:

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

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

11 “(B) \$60,000,000 for each of fiscal years
12 2016 and 2017;

13 “(C) \$126,500,000 for each of fiscal years
14 2018 through 2023;

15 “(D) \$16,635,616 for the period beginning
16 on October 1, 2023, and ending on November
17 17, 2023;

18 “(E) \$21,834,247 for the period beginning
19 on November 18, 2023, and ending on January
20 19, 2024;

21 “(F) \$136,530,137 for the period begin-
22 ning on January 20, 2024, and ending on Sep-
23 tember 30, 2024;

24 “(G) \$175,000,000 for fiscal year 2025;

1 “(H) \$225,000,000 for each of fiscal years
2 2026 and 2027; and

3 “(I) \$300,000,000 for each of fiscal years
4 2028, 2029, and 2030.”; and

5 (B) by adding at the end the following:

6 “(3) AVAILABILITY.—The amounts made avail-
7 able under paragraph (1) shall remain available until
8 expended.”.

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

13 (1) by striking “and” before “\$690,410,959”;
14 and

15 (2) by inserting “, \$3,183,561,644 for the pe-
16 riod beginning on January 20, 2024, and ending on
17 September 30, 2024, \$4,400,000,000 for fiscal year
18 2025, and \$1,109,000,000 for the period beginning
19 October 1, 2025, and ending December 31, 2025”
20 before the semicolon at the end.

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

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

3 (2) in subparagraph (I), by striking the period
4 at the end and inserting “; and”; and

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

6 “(J) \$255,726,028 for the period begin-
7 ning on January 20, 2024, and ending on Sep-
8 tember 30, 2024, \$350,000,000 for fiscal year
9 2025, and \$88,219,178 for the period beginning
10 October 1, 2025, and ending December 31,
11 2025.”.

12 (d) GOVERNMENT ACCOUNTABILITY OFFICE RE-
13 PORT.—

14 (1) IN GENERAL.—Not later than one year
15 after the date of enactment of this Act, the Comp-
16 troller General of the United States shall submit to
17 the Committee on Energy and Commerce of the
18 House of Representatives and the Committee on
19 Health, Education, Labor, and Pensions of the Sen-
20 ate a report assessing the effectiveness of the Na-
21 tional Health Service Corps at attracting health care
22 professionals to HPSAs, including by—

23 (A) assessing the metrics used by the
24 Health Resources and Services Administration
25 in evaluating the program;

1 (B) comparing the retention rates of
2 NHSC participants in the HPSAs where they
3 completed their period of obligated service to
4 the retention rate of non-NHSC participants in
5 the corresponding HPSAs;

6 (C) comparing the retention rates of
7 NHSC participants in the HPSAs where they
8 completed their period of obligated service to
9 the retention rates of NHSC participants in
10 HPSAs other than those where they completed
11 their period of obligated service;

12 (D) identifying factors that influence a
13 NHSC participant's decision to practice in a
14 HPSA other than the HPSA where they com-
15 pleted their period of obligated service;

16 (E) identifying factors other than partici-
17 pation in the National Health Service Corps
18 Scholarship and Loan Repayment Programs
19 that attract health care professionals to a
20 HPSA;

21 (F) assessing the impact the National
22 Health Service Corps has on wages for health
23 care professionals in a HPSA; and

1 (G) comparing the distribution of NHSC
2 participants across HPSAs, including a com-
3 parison of rural versus non-rural HPSAs.

4 (2) DEFINITION.—In this section:

5 (A) The term “HPSA” means a health
6 professional shortage area designated under
7 section 332 of the Public Health Service Act
8 (42 U.S.C. 254e).

9 (B) The term “NHSC participant” means
10 a National Health Service Corps member par-
11 ticipating in the National Health Service Corps
12 Scholarship or Loan Repayment Program.

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

19 (f) CONFORMING AMENDMENT.—Paragraph (4) of
20 section 3014(h) of title 18, United States Code, is amend-
21 ed by striking “and section 2321(d) of the Continuing Ap-
22 propriations Act, 2024 and Other Extensions Act” and in-
23 serting “section 2321(d) of the Continuing Appropriations
24 Act, 2024 and Other Extensions Act, and section 301(e)
25 of the Lower Costs, More Transparency Act”.

1 **SEC. 302. 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 (D), by striking “and” at
7 the end;

8 (2) in subparagraph (E), by striking the period
9 at the end and inserting a semicolon; and

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

11 “(F) \$124,383,562 for the period begin-
12 ning on January 20, 2024, and ending on Sep-
13 tember 30, 2024, to remain available until ex-
14 pended;

15 “(G) \$170,000,000 for fiscal year 2025, to
16 remain available until expended; and

17 “(H) \$42,849,315 for the period beginning
18 October 1, 2025, and ending December 31,
19 2025, to remain available until expended.”.

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

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

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

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

4 “(F) \$124,383,562 for the period begin-
5 ning on January 20, 2024, and ending on Sep-
6 tember 30, 2024, to remain available until ex-
7 pended;

8 “(G) \$170,000,000 for fiscal year 2025, to
9 remain available until expended; and

10 “(H) \$42,849,315 for the period beginning
11 October 1, 2025, and ending December 31,
12 2025, to remain available until expended.”.

13 **SEC. 303. DELAYING CERTAIN DISPROPORTIONATE SHARE**
14 **PAYMENT CUTS.**

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

17 (1) in clause (i)—

18 (A) by striking “For the period beginning
19 January 20, 2024, and ending September 30,
20 2024, and for each of fiscal years 2025” and
21 inserting “For each of fiscal years 2026”; and

22 (B) by striking “or period” each place
23 such term appears; and

24 (2) in clause (ii), by striking “for the period be-
25 ginning January 20, 2024, and ending September

1 30, 2024, and for each of fiscal years 2025” and in-
2 serting “for each of fiscal years 2026”.

3 **SEC. 304. MEDICAID IMPROVEMENT FUND.**

4 Section 1941(b)(3)(A) of the Social Security Act (42
5 U.S.C. 1396w-1(b)(3)(A)) is amended by striking “
6 \$6,357,117,810” and inserting “\$0”.

7 **TITLE IV—INCREASING ACCESS**
8 **TO QUALITY HEALTH DATA**
9 **AND LOWERING HIDDEN**
10 **FEES**

11 **SEC. 401. INCREASING PLAN FIDUCIARIES’ ACCESS TO**
12 **HEALTH DATA.**

13 (a) PLAN FIDUCIARY ACCESS TO INFORMATION.—

14 (1) IN GENERAL.—Paragraph (2) of section
15 408(b) of the Employee Retirement Income Security
16 Act of 1974 (29 U.S.C. 1108(b)) is amended by
17 adding at the end the following new subparagraph:

18 “(C) No contract or arrangement for services
19 between a group health plan and any other entity,
20 including a health care provider (including a health
21 care facility), network or association of providers,
22 service provider offering access to a network of pro-
23 viders, third-party administrator, or pharmacy ben-
24 efit manager, is reasonable within the meaning of

1 this paragraph unless such contract or arrange-
2 ment—

3 “(i) allows the responsible plan fiduciary
4 (as defined in subparagraph (B)(ii)(I)(ee)) to
5 audit or review all de-identified claims and en-
6 counter information or data described in section
7 724(a)(1)(B) to—

8 “(I) ensure that such entity complies
9 with the terms of the plan and any appli-
10 cable law; and

11 “(II) determine the reasonableness of
12 compensation received by such entity; and

13 “(ii) does not—

14 “(I) unreasonably limit the number of
15 audits permitted during a given period of
16 time;

17 “(II) limit the number of de-identified
18 claims and encounter information or data
19 that the responsible plan fiduciary may ac-
20 cess during an audit;

21 “(III) limit the disclosure of pricing
22 terms for value-based payment arrange-
23 ments or capitated payment arrangements,
24 including—

1 “(aa) payment calculations and
2 formulas;
3 “(bb) quality measures;
4 “(cc) contract terms;
5 “(dd) payment amounts;
6 “(ee) measurement periods for all
7 incentives; and
8 “(ff) other payment methodolo-
9 gies used by an entity, including a
10 health care provider (including a
11 health care facility), network or asso-
12 ciation of providers, service provider
13 offering access to a network of pro-
14 viders, third-party administrator, or
15 pharmacy benefit manager;
16 “(IV) limit the disclosure of overpay-
17 ments and overpayment recovery terms;
18 “(V) limit the right of the responsible
19 plan fiduciary to select an auditor;
20 “(VI) otherwise limit or unduly delay
21 by greater than 60 calendar days after the
22 date of request the responsible plan fidu-
23 ciary from auditing all de-identified claims
24 and encounter information or data; or

1 “(VII) permit the entity to charge a
2 fee beyond the reasonable direct costs to
3 provide the required information and oth-
4 erwise comply and assist with an audit re-
5 quest.”.

6 (2) CIVIL ENFORCEMENT.—

7 (A) IN GENERAL.—Subsection (e) of sec-
8 tion 502 of such Act (29 U.S.C. 1132) is
9 amended by adding at the end the following
10 new paragraph:

11 “(13) In the case of an agreement between a group
12 health plan and a health care provider (including a health
13 care facility), network or association of providers, service
14 provider offering access to a network of providers, third-
15 party administrator, or pharmacy benefit manager, that
16 violates the provisions of section 724, the Secretary may
17 assess a civil penalty against such provider, network or
18 association, service provider offering access to a network
19 of providers, third-party administrator, pharmacy benefit
20 manager, or other service provider in the amount of
21 \$10,000 for each day during which such violation con-
22 tinues. Such penalty shall be in addition to other penalties
23 as may be prescribed by law.”.

24 (B) CONFORMING AMENDMENT.—Para-
25 graph (6) of section 502(a) of such Act is

1 amended by striking “or (9)” and inserting
2 “(9), or (13)”.

3 (3) EXISTING PROVISIONS VOID.—Section 410
4 of such Act is amended by adding at the end the fol-
5 lowing new subsection:

6 “(c) Any provision in an agreement or instrument
7 shall be void as against public policy if such provision—

8 “(1) unduly delays or limits a plan fiduciary
9 from accessing the de-identified claims and encoun-
10 ter information or data described in section
11 724(a)(1)(B); or

12 “(2) violates the requirements of section
13 408(b)(2)(C).”.

14 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
15 ITY INFORMATION.—Section 724(a)(3) of the Employee
16 Retirement Income Security Act (29 U.S.C. 1185m(a)(3))
17 is amended to read as follows:

18 “(3) ATTESTATION.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (C), the plan fiduciary of a group health
21 plan or health insurance issuer offering group
22 health insurance coverage shall annually submit
23 to the Secretary an attestation that such plan
24 or issuer of such coverage is in compliance with
25 the requirements of this subsection. Such attes-

1 tation shall also include a statement verifying
2 that—

3 “(i) the information or data described
4 under subparagraphs (A) and (B) of para-
5 graph (1) is available upon request and
6 provided to the plan fiduciary, the plan ad-
7 ministrator, or the issuer in a timely man-
8 ner; and

9 “(ii) there are no terms in the agree-
10 ment under such paragraph (1) that di-
11 rectly or indirectly restrict or unduly delay
12 a plan fiduciary, the plan administrator, or
13 the issuer from auditing, reviewing, or oth-
14 erwise accessing such information, except
15 as permitted under section 408(b)(2)(C).

16 “(B) LIMITATION ON SUBMISSION.—Sub-
17 ject to clause (ii), a group health plan or issuer
18 offering group health insurance coverage may
19 not enter into an agreement with a third-party
20 administrator or other service provider to sub-
21 mit the attestation required under subpara-
22 graph (A).

23 “(C) EXCEPTION.—In the case of a group
24 health plan or issuer offering group health in-
25 surance coverage that is unable to obtain the

1 information or data needed to submit the attes-
2 tation required under subparagraph (A), such
3 plan or issuer may submit a written statement
4 in lieu of such attestation that includes—

5 “(i) an explanation of why such plan
6 or issuer was unsuccessful in obtaining
7 such information or data, including wheth-
8 er such plan or issuer was limited or pre-
9 vented from auditing, reviewing, or other-
10 wise accessing such information or data;

11 “(ii) a description of the efforts made
12 by the plan fiduciary to remove any gag
13 clause provisions from the agreement
14 under paragraph (1); and

15 “(iii) a description of any response by
16 the third-party administrator or other serv-
17 ice provider with respect to efforts to com-
18 ply with the attestation requirement under
19 subparagraph (A).”.

20 (c) REPORT ON PLAN ASSETS.—Not later than 1
21 year after the date of enactment of this Act, the Secretary
22 of Labor shall submit to the Committee on Education and
23 the Workforce of the House of Representatives and the
24 Committee on Health, Education, Labor, and Pensions of
25 the Senate a report on the status of de-identified claims

1 and encounter information or data described in section
2 724(a)(1)(B) of the Employee Retirement Income Secu-
3 rity Act of 1974 (29 U.S.C. 1185m), including informa-
4 tion on the following:

5 (1) Whether changes to regulations or guidance
6 would permit such information or data to be deemed
7 a group health plan asset (as defined under section
8 3(42) of such Act).

9 (2) Whether restrictions on the ability of a plan
10 fiduciary to access such information or data violates
11 a requirement of current law.

12 (3) The existing regulatory authority of the
13 Secretary to clarify whether such information or
14 data is the property of a group health plan, rather
15 than a service provider.

16 (4) Legislative recommendations to establish
17 that such information or data related to a plan be-
18 longs to a group health plan and is handled in the
19 best interests of plan participants and beneficiaries.

20 (d) EFFECTIVE DATE.—The amendments made by
21 subsections (a) and (b) shall apply with respect to a plan
22 beginning with the first plan year that begins on or after
23 the date that is 1 year after the date of enactment of this
24 Act.

1 **SEC. 402. HIDDEN FEES DISCLOSURE REQUIREMENTS.**

2 (a) CLARIFICATION OF THE APPLICATION OF FEE
3 DISCLOSURE REQUIREMENTS TO COVERED SERVICE PRO-
4 VIDERS.—

5 (1) SERVICES.—Clause (ii)(I)(bb) of section
6 408(b)(2)(B) of the Employee Retirement Income
7 Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is
8 amended—

9 (A) in subitem (AA) by striking “Broker-
10 age services,” and inserting “Services (includ-
11 ing brokerage services),”; and

12 (B) in subitem (BB)—

13 (i) by striking “Consulting,” and in-
14 serting “Other services,”; and

15 (ii) by inserting “any of the fol-
16 lowing:” before “plan design”.

17 (2) DISCLOSURES.—Clause (iii)(III) of section
18 408(b)(2)(B) of the Employee Retirement Income
19 Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is
20 amended by striking “, either in the aggregate or by
21 service,” and inserting “by service”.

22 (b) STRENGTHENING DISCLOSURE REQUIREMENTS
23 WITH RESPECT TO PHARMACY BENEFIT MANAGERS AND
24 THIRD PARTY ADMINISTRATORS FOR GROUP HEALTH
25 PLANS.—

1 (1) CERTAIN ARRANGEMENTS FOR PHARMACY
2 BENEFIT MANAGER SERVICES CONSIDERED AS INDI-
3 RECT.—

4 (A) IN GENERAL.—Clause (i) of section
5 408(b)(2)(B) of the Employee Retirement In-
6 come Security Act of 1974 (29 U.S.C.
7 1108(b)(2)(B)) is amended—

8 (i) by striking “requirements of this
9 clause” and inserting “requirements of this
10 subparagraph”; and

11 (ii) by adding at the end the fol-
12 lowing: “For purposes of applying section
13 406(a)(1)(C) with respect to a transaction
14 described under this subparagraph, a con-
15 tract or arrangement for services between
16 a covered plan and a health insurance
17 issuer providing health insurance coverage
18 in connection with the covered plan in
19 which the health insurance issuer con-
20 tracts, in connection with such plan, with
21 a service provider for pharmacy benefit
22 management services shall be considered to
23 constitute an indirect furnishing of goods,
24 services, or facilities between the plan and

1 the service provider acting as the party in
2 interest.”.

3 (B) HEALTH INSURANCE ISSUER AND
4 HEALTH INSURANCE COVERAGE DEFINED.—
5 Clause (ii)(I)(aa) of section 408(b)(2)(B) of
6 such Act (29 U.S.C. 1108(b)(2)(B)) is amended
7 by inserting before the period at the end “and
8 the terms ‘health insurance coverage’ and
9 ‘health insurance issuer’ have the meanings
10 given such terms in section 733(b)”.

11 (C) TECHNICAL AMENDMENT.—Clause
12 (ii)(I)(aa) of section 408(b)(2)(B) of the Em-
13 ployee Retirement Income Security Act of 1974
14 (29 U.S.C. 1108(b)(2)(B)) is further amended
15 by inserting “in” after “defined”.

16 (2) SPECIFIC DISCLOSURE REQUIREMENTS
17 WITH RESPECT TO PHARMACY BENEFIT MANAGE-
18 MENT SERVICES.—

19 (A) IN GENERAL.—Clause (iii) of section
20 408(b)(2)(B) of such Act (29 U.S.C.
21 1108(b)(2)(B)) is amended by adding at the
22 end the following:

23 “(VII) With respect to a contract or ar-
24 rangement with the covered plan in connection
25 with the provision of pharmacy benefit manage-

1 ment services, as part of the description re-
2 quired under subclauses (III) and (IV)—

3 “(aa) all compensation described in
4 clause (ii)(I)(dd)(AA), including fees, re-
5 bates, alternative discounts, co-payment
6 offsets, and other remuneration expected
7 to be received by the covered service pro-
8 vider, an affiliate, or a subcontractor from
9 a pharmaceutical manufacturer, dis-
10 tributor, rebate aggregator, accumulator,
11 and maximizer, group purchasing organiza-
12 tion, or any other third party;

13 “(bb) the amount and form of any re-
14 bates, discounts, or price concessions, in-
15 cluding the amount expected to be passed
16 through to the plan sponsor or the partici-
17 pants and beneficiaries under the covered
18 plan;

19 “(cc) all compensation expected to be
20 received by the covered service provider, an
21 affiliate, or a subcontractor as a result of
22 paying a lower amount for the drug than
23 the amount charged as a copayment, coin-
24 surance amount, or deductible;

1 “(dd) all compensation expected to be
2 received by the covered service provider, an
3 affiliate, or a subcontractor as a result of
4 paying pharmacies less than what is
5 charged the health plan, plan sponsor, or
6 participants and beneficiaries under the
7 covered plan; and

8 “(ee) all compensation expected to be
9 received by the covered service provider, an
10 affiliate, or a subcontractor from drug
11 manufacturers and any other third party
12 in exchange for—

13 “(AA) administering, invoicing,
14 allocating, or collecting rebates related
15 to the covered plan;

16 “(BB) providing business serv-
17 ices and activities, including providing
18 access to drug utilization data;

19 “(CC) keeping a percentage of
20 the list price of a drug; or

21 “(DD) any other reason related
22 to the role of a covered service pro-
23 vider as a conduit between the drug
24 manufacturers or any other third
25 party and the covered plan.”.

1 (B) ANNUAL DISCLOSURE.—Clause (v) of
2 section 408(b)(2)(B) of such Act (29 U.S.C.
3 1108(b)(2)(B)) is amended by adding at the
4 end the following:

5 “(III) A covered service provider, with re-
6 spect to a contract or arrangement with the
7 covered plan in connection with providing phar-
8 macy benefit management services, shall dis-
9 close, on an annual basis not later than 60 days
10 after the beginning of the current plan year, to
11 a responsible plan fiduciary, in writing, the fol-
12 lowing with respect to the twelve months pre-
13 ceding the current plan year:

14 “(aa) All direct compensation de-
15 scribed in subclause (III) of clause (iii)
16 and indirect compensation described in
17 subclause (IV) of clause (iii) received by
18 the covered service provider (including
19 such compensation described in subclause
20 (VII) of clause (iii)).

21 “(bb) The total gross spending by the
22 covered plan on drugs (excluding rebates,
23 discounts, or other price concessions).

24 “(cc) The total net spending by the
25 covered plan on drugs.

1 “(dd) The total gross spending at all
2 pharmacies wholly or partially owned by
3 the covered service provider or any entity
4 affiliated with the covered service provider,
5 including mail-order, specialty and retail
6 pharmacies, with a breakdown by indi-
7 vidual pharmacy location.

8 “(ee) The aggregate amount of
9 clawback from such pharmacies, including
10 mail-order, specialty, and retail phar-
11 macies.

12 “(AA) categorical explanations
13 (grouped by the reason for clawback,
14 such as contractual true-up provi-
15 sions, overpayments, or non-covered
16 medication dispensed, and including
17 information on the amount in each
18 category that was passed through to
19 the covered plan and to participants
20 and beneficiaries of the covered plan);
21 or

22 “(BB) individual explanations for
23 such clawbacks.

24 “(ff) Total aggregate amounts of fees
25 collected by the covered service provider,

1 an affiliate, or a subcontractor in connec-
2 tion with the provision of pharmacy benefit
3 management services to the covered plan.

4 “(gg) Any other information specified
5 by the Secretary through regulations or
6 guidance that may be necessary for a re-
7 sponsible plan fiduciary to consider the
8 merits of the contract or arrangement with
9 the covered service provider and any con-
10 flicts of interest that may exist.”.

11 (C) PHARMACY BENEFIT MANAGEMENT
12 SERVICES DEFINED.—Clause (ii)(I) of section
13 408(b)(2)(B) of such Act (29 U.S.C.
14 1108(b)(2)(B)) is amended by adding at the
15 end the following:

16 “(gg) The term ‘pharmacy benefit
17 management services’ includes any services
18 provided by a covered service provider to a
19 covered plan with respect to the adminis-
20 tration of prescription drug benefits under
21 the covered plan, including—

22 “(AA) processing and payment of
23 claims;

24 “(BB) design of pharmacy net-
25 works;

1 “(CC) negotiation, aggregation,
2 and distribution of rebates, discounts,
3 and other price concessions;

4 “(DD) formulary design and
5 maintenance;

6 “(EE) operation of pharmacies
7 (whether retail, mail order, specialty
8 drug, or otherwise);

9 “(FF) recordkeeping;

10 “(GG) utilization review;

11 “(HH) adjudication of claims;

12 and

13 “(II) any other services specified
14 by the Secretary through guidance or
15 rulemaking.”.

16 (D) CLAWBACK DEFINED.—Clause (ii)(I)
17 of section 408(b)(2)(B) of such Act (29 U.S.C.
18 1108(b)(2)(B)), as amended by subparagraph
19 (C), is amended by adding at the end the fol-
20 lowing:

21 “(hh) The term ‘clawback’ means
22 amounts collected by a provider of phar-
23 macy benefit management services from a
24 pharmacy for copayments collected from a

1 participant or beneficiary in excess of the
2 contracted rate.”.

3 (3) SPECIFIC DISCLOSURE REQUIREMENTS
4 WITH RESPECT TO THIRD PARTY ADMINISTRATION
5 SERVICES FOR GROUP HEALTH PLANS.—

6 (A) IN GENERAL.—Clause (iii) of section
7 408(b)(2)(B) of such Act (29 U.S.C.
8 1108(b)(2)(B)), as amended by paragraph
9 (2)(A), is further amended by adding at the end
10 the following:

11 “(VIII) With respect to a contract or ar-
12 rangement with the covered plan in connection
13 with the provision of third party administration
14 services for group health plans, as part of the
15 description required under subclauses (III) and
16 (IV)—

17 “(aa) the amount and form of any re-
18 bates, discounts, savings fees, refunds, or
19 amounts received from providers and facili-
20 ties, including the amounts that will be re-
21 tained by the covered service provider as a
22 fee;

23 “(bb) the amount and form of fees ex-
24 pected to be received from other service
25 providers in relation to the covered plan,

1 including the amounts that will be retained
2 by the covered service provider as a fee;
3 and

4 “(cc) the amount and form of ex-
5 pected recoveries by the covered service
6 provider, including the amounts that will
7 be retained by the covered service provider
8 as a fee (disaggregated by category), as a
9 result of—

10 “(AA) overpayments;

11 “(BB) erroneous payments;

12 “(CC) uncashed checks or incom-
13 plete payments;

14 “(DD) billing errors;

15 “(EE) subrogation;

16 “(FF) fraud; or

17 “(GG) any other reason on behalf
18 of the covered plan.”.

19 (B) ANNUAL DISCLOSURE.—Clause (v) of
20 section 408(b)(2)(B) of such Act (29 U.S.C.
21 1108(b)(2)(B)), as amended by paragraph
22 (2)(B), is amended by adding at the end the
23 following:

24 “(IV) A covered service provider, with re-
25 spect to a contract or arrangement with the

1 covered plan in connection with providing third
2 party administration services for group health
3 plans, shall disclose, on an annual basis not
4 later than 60 days after the beginning of the
5 current plan year, to a responsible plan fidu-
6 ciary, in writing, the following with respect to
7 the twelve months preceding the current plan
8 year:

9 “(aa) All direct compensation de-
10 scribed in subclause (III) of clause (iii).

11 “(bb) All indirect compensation de-
12 scribed in subclause (IV) of clause (iii) re-
13 ceived by the covered service provider, an
14 affiliate, or a subcontractor (including such
15 compensation described in subclause (VIII)
16 of clause (iii)).

17 “(cc) The aggregate amount for which
18 the covered service provider, an affiliate, or
19 a subcontractor received indirect com-
20 pensation and the estimated amount of
21 cost-sharing incurred by plan participants
22 and beneficiaries as a result.

23 “(dd) The total gross spending by the
24 covered plan on all costs and fees arising
25 under or paid under the administrative

1 services agreement with the covered service
2 provider (not including any amounts de-
3 scribed in items (aa) through (cc) of clause
4 (iii)(VIII)).

5 “(ee) The total net spending by the
6 covered plan on all costs and fees arising
7 under or paid under the administrative
8 services agreement with the covered service
9 provider.

10 “(ff) The aggregate fees collected by
11 the covered service provider, an affiliate, or
12 a subcontractor.

13 “(gg) Any other information specified
14 by the Secretary through regulations or
15 guidance that may be necessary for a re-
16 sponsible plan fiduciary to consider the
17 merits of the contract or arrangement with
18 the covered service provider and any con-
19 flicts of interest that may exist.”.

20 (C) THIRD PARTY ADMINISTRATION SERV-
21 ICES FOR GROUP HEALTH PLANS DEFINED.—
22 Clause (ii)(I) of section 408(b)(2)(B) of such
23 Act (29 U.S.C. 1108(b)(2)(B)), as amended by
24 paragraph (2)(C), is amended by adding at the
25 end the following:

1 “(ii) The term ‘third party adminis-
2 tration services for group health plans’ in-
3 cludes any services provided by a covered
4 service provider, an affiliate, or a subcon-
5 tractor to a covered plan with respect to
6 the administration of health benefits under
7 the covered plan, including—

8 “(AA) the processing, repricing,
9 and payment of claims;

10 “(BB) design, creation, and
11 maintenance of provider networks;

12 “(CC) negotiation of discounts
13 off gross rates;

14 “(DD) benefit and plan design;

15 “(EE) negotiation of payment
16 rates;

17 “(FF) recordkeeping;

18 “(GG) utilization review;

19 “(HH) adjudication of claims;

20 “(II) regulatory compliance; and

21 “(JJ) any other services set forth
22 in an administrative services agree-
23 ment or similar agreement or specified
24 by the Secretary through rule-
25 making.”.

1 (4) RULE OF CONSTRUCTION.—Nothing in the
2 amendments made by this section shall be construed
3 to imply that a practice in relation to which a cov-
4 ered service provider is required to provide informa-
5 tion as a result of such amendments is permissible
6 under Federal law.

7 (5) EFFECTIVE DATE.—No contract or ar-
8 rangement entered into prior to January 1, 2025,
9 shall be subject to the requirements of subsection
10 (b).

11 (c) PRIVACY REQUIREMENTS.—Section 408(b)(2) of
12 the Employee Retirement Income Security Act of 1974
13 (29 U.S.C. 1108(b)(2)), as amended by section 401, is
14 further amended by adding at the end the following:

15 “(D) PRIVACY REQUIREMENTS.—Covered serv-
16 ice providers shall provide information under sub-
17 paragraph (B) in a manner consistent with the pri-
18 vacy, security, and breach notification regulations
19 promulgated under section 13402(a) of the Health
20 Information Technology for Clinical Health Act (42
21 U.S.C. 17932(a)), and consistent with the HIPAA
22 privacy regulations (as defined in section 1180(b)(3)
23 of the Social Security Act) and shall restrict the use
24 and disclosure of such information according to such

1 privacy, security, and breach notification regulations
2 and such HIPAA privacy regulations.

3 “(E) DISCLOSURE AND REDISCLOSURE.—

4 “(i) LIMITATION TO BUSINESS ASSOCI-
5 ATES.—A responsible plan fiduciary receiving
6 information disclosed under subparagraph (B)
7 may disclose such information only to the entity
8 from which the information was received, the
9 group health plan for which the information
10 pertains, or to that entity’s business associates
11 as defined in section 160.103 of title 45, Code
12 of Federal Regulations (or successor regula-
13 tions) or as permitted by the HIPAA Privacy
14 Rule (45 CFR parts 160 and 164, subparts A
15 and E).

16 “(ii) CLARIFICATION REGARDING PUBLIC
17 DISCLOSURE OF INFORMATION.—Nothing in
18 this section shall prevent a group health plan or
19 health insurance issuer offering group health
20 insurance coverage, or a covered service pro-
21 vider, from placing reasonable restrictions on
22 the public disclosure of the information de-
23 scribed in this subparagraph, except that such
24 plan, issuer, or entity may not restrict dislo-

1 sure of such information to the Department of
2 Labor.

3 “(F) ADDITIONAL PRIVACY REQUIREMENTS.—

4 “(i) IN GENERAL.—Covered service pro-
5 viders shall ensure that information provided
6 under subparagraph (B) contains only summary
7 health information, as defined in section
8 164.504(a) of title 45, Code of Federal Regula-
9 tions (or successor regulations).

10 “(ii) RESTRICTIONS.—A group health plan
11 must comply with section 164.504(f) of title 45,
12 Code of Federal Regulations and a responsible
13 plan administrator who is a plan sponsor must
14 act in accordance with the terms of the agree-
15 ment described in such section.

16 “(G) RULE OF CONSTRUCTION.—Nothing in
17 this section shall be construed to modify the require-
18 ments for the creation, receipt, maintenance, or
19 transmission of protected health information under
20 the HIPAA privacy regulations (as defined in sec-
21 tion 1180(b)(3) of the Social Security Act).”.

22 (d) IMPLEMENTATION.—Not later than 1 year after
23 the date of enactment of this Act, the Secretary of Labor
24 shall issue notice and comment rulemaking as necessary

1 to implement the provisions of this section. The Secretary
2 shall ensure that such rulemaking—

3 (1) accounts for the varied compensation prac-
4 tices of covered service providers (as defined under
5 section 408(b)(2)(B); and

6 (2) establishes standards for the disclosure of
7 expected compensation by such covered service pro-
8 viders.

9 **SEC. 403. PRESCRIPTION DRUG PRICE INFORMATION RE-**
10 **QUIREMENT.**

11 (a) PHSA.—

12 (1) IN GENERAL.—Part D of title XXVII of the
13 Public Health Service Act, as amended by section
14 106, is further amended by adding at the end the
15 following new section:

16 **“SEC. 2799A–12. INFORMATION ON PRESCRIPTION DRUGS.**

17 “(a) IN GENERAL.—A group health plan or a health
18 insurance issuer offering group or individual health insur-
19 ance coverage shall—

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

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

5 “(2) ensure that any entity that provides phar-
6 macy benefits management services under a contract
7 with any such health plan or health insurance cov-
8 erage does not, with respect to such plan or cov-
9 erage, restrict, directly or indirectly, a pharmacy
10 that dispenses a prescription drug from informing
11 (or penalize such pharmacy for informing) an en-
12 rollee of any differential between the enrollee’s out-
13 of-pocket cost under such plan or coverage with re-
14 spect to acquisition of the drug and the amount an
15 individual would pay for acquisition of the drug
16 without using any group health plan or health insur-
17 ance coverage.

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

24 (2) CONFORMING AMENDMENT.—Section 2729
25 of the Public Health Service Act (42 U.S.C. 300gg–

1 29) is amended by adding at the end the following
2 new subsection:

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

6 (b) ERISA.—

7 (1) IN GENERAL.—Subpart B of part 7 of Sub-
8 title B of title I of the Employee Retirement Income
9 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
10 amended by section 106, is further amended by add-
11 ing at the end the following new section:

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

13 “(a) IN GENERAL.—A group health plan or a health
14 insurance issuer offering group health insurance coverage
15 shall—

16 “(1) not restrict, directly or indirectly, any
17 pharmacy that dispenses a prescription drug to a
18 participant or beneficiary in the plan or coverage
19 from informing (or penalize such pharmacy for in-
20 forming) a participant or beneficiary of any differen-
21 tial between the participant’s or beneficiary’s out-of-
22 pocket cost under the plan or coverage with respect
23 to acquisition of the drug and the amount an indi-
24 vidual would pay for acquisition of the drug without

1 using any group health plan or health insurance cov-
2 erage; and

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

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

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

1 as amended by section 106, is further amended by
2 inserting after the item relating to section 726 the
3 following new item:

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

4 (c) IRC.—

5 (1) IN GENERAL.—Subchapter B of chapter
6 100 of the Internal Revenue Code of 1986, as
7 amended by section 106, is further amended by add-
8 ing at the end the following:

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

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

11 “(1) not restrict, directly or indirectly, any
12 pharmacy that dispenses a prescription drug to a
13 participant or beneficiary in the plan from informing
14 (or penalize such pharmacy for informing) a partici-
15 pant or beneficiary of any differential between the
16 participant’s or beneficiary’s out-of-pocket cost
17 under the plan with respect to acquisition of the
18 drug and the amount an individual would pay for ac-
19 quisition of the drug without using any group health
20 plan or health insurance coverage; and

21 “(2) ensure that any entity that provides phar-
22 macy benefits management services under a contract
23 with any such plan does not, with respect to such
24 plan or coverage, restrict, directly or indirectly, a
25 pharmacy that dispenses a prescription drug from

1 informing (or penalize such pharmacy for informing)
2 a participant or beneficiary of any differential be-
3 tween the participant's or beneficiary's out-of-pocket
4 cost under the plan with respect to acquisition of the
5 drug and the amount an individual would pay for ac-
6 quisition of the drug without using any group health
7 plan or health insurance coverage.

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

14 (2) CLERICAL AMENDMENT.—The table of sec-
15 tions for subchapter B of chapter 100 of the Inter-
16 nal Revenue Code of 1986, as amended by section
17 106, is further amended by adding at the end the
18 following new item:

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

19 **SEC. 404. IMPLEMENTATION FUNDING.**

20 (a) IN GENERAL.—For the purposes described in
21 subsection (b), and in addition to amounts otherwise avail-
22 able for such purposes there are appropriated, out of
23 amounts in the Treasury not otherwise appropriated, to
24 the Secretary of Labor \$35,000,000, for fiscal year 2024,
25 to remain available through fiscal year 2029.

1 (b) PERMITTED PURPOSES.—The purposes described
2 in this subsection are limited to the following purposes,
3 insofar as such purposes are to carry out the provisions
4 of, including the amendments made by, title I and IV:

5 (1) Preparing, drafting, and issuing proposed
6 and final regulations or interim regulations.

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

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

10 (4) Enforcement of such provisions.

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

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

14 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—

15 The Secretary of Labor shall annually submit, no later
16 than September 1st of each year, to the Committees on
17 Education and Workforce and on Appropriations of the
18 House of Representatives and the Committees on Health,
19 Education, Labor, and Pensions and on Appropriations of
20 the Senate a report on funds expended pursuant to funds
21 appropriated under this section.