

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 9645
OFFERED BY MR. SMITH OF MISSOURI**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Health Care Price Cer-
3 tainty for All Americans Act”.

**4 SEC. 2. REQUIRING CERTAIN FACILITIES UNDER THE MEDI-
5 CARE PROGRAM TO DISCLOSE CERTAIN IN-
6 FORMATION RELATING TO CHARGES AND
7 PRICES.**

8 (a) IN GENERAL.—Part E of title XVIII of the Social
9 Security Act (42 U.S.C. 1395x et seq.) is amended by add-
10 ing at the end the following new section:

**11 “SEC. 1899D. HEALTH CARE PROVIDER PRICE TRANS-
12 PARENCY.**

13 “(a) HOSPITALS.—

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

1 “(2) REQUIREMENT DESCRIBED.—

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

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

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

19 “(II) information—

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

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

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

17 “(ii) post in a publicly accessible loca-
18 tion of such hospital (in a form and man-
19 ner specified by the Secretary) the dis-
20 counted cash price, as applicable, expressed
21 as a dollar amount, for each Centers for
22 Medicare & Medicaid Services-specified
23 shoppable service that is furnished by the
24 hospital when provided in, as applicable,
25 the inpatient setting and outpatient de-

1 partment setting (or, in the case no dis-
2 counted cash price is available for such
3 service, the median cash price charged by
4 the hospital to self-pay individuals for such
5 service when provided in such settings for
6 the previous three years, expressed as a
7 dollar amount); and

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

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

23 “(i) A plain language description (as
24 specified by the Secretary) of each item or
25 service, accompanied by, as applicable,

1 commonly recognized billing code sets, in-
2 cluding the Healthcare Common Procedure
3 Coding System code, the diagnosis-related
4 group, the national drug code, or other ap-
5 plicable identifier determined appropriate
6 by the Secretary.

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

10 “(I) the gross charge, as applica-
11 ble, expressed as a dollar amount;

12 “(II) each payer-specific nego-
13 tiated charge in effect between such
14 hospital and a third party payer, ex-
15 pressed as a dollar amount;

16 “(III) the deidentified maximum
17 and minimum payer-specific nego-
18 tiated charges in effect between such
19 hospital and any third party payer;
20 and

21 “(IV) the discounted cash price,
22 as applicable, expressed as a dollar
23 amount (or, in the case no discounted
24 cash price is available for such item or
25 service, the median cash price charged

1 by the hospital (not including charity
2 care) to self-pay individuals for such
3 item or service when provided in such
4 settings for the previous three years,
5 expressed as a dollar amount).

6 “(iii) With respect to prices made
7 public pursuant to subparagraph (A)(ii), a
8 link to a consumer-friendly document that
9 clearly explains the hospital’s charity care
10 policy that includes, if applicable, any slid-
11 ing scale payment structure employed for
12 determining prices.

13 “(iv) Any other additional information
14 the Secretary may require (in consultation
15 with stakeholders) for the purpose of im-
16 proving the accuracy of, or enabling con-
17 sumers to easily understand and compare,
18 standard charges and prices for an item or
19 service (which may include, in the case
20 that charges described in clause (iii) for an
21 item or service are unable to be expressed
22 as a dollar amount, such information relat-
23 ing to past allowed charges for such item
24 or service as may be specified by the Sec-
25 retary), except information that is duplica-

1 tive of any other reporting requirement
2 under this subsection.

3 In the case of standard charges and prices for
4 an item or service included as part of a bun-
5 dled, per diem, episodic, or other similar ar-
6 rangement, the information described in this
7 subparagraph shall be made available as deter-
8 mined appropriate by the Secretary.

9 “(C) UNIFORM METHOD AND FORMAT.—
10 Not later than January 1, 2028, the Secretary
11 shall establish a standard, uniform method and
12 format for specified hospitals to use in com-
13 piling and making public standard charges pur-
14 suant to subparagraph (A)(i)(I) and a stand-
15 ard, uniform method and format for such hos-
16 pitals to use in compiling and making public
17 prices pursuant to subparagraph (A)(i)(II).
18 Such methods and formats—

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

21 “(I) standard charges pursuant
22 to subparagraph (A)(i)(I), ensure that
23 such charges are made available in a
24 machine-readable format (or a suc-

1 cessor technology specified by the Sec-
2 retary); and

3 “(II) prices pursuant to subpara-
4 graph (A)(i)(II), ensure that such
5 prices are made available in a con-
6 sumer-friendly format (as specified by
7 the Secretary);

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

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

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

19 “(D) DEEMED COMPLIANCE WITH
20 SHOPPABLE SERVICES REQUIREMENT FOR HOS-
21 PITALS WITH A PRICE ESTIMATOR TOOL.—

22 “(i) IN GENERAL.—Before the effec-
23 tive date of regulations implementing the
24 provisions of sections 2799A–1(f) and
25 2799B–6 of the Public Health Service Act

1 (relating to advanced explanations of bene-
2 fits), including regulations on establishing
3 data transfer standards to effectuate such
4 provisions, a specified hospital shall be
5 deemed to have compiled and made public
6 information described in subparagraph
7 (A)(i)(II) (relating to shoppable services)
8 in accordance with a method and format
9 specified by the Secretary under subpara-
10 graph (C) if such hospital maintains a
11 price estimator tool described in clause (ii).

12 “(ii) PRICE ESTIMATOR TOOL DE-
13 SCRIBED.—For purposes of clause (i), a
14 price estimator tool described in this sub-
15 paragraph is, with respect to a specified
16 hospital, a tool that meets the following re-
17 quirements:

18 “(I) Such tool allows an indi-
19 vidual to immediately obtain a price
20 estimate (taking into account whether
21 such individual is covered under any
22 plan, coverage, or program described
23 in subclause (IV)(cc)) and the dis-
24 counted cash price charged by a speci-
25 fied hospital for each Centers for

1 Medicare & Medicaid Services-specified shoppable service that is furnished by such hospital, and for each
2 additional shoppable service as such
3 hospital may select, such that price
4 estimates are available through such
5 tool for at least 300 shoppable services (or for all such services, if such
6 hospital furnishes fewer than 300
7 shoppable services).

11 “(II) Such tool allows an individual to obtain such an estimate by
12 billing code and by service description.

14 “(III) Such tool is prominently displayed on the public internet
15 website of such hospital.

17 “(IV) Such tool does not require
18 an individual seeking such an estimate
19 to create an account or otherwise
20 input personal information, except
21 that such tool may require that such
22 individual provide information specified by the Secretary, which may include the following:

1 “(aa) The name of such in-
2 dividual.

3 “(bb) The date of birth of
4 such individual.

5 “(cc) In the case such indi-
6 vidual is covered under a group
7 health plan, group or individual
8 health insurance coverage, a Fed-
9 eral health care program, or the
10 program established under chap-
11 ter 89 of title 5, United States
12 Code, an identifying number as-
13 signed by such plan, coverage, or
14 program to such individual.

15 “(dd) In the case of an indi-
16 vidual described in item (cc), an
17 indication as to whether such in-
18 dividual is the primary insured
19 individual under such plan, cov-
20 erage, or program (and, if such
21 individual is not the primary in-
22 sured individual, a description of
23 the individual’s relationship to
24 such primary insured individual).

1 “(ee) Any other information
2 specified by the Secretary.

3 “(V) Such tool contains a state-
4 ment confirming the accuracy and
5 completeness of information presented
6 through such tool as of the date such
7 request is made.

8 “(VI) Such tool meets any other
9 requirement specified by the Sec-
10 retary.

11 “(3) MONITORING COMPLIANCE.—The Sec-
12 retary shall establish processes to monitor and as-
13 sess specified hospitals’ compliance with this sub-
14 section. Such processes shall ensure that each speci-
15 fied hospital’s compliance with this subsection is re-
16 viewed not less frequently than once every 3 years
17 and include processes relating to the following:

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

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

24 “(C) The obtaining of additional informa-
25 tion from such hospitals to determine such hos-

1 pitals’ compliance with this subsection (as de-
2 termined appropriate by the Secretary).

3 “(4) ENFORCEMENT.—

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

7 “(i) not later than 30 days after the
8 date on which the Secretary determines
9 such failure exists, the Secretary shall sub-
10 mit to such hospital a notification of such
11 determination (which may include, as de-
12 termined appropriate by the Secretary, a
13 request for a corrective action plan (to be
14 submitted not later than 45 days after
15 such request is made) to comply with such
16 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 60 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 be submitted not
9 later than 45 days after such re-
10 quest is made) to comply with
11 such requirements; or

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

19 “(B) CIVIL MONETARY PENALTY.—

20 “(i) IN GENERAL.—Subject to clause
21 (vii), in addition to any other enforcement
22 actions or penalties that may apply under
23 another provision of Federal law, a speci-
24 fied hospital that has received a request
25 for a corrective action plan under clause (i)

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

20 “(I) in the case of a specified
21 hospital with 30 or fewer beds, \$342
22 per day;

23 “(II) in the case of a specified
24 hospital with more than 30 beds but

1 fewer than 550 beds, \$11 per bed per
2 day; and

3 “(III) in the case of a specified
4 hospital with 550 beds or more,
5 \$6,277 per day.

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

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

16 “(II) the limitations on the per
17 bed per day amount of any penalty
18 applicable under clause (i)(II); and

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

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

23 “(I) IN GENERAL.—In the case
24 of a specified hospital (other than a
25 specified hospital with 30 or fewer

1 beds) that the Secretary has deter-
2 mined to be knowingly and willfully
3 noncompliant with the provisions of
4 this subsection for two or more 6-
5 month periods during any 3-year pe-
6 riod, the Secretary may increase any
7 penalty otherwise applicable under
8 this subparagraph by the amount
9 specified in subclause (II) with respect
10 to such hospital and may require such
11 hospital to complete such additional
12 corrective actions plans as the Sec-
13 retary may specify.

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

18 “(aa) with more than 30
19 beds but fewer than 101 beds, an
20 amount that is not less than
21 \$500,000 and not more than
22 \$1,000,000;

23 “(bb) with more than 100
24 beds but fewer than 301 beds, an
25 amount that is greater than

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

3 “(cc) with more than 300
4 beds but fewer than 501 beds, an
5 amount that is greater than
6 \$2,000,000 and not more than
7 \$4,000,000; and

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

12 “(iv) AUTHORITY TO WAIVE OR RE-
13 DUCE PENALTY.—

14 “(I) IN GENERAL.—Subject to
15 subclause (II), the Secretary may
16 waive any penalty, or reduce any pen-
17 alty by not more than 75 percent, oth-
18 erwise applicable under this subpara-
19 graph with respect to a specified hos-
20 pital located in a rural area (as de-
21 fined by the Federal Office of Rural
22 Health Policy for the purpose of rural
23 health grant programs administered
24 by such Office) or an underserved
25 area if the Secretary determines that

1 imposition of such penalty would re-
2 sult in an immediate threat to access
3 to care for individuals in the service
4 area of such hospital.

5 “(II) LIMITATION ON APPLICA-
6 TION.—The Secretary may not elect
7 to waive a penalty under subclause (I)
8 with respect to a specified hospital
9 more than once in a 6-year period and
10 may not elect to reduce such a penalty
11 with respect to such a hospital more
12 than once in such a period. Nothing
13 in the preceding sentence shall be con-
14 strued as prohibiting the Secretary
15 from both waiving and reducing a
16 penalty with respect to a specified
17 hospital during a 6-year period.

18 “(v) HARDSHIP EXEMPTION.—Not-
19 withstanding any limit on the waiver or re-
20 duction of a penalty under clause (iv), the
21 Secretary may waive any penalty with re-
22 spect to a specified hospital on a case-by-
23 case basis if the Secretary determines that
24 a circumstance exists interfering with such
25 hospital’s ability to comply with the provi-

1 sions of this subsection (such as a natural
2 disaster (as defined in section 602(a) of
3 the Robert T. Stafford Disaster Relief and
4 Emergency Assistance Act), a public health
5 emergency, or other unique or unexpected
6 event).

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

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

21 “(C) PUBLICATION OF HOSPITAL PRICE
22 TRANSPARENCY INFORMATION.—Beginning on
23 January 1, 2028, the Secretary shall make pub-
24 licly available on the website of the Centers for
25 Medicare & Medicaid Services information with

1 respect to compliance with the requirements of
2 this subsection and enforcement activities un-
3 dertaken by the Secretary under this sub-
4 section. Such information shall be updated in
5 real time (if practicable) and include—

6 “(i) the number of reviews of compli-
7 ance with this subsection undertaken by
8 the Secretary;

9 “(ii) the number of notifications de-
10 scribed in subparagraph (A)(i) sent by the
11 Secretary;

12 “(iii) the identity of each specified
13 hospital that was sent such a notification
14 and a description of the nature of such
15 hospital’s noncompliance with this sub-
16 section;

17 “(iv) the amount of any civil monetary
18 penalty imposed on such hospital under
19 subparagraph (B);

20 “(v) whether such hospital subse-
21 quently came into compliance with this
22 subsection;

23 “(vi) any waivers or reductions of
24 penalties made pursuant to a certification

1 by the Secretary under subparagraph
2 (B)(iv), including—

3 “(I) the name of any specified
4 hospital that received such a waiver or
5 reduction;

6 “(II) the dollar amount of each
7 such penalty so waived or reduced;
8 and

9 “(III) the rationale for the grant-
10 ing of each such waiver or reduction,
11 but only to the extent that such ra-
12 tionale does not make public commer-
13 cially sensitive information; and

14 “(vii) any other information as deter-
15 mined by the Secretary.

16 “(b) CLINICAL DIAGNOSTIC LABORATORY SERV-
17 ICES.—

18 “(1) IN GENERAL.—Beginning January 1,
19 2028, any applicable laboratory that receives pay-
20 ment under this title for furnishing any specified
21 clinical diagnostic laboratory test under this title
22 shall—

23 “(A) make publicly available, in accordance
24 with a method and format established by the
25 Secretary under paragraph (3), the information

1 described in paragraph (2) with respect to each
2 such specified clinical diagnostic laboratory test
3 that such laboratory so furnishes;

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

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

13 “(D) post in a publicly accessible location
14 of such laboratory (in a form and manner speci-
15 fied by the Secretary) the discounted cash price,
16 as applicable, expressed as a dollar amount, for
17 each Centers for Medicare & Medicaid Services-
18 specified shoppable service that is furnished by
19 the laboratory (or, in the case no discounted
20 cash price is available for such service, the me-
21 dian cash price charged by the laboratory to
22 self-pay individuals for such service for the pre-
23 vious three years, expressed as a dollar
24 amount).

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

7 “(3) UNIFORM METHOD AND FORMAT.—Not
8 later than January 1, 2028, the Secretary shall es-
9 tablish a standard, uniform method and format for
10 applicable laboratories to use in compiling and mak-
11 ing public information pursuant to paragraph (1).
12 Such method and format—

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

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

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

24 “(4) INCLUSION OF ANCILLARY SERVICES.—
25 Any price or charge for a specified clinical diagnostic

1 laboratory test furnished by an applicable laboratory
2 made publicly available in accordance with para-
3 graph (1) shall include the price or charge (as appli-
4 cable) for any ancillary item or service (such as
5 specimen collection services) that would normally be
6 furnished by such laboratory as part of such test, as
7 specified by the Secretary.

8 “(5) MONITORING COMPLIANCE.—The Sec-
9 retary shall, through notice and comment rule-
10 making, establish a process to monitor compliance
11 with this subsection.

12 “(6) ENFORCEMENT.—

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

17 “(i) not later than 30 days after such
18 determination, the Secretary shall notify
19 such laboratory of such determination
20 (which may include, as determined appro-
21 priate by the Secretary, a request for a
22 corrective action plan (to be submitted not
23 later than 45 days after such request is
24 made)); and

1 “(ii) in the case of a laboratory that
2 does not receive a request for a corrective
3 action plan as part of a notification under
4 clause (i)—

5 “(I) the Secretary shall, not later
6 than 90 days after such notification is
7 sent, determine whether such labora-
8 tory is in compliance with such re-
9 quirements; and

10 “(II) if the Secretary determines
11 under subclause (I) that such labora-
12 tory is not in compliance with such re-
13 quirements, the Secretary shall ei-
14 ther—

15 “(aa) submit to such labora-
16 tory a request for a corrective ac-
17 tion plan (to be submitted not
18 later than 45 days after such re-
19 quest is made) to comply with
20 such requirements; or

21 “(bb) if the Secretary deter-
22 mines that such laboratory has
23 not taken meaningful actions to
24 come into compliance since such
25 notification was sent, impose a

1 civil monetary penalty in accord-
2 ance with subparagraph (B).

3 “(B) CIVIL MONETARY PENALTY.—An ap-
4 plicable laboratory that has received a request
5 for a corrective action plan under clause (i) or
6 (ii) of subparagraph (A) and fails to comply
7 with the requirements of paragraph (1) by the
8 date that is 90 days after such request is made,
9 and an applicable laboratory with respect to
10 which the Secretary has made a determination
11 described in clause (ii)(II)(bb) of such subpara-
12 graph, shall be subject to a civil monetary pen-
13 alty in an amount not to exceed \$300 for each
14 day (beginning with the day on which the Sec-
15 retary first determined that such hospital was
16 not complying with such requirements) during
17 which such failure was ongoing.

18 “(C) INCREASE AUTHORITY.—In applying
19 this paragraph with respect to failures to com-
20 ply occurring in 2029 or a subsequent year, the
21 Secretary may through notice and comment
22 rulemaking increase the per day limitation on
23 civil monetary penalties under subparagraph
24 (B).

1 “(D) APPLICATION OF CERTAIN PROVI-
2 SIONS.—The provisions of section 1128A (other
3 than subsections (a) and (b) of such section)
4 shall apply to a civil monetary penalty imposed
5 under this paragraph in the same manner as
6 such provisions apply to a civil monetary pen-
7 alty imposed under subsection (a) of such sec-
8 tion.

9 “(E) AUTHORITY TO WAIVE OR REDUCE
10 PENALTY.—

11 “(i) IN GENERAL.—Subject to clause
12 (ii), the Secretary may waive or reduce any
13 penalty otherwise applicable with respect to
14 an applicable laboratory under this para-
15 graph if the Secretary determines that im-
16 position of such penalty would result in an
17 immediate threat to access to care for indi-
18 viduals in the service area of such labora-
19 tory.

20 “(ii) LIMITATION.—The Secretary
21 may not elect to waive or reduce a penalty
22 under clause (i) with respect to an applica-
23 ble laboratory more than 3 times in a 10
24 year period.

1 “(F) HARDSHIP EXEMPTION.—Notwith-
2 standing any limit on the waiver or reduction of
3 a penalty under subparagraph (E), the Sec-
4 retary may waive any penalty with respect to an
5 applicable laboratory on a case-by-case basis if
6 the Secretary determines that a circumstance
7 exists interfering with such laboratory’s ability
8 to comply with the provisions of this subsection
9 (such as a natural disaster (as defined in sec-
10 tion 602(a) of the Robert T. Stafford Disaster
11 Relief and Emergency Assistance Act), a public
12 health emergency, or other unique or unex-
13 pected event).

14 “(7) PROVISION OF TECHNICAL ASSISTANCE.—
15 The Secretary shall, to the extent practicable, pro-
16 vide technical assistance relating to compliance with
17 the provisions of this subsection to applicable labora-
18 tories requesting such assistance.

19 “(8) DEFINITIONS.—In this subsection:

20 “(A) APPLICABLE LABORATORY.—The
21 term ‘applicable laboratory’ has the meaning
22 given such term in section 414.502, of title 42,
23 Code of Federal Regulations (or a successor
24 regulation), except that such term does not in-
25 clude a laboratory with respect to which stand-

1 ard charges and prices for specified clinical di-
2 agnostic laboratory tests furnished by such lab-
3 oratory are made available by—

4 “(i) a specified hospital pursuant to
5 subsection (a); or

6 “(ii) an ambulatory surgical center
7 pursuant to subsection (d).

8 “(B) SPECIFIED CLINICAL DIAGNOSTIC
9 LABORATORY TEST.—the term ‘specified clinical
10 diagnostic laboratory test’ means a clinical di-
11 agnostic laboratory test that is included on the
12 list of shoppable services specified by the Cen-
13 ters for Medicare & Medicaid Services (as de-
14 scribed in subsection (a)(2)(A)(i)(II)), other
15 than an advanced diagnostic laboratory test (as
16 defined in section 1834A(d)(5)).

17 “(c) IMAGING SERVICES.—

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

1 pursuant to subsection (a) or an ambulatory surgical
2 center pursuant to subsection (d), shall—

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

9 “(B) updated such information not less
10 frequently than annually (or at such greater
11 frequency as the Secretary may specify);

12 “(C) submit to the Secretary on an annual
13 basis an attestation, signed by the chief execu-
14 tive officer, chief financial officer, or other com-
15 parable official (as specified by the Secretary)
16 of such provider or supplier, that all such infor-
17 mation is complete and accurate; and

18 “(D) post in a publicly accessible location
19 of such provider or supplier (in a form and
20 manner specified by the Secretary) the dis-
21 counted cash price, as applicable, expressed as
22 a dollar amount, for each Centers for Medicare
23 & Medicaid Services-specified shoppable service
24 that is furnished by the provider or supplier
25 (or, in the case no discounted cash price is

1 available for such service, the median cash price
2 charged by the provider or supplier to self-pay
3 individuals for such service for the previous
4 three years, expressed as a dollar amount).

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

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

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

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

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

4 “(4) MONITORING COMPLIANCE.—The Sec-
5 retary shall, through notice and comment rule-
6 making, establish a process to monitor compliance
7 with this subsection.

8 “(5) ENFORCEMENT.—

9 “(A) IN GENERAL.—In the case that the
10 Secretary determines that a provider of services
11 or supplier is not in compliance with the re-
12 quirements of paragraph (1)—

13 “(i) not later than 30 days after such
14 determination, the Secretary shall notify
15 such provider or supplier of such deter-
16 mination (which may include, as deter-
17 mined appropriate by the Secretary, a re-
18 quest for a corrective action plan (to be
19 submitted not later than 45 days after
20 such request is made)); and

21 “(ii) in the case of a provider of serv-
22 ices or supplier that does not receive a re-
23 quest for a corrective action plan as part
24 of a notification under clause (i)—

1 “(I) the Secretary shall, not later
2 than 90 days after such notification is
3 sent, determine whether such provider
4 or supplier is in compliance with such
5 requirements; and

6 “(II) if the Secretary determines
7 under subclause (I) that such provider
8 or supplier is not in compliance with
9 such requirements, the Secretary shall
10 either—

11 “(aa) submit to such pro-
12 vider or supplier a request for a
13 corrective action plan (to be sub-
14 mitted not later than 45 days
15 after such request is made) to
16 comply with such requirements;
17 or

18 “(bb) if the Secretary deter-
19 mines that such provider or sup-
20 plier has not taken meaningful
21 actions to come into compliance
22 since such notification was sent,
23 impose a civil monetary penalty
24 in accordance with subparagraph
25 (B).

1 “(B) CIVIL MONETARY PENALTY.—A pro-
2 vider of services or supplier that has received a
3 request for a corrective action plan under clause
4 (i) or (ii) of subparagraph (A) and fails to com-
5 ply with the requirements of paragraph (1) by
6 the date that is 90 days after such request is
7 made, and a provider of services or supplier
8 with respect to which the Secretary has made
9 a determination described in clause (ii)(II)(bb)
10 of such subparagraph, shall be subject to a civil
11 monetary penalty in an amount not to exceed
12 \$300 for each day (beginning with the day on
13 which the Secretary first determined that such
14 provider or supplier was not complying with
15 such requirements) during which such failure
16 was ongoing.

17 “(C) INCREASE AUTHORITY.—In applying
18 this paragraph with respect to failures to com-
19 ply occurring in 2029 or a subsequent year, the
20 Secretary may through notice and comment
21 rulemaking increase the amount of the civil
22 monetary penalty under subparagraph (B).

23 “(D) APPLICATION OF CERTAIN PROVI-
24 SIONS.—The provisions of section 1128A (other
25 than subsections (a) and (b) of such section)

1 shall apply to a civil monetary penalty imposed
2 under this paragraph in the same manner as
3 such provisions apply to a civil monetary pen-
4 alty imposed under subsection (a) of such sec-
5 tion.

6 “(E) AUTHORITY TO WAIVE OR REDUCE
7 PENALTY.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii), the Secretary may waive or reduce any
10 penalty otherwise applicable with respect to
11 a provider of services or supplier under
12 this paragraph if the Secretary determines
13 that imposition of such penalty would re-
14 sult in an immediate threat to access to
15 care for individuals in the service area of
16 such provider or supplier.

17 “(ii) LIMITATION.—The Secretary
18 may not elect to waive or reduce a penalty
19 under clause (i) with respect to a specific
20 provider of services or supplier more than
21 3 times in a 10 year period.

22 “(F) HARDSHIP EXEMPTION.—Notwith-
23 standing any limit on the waiver or reduction of
24 a penalty under subpagraph (E), the Secretary
25 may waive any penalty with respect to a pro-

1 vider of services or supplier on a case-by-case
2 basis if the Secretary determines that a cir-
3 cumstance exists interfering with such pro-
4 vider’s or supplier’s ability to comply with the
5 provisions of this subsection (such as a natural
6 disaster (as defined in section 602(a) of the
7 Robert T. Stafford Disaster Relief and Emer-
8 gency Assistance Act), a public health emer-
9 gency, or other unique or unexpected event).

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

16 “(6) DEFINITION.—In this subsection, the term
17 ‘specified imaging service’ means an imaging service
18 that is included on the list of Centers for Medicare
19 & Medicaid Services-specified shoppable services (as
20 described in subsection (a)(i)(II)).

21 “(d) AMBULATORY SURGICAL CENTERS.—

22 “(1) IN GENERAL.—Beginning January 1,
23 2028, each ambulatory surgical center that receives
24 payment under this title for furnishing items and

1 services shall comply with the price transparency re-
2 quirement described in paragraph (2).

3 “(2) REQUIREMENT DESCRIBED.—

4 “(A) IN GENERAL.—For purposes of para-
5 graph (1), the price transparency requirement
6 described in this subsection is, with respect to
7 an ambulatory surgical center, that such cen-
8 ter—

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

17 “(I) all of the ambulatory sur-
18 gical center’s standard charges (in-
19 cluding the information described in
20 subparagraph (B)) for each item and
21 service furnished by such surgical cen-
22 ter;

23 “(II) information on the ambula-
24 tory surgical center’s prices (including
25 the information described in subpara-

1 graph (B)) for as many of the Centers
2 for Medicare & Medicaid Services-
3 specified shoppable services (as speci-
4 fied by the Secretary) that are fur-
5 nished by such surgical center, and as
6 many additional ambulatory surgical
7 center-selected shoppable services (or
8 all such additional services, if such
9 surgical center furnishes fewer than
10 300 shoppable services) as may be
11 necessary for a combined total of at
12 least 300 shoppable services; and

13 “(III) with respect to each Cen-
14 ters for Medicare & Medicaid Serv-
15 ices-specified shoppable service that is
16 not furnished by the ambulatory sur-
17 gical center, an indication that such
18 service is not so furnished;

19 “(ii) submit to the Secretary on an
20 annual basis an attestation, signed by the
21 chief executive officer, chief financial offi-
22 cer, or other comparable official (as speci-
23 fied by the Secretary) of such center, that
24 all information made public pursuant to

1 this subparagraph is complete and accu-
2 rate; and

3 “(iii) post in a publicly accessible loca-
4 tion of such center (in a form and manner
5 specified by the Secretary) the discounted
6 cash price, as applicable, expressed as a
7 dollar amount, for each Centers for Medi-
8 care & Medicaid Services-specified
9 shoppable service that is furnished by the
10 center (or, in the case no discounted cash
11 price is available for such service, the me-
12 dian cash price charged by the center to
13 self-pay individuals for such service for the
14 previous three years, expressed as a dollar
15 amount).

16 “(B) INFORMATION DESCRIBED.—For pur-
17 poses of subparagraph (A), the information de-
18 scribed in this subparagraph is, with respect to
19 standard charges and prices, as applicable,
20 made public by an ambulatory surgical center,
21 the following:

22 “(i) A plain language description (as
23 specified by the Secretary) of each item or
24 service, accompanied by, as applicable,
25 commonly recognized billing code sets, in-

1 including the Healthcare Common Procedure
2 Coding System code, the national drug
3 code, or other applicable identifier deter-
4 mined appropriate by the Secretary.

5 “(ii) For each such item or service—

6 “(I) the gross charge, as applica-
7 ble, expressed as a dollar amount;

8 “(II) each payer-specific nego-
9 tiated charge in effect between such
10 center and a third party payer, ex-
11 pressed as a dollar amount;

12 “(III) the deidentified maximum
13 and minimum payer-specific nego-
14 tiated charges in effect between such
15 center and any third party payer; and

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

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

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

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

25 “(i) shall, in the case of—

1 “(I) standard charges made pub-
2 lic by an ambulatory surgical center
3 under subparagraph (A)(i), ensure
4 that such charges are made available
5 in a machine-readable format (or suc-
6 cessor technology); and

7 “(II) prices made public by an
8 ambulatory surgical center under sub-
9 paragraph (A)(ii), ensure that such
10 prices are made available in a con-
11 sumer-friendly format (as specified by
12 the Secretary);

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

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

21 “(iv) shall be updated as determined
22 appropriate by the Secretary, in consulta-
23 tion with stakeholders.

1 “(D) DEEMED COMPLIANCE WITH
2 SHOPPABLE SERVICES REQUIREMENT FOR CEN-
3 TERS WITH A PRICE ESTIMATOR TOOL.—

4 “(i) IN GENERAL.—Before the effec-
5 tive date of regulations implementing the
6 provisions of sections 2799A–1(f) and
7 2799B–6 of the Public Health Service Act
8 (relating to advanced explanations of bene-
9 fits), including regulations on establishing
10 data transfer standards to effectuate such
11 provisions, a specified hospital shall be
12 deemed to have compiled and made public
13 information described in subparagraph
14 (A)(i)(II) (relating to shoppable services)
15 in accordance with a method and format
16 specified by the Secretary under subpara-
17 graph (C) if such hospital maintains a
18 price estimator tool described in clause (ii).

19 “(ii) PRICE ESTIMATOR TOOL DE-
20 SCRIBED.—For purposes of clause (i), a
21 price estimator tool described in this sub-
22 paragraph is, with respect to an ambula-
23 tory surgical center, a tool that meets the
24 following requirements:

1 “(I) Such tool allows an indi-
2 vidual to immediately obtain a price
3 estimate (taking into account whether
4 such individual is covered under any
5 plan, coverage, or program described
6 in subclause (IV)(cc)) and the dis-
7 counted cash price charged by an am-
8 bulatory surgical center for each Cen-
9 ters for Medicare & Medicaid Serv-
10 ices-specified shoppable service that is
11 furnished by such center, and for each
12 additional shoppable service as such
13 center may select, such that price esti-
14 mates are available through such tool
15 for at least 300 shoppable services (or
16 for all such services, if such hospital
17 furnishes fewer than 300 shoppable
18 services).

19 “(II) Such tool allows an indi-
20 vidual to obtain such an estimate by
21 billing code and by service description.

22 “(III) Such tool is prominently
23 displayed on the public internet
24 website of such center.

1 “(IV) Such tool does not require
2 an individual seeking such an estimate
3 to create an account or otherwise
4 input personal information, except
5 that such tool may require that such
6 individual provide information speci-
7 fied by the Secretary, which may in-
8 clude the following:

9 “(aa) The name of such in-
10 dividual.

11 “(bb) The date of birth of
12 such individual.

13 “(cc) In the case such indi-
14 vidual is covered under a group
15 health plan, group or individual
16 health insurance coverage, a Fed-
17 eral health care program, or the
18 program established under chap-
19 ter 89 of title 5, United States
20 Code, an identifying number as-
21 signed by such plan, coverage, or
22 program to such individual.

23 “(dd) In the case of an indi-
24 vidual described in item (cc), an
25 indication as to whether such in-

1 individual is the primary insured
2 individual under such plan, cov-
3 erage, or program (and, if such
4 individual is not the primary in-
5 sured individual, a description of
6 the individual's relationship to
7 such primary insured individual).

8 “(ee) Any other information
9 specified by the Secretary.

10 “(V) Such tool contains a state-
11 ment confirming the accuracy and
12 completeness of information presented
13 through such tool as of the date such
14 request is made.

15 “(VI) Such tool meets any other
16 requirement specified by the Sec-
17 retary.

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

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

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

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

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

9 “(4) ENFORCEMENT.—

10 “(A) IN GENERAL.—In the case that the
11 Secretary determines that an ambulatory sur-
12 gical center is not in compliance with the re-
13 quirements of paragraph (1)—

14 “(i) not later than 30 days after such
15 determination, the Secretary shall notify
16 such center of such determination (which
17 may include, as determined appropriate by
18 the Secretary, a request for a corrective
19 action plan (to be submitted not later than
20 45 days after such request is made)); and

21 “(ii) in the case of an ambulatory sur-
22 gical center that does not receive a request
23 for a corrective action plan as part of a no-
24 tification under clause (i)—

1 “(I) the Secretary shall, not later
2 than 90 days after such notification is
3 sent, determine whether such center is
4 in compliance with such requirements;
5 and

6 “(II) if the Secretary determines
7 under subclause (I) that such center
8 is not in compliance with such re-
9 quirements, the Secretary shall ei-
10 ther—

11 “(aa) submit to such center
12 a request for a corrective action
13 plan (to be submitted not later
14 than 45 days after such request
15 is made) to comply with such re-
16 quirements; or

17 “(bb) if the Secretary deter-
18 mines that such center has not
19 taken meaningful actions to come
20 into compliance since such notifi-
21 cation was sent, impose a civil
22 monetary penalty in accordance
23 with subparagraph (B).

24 “(B) CIVIL MONETARY PENALTY.—

1 “(i) IN GENERAL.—An ambulatory
2 surgical center that has received a request
3 for a corrective action plan under clause (i)
4 or (ii) of subparagraph (A) and fails to
5 comply with the requirements of paragraph
6 (1) by the date that is 90 days after such
7 request is made, and an ambulatory sur-
8 gical center with respect to which the Sec-
9 retary has made a determination described
10 in clause (ii)(II)(bb) of such subparagraph,
11 shall be subject to a civil monetary penalty
12 in an amount not to exceed \$300 for each
13 day (beginning with the day on which the
14 Secretary first determined that such center
15 was not complying with such requirements)
16 during which such failure was ongoing.

17 “(ii) INCREASE AUTHORITY.—In ap-
18 plying this subparagraph with respect to
19 failures to comply occurring in 2029 or a
20 subsequent year, the Secretary may
21 through notice and comment rulemaking
22 increase the limitation on the per day
23 amount of any penalty under clause (i).

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

1 (other than subsections (a) and (b) of such
2 section) shall apply to a civil monetary
3 penalty imposed under this subparagraph
4 in the same manner as such provisions
5 apply to a civil monetary penalty imposed
6 under subsection (a) of such section.

7 “(iv) AUTHORITY TO WAIVE OR RE-
8 DUCE PENALTY.—

9 “(I) IN GENERAL.—Subject to
10 subclause (II), the Secretary may
11 waive any penalty, or reduce any pen-
12 alty by not more than 75 percent, oth-
13 erwise applicable under this subpara-
14 graph with respect to an ambulatory
15 surgical center located in a rural or
16 underserved area if the Secretary cer-
17 tifies that imposition of such penalty
18 would result in an immediate threat
19 to access to care for individuals in the
20 service area of such surgical center.

21 “(II) LIMITATION ON APPLICA-
22 TION.—The Secretary may not elect
23 to waive a penalty under subclause (I)
24 with respect to an ambulatory surgical
25 center more than once in a 6-year pe-

1 riod and may not elect to reduce such
2 a penalty with respect to such a sur-
3 gical center more than once in such a
4 period. Nothing in the preceding sen-
5 tence shall be construed as prohibiting
6 the Secretary from both waiving and
7 reducing a penalty with respect to an
8 ambulatory surgical center during a
9 6-year period.

10 “(v) HARDSHIP EXEMPTION.—Not-
11 withstanding any limit on the waiver or re-
12 duction of a penalty under clause (iv), the
13 Secretary may waive any penalty with re-
14 spect to an ambulatory surgical center on
15 a case-by-case basis if the Secretary deter-
16 mines that a circumstance exists inter-
17 fering with such center’s ability to comply
18 with the provisions of this subsection (such
19 as a natural disaster (as defined in section
20 602(a) of the Robert T. Stafford Disaster
21 Relief and Emergency Assistance Act), a
22 public health emergency, or other unique
23 or unexpected event).

24 “(5) PROVISION OF TECHNICAL ASSISTANCE.—

25 The Secretary shall, to the extent practicable, pro-

1 vide technical assistance relating to compliance with
2 the provisions of this subsection to ambulatory sur-
3 gical centers requesting such assistance.

4 “(e) ENSURING ACCESSIBILITY THROUGH IMPLE-
5 MENTATION.—In implementing this section, the Secretary
6 shall through rulemaking ensure that a provider of serv-
7 ices or supplier making public charges and prices pursuant
8 to this section takes reasonable steps (as specified by the
9 Secretary) to ensure the accessibility of such charges and
10 information to individuals with limited English pro-
11 ficiency. Such steps may include the provision of interpre-
12 tation services or the provision of translations of charges
13 and information.

14 “(f) DEFINITIONS.—For purposes of this section:

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

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

1 “(3) PAYER-SPECIFIC NEGOTIATED CHARGE.—

2 The term ‘payer-specific negotiated charge’ means
3 the charge that an applicable laboratory has nego-
4 tiated with a third party payer for an item or serv-
5 ice.

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

11 “(5) SPECIFIED HOSPITAL.—The term ‘speci-
12 fied hospital’ means a hospital (as defined in section
13 1861(e)), a critical access hospital (as defined in
14 section 1861(mmm)(1)), or a rural emergency hos-
15 pital (as defined in section 1861(kkk)).

16 “(6) THIRD PARTY PAYER.—The term ‘third
17 party payer’ means an entity that is, by statute, con-
18 tract, or agreement, legally responsible for payment
19 of a claim for an item or service.”.

20 (b) CONFORMING AMENDMENT.—Section 2718(e) of
21 the Public Health Service Act (42 U.S.C. 300gg–18(e))
22 is amended by adding at the end the following new sen-
23 tence: “The preceding provisions of this subsection shall
24 not apply beginning on January 1, 2028.”.

1 **SEC. 3. HEALTH COVERAGE PRICE TRANSPARENCY.**

2 (a) PRICE TRANSPARENCY REQUIREMENTS.—

3 (1) IRC.—

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

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

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

12 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
13 FOR PLAN YEARS BEFORE 2029.—

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

15 (iii) in subsection (a), as inserted by
16 clause (ii), by adding at the end the fol-
17 lowing new paragraph:

18 “(2) SUNSET.—Paragraph (1) shall not apply
19 with respect to plan years beginning on or after Jan-
20 uary 1, 2029.”; and

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

23 “(b) COST-SHARING TRANSPARENCY.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after January 1, 2029, a group health plan
26 shall provide a participant or beneficiary, in a timely

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

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

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

4 “(B) If such provider is not a participating
5 provider with respect to such item or service,
6 the maximum allowed amount or other dollar
7 amount that such plan will recognize as pay-
8 ment for such item or service, along with a no-
9 tice that such participant or beneficiary may be
10 liable for additional charges.

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

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

1 the plan, by such separate deductibles or maxi-
2 mums, in addition to any cumulative deductible
3 or maximum).

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

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

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

20 “(H) Other information determined appro-
21 priate by the Secretary.

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

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

4 “(B) is made available in plain language at
5 no cost;

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

8 “(D) 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 “(E) 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;

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

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

24 “(F) provides that such a request may be
25 made with respect to an item or service through

1 use of the billing code for such item or service
2 or through use of a descriptive term for such
3 item or service; and

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

9 “(c) RATE AND PAYMENT INFORMATION.—

10 “(1) IN GENERAL.—For plan years beginning
11 on or after January 1, 2029, each group health plan
12 (other than a grandfathered health plan (as defined
13 in section 1251(e) of the Patient Protection and Af-
14 fordable Care Act) or a church plan (as defined in
15 section 414(e))) shall make available to the public
16 the rate and payment information described in para-
17 graph (2) in accordance with paragraph (3).

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

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

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

13 “(ii) with respect to each such partici-
14 pating provider (other than a provider that
15 is an excluded provider with respect to
16 such item or service), an indication of
17 whether, during the 1-year period begin-
18 ning 18 months before the date such infor-
19 mation is made public, such provider sub-
20 mitted a claim for such item or service to
21 such plan for which payment was made (in
22 whole or in part) under such plan.

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

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

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

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

1 “(I) a specification that such
2 drug is such an applicable spread
3 price drug; and

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

13 “(C) With respect to each item or service
14 for which benefits are available under such
15 plan, the amount billed, and the amount al-
16 lowed by the plan, for each such item or service
17 furnished during the 6-month period beginning
18 9 months before the date such information is
19 made public by a provider that was not a par-
20 ticipating provider with respect to such item or
21 service, broken down by each such provider,
22 other than such an amount with respect to an
23 item or service for which, during such period,
24 fewer than 11 claims were made under such
25 plan. In determining the number of claims

1 made under such plan with respect to an item
2 or service during such period for purposes of
3 the preceding sentence, such number shall be
4 deemed to include all claims for such item or
5 service made during such period under all
6 group health plans offered in the same insur-
7 ance market (specified in subclause (I), (II),
8 (III), of section 9816(a)(3)(E)(iv)) by the spon-
9 sor of the plan at issue.

10 In the case that a specific dollar amount for an in-
11 network rate required to be made available pursuant
12 to this subsection with respect to an item or service
13 cannot be determined prospectively on the basis that
14 such rate is determined as a percentage of the billed
15 charges for such item or service, such percentage
16 and the median amount recognized by such plan as
17 payment for such item or service with respect to
18 claims for such item or service submitted by partici-
19 pating providers during the period described in sub-
20 paragraph (A)(ii) shall be reported by such plan in
21 lieu of such rate. Such plan shall identify that such
22 median amount represents an estimate of such in-
23 network rate for such item or service.

24 “(3) MANNER OF PUBLICATION.—

1 “(A) IN GENERAL.—Rate and payment in-
2 formation required to be made available under
3 this subsection shall be so made available in
4 dollar amounts through separate machine-read-
5 able files (and any successor technology, as ap-
6 plicable, such as application programming inter-
7 face technology, determined appropriate by the
8 Secretary) corresponding to the information de-
9 scribed in each of subparagraphs (A) through
10 (C) of paragraph (2) that meet such require-
11 ments as specified by the Secretary (which may
12 be so specified through subregulatory guid-
13 ance), including requirements relating to wheth-
14 er such information should be so made available
15 on the plan or coverage level, with respect to in-
16 dividual provider networks, or aggregated in
17 such manner as specified by the Secretary.
18 Such requirements shall ensure that such files
19 are limited to an appropriate size, do not in-
20 clude disclosure of unnecessary duplicative in-
21 formation contained in other files made avail-
22 able under this subsection, are made available
23 in a widely available format through a publicly
24 available website that allows for information
25 contained in such files to be compared across

1 group health plans and group or individual
2 health insurance coverage, and are accessible to
3 individuals at no cost and without the need to
4 establish a user account or provide other cre-
5 dentials or undertake other steps as may be
6 specified by the Secretary.

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

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

19 “(5) SUMMARY.—For each plan year beginning
20 on or after January 1, 2029, each group health plan
21 shall make public a data file, in a manner that en-
22 sures that such file may be easily downloaded and
23 read by standard spreadsheet software and that
24 meets such requirements as established by the Sec-
25 retary, containing a summary of all rate and pay-

1 ment information made public by such plan with re-
2 spect to such plan during such plan year. Such file
3 shall include the following:

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

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

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

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

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

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

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

15 “(d) ATTESTATION.— A group health plan shall an-
16 nually submit to the Secretary an attestation, signed by
17 the chief executive officer, chief financial officer, or other
18 comparable official (as specified by the Secretary) of such
19 plan, of such plan’s compliance with the provisions of this
20 section and that information made available under this
21 section is true, accurate, and complete. Such attestation
22 shall, except in the case of a grandfathered health plan
23 (as defined in section 1251(e) of the Patient Protection
24 and Affordable Care Act) or a church plan (as defined
25 in section 414(e)), include a link to the website (or other

1 successor technology) where rate and payment information
2 required to be made public under subsection (c) may be
3 accessed.

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

13 “(f) DEFINITIONS.—In this section:

14 “(1) APPLICABLE SPREAD PRICE DRUG.—The
15 term ‘applicable spread price drug’ means, with re-
16 spect to a group health plan, a drug for which bene-
17 fits are available under such plan and with respect
18 to which, at the time rate and payment information
19 is made public by such plan under subsection (c)—

20 “(A) a contract is in effect between an en-
21 tity providing pharmacy benefit management
22 services on behalf of such plan and a pharmacy
23 for the dispensing of such drug under such
24 plan; and

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

5 “(2) IN-NETWORK RATE.—The term ‘in-net-
6 work rate’ means, with respect to a group health
7 plan 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 “(3) PARTICIPATING PROVIDER.—The term
17 ‘participating provider’ means, with respect to an
18 item or service and a group health plan, a physician
19 or other health care provider (as defined in para-
20 graph (4)) who is acting within the scope of practice
21 of that provider’s license or certification under appli-
22 cable State law and who has a contractual relation-
23 ship with the plan for furnishing such item or serv-
24 ice under the plan.

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

3 “(5) SPECIFIED PAYMENT AMOUNT.—The term
4 ‘specified payment amount’ means, with respect to a
5 drug to be dispensed by a pharmacy to a participant
6 or beneficiary of a group health plan where such
7 pharmacy has in effect a contract with an entity
8 providing pharmacy benefit management services on
9 behalf of such plan for the dispensing of such drug
10 under such plan, the amount that such entity has
11 agreed to pay such pharmacy for the ingredient
12 costs and any applicable dispensing fee for such
13 drug (or the amount that such entity has agreed to
14 pay such pharmacy for such drug under any other
15 compensation structure specified by the Secretary)
16 under such contract, taking into account any cost
17 sharing requirement applicable to such drug and
18 participant or beneficiary.

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

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

10 (B) CLERICAL AMENDMENT.—The item re-
11 lating to section 9819 of the table of sections
12 for subchapter B of chapter 100 of the Internal
13 Revenue Code of 1986 is amended to read as
14 follows:

“Sec. 9819. Transparency in coverage.”.

15 (2) PHSA.—Section 2799A–4 of the Public
16 Health Service Act (42 U.S.C. 300gg–114) is
17 amended—

18 (A) in the header, by striking “**MAINTENANCE OF PRICE COMPARISON TOOL**” and
19 inserting “**TRANSPARENCY IN COVERAGE**”;
20

21 (B) by striking “A group health plan” and
22 inserting the following:

23 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
24 FOR PLAN YEARS BEFORE 2029.—

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

1 (C) in subsection (a), as inserted by sub-
2 paragraph (B), by adding at the end the fol-
3 lowing new paragraph:

4 “(2) SUNSET.—Paragraph (1) shall not apply
5 with respect to plan years beginning on or after Jan-
6 uary 1, 2029.”; and

7 (D) by adding at the end the following new
8 subsections:

9 “(b) COST-SHARING TRANSPARENCY.—

10 “(1) IN GENERAL.—For plan years beginning
11 on or after January 1, 2029, a group health plan
12 and a health insurance issuer offering group or indi-
13 vidual health insurance coverage shall provide a par-
14 ticipant, beneficiary, or enrollee, in a timely manner
15 upon request of the participant, beneficiary, or en-
16 rollee, information on the amount of cost-sharing
17 (including deductibles, copayments, and coinsurance)
18 under the participant, beneficiary, or enrollee’s plan
19 or coverage that the participant, beneficiary, or en-
20 rollee would be responsible for paying with respect
21 to the furnishing of a specific item or service by a
22 provider. At a minimum, such information shall in-
23 clude the information specified in paragraph (2) and
24 shall be made available to such participant, bene-
25 ficiary, or enrollee through a self-service tool that

1 meets the requirements of paragraph (3) or, at the
2 option of such participant, beneficiary, or enrollee,
3 through a paper disclosure or phone or other elec-
4 tronic disclosure (as selected by such individual and
5 provided at no cost to such individual) that meets
6 such requirements as the Secretary may specify.

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

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

18 “(B) If such provider is not a participating
19 provider with respect to such item or service,
20 the maximum allowed amount or other dollar
21 amount that such plan or coverage will recog-
22 nize as payment for such item or service, along
23 with a notice that such individual may be liable
24 for additional charges.

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

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

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

23 “(F) Any prior authorization, concurrent
24 review, step therapy, fail first, or similar re-

1 quirements applicable to coverage of such item
2 or service under such plan or coverage.

3 “(G) Any financial incentives (such as any
4 credit, payment, or other benefit provided by
5 such plan or issuer) available to the individual
6 with respect to such item or service furnished
7 by such provider known at the time such re-
8 quest is made.

9 “(H) Other information determined appro-
10 prium by the Secretary.

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

16 “(A) is based on an internet website (or
17 successor technology specified by the Sec-
18 retary);

19 “(B) is made available in plain language at
20 no cost;

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

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

1 “(E) allows such a request to be made
2 with respect to an item or service furnished
3 by—

4 “(i) a specific provider that is a par-
5 ticipating provider with respect to such
6 item or service;

7 “(ii) all providers that are partici-
8 pating providers with respect to such item
9 or service; or

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

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

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

24 “(c) RATE AND PAYMENT INFORMATION.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2029, each group health plan
3 and health insurance issuer offering group or indi-
4 vidual health insurance coverage (other than a
5 grandfathered health plan (as defined in section
6 1251(e) of the Patient Protection and Affordable
7 Care Act) and other than such an issuer offering
8 group health insurance coverage in connection with
9 a church plan (as defined in section 414(e) of the
10 Internal Revenue Code of 1986)) shall make avail-
11 able to the public the rate and payment information
12 described in paragraph (2) in accordance with para-
13 graph (3).

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

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

23 “(i) the in-network rate (expressed as
24 a dollar amount) in effect as of the date on
25 which such information is made public

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

10 “(ii) with respect to each such partici-
11 pating provider (other than a provider that
12 is an excluded provider with respect to
13 such item or service), an indication of
14 whether, during the 1-year period begin-
15 ning 18 months before the date such infor-
16 mation is made public, such provider sub-
17 mitted a claim for such item or service to
18 such plan or coverage for which payment
19 was made (in whole or in part) under such
20 plan or coverage.

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

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

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

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

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

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

1 “(II) for each pharmacy that has
2 a contractual relationship for dis-
3 pensing such drug under such plan or
4 coverage, a specification of the dif-
5 ference (if any) between the specified
6 payment amount for such drug so dis-
7 pensed by such pharmacy and the
8 specified reimbursement amount for
9 such drug so dispensed by such phar-
10 macy.

11 “(C) With respect to each item or service
12 for which benefits are available under such plan
13 or coverage, the amount billed, and the amount
14 allowed by the plan or coverage, for each such
15 item or service furnished during the 6-month
16 period beginning 9 months before the date such
17 information is made public by a provider that
18 was not a participating provider with respect to
19 such item or service, broken down by each such
20 provider, other than such an amount with re-
21 spect to an item or service for which, during
22 such period, fewer than 11 claims were made
23 under such plan or coverage. In determining the
24 number of claims made under such plan or cov-
25 erage with respect to an item or service during

1 such period for purposes of the preceding sen-
2 tence, such number shall be deemed to include
3 all claims for such item or service made during
4 such period under all group health plans and
5 health insurance coverage offered in the same
6 insurance market (specified in subclause (I),
7 (II), (III), or (IV) of section 2799A-
8 1(a)(3)(E)(iv)) by the sponsor or issuer (as ap-
9 plicable) of the plan or coverage at issue.

10 In the case that a specific dollar amount for an in-
11 network rate required to be made available pursuant
12 to this subsection with respect to an item or service
13 cannot be determined prospectively on the basis that
14 such rate is determined as a percentage of the billed
15 charges for such item or service, such percentage
16 and the median amount recognized by such plan or
17 coverage as payment for such item or service with
18 respect to claims for such item or service submitted
19 by participating providers during the period de-
20 scribed in subparagraph (A)(ii) shall be reported by
21 such plan in lieu of such rate. Such plan or coverage
22 shall identify that such median amount represents
23 an estimate of such in-network rate for such item or
24 service.

25 “(3) MANNER OF PUBLICATION.—

1 “(A) IN GENERAL.—Rate and payment in-
2 formation required to be made available under
3 this subsection shall be so made available in
4 dollar amounts through separate machine-read-
5 able files (and any successor technology, as ap-
6 plicable, such as application programming inter-
7 face technology, determined appropriate by the
8 Secretary) corresponding to the information de-
9 scribed in each of subparagraphs (A) through
10 (C) of paragraph (2) that meet such require-
11 ments as specified by the Secretary (which may
12 be so specified through subregulatory guid-
13 ance), including requirements relating to wheth-
14 er such information should be so made available
15 on the plan or coverage level, with respect to in-
16 dividual provider networks, or aggregated in
17 such manner as specified by the Secretary.
18 Such requirements shall ensure that such files
19 are limited to an appropriate size, do not in-
20 clude disclosure of unnecessary duplicative in-
21 formation contained in other files made avail-
22 able under this subsection, are made available
23 in a widely-available format through a publicly-
24 available website that allows for information
25 contained in such files to be compared across

1 group health plans and group or individual
2 health insurance coverage, and are accessible to
3 individuals at no cost and without the need to
4 establish a user account or provide other cre-
5 dentials.

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

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

20 “(5) SUMMARY.—For each plan year beginning
21 on or after January 1, 2029, each group health plan
22 and health insurance issuer offering group or indi-
23 vidual health insurance coverage shall make public a
24 data file, in a manner that ensures that such file
25 may be easily downloaded and read by standard

1 spreadsheet software and that meets such require-
2 ments as established by the Secretary, containing a
3 summary of all rate and payment information made
4 public by such plan or issuer with respect to such
5 plan or coverage during such plan year. Such file
6 shall include the following:

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

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

24 “(C) The name of such plan, a description
25 of the type of network of participating providers

1 used by such plan or coverage, and, in the case
2 of a group health plan, a description of whether
3 such plan is self-insured or fully-insured.

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

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

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

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

18 “(d) ATTESTATION.—Each group health plan and
19 health insurance issuer offering group or individual health
20 insurance coverage shall annually submit to the Secretary
21 an attestation, signed by the chief executive officer, chief
22 financial officer, or other comparable official (as specified
23 by the Secretary) of such plan or issuer, of such plan’s
24 or coverage’s compliance with the provisions of this section
25 and that information made available under this section is

1 true, accurate, and complete. Such attestation shall, ex-
2 cept in the case of a grandfathered health plan (as defined
3 in section 1251(e) of the Patient Protection and Afford-
4 able Care Act) or in the case of such an issuer offering
5 group health insurance coverage in connection with a
6 church plan (as defined in section 414(e) of the Internal
7 Revenue Code of 1986), include a link to the website (or
8 other successor technology) where rate and payment infor-
9 mation required to be made public under subsection (c)
10 may be accessed.

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

21 “(f) DEFINITIONS.—In this section:

22 “(1) APPLICABLE SPREAD PRICE DRUG.—The
23 term ‘applicable spread price drug’ means, with re-
24 spect to a group health plan or group or individual
25 health insurance coverage, a drug for which benefits

1 are available under such plan or coverage and with
2 respect to which, at the time rate and payment in-
3 formation is made public by such plan under sub-
4 section (c)—

5 “(A) a contract is in effect between an en-
6 tity providing pharmacy benefit management
7 services on behalf of such plan or coverage and
8 a pharmacy for the dispensing of such drug
9 under such plan or coverage; and

10 “(B) the specified payment amount for
11 such drug so dispensed is less than the specified
12 reimbursement amount for such drug so dis-
13 pensed.

14 “(2) IN-NETWORK RATE.—The term ‘in-net-
15 work rate’ means, with respect to a group health
16 plan or group or individual health insurance cov-
17 erage and an item or service furnished by a provider
18 that is a participating provider with respect to such
19 plan or coverage and item or service, the contracted
20 rate (reflected as a dollar amount) in effect between
21 such plan or coverage and such provider for such
22 item or service, regardless of whether such rate is
23 calculated based on a set amount, a fee schedule, or
24 an amount derived from another amount, or a for-
25 mula, or other method.

1 “(3) PARTICIPATING PROVIDER.—The term
2 ‘participating provider’ means, with respect to an
3 item or service and a group health plan or health in-
4 surance issuer offering group or individual health in-
5 surance coverage, a physician or other health care
6 provider (as defined in paragraph (4)) who is acting
7 within the scope of practice of that provider’s license
8 or certification under applicable State law and who
9 has a contractual relationship with the plan or
10 issuer, respectively, for furnishing such item or serv-
11 ice under the plan or coverage, respectively.

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

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

1 amount that such entity has agreed to pay such
2 pharmacy for such drug under any other compensa-
3 tion structure specified by the Secretary) under such
4 contract, taking into account any cost sharing re-
5 quirement applicable to such drug and participant,
6 beneficiary, or enrollee.

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

25 (3) ERISA.—

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

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

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

10 “(a) MAINTENANCE OF PRICE COMPARISON TOOL
11 FOR PLAN YEARS BEFORE 2029.—

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

13 (iii) in subsection (a), as inserted by
14 clause (ii), by adding at the end the fol-
15 lowing new paragraph:

16 “(2) SUNSET.—Paragraph (1) shall not apply
17 with respect to plan years beginning on or after Jan-
18 uary 1, 2029.”; and

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

21 “(b) COST-SHARING TRANSPARENCY.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after January 1, 2029, a group health plan
24 and a health insurance issuer offering group health
25 insurance coverage shall provide a participant or

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

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

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

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

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

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

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

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

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

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

20 “(H) Other information determined appro-
21 priate by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

11 “(c) RATE AND PAYMENT INFORMATION.—

12 “(1) IN GENERAL.—For plan years beginning
13 on or after January 1, 2029, each group health plan
14 and health insurance issuer offering group health in-
15 surance coverage (other than a grandfathered health
16 plan (as defined in section 1251(e) of the Patient
17 Protection and Affordable Care Act)) shall make
18 available to the public the rate and payment infor-
19 mation described in paragraph (2) in accordance
20 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
25 group health insurance coverage, the following:

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

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

16 “(ii) with respect to each such partici-
17 pating provider (other than a provider that
18 is an excluded provider with respect to
19 such item or service), an indication of
20 whether, during the 1-year period begin-
21 ning 18 months before the date such infor-
22 mation is made public, such provider sub-
23 mitted a claim for such item or service to
24 such plan or coverage for which payment

1 was made (in whole or in part) under such
2 plan or coverage.

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

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

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

1 “(iii) in the case such drug is an ap-
2 plicable spread price drug dispensed by a
3 pharmacy—

4 “(I) a specification that such
5 drug is such an applicable spread
6 price drug; and

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

17 “(C) With respect to each item or service
18 for which benefits are available under such plan
19 or coverage, the amount billed, and the amount
20 allowed by the plan or coverage, for each such
21 item or service furnished during the 6-month
22 period beginning 9 months before the date such
23 information is made public by a provider that
24 was not a participating provider with respect to
25 such item or service, broken down by each such

1 provider, other than such an amount with re-
2 spect to an item or service for which, during
3 such period, fewer than 11 claims were made
4 under such plan or coverage. In determining the
5 number of claims made under such plan or cov-
6 erage with respect to an item or service during
7 such period for purposes of the preceding sen-
8 tence, such number shall be deemed to include
9 all claims for such item or service made during
10 such period under all group health plans and
11 health insurance coverage offered in the same
12 insurance market (specified in subclause (I),
13 (II), (III), or (IV) of section 716(a)(3)(E)(iv))
14 by the sponsor or issuer (as applicable) of the
15 plan or coverage at issue.

16 In the case that a specific dollar amount for an in-
17 network rate required to be made available pursuant
18 to this subsection with respect to an item or service
19 cannot be determined prospectively on the basis that
20 such rate is determined as a percentage of the billed
21 charges for such item or service, such percentage
22 and the median amount recognized by such plan or
23 coverage as payment for such item or service with
24 respect to claims for such item or service submitted
25 by participating providers during the period de-

1 scribed in subparagraph (A)(ii) shall be reported by
2 such plan or coverage in lieu of such rate. Such plan
3 or coverage shall identify that such median amount
4 represents an estimate of such in-network rate for
5 such item or service.

6 “(3) MANNER OF PUBLICATION.—

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

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

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

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

1 “(5) SUMMARY.—For each plan year beginning
2 on or after January 1, 2029, each group health plan
3 and health insurance issuer offering group health in-
4 surance coverage shall make public a data file, in a
5 manner that ensures that such file may be easily
6 downloaded and read by standard spreadsheet soft-
7 ware and that meets such requirements as estab-
8 lished by the Secretary, containing a summary of all
9 rate and payment information made public by such
10 plan or issuer with respect to such plan or coverage
11 during such plan year. Such file shall include the fol-
12 lowing:

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

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

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

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

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

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

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

1 “(d) ATTESTATION.—Each group health plan and
2 health insurance issuer offering group health insurance
3 coverage shall annually submit to the Secretary an attesta-
4 tion, signed by the chief executive officer, chief financial
5 officer, or other comparable official (as specified by the
6 Secretary) of such plan or issuer, of such plan’s or cov-
7 erage’s compliance with the provisions of this section and
8 that information made available under this section is true,
9 accurate, and complete. Such attestation shall, except in
10 the case of a grandfathered health plan (as defined in sec-
11 tion 1251(e) of the Patient Protection and Affordable
12 Care Act), include a link to the website (or other successor
13 technology) where rate and payment information required
14 to be made public under subsection (c) may be accessed.

15 “(e) ACCESSIBILITY.—A group health plan and a
16 health insurance issuer offering group health insurance
17 coverage shall take reasonable steps (as specified by the
18 Secretary) to ensure that information provided in response
19 to a request described in subsection (b), and rate and pay-
20 ment information made public under subsection (c), is pro-
21 vided in plain, easily understandable language and that
22 interpretation, translations, and assistive services are pro-
23 vided to those with limited English proficiency and those
24 with disabilities.

25 “(f) DEFINITIONS.—In this section:

1 “(1) APPLICABLE SPREAD PRICE DRUG.—The
2 term ‘applicable spread price drug’ means, with re-
3 spect to a group health plan or group health insur-
4 ance coverage, a drug for which benefits are avail-
5 able under such plan or coverage and with respect
6 to which, at the time rate and payment information
7 is made public by such plan under subsection (c)—

8 “(A) a contract is in effect between an en-
9 tity providing pharmacy benefit management
10 services on behalf of such plan or coverage and
11 a pharmacy for the dispensing of such drug
12 under such plan or coverage; and

13 “(B) the specified payment amount for
14 such drug so dispensed is less than the specified
15 reimbursement amount for such drug so dis-
16 pensed.

17 “(2) IN-NETWORK RATE.—The term ‘in-net-
18 work rate’ means, with respect to a group health
19 plan or group health insurance coverage and an item
20 or service furnished by a provider that is a partici-
21 pating provider with respect to such plan or cov-
22 erage and item or service, the contracted rate (re-
23 flected as a dollar amount) in effect between such
24 plan or coverage and such provider for such item or
25 service, regardless of whether such rate is calculated

1 based on a set amount, a fee schedule, or an amount
2 derived from another amount, or a formula, or other
3 method.

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

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

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

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

9 “(6) SPECIFIED REIMBURSEMENT AMOUNT.—

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

1 applicable to such drug and participant or bene-
2 ficiary.”.

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

“Sec. 719. Transparency in coverage.”.

8 (b) APPLICATION PROGRAMMING INTERFACE RE-
9 PORT.—Not later than January 1, 2029, and annually
10 thereafter, the Secretary of Health and Human Services
11 shall, in consultation with the Office of the National Coor-
12 dinator for Health Information Technology, Department
13 of Labor, the Department of the Treasury, and stake-
14 holders, submit to the House Committees on Education
15 and the Workforce, Energy and Commerce, and Ways and
16 Means, and the Senate Committees on Finance and
17 Health, Education, Labor, and Pensions a report on the
18 use of standards-based application programming inter-
19 faces (in this subsection referred to as “APIs”) to facili-
20 tate access to health care price transparency information
21 and the interoperability of other medical information.
22 Such report shall include an evaluation of the capacity of
23 the Department of Health and Human Services, the De-
24 partment of Labor, and the Department of the Treasury
25 to regulate and implement standards related to APIs and

1 recommendations for improving such capacity. Such re-
2 port shall include the following:

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

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

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

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

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

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

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

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

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

19 (c) PROVIDER TOOL REPORT.—

20 (1) IN GENERAL.—Not later than 1 year after
21 the date of the enactment of this Act, The Secretary
22 of Health and Human Services, acting through the
23 Administrator of the Centers for Medicare & Med-
24 icaid Services, shall, in consultation with stake-
25 holders, conduct a study and submit to the House

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

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

19 (B) An evaluation on the usefulness of a
20 provider tool to aid patient-decision making and
21 how such tool would coordinate with other in-
22 formation available to a patient and their pro-
23 vider under other Federal requirements in place
24 or under consideration.

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

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

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

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

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

21 (G) An analysis of the feasibility of a pro-
22 vider tool to include additional functionality to
23 facilitate and improve the administration of the
24 requirements on providers to submit notifica-
25 tions to such plan or coverage under section

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

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

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

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

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

20 (2) DEFINITION.—The term “provider tool”
21 means a tool designed to facilitate the provision of
22 information made available pursuant to the amend-
23 ments made by subsection (a) and established by a
24 group health plan or a health insurance issuer offer-
25 ing group or individual health insurance coverage

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

7 (d) REPORTS.—

8 (1) COMPLIANCE.—Not later than January 1,
9 2029, the Comptroller General of the United States
10 shall submit to Congress a report containing—

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

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

16 (C) recommendations relating to improving
17 such enforcement; and

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

23 (2) PRICES.—Not later than January 1, 2029,
24 and biennially thereafter, the Secretaries of Health
25 and Human Services, Labor, and the Treasury shall

1 jointly submit to Congress a report containing an as-
2 sessment of differences in negotiated prices (and any
3 trends in such prices) in the private market be-
4 tween—

5 (A) rural and urban areas;

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

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

11 (D) nonprofit and for-profit hospitals;

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

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

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

1 identify appropriate metrics for assessing and comparing
2 quality of care.

3 (f) CONTINUED APPLICABILITY OF RULES FOR PRE-
4 VIOUS YEARS.—Nothing in the amendments made by sub-
5 section (a) may be construed as affecting the applicability
6 of the rule entitled “Transparency in Coverage” published
7 by the Department of the Treasury, the Department of
8 Labor, and the Department of Health and Human Serv-
9 ices on November 12, 2020 (85 Fed. Reg. 72158), for any
10 plan year beginning before January 1, 2029.

11 **SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.**

12 (a) PHSA.—

13 (1) IN GENERAL.—Part D of title XXVII of the
14 Public Health Service Act is amended by adding at
15 the end the 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.) is
10 amended by adding at the end the following new sec-
11 tion:

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 is amended by inserting after the item relating to
2 section 726 the following new item:

“Sec. 727. Information on prescription drugs.”.

3 (c) IRC.—

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

7 **“SEC. 9827. INFORMATION ON PRESCRIPTION DRUGS.**

8 “(a) IN GENERAL.—A group health plan shall—

9 “(1) not restrict, directly or indirectly, any
10 pharmacy that dispenses a prescription drug to a
11 participant or beneficiary in the plan from informing
12 (or penalize such pharmacy for informing) a partici-
13 pant or beneficiary of any differential between the
14 participant’s or beneficiary’s out-of-pocket cost
15 under the plan with respect to acquisition of the
16 drug and the amount an individual would pay for ac-
17 quisition of the drug without using any group health
18 plan or health insurance coverage; and

19 “(2) ensure that any entity that provides phar-
20 macy benefits management services under a contract
21 with any such plan does not, with respect to such
22 plan or coverage, restrict, directly or indirectly, a
23 pharmacy that dispenses a prescription drug from
24 informing (or penalize such pharmacy for informing)
25 a participant or beneficiary of any differential be-

1 tween the participant’s or beneficiary’s out-of-pocket
2 cost under the plan with respect to acquisition of the
3 drug and the amount an individual would pay for ac-
4 quisition of the drug without using any group health
5 plan or health insurance coverage.

6 “(b) DEFINITION.—For purposes of this section, the
7 term ‘out-of-pocket cost’, with respect to acquisition of a
8 drug, means the amount to be paid by the participant or
9 beneficiary under the plan, including any cost-sharing (in-
10 cluding any deductible, copayment, or coinsurance) and,
11 as determined by the Secretary, any other expenditure.”.

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

“Sec. 9827. Information on prescription drugs.”.

16 **SEC. 5. VERTICAL INTEGRATION ACCOUNTABILITY.**

17 (a) REQUIRED MA AND PDP REPORTING.—

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

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

24 “(A) IN GENERAL.—For plan year 2028
25 and for every third plan year thereafter, each

1 applicable MA organization offering an MA
2 plan under this part during such plan year shall
3 submit to the Secretary, at a time and in a
4 manner specified by the Secretary—

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

10 “(ii) the total amount of incentive-
11 based payments made with respect to such
12 plan year to such specified health care pro-
13 viders that have in effect a financial risk
14 arrangement with respect to such plan
15 year;

16 “(iii) the total amount of recoupments
17 collected with respect to such plan year
18 from such specified health care providers
19 that have in effect a financial risk arrange-
20 ment with respect to such plan year;

21 “(iv) the total amount of incentive-
22 based payments made with respect to such
23 plan year to providers of services and sup-
24 pliers not that are not specified health care
25 providers and that have in effect a finan-

1 cial risk arrangement with respect to such
2 plan year; and

3 “(v) the total amount of recoupments
4 collected with respect to such plan year
5 from such providers of services and sup-
6 pliers that have in effect a financial risk
7 arrangement with respect to such plan
8 year.

9 “(B) DEFINITIONS.—For purposes of this
10 paragraph:

11 “(i) APPLICABLE MA ORGANIZA-
12 TION.—The term ‘applicable MA organiza-
13 tion’ means, with respect to a plan year,
14 an MA organization with at least 25,000
15 individuals enrolled across all Medicare Ad-
16 vantage plans offered by such organization
17 during such plan year.

18 “(ii) SPECIFIED HEALTH CARE PRO-
19 VIDER.—The term ‘specified health care
20 provider’ means, with respect to an appli-
21 cable MA organization and a plan year, a
22 provider of services or supplier that—

23 “(I) is owned by, controlled by,
24 or related under a common ownership
25 structure with such MA organization;

1 “(II) has in effect a contract
2 solely with such organization (or with
3 an entity owned by, controlled by, or
4 related under a common ownership
5 structure with such organization (or
6 that has in effect any comparable ar-
7 rangement with such organization))
8 for furnishing items and services;

9 “(III) is a partner under a part-
10 nership (as defined in section
11 7701(a)(2) of the Internal Revenue
12 Code of 1986) with such organization
13 (or with any an entity owned by, con-
14 trolled by, or related under a common
15 ownership structure with such organi-
16 zation); or

17 “(IV) through contract, owner-
18 ship, or otherwise—

19 “(aa) directly or indirectly
20 controls, is controlled by, or is
21 under common ownership with
22 such organization (or with an en-
23 tity owned by, controlled by, or
24 related under a common owner-

1 ship structure with such organi-
2 zation);

3 “(bb) is part of a controlled
4 group of corporations under sec-
5 tion 1563 of the Internal Rev-
6 enue Code of 1986 with such or-
7 ganization (or with any such en-
8 tity);

9 “(cc) is a participant in a
10 lawful combination under which
11 such provider or supplier shares
12 substantial financial risk in con-
13 nection with such organization’s
14 operations (or with the oper-
15 ations of any such entity); or

16 “(dd) part of an affiliated
17 service group under section 414
18 of such Code with such organiza-
19 tion (or with any such entity).”.

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

24 “(9) PROVISION OF INFORMATION RELATING TO
25 PHARMACY OWNERSHIP.—

1 “(A) IN GENERAL.—For plan year 2028
2 and for every third plan year thereafter, each
3 PDP sponsor offering a prescription drug plan
4 under this part during such plan year shall sub-
5 mit to the Secretary, at a time and in a manner
6 specified by the Secretary, the taxpayer identi-
7 fication number and National Provider Identifi-
8 fier for each pharmacy that was a specified
9 pharmacy with respect to such plan during such
10 year.

11 “(B) DEFINITION.—For purposes of this
12 paragraph, the term ‘specified pharmacy’
13 means, with respect to a prescription drug plan
14 offered by a PDP sponsor and a plan year, a
15 pharmacy that—

16 “(i) is owned by, controlled by, or re-
17 lated under a common ownership structure
18 with such sponsor;

19 “(ii) has in effect a contract solely
20 with such sponsor (or with an entity owned
21 by, controlled by, or related under a com-
22 mon ownership structure with such spon-
23 sor (or that has in effect any comparable
24 arrangement with such sponsor)) for dis-
25 pensing covered part D drugs;

1 “(iii) is a partner under a partnership
2 (as defined in section 7701(a)(2) of the In-
3 ternal Revenue Code of 1986) with such
4 sponsor (or with any an entity owned by,
5 controlled by, or related under a common
6 ownership structure with such sponsor); or

7 “(iv) through contract, ownership, or
8 otherwise—

9 “(I) directly or indirectly con-
10 trols, is controlled by, or is under
11 common ownership with such sponsor
12 (or with an entity owned by, con-
13 trolled by, or related under a common
14 ownership structure with such spon-
15 sor);

16 “(II) is part of a controlled
17 group of corporations under section
18 1563 of the Internal Revenue Code of
19 1986 with such sponsor (or with any
20 such entity);

21 “(III) is a participant in a lawful
22 combination under which such pro-
23 vider or supplier shares substantial fi-
24 nancial risk in connection with such

1 sponsor's operations (or with the op-
2 erations of any such sponsor); or
3 “(IV) part of an affiliated service
4 group under section 414 of such Code
5 with such sponsor (or with any such
6 entity).”.

7 (b) REPORTS ON VERTICAL INTEGRATION UNDER
8 MEDICARE.—

9 (1) IN GENERAL.—Not later than the first June
10 15 occurring on or after the date that is 2 years
11 after the Secretary of Health and Human Services
12 first makes available information submitted under
13 sections 1857(e)(6) and 1860D–12(b)(9) of the So-
14 cial Security Act (as added by paragraphs (1) and
15 (2), respectively, of subsection (a)) to the Medicare
16 Payment Advisory Commission, and again not later
17 than 4 years after the first report is submitted
18 under this paragraph, the Medicare Payment Advi-
19 sory Commission shall submit to Congress a report
20 on the state of vertical integration in the health care
21 sector during the applicable year with respect to en-
22 tities participating in the Medicare program under
23 part C of title XVIII of the Social Security Act (42
24 U.S.C. 1395w–21 et seq.) or part D of such title (42
25 U.S.C. 1395w–101 et seq.), including health care

1 providers, pharmacies, prescription drug plan spon-
2 sors, Medicare Advantage organizations, and phar-
3 macy benefit managers. Such report shall include, to
4 the extent practicable—

5 (A) with respect to Medicare Advantage
6 organizations, the evaluation described in para-
7 graph (2);

8 (B) with respect to prescription drug
9 plans, pharmacy benefit managers, and phar-
10 macies, the comparisons and summary de-
11 scribed in paragraph (3);

12 (C) an assessment of the Medicare Advan-
13 tage organization and PDP sponsor integration
14 information described in paragraph (4); and

15 (D) an analysis of the impact of such inte-
16 gration on health care access, price, quality,
17 and outcomes.

18 (2) MEDICARE ADVANTAGE ORGANIZATIONS.—
19 For purposes of paragraph (1)(A), the evaluation
20 described in this paragraph is, with respect to Medi-
21 care Advantage organizations and an applicable
22 year, an evaluation, taking into account patient acu-
23 ity and the types of areas serviced by such organiza-
24 tion, of—

1 (A) the average number of qualifying diag-
2 noses made during such year with respect to
3 enrollees of a Medicare Advantage plan offered
4 by such organization who, during such year, re-
5 ceived a health risk assessment from a specified
6 health care provider, compared to the average
7 number of such diagnoses made during such
8 year with respect to enrollees of such plan who,
9 during such year, did not receive such an as-
10 sessment from such a provider;

11 (B) the average risk score for enrollees of
12 a Medicare Advantage plan who received such
13 an assessment from a specified health care pro-
14 vider during such year compared to the average
15 risk score for enrollees of such plan who did not
16 receive such an assessment from such a pro-
17 vider during such year;

18 (C) any relationship between risk scores
19 for such enrollees receiving such an assessment
20 from such a provider during such year and in-
21 centive-based payments made to such providers;

22 (D) the average risk score for enrollees of
23 such plan who received any item or service from
24 a specified health care provider during such
25 year compared to the average risk score for en-

1 rollees of such plan who did not receive any
2 item or service from such a provider during
3 such year;

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

8 (F) any relationship between the risk
9 scores of enrollees under such plan that have
10 received any item or service from a specified
11 provider and incentive-based payments made
12 under the plan to specified providers.

13 (3) PRESCRIPTION DRUG PLANS.—For purposes
14 of paragraph (1)(B), the comparisons and summary
15 described in this paragraph are, with respect to pre-
16 scription drug plans and an applicable year, the fol-
17 lowing:

18 (A) For each covered part D drug for
19 which benefits are available under such a plan,
20 a comparison of information about payments
21 submitted with respect to such plan under sec-
22 tion 1860D–12(h)(1)(C)(i)(I) of the Social Se-
23 curity Act (42 U.S.C. 1395w–
24 112(h)(1)(C)(i)(I)) with respect to specified
25 pharmacies with the same such information

1 about payments submitted by such plan with
2 respect to in-network pharmacies that are not
3 specified pharmacies.

4 (B) Comparisons of the following:

5 (i) The total amount paid by phar-
6 macy benefit managers to specified phar-
7 macies for covered part D drugs and the
8 total amount so paid to pharmacies that
9 are not specified pharmacies for such
10 drugs.

11 (ii) The total amount paid by such
12 sponsors to specified pharmacy benefit
13 managers as reimbursement for covered
14 part D drugs and the total amount so paid
15 to pharmacy benefit managers that are not
16 specified pharmacy benefit managers as
17 such reimbursement.

18 (C) A summary of the total manufacturer-
19 derived revenue retained by pharmacy benefit
20 managers and any affiliates of such pharmacy
21 benefit managers (as reported under section
22 1860D–12(h)(1)(C)(i)(I)(kk) of the Social Se-
23 curity Act (42 U.S.C. 1395w–
24 112(h)(1)(C)(i)(I)(kk)).

1 (4) MEDICARE ADVANTAGE ORGANIZATION AND
2 PDP SPONSOR INTEGRATION INFORMATION.—For
3 purposes of paragraph (1)(C), the Medicare Advan-
4 tage organization and PDP sponsor integration in-
5 formation described in this paragraph is information
6 submitted under sections 1857(e)(6) and 1860D–
7 12(b)(9) of the Social Security Act (as added by
8 paragraphs (1) and (2), respectively, of subsection
9 (a)) and section 1860D–12(h) of such Act (42 U.S.C.
10 1395w–112(h)).

11 (5) DEFINITIONS.—In this subsection:

12 (A) APPLICABLE YEAR.—The term “appli-
13 cable year” means—

14 (i) with respect to the first report sub-
15 mitted under paragraph (1), plan year
16 2028; and

17 (ii) with respect to the second report
18 submitted under paragraph (1), plan year
19 2031.

20 (B) COVERED PART D DRUG.—The term
21 “covered part D drug” has the meaning given
22 such term in section 1860D–2(e) of the Social
23 Security Act (42 U.S.C. 1395w–102(e)).

24 (C) QUALIFYING DIAGNOSIS.—The term
25 “qualifying diagnosis” means, with respect to

1 an enrollee of a Medicare Advantage plan, a di-
2 agnosis that is taken into account in calculating
3 a risk score for such enrollee under the risk ad-
4 justment methodology established by the Sec-
5 retary pursuant to section 1853(a)(3) of the
6 Social Security Act (42 U.S.C. 1305w-
7 23(a)(3)).

8 (D) RISK SCORE.—The term “risk score”
9 means, with respect to an enrollee of a Medi-
10 care Advantage plan, the score calculated for
11 such individual using the methodology described
12 in subparagraph (E).

13 (E) SPECIFIED HEALTH CARE PRO-
14 VIDER.—The term “specified health care pro-
15 vider” means, with respect to a Medicare Ad-
16 vantage plan offered by a Medicare Advantage
17 organization, a health care provider that—

18 (i) is owned by, controlled by, or re-
19 lated under a common ownership structure
20 with such organization;

21 (ii) has in effect a contract solely with
22 such organization (or with an entity owned
23 by, controlled by, or related under a com-
24 mon ownership structure with such organi-
25 zation (or that has in effect any com-

1 parable arrangement with such organiza-
2 tion)) for furnishing items and services;

3 (iii) is a partner under a partnership
4 (as defined in section 7701(a)(2) of the In-
5 ternal Revenue Code of 1986) with such
6 organization (or with any an entity owned
7 by, controlled by, or related under a com-
8 mon ownership structure with such organi-
9 zation); or

10 (iv) through contract, ownership, or
11 otherwise—

12 (I) directly or indirectly controls,
13 is controlled by, or is under common
14 ownership with such organization (or
15 with an entity owned by, controlled
16 by, or related under a common owner-
17 ship structure with such organiza-
18 tion);

19 (II) is part of a controlled group
20 of corporations under section 1563 of
21 the Internal Revenue Code of 1986
22 with such organization (or with any
23 such entity);

24 (III) is a participant in a lawful
25 combination under which such pro-

1 vider or supplier shares substantial fi-
2 nancial risk in connection with such
3 organization’s operations (or with the
4 operations of any such entity); or

5 (IV) part of an affiliated service
6 group under section 414 of such Code
7 with such organization (or with any
8 such entity).

9 (F) SPECIFIED PHARMACY.—The term
10 “specified pharmacy” means, with respect to a
11 prescription drug plan offered by a prescription
12 drug plan sponsor, a pharmacy that—

13 (i) is owned by, controlled by, or re-
14 lated under a common ownership structure
15 with such sponsor;

16 (ii) has in effect a contract solely with
17 such sponsor (or with an entity owned by,
18 controlled by, or related under a common
19 ownership structure with such sponsor (or
20 that has in effect any comparable arrange-
21 ment with such sponsor)) for dispensing
22 covered part D drugs;

23 (iii) is a partner under a partnership
24 (as defined in section 7701(a)(2) of the In-
25 ternal Revenue Code of 1986) with such

1 sponsor (or with any an entity owned by,
2 controlled by, or related under a common
3 ownership structure with such sponsor); or
4 (iv) through contract, ownership, or
5 otherwise—

6 (I) directly or indirectly controls,
7 is controlled by, or is under common
8 ownership with such sponsor (or with
9 an entity owned by, controlled by, or
10 related under a common ownership
11 structure with such sponsor);

12 (II) is part of a controlled group
13 of corporations under section 1563 of
14 the Internal Revenue Code of 1986
15 with such sponsor (or with any such
16 entity);

17 (III) is a participant in a lawful
18 combination under which such pro-
19 vider or supplier shares substantial fi-
20 nancial risk in connection with such
21 sponsor's operations (or with the op-
22 erations of any such entity); or

23 (IV) part of an affiliated service
24 group under section 414 of such Code

1 with such sponsor (or with any such
2 entity).

3 (G) SPECIFIED PHARMACY BENEFIT MAN-
4 AGER.—The term “specified pharmacy benefit
5 manager” means, with respect to a prescription
6 drug plan offered by a prescription drug plan
7 sponsor, a pharmacy benefit manager that—

8 (i) is owned by, controlled by, or re-
9 lated under a common ownership structure
10 with such sponsor;

11 (ii) has in effect a contract solely with
12 such sponsor (or with an entity owned by,
13 controlled by, or related under a common
14 ownership structure with such sponsor (or
15 that has in effect any comparable arrange-
16 ment with such sponsor)) for furnishing
17 pharmacy benefit management services;

18 (iii) is a partner under a partnership
19 (as defined in section 7701(a)(2) of the In-
20 ternal Revenue Code of 1986) with such
21 sponsor (or with any an entity owned by,
22 controlled by, or related under a common
23 ownership structure with such sponsor); or

24 (iv) through contract, ownership, or
25 otherwise—

1 (I) directly or indirectly controls,
2 is controlled by, or is under common
3 ownership with such sponsor (or with
4 an entity owned by, controlled by, or
5 related under a common ownership
6 structure with such sponsor);

7 (II) is part of a controlled group
8 of corporations under section 1563 of
9 the Internal Revenue Code of 1986
10 with such sponsor (or with any such
11 entity);

12 (III) is a participant in a lawful
13 combination under which such pro-
14 vider or supplier shares substantial fi-
15 nancial risk in connection with such
16 sponsor's operations (or with the op-
17 erations of any such entity); or

18 (IV) part of an affiliated service
19 group under section 414 of such Code
20 with such sponsor (or with any such
21 entity).

22 **SEC. 6. IMPLEMENTATION FUNDING.**

23 (a) IN GENERAL.—For the purposes described in
24 subsection (b), there are appropriated, in addition to

1 amounts otherwise available, out of amounts in the Treas-
2 ury not otherwise appropriated—

3 (1) to the Secretary of Health and Human
4 Services and the Secretary of the Treasury,
5 \$65,000,000 for fiscal year 2027, to remain avail-
6 able through fiscal year 2032; and

7 (2) to the Secretary of Labor, \$35,000,000 for
8 fiscal year 2027, to remain available through fiscal
9 year 2032.

10 (b) PERMITTED PURPOSES.—The purposes described
11 in this subsection are the following purposes, insofar as
12 such purposes are to carry out the provisions of, including
13 the amendments made by, this title:

14 (1) Preparing, drafting, and issuing proposed
15 and final regulations or interim regulations.

16 (2) Preparing, drafting, and issuing guidance
17 and public information.

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

19 (4) Enforcement of such provisions.

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

21 (6) Other administrative duties necessary for
22 implementation of such provisions.

23 (c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—

24 Each Secretary described in subsection (a) shall annually
25 submit, not later than September 1st of each year, to the

1 Committees on Energy and Commerce, on Ways and
2 Means, on Education and the Workforce, and on Appro-
3 priations of the House of Representatives and the Com-
4 mittees on Health, Education, Labor, and Pensions, on
5 Finance, and on Appropriations of the Senate a report on
6 funds expended pursuant to funds appropriated under this
7 section.

