

[DISCUSSION DRAFT]

119<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

**H. R.** \_\_\_\_\_

To promote price transparency in the health care sector.

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IN THE HOUSE OF REPRESENTATIVES

M\_\_\_\_, \_\_\_\_\_ introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

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**A BILL**

To promote price transparency in the health care sector.

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

3 **SECTION 1. HOSPITAL PRICE TRANSPARENCY.**

4 (a) MEDICARE.—

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

9 **“SEC. 1899D. HOSPITAL PRICE TRANSPARENCY.**

10 **“(a) TRANSPARENCY REQUIREMENT.—**

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

6           “(2) REQUIREMENT DESCRIBED.—

7                   “(A) IN GENERAL.—For purposes of para-  
8                   graph (1), the price transparency requirement  
9                   described in this paragraph is, with respect to  
10                  a specified hospital, that such hospital, in ac-  
11                  cordance with a method and format established  
12                  by the Secretary under subparagraph (C), com-  
13                  pile and make public (without subscription and  
14                  free of charge) for each year—

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

19                           “(ii) information in a consumer-  
20                           friendly format (as specified by the Sec-  
21                           retary)—

22                                   “(I) on the hospital’s prices (in-  
23                                   cluding the information described in  
24                                   subparagraph (B)) for as many of the  
25                                   Centers for Medicare & Medicaid

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

10 “(II) that includes, with respect  
11 to each Centers for Medicare & Med-  
12 icaid Services-specified shoppable  
13 service that is not furnished by the  
14 hospital, an indication that such serv-  
15 ice is not so furnished;

16 “(iii) each type 2 national provider  
17 identifier associated with the hospital or a  
18 unit of the hospital; and

19 “(iv) an attestation that all informa-  
20 tion made public pursuant to this subpara-  
21 graph is complete and accurate.

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

1           made public by a specified hospital, the fol-  
2           lowing:

3                   “(i) A plain language description (as  
4                   specified by the Secretary) of each item or  
5                   service, accompanied by, as applicable, the  
6                   Healthcare Common Procedure Coding  
7                   System code, the diagnosis-related group,  
8                   the national drug code, or other identifier  
9                   used or approved by the Centers for Medi-  
10                  care & Medicaid Services.

11                   “(ii) The gross charge, as applicable,  
12                   expressed as a dollar amount, for each  
13                   such item or service, when provided in, as  
14                   applicable, the inpatient setting and out-  
15                   patient department setting.

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

19                           “(I) the discounted cash price, as  
20                           applicable, expressed as a dollar  
21                           amount; or

22                           “(II) in the case no discounted  
23                           cash price is available for such item or  
24                           service, the median cash price charged  
25                           by the hospital (not including charity

1 care) to self-pay individuals for such  
2 item or service when provided in such  
3 settings for the previous three years,  
4 expressed as a dollar amount.

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

12 “(v) Any other additional information  
13 the Secretary may require (in consultation  
14 with stakeholders) for the purpose of im-  
15 proving the accuracy of, or enabling con-  
16 sumers to easily understand and compare,  
17 standard charges and prices for an item or  
18 service, except information that is duplica-  
19 tive of any other reporting requirement  
20 under this subsection.

21 In the case of standard charges and prices for  
22 an item or service included as part of a bun-  
23 dled, per diem, episodic, or other similar ar-  
24 rangement, the information described in this

1           subparagraph shall be made available as deter-  
2           mined appropriate by the Secretary.

3           “(C) UNIFORM METHOD AND FORMAT.—

4           Not later than January 1, 2028, the Secretary  
5           shall establish a standard, uniform method and  
6           format for specified hospitals to use in com-  
7           piling and making public standard charges pur-  
8           suant to subparagraph (A)(i) and a standard,  
9           uniform method and format for such hospitals  
10          to use in compiling and making public prices  
11          pursuant to subparagraph (A)(ii). Such meth-  
12          ods and formats—

13                 “(i) shall, in the case of such method  
14                 and format for making public standard  
15                 charges pursuant to subparagraph (A)(i),  
16                 ensure that such charges are made avail-  
17                 able in a machine-readable format (or a  
18                 successor technology specified by the Sec-  
19                 retary);

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

24                 “(iii) shall meet such standards as de-  
25                 termined appropriate by the Secretary in

1           order to ensure the accessibility and  
2           usability of such charges and prices; and

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

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

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

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

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

21          “(4) ENFORCEMENT.—

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

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

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

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

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

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

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

14                  “(B) CIVIL MONETARY PENALTY.—

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

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

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

23 “(II) in the case of a specified  
24 hospital with more than 30 beds but  
25 fewer than 101 beds, \$12.50 per bed

1 per day (or, in the case of such a hos-  
2 pital that has been noncompliant with  
3 such requirements for a 1-year period  
4 or longer, beginning with the first day  
5 following such 1-year period, \$15 per  
6 bed per day);

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

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

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

9                   “(ii) INCREASE AUTHORITY.—In ap-  
10                  plying this subparagraph with respect to  
11                  violations occurring in 2029 or a subse-  
12                  quent year, the Secretary may through no-  
13                  tice and comment rulemaking increase—

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

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

21                   “(III) the amounts specified in  
22                   clause (iii)(II).

23                   “(iii) PERSISTENT NONCOMPLI-  
24                  ANCE.—

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

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

21                         “(aa) with more than 30  
22                         beds but fewer than 101 beds, an  
23                         amount that is not less than  
24                         \$500,000 and not more than  
25                         \$1,000,000;

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

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

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

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

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

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

1 cated in a rural or underserved  
2 area if the Secretary certifies  
3 that imposition of such penalty  
4 would result in an immediate  
5 threat to access to care for indi-  
6 viduals in the service area of  
7 such hospital.

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

23 “(II) REDUCTION IF HEARING  
24 WAIVED.—The Secretary may reduce  
25 any penalty otherwise applicable

1 under this subparagraph (as reduced,  
2 if applicable, under subclause (I)) by  
3 not more than 35 percent if the speci-  
4 fied hospital that is the subject of  
5 such penalty agrees to waive any right  
6 of such hospital to a hearing before  
7 an administrative law judge with re-  
8 spect to the imposition of such pen-  
9 alty.

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 a specified hospital on a case-by-  
15 case basis if the Secretary determines that  
16 a circumstance exists interfering with such  
17 hospital’s ability to comply with the provi-  
18 sions of this subsection (such as a natural  
19 disaster (as defined in section 602(a) of  
20 the Robert T. Stafford Disaster Relief and  
21 Emergency Assistance Act), a public health  
22 emergency, or other similar or unexpected  
23 catastrophe or similar situation).

24 “(vi) **PROVISION OF TECHNICAL AS-**  
25 **SISTANCE.**—The Secretary shall, to the ex-

1 tent practicable, provide technical assist-  
2 ance relating to compliance with the provi-  
3 sions of this subsection to specified hos-  
4 pitals requesting such assistance.

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

13 “(viii) NONDUPLICATION OF CERTAIN  
14 PENALTIES.—

15 “(I) IN GENERAL.—The Sec-  
16 retary may not subject a specified  
17 hospital to a civil monetary penalty  
18 under this subparagraph with respect  
19 to noncompliance with the provisions  
20 of this subsection for a period if the  
21 Secretary has imposed a civil mone-  
22 tary penalty on such hospital under  
23 section 2718(f) of the Public Health  
24 Service Act for failure to comply with

1 the provisions of such section for such  
2 period.

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

12 “(C) PUBLICATION OF HOSPITAL PRICE  
13 TRANSPARENCY INFORMATION.—Beginning on  
14 January 1, 2028, the Secretary shall make pub-  
15 licly available on the public website of the Cen-  
16 ters for Medicare & Medicaid Services informa-  
17 tion with respect to compliance with the re-  
18 quirements of this subsection and enforcement  
19 activities undertaken by the Secretary under  
20 this subsection. Such information shall be up-  
21 dated in real time (if practicable) and include—

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

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

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

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

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

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

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

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

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

6                   “(vii) any other information as deter-  
7                   mined by the Secretary.

8           “(b) ENSURING ACCESSIBILITY THROUGH IMPLE-  
9           MENTATION.—In implementing this section, the Secretary  
10           shall through rulemaking ensure that a hospital making  
11           public charges and prices pursuant to this section takes  
12           reasonable steps (as specified by the Secretary) to ensure  
13           the accessibility of such charges and information to indi-  
14           viduals with limited English proficiency. Such steps may  
15           include the hospital’s provision of interpretation services  
16           or the hospital’s provision of translations of charges and  
17           information.

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

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

23                   “(2) GROSS CHARGE.—The term ‘gross charge’  
24                   means the charge for an individual item or service  
25                   that is reflected on a specified hospital’s

1       chargemaster or provider of service or supplier’s, as  
2       applicable, chargemaster (or similar list of prices),  
3       absent any discounts.

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

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

14           (2) RULE OF CONSTRUCTION.—Nothing in the  
15      amendments made by this subsection may be con-  
16      strued to impede, prohibit, or prevent the Secretary  
17      of Health and Human Services from implementing,  
18      executing, carrying out, or enforcing the require-  
19      ments of section 2718(f) of the Public Health Serv-  
20      ice Act.

21      (b) PHSA.—

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

1 “(f) HOSPITAL TRANSPARENCY REQUIREMENT.—

2 “(1) IN GENERAL.—Beginning January 1,  
3 2028, each hospital operating within the United  
4 States (including a specified hospital (as defined in  
5 section 1899D of the Social Security Act)) shall  
6 comply with the price transparency requirement de-  
7 scribed in paragraph (2).

8 “(2) REQUIREMENT DESCRIBED.—

9 “(A) IN GENERAL.—For purposes of para-  
10 graph (1), the price transparency requirement  
11 described in this paragraph is, with respect to  
12 a hospital, that such hospital, in accordance  
13 with a method and format established by the  
14 Secretary under subparagraph (C), compile and  
15 make public (without subscription and free of  
16 charge) for each year—

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

21 “(ii) information in a consumer-  
22 friendly format (as specified by the Sec-  
23 retary)—

24 “(I) on the hospital’s prices (in-  
25 cluding the information described in

1                   subparagraph (B)) for as many of the  
2                   Centers for Medicare & Medicaid  
3                   Services-specified shoppable services  
4                   that are furnished by the hospital,  
5                   and as many additional hospital-se-  
6                   lected shoppable services (or all such  
7                   additional services, if such hospital  
8                   furnishes fewer than 300 shoppable  
9                   services) as may be necessary for a  
10                  combined total of at least 300  
11                  shoppable services; and

12                   “(II) that includes, with respect  
13                  to each Centers for Medicare & Med-  
14                  icaid Services-specified shoppable  
15                  service that is not furnished by the  
16                  hospital, an indication that such serv-  
17                  ice is not so furnished;

18                   “(iii) each type 2 national provider  
19                  identifier associated with the hospital or a  
20                  unit of the hospital; and

21                   “(iv) an attestation that all informa-  
22                  tion made public pursuant to this subpara-  
23                  graph is complete and accurate.

24                   “(B) INFORMATION DESCRIBED.—For pur-  
25                  poses of subparagraph (A), the information de-

1 scribed in this subparagraph is, with respect to  
2 standard charges and prices, as applicable,  
3 made public by a hospital, the following:

4 “(i) A plain language description (as  
5 specified by the Secretary) of each item or  
6 service, accompanied by, as applicable, the  
7 Healthcare Common Procedure Coding  
8 System code, the diagnosis-related group,  
9 the national drug code, current procedure  
10 terminology codes, or other identifier used  
11 or approved by the Centers for Medicare &  
12 Medicaid Services.

13 “(ii) The gross charge, as applicable,  
14 expressed as a dollar amount (as specified  
15 by the Secretary), for each such item or  
16 service, when provided in, as applicable,  
17 the inpatient setting and outpatient de-  
18 partment setting.

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

22 “(I) the discounted cash price, as  
23 applicable, expressed as a dollar  
24 amount; or

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

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

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

24                  “(vi) The de-identified maximum and  
25                  minimum negotiated charges, as applica-

1                   ble, for each such item or service, not in-  
2                   cluding any such charge that is \$0.

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

12                  In the case of standard charges and prices for  
13                  an item or service included as part of a bun-  
14                  dled, per diem, episodic, or other similar ar-  
15                  rangement, and in the case of standard charges  
16                  and prices for an item or service that the Sec-  
17                  retary determines, on a case by case basis, may  
18                  only be expressed as an algorithm, the informa-  
19                  tion described in this subparagraph shall be  
20                  made available as determined appropriate by  
21                  the Secretary.

22                  “(C) UNIFORM METHOD AND FORMAT.—  
23                  Not later than January 1, 2028, the Secretary  
24                  shall establish a standard, uniform method and  
25                  format for hospitals to use in compiling and

1 making public standard charges pursuant to  
2 subparagraph (A)(i) and a standard, uniform  
3 method and format for such hospitals to use in  
4 compiling and making public prices pursuant to  
5 subparagraph (A)(ii). Such methods and for-  
6 mats—

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

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

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

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

1           “(3) MONITORING COMPLIANCE.—The Sec-  
2           retary shall establish processes to monitor and as-  
3           sess specified hospitals’ compliance with this sub-  
4           section. Such processes shall include processes relat-  
5           ing to the following:

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

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

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

16           “(4) ENFORCEMENT.—

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

20                           “(i) not later than 30 days after the  
21                           date on which the Secretary determines  
22                           such failure exists, the Secretary shall sub-  
23                           mit to such hospital a notification of such  
24                           determination (which may include, as de-  
25                           termined appropriate by the Secretary, a

1 request for a corrective action plan (to be  
2 submitted not later than 45 days after  
3 such request is made) to comply with such  
4 requirements); and

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

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

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

19 “(aa) submit to such hos-  
20 pital a request for a corrective  
21 action plan (to be submitted not  
22 later than 45 days after such re-  
23 quest is made) to comply with  
24 such requirements; or

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

8                   “(B) CIVIL MONETARY PENALTY.—

9                   “(i) IN GENERAL.—In addition to any  
10                  other enforcement actions or penalties that  
11                  may apply under another provision of Fed-  
12                  eral law, a hospital that has received a re-  
13                  quest for a corrective action plan under  
14                  clause (i) or (ii) of subparagraph (A) and  
15                  fails to comply with the requirements of  
16                  this subsection by the date that is 90 days  
17                  after such request is made (or, if such hos-  
18                  pital has submitted such a corrective ac-  
19                  tion plan not later than 45 days after the  
20                  date such request was made, by the date  
21                  that is 90 days after the date of the sub-  
22                  mission of such corrective action plan), and  
23                  a hospital with respect to which the Sec-  
24                  retary has made a determination described  
25                  in clause (ii)(II)(bb) of such subparagraph,

1 shall be subject to a civil monetary penalty  
2 of an amount specified by the Secretary for  
3 each day (beginning with the day on which  
4 the Secretary first determined that such  
5 hospital was not complying with such re-  
6 quirements) during which such failure was  
7 ongoing. Such amount shall not exceed—

8 “(I) in the case of a hospital with  
9 30 or fewer beds, \$300 per day (or, in  
10 the case of such a hospital that has  
11 been noncompliant with such require-  
12 ments for a 1-year period or longer,  
13 beginning with the first day following  
14 such 1-year period, \$400 per bed per  
15 day);

16 “(II) in the case of a hospital  
17 with more than 30 beds but fewer  
18 than 101 beds, \$12.50 per bed per  
19 day (or, in the case of such a hospital  
20 that has been noncompliant with such  
21 requirements for a 1-year period or  
22 longer, beginning with the first day  
23 following such 1-year period, \$15 per  
24 bed per day);

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

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

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

1 following such 1-year period, \$35 per  
2 bed per day).

3 “(ii) INCREASE AUTHORITY.—In ap-  
4 plying this subparagraph with respect to  
5 violations occurring in 2029 or a subse-  
6 quent year, the Secretary may through no-  
7 tice and comment rulemaking increase—

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

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

15 “(III) the amounts specified in  
16 clause (iii)(II).

17 “(iii) PERSISTENT NONCOMPLI-  
18 ANCE.—

19 “(I) IN GENERAL.—In the case  
20 of a hospital (other than a hospital  
21 with 30 or fewer beds) that the Sec-  
22 retary has determined to be knowingly  
23 and willfully noncompliant with the  
24 provisions of this subsection for two  
25 or more 6-month periods during any

1                   3-year period, the Secretary may in-  
2                   crease any penalty otherwise applica-  
3                   ble under this subparagraph by the  
4                   amount specified in subclause (II)  
5                   with respect to such hospital and may  
6                   require such hospital to complete such  
7                   additional corrective actions plans as  
8                   the Secretary may specify.

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

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

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

23                  “(cc) with more than 300  
24                  beds but fewer than 501 beds, an  
25                  amount that is greater than

1 \$2,000,000 and not more than  
2 \$4,000,000; and

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

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

9 “(I) HOSPITALS LOCATED IN  
10 RURAL OR UNDERSERVED AREAS.—

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

24 “(bb) LIMITATION ON AP-  
25 PPLICATION.—The Secretary may

1 not elect to waive a penalty  
2 under item (aa) with respect to a  
3 hospital more than once in a 6-  
4 year period and may not elect to  
5 reduce such a penalty with re-  
6 spect to such a hospital more  
7 than once in such a period. Noth-  
8 ing in the preceding sentence  
9 shall be construed as prohibiting  
10 the Secretary from both waiving  
11 and reducing a penalty with re-  
12 spect to a hospital during a 6-  
13 year period.

14 “(II) REDUCTION IF HEARING  
15 WAIVED.—The Secretary may reduce  
16 any penalty otherwise applicable  
17 under this subparagraph (as reduced,  
18 if applicable, under subclause (I)) by  
19 not more than 35 percent if the speci-  
20 fied hospital that is subject of such  
21 penalty agrees to waive any right of  
22 such hospital to a hearing before an  
23 administrative law judge with respect  
24 to the imposition of such penalty.

1           “(v) PROVISION OF TECHNICAL AS-  
2           SISTANCE.—The Secretary shall, to the ex-  
3           tent practicable, provide technical assist-  
4           ance relating to compliance with the provi-  
5           sions of this subsection to hospitals re-  
6           questing such assistance.

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

21          “(vii) APPLICATION OF CERTAIN PRO-  
22          VISIONS.—The provisions of section 1128A  
23          of the Social Security Act (other than sub-  
24          sections (a) and (b) of such section) shall  
25          apply to a civil monetary penalty imposed

1 under this subparagraph in the same man-  
2 ner as such provisions apply to a civil mon-  
3 etary penalty imposed under subsection (a)  
4 of such section.

5 “(viii) NONDUPLICATION OF PEN-  
6 ALTIES.—

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

18 “(II) PRIORITIZATION.—In the  
19 case of a hospital that the Secretary  
20 determines to be in violation of the  
21 provisions of this subsection and of  
22 section 1899D of the Social Security  
23 Act, the Secretary shall impose pen-  
24 alties as prescribed in this subsection

1 in lieu of any penalties prescribed in  
2 such section 1899D.

3 “(C) PUBLICATION OF HOSPITAL PRICE  
4 TRANSPARENCY INFORMATION.—Beginning on  
5 January 1, 2028, the Secretary shall make pub-  
6 licly available on the public website of the Cen-  
7 ters for Medicare & Medicaid Services informa-  
8 tion with respect to compliance with the re-  
9 quirements of this subsection and enforcement  
10 activities undertaken by the Secretary under  
11 this subsection. Such information shall be up-  
12 dated in real time (if practicable) and include—

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

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

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

23 “(iv) the amount of any civil monetary  
24 penalty imposed on such hospital under  
25 subparagraph (B);

1           “(v) whether such hospital subse-  
2           quently came into compliance with this  
3           subsection;

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

8                   “(I) the name of any hospital  
9                   that received such a waiver or reduc-  
10                  tion;

11                  “(II) the dollar amount of each  
12                  such penalty so waived or reduced;  
13                  and

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

19                  “(vii) any other information as deter-  
20                  mined by the Secretary.

21           “(5) ENSURING ACCESSIBILITY THROUGH IM-  
22           PLEMENTATION.—In implementing this subsection,  
23           the Secretary shall through rulemaking ensure that  
24           a hospital making public charges and prices pursu-  
25           ant to this section takes reasonable steps (as speci-

1       fied by the Secretary) to ensure the accessibility of  
2       such charges and information to individuals with  
3       limited English proficiency. Such steps may include  
4       the hospital’s provision of interpretation services or  
5       the hospital’s provision of translations of charges  
6       and information.

7               “(6) DEFINITIONS.—For purposes of this sub-  
8       section:

9               “(A) DISCOUNTED CASH PRICE.—The  
10       term ‘discounted cash price’ means the charge  
11       that applies to an individual who pays cash, or  
12       cash equivalent, for a hospital-furnished item or  
13       service.

14              “(B) GROSS CHARGE.—The term ‘gross  
15       charge’ means the charge for an individual item  
16       or service that is reflected on a hospital’s  
17       chargemaster, absent any discounts.

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

23              “(D) SHOPPABLE SERVICE.—The term  
24       ‘shoppable service’ means a service that can be  
25       scheduled by a health care consumer in advance

1 and includes all ancillary items and services  
2 customarily furnished as part of such service.

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

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

11 (A) in subsection (b)(3), by inserting  
12 “(other than the provisions of subsection (f))”  
13 after “this section”; and

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

18 (3) RULE OF CONSTRUCTION.—Nothing in the  
19 amendments made by this subsection may be con-  
20 strued to impede, prohibit, or prevent the Secretary  
21 of Health and Human Services from implementing,  
22 executing, carrying out, or enforcing the require-  
23 ments of section 1899D of the Social Security Act.

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

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

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

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

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

11 “(1) **IN GENERAL.**—Beginning January 1,  
12 2028, any applicable laboratory that receives pay-  
13 ment under this title for furnishing any specified  
14 clinical diagnostic laboratory test under this title  
15 shall—

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

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

23 “(C) include on the website described in  
24 subparagraph (A) an attestation that all such  
25 information is complete and accurate.

1           “(2) INFORMATION DESCRIBED.—For purposes  
2 of paragraph (1), the information described in this  
3 paragraph is, with respect to 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 section  
16 1899D(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) ENFORCEMENT.—

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

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

15 “(ii) if such laboratory continues to  
16 fail to comply with such paragraph after  
17 the date that is 90 days after such notifi-  
18 cation is sent, the Secretary may impose a  
19 civil monetary penalty in an amount not to  
20 exceed \$300 for each day (beginning with  
21 the day on which the Secretary first deter-  
22 mined that such laboratory was failing to  
23 comply with such paragraph) during which  
24 such failure is ongoing.

1           “(B) INCREASE AUTHORITY.—In applying  
2           this paragraph with respect to violations occur-  
3           ring in 2029 or a subsequent year, the Sec-  
4           retary may through notice and comment rule-  
5           making increase the per day limitation on civil  
6           monetary penalties under subparagraph (A)(ii).

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

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

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

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

1           clude a laboratory with respect to which stand-  
2           ard charges and prices for specified clinical di-  
3           agnostic laboratory tests furnished by such lab-  
4           oratory are made available by—

5                   “(i) a specified hospital pursuant to  
6                   section 1899D;

7                   “(ii) a hospital pursuant to section  
8                   2718(f) of the Public Health Service Act;  
9                   or

10                   “(iii) an ambulatory surgical center  
11                   pursuant to section 1834(bb).

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

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

21                   “(D) SPECIFIED CLINICAL DIAGNOSTIC  
22                   LABORATORY TEST.—the term ‘specified clinical  
23                   diagnostic laboratory test’ means a clinical di-  
24                   agnostic laboratory test that is included on the  
25                   list of shoppable services specified by the Cen-

1           ters for Medicare & Medicaid Services (as de-  
2           scribed in section 1899D(a)(2)(A)(ii)(I)), other  
3           than an advanced diagnostic laboratory test (as  
4           defined in section 1834A(d)(5)).

5           “(E) SPECIFIED HOSPITAL.—The term  
6           ‘specified hospital’ has the meaning given such  
7           term in section 1899D.”.

8   **SEC. 3. IMAGING PRICE TRANSPARENCY.**

9           Section 1899D of the Social Security Act, as added  
10          by section 1, is amended—

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

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

15          “(b) IMAGING SERVICES PRICE TRANSPARENCY.—

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

1 an ambulatory surgical center pursuant to section  
2 1834(bb), shall—

3 “(A) make publicly available (in accord-  
4 ance with paragraph (3)) on an internet website  
5 the information described in paragraph (2) with  
6 respect to each such service that such provider  
7 of services or supplier furnishes;

8 “(B) ensure that such information is up-  
9 dated not less frequently than annually; and

10 “(C) include on the website described in  
11 subparagraph (A) an attestation that all such  
12 information is complete and accurate.

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

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

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

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

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

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

16          “(5) ENFORCEMENT.—

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

21                         “(i) not later than 30 days after such  
22                         determination, the Secretary shall notify  
23                         such provider or supplier of such deter-  
24                         mination;

1           “(ii) upon request of the Secretary,  
2           such provider or supplier shall submit to  
3           the Secretary, not later than 45 days after  
4           the date of such request, a corrective ac-  
5           tion plan to comply with such paragraph;  
6           and

7           “(iii) if such provider or supplier con-  
8           tinues to fail to comply with such para-  
9           graph after the date that is 90 days after  
10          such notification is sent (or, in the case of  
11          such a provider or supplier that has sub-  
12          mitted a corrective action plan described in  
13          clause (ii) in response to a request so de-  
14          scribed, after the date that is 90 days after  
15          such submission), the Secretary may im-  
16          pose a civil monetary penalty in an amount  
17          not to exceed \$300 for each day (beginning  
18          with the day on which the Secretary first  
19          determined that such provider or supplier  
20          was failing to comply with such paragraph)  
21          during which such failure to comply or fail-  
22          ure to submit is ongoing.

23          “(B) INCREASE AUTHORITY.—In applying  
24          this paragraph with respect to violations occur-  
25          ring in 2029 or a subsequent year, the Sec-

1           retary may through notice and comment rule-  
2           making increase the amount of the civil mone-  
3           etary penalty under subparagraph (A)(iii).

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

12          “(D) AUTHORITY TO WAIVE OR REDUCE  
13          PENALTY.—

14                 “(i) IN GENERAL.—Subject to clause  
15                 (ii), the Secretary may waive or reduce any  
16                 penalty otherwise applicable with respect to  
17                 a provider of services or supplier under  
18                 this subparagraph if the Secretary deter-  
19                 mines that imposition of such penalty  
20                 would result in an immediate threat to ac-  
21                 cess to care for individuals in the service  
22                 area of such provider or supplier.

23                 “(ii) LIMITATION.—The Secretary  
24                 may not elect to waive or reduce a penalty  
25                 under clause (i) with respect to a specific

1 provider of services or supplier more than  
2 3 times in a 10 year period.

3 “(E) PROVISION OF TECHNICAL ASSIST-  
4 ANCE.—The Secretary shall, to the extent prac-  
5 ticable, provide technical assistance relating to  
6 compliance with the provisions of this sub-  
7 section to providers of services and suppliers re-  
8 questing such assistance.

9 “(F) CLARIFICATION OF NONAPPLICA-  
10 BILITY OF OTHER ENFORCEMENT PROVI-  
11 SIONS.—Notwithstanding any other provision of  
12 this title, this paragraph shall be the sole  
13 means of enforcing the provisions of this sub-  
14 section.”; and

15 (3) in subsection (d), as so redesignated by  
16 paragraph (1), by adding at the end the following  
17 new paragraph:

18 “(5) SPECIFIED IMAGING SERVICE.—the term  
19 ‘specified imaging service’ means an imaging service  
20 that is included on the list of Centers for Medicare  
21 & Medicaid Services-specified shoppable services (as  
22 described in subsection (a)(2)(A)(ii)(I)).”.

1 **SEC. 4. AMBULATORY SURGICAL CENTER PRICE TRANS-**  
2 **PARENCY.**

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

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

8 “(1) IN GENERAL.—Beginning January 1,  
9 2028, each ambulatory surgical center that receives  
10 payment under this title for furnishing items and  
11 services shall comply with the price transparency re-  
12 quirement described in paragraph (2).

13 “(2) REQUIREMENT DESCRIBED.—

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

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

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

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

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

24 “(iv) an attestation that all standard  
25 charges described in clause (i), information

1 described in clause (ii), and indications de-  
2 scribed in clause (iii) are complete and ac-  
3 curate.

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

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

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

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

21 “(I) the discounted cash price, as  
22 applicable, expressed as a dollar  
23 amount; or

24 “(II) in the case no discounted  
25 cash price is available for an item or

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

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

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

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

1 method and format for such centers to use in  
2 making public prices pursuant to subparagraph  
3 (A)(ii). Any such method and format—

4 “(i) shall, in the case of such charges  
5 made public by an ambulatory surgical  
6 center, ensure that such charges are made  
7 available in a machine-readable format (or  
8 successor technology);

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

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

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

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

1           “(A) The evaluation and analysis of com-  
2           plaints made by individuals or other entities re-  
3           lating to such centers’ compliance with this sub-  
4           section.

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

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

11          “(4) ENFORCEMENT.—

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

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

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

1 “(B) CIVIL MONETARY PENALTY.—

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

24 “(ii) INCREASE AUTHORITY.—In ap-  
25 plying this subparagraph with respect to

1 violations occurring in 2029 or a subse-  
2 quent year, the Secretary may through no-  
3 tice and comment rulemaking increase the  
4 limitation on the per day amount of any  
5 penalty applicable to an ambulatory sur-  
6 gical center under clause (i).

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

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

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

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

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

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

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

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

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

16 “(6) DEFINITIONS.—For purposes of this sub-  
17 section:

18 “(A) DISCOUNTED CASH PRICE.—The  
19 term ‘discounted cash price’ means the charge  
20 that applies to an individual who pays cash, or  
21 cash equivalent, for an item or service furnished  
22 by an ambulatory surgical center.

23 “(B) GROSS CHARGE.—The term ‘gross  
24 charge’ means the charge for an individual item  
25 or service that is reflected on an ambulatory

1 surgical center’s chargemaster, absent any dis-  
2 counts.

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

8 **SEC. 5. HEALTH COVERAGE PRICE TRANSPARENCY.**

9 (a) PRICE TRANSPARENCY REQUIREMENTS.—

10 (1) IRC.—

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

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

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

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

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

22 (iii) in subsection (a), as inserted by  
23 clause (ii), by adding at the end the fol-  
24 lowing new paragraph:

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

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

6           “(b) COST-SHARING TRANSPARENCY.—

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

1       pant or beneficiary) that meets such requirements as  
2       the Secretary may specify.

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

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

12          “(B) If such provider is not a participating  
13       provider with respect to such item or service,  
14       the maximum allowed amount or other dollar  
15       amount that such plan will recognize as pay-  
16       ment for such item or service, along with a no-  
17       tice that such participant or beneficiary may be  
18       liable for additional charges.

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

1 amount or other dollar amount described in  
2 such subparagraph).

3 “(D) The amount the participant or bene-  
4 ficiary has already accumulated with respect to  
5 any deductible or out of pocket maximum under  
6 the plan (broken down, in the case separate  
7 deductibles or maximums apply to a participant  
8 and such participant’s beneficiaries enrolled in  
9 the plan, by such separate deductibles or maxi-  
10 mums, in addition to any cumulative deductible  
11 or maximum).

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

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

22 “(G) Any financial incentives (such as any  
23 credit, payment, or other benefit provided by  
24 such plan) available to the participant or bene-  
25 ficiary with respect to such item or service fur-

1 nished by such provider known at the time such  
2 request is made.

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

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

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

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

23 “(iv) a plain language statement spec-  
24 ified by the Secretary informing the partic-  
25 ipant or beneficiary of the participant’s or

1 beneficiary's ability to obtain a summary  
2 document relating to drug pricing informa-  
3 tion described in section 9826(b)(2)(B)(ii).

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

8 “(A) is based on an Internet website (or  
9 successor technology specified by the Sec-  
10 retary);

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

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

16 “(D) allows such a request to be made  
17 with respect to an item or service furnished  
18 by—

19 “(i) a specific provider that is a par-  
20 ticipating provider with respect to such  
21 item or service;

22 “(ii) all providers that are partici-  
23 pating providers with respect to such item  
24 or service; or

1                   “(iii) a provider located in a relevant  
2                   geographic region that is not a partici-  
3                   pating provider with respect to such item  
4                   or service;

5                   “(E) provides that such a request may be  
6                   made with respect to an item or service through  
7                   use of the billing code for such item or service  
8                   or through use of a descriptive term for such  
9                   item or service; and

10                  “(F) meets any other requirement deter-  
11                  mined appropriate by the Secretary, including  
12                  requirements to ensure the accessibility and  
13                  usability of information provided through such  
14                  tool.

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

20                  “(c) RATE AND PAYMENT INFORMATION.—

21                  “(1) IN GENERAL.—For plan years beginning  
22                  on or after January 1, 2028, each group health plan  
23                  (other than a grandfathered health plan (as defined  
24                  in section 1251(e) of the Patient Protection and Af-  
25                  fordable Care Act)) shall make available to the pub-

1       lic the rate and payment information described in  
2       paragraph (2) in accordance with paragraph (3).

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

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

11           “(i) the in-network rate (expressed as  
12      a dollar amount) in effect as of the date on  
13      which such information is made public  
14      with each provider that is a participating  
15      provider with respect to such item or serv-  
16      ice;

17           “(ii) with respect to each such pro-  
18      vider, an indication of whether, during the  
19      1-year period beginning 18 months before  
20      the date such information is made public,  
21      such provider submitted a claim for such  
22      item or service to such plan; and

23           “(iii) in the case that such plan pro-  
24      vides benefits for such item or service only  
25      when furnished by a specific type of pro-

1           vider, a specification of each type of pro-  
2           vider that may furnish such item or service  
3           under such plan;

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

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

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

1 submitted to such plan during such period;  
2 and

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

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

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

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

1 service, broken down by each such provider,  
2 other than such an amount with respect to an  
3 item or service furnished by a provider that,  
4 during such period, submitted fewer than 11  
5 claims for such item or service to such plan.

6 In the case that the Secretary finds a circumstance  
7 in which a specific dollar amount required to be  
8 made available pursuant to this subsection cannot be  
9 determined prospectively, the Secretary shall identify  
10 an accurate proxy for such dollar amount and speci-  
11 fy through guidance such accurate proxy.

12 “(3) MANNER OF PUBLICATION.—

13 “(A) IN GENERAL.—Rate and payment in-  
14 formation required to be made available under  
15 this subsection shall be so made available in  
16 dollar amounts through separate machine-read-  
17 able files (and any successor technology, as ap-  
18 plicable, such as application programming inter-  
19 face technology, determined appropriate by the  
20 Secretary) corresponding to the information de-  
21 scribed in each of subparagraphs (A) through  
22 (C) of paragraph (2) that meet such require-  
23 ments as specified by the Secretary (which may  
24 be so specified through subregulatory guid-  
25 ance). Such requirements shall ensure that such

1 files are limited to an appropriate size, do not  
2 include disclosure of unnecessary duplicative in-  
3 formation contained in other files made avail-  
4 able under this subsection, are made available  
5 in a widely available format through a publicly  
6 available website that allows for information  
7 contained in such files to be compared across  
8 group health plans and group or individual  
9 health insurance coverage, and are accessible to  
10 individuals at no cost and without the need to  
11 establish a user account or provide other cre-  
12 dentials.

13 “(B) TIMING.—Rate and payment infor-  
14 mation—

15 “(i) described in subparagraph (A) or  
16 (B) of paragraph (2) shall be made public  
17 on a quarterly basis; and

18 “(ii) described in subparagraph (C) of  
19 paragraph (2) shall be made public on a  
20 monthly basis.

21 “(4) USER INSTRUCTIONS.—Each group health  
22 plan shall make available to the public instructions  
23 written in plain language explaining how individuals  
24 may search for information described in paragraph  
25 (2) in files submitted in accordance with paragraph

1 (3). The Secretary shall develop and publish through  
2 subregulatory guidance a template that such a plan  
3 may use in developing instructions for purposes of  
4 the preceding sentence.

5 “(5) SUMMARY.—For each plan year beginning  
6 on or after January 1, 2028, each group health plan  
7 shall make public a data file, in a manner that en-  
8 sures that such file may be easily downloaded and  
9 read by standard spreadsheet software and that  
10 meets such requirements as established by the Sec-  
11 retary, containing a summary of all rate and pay-  
12 ment information made public by such plan with re-  
13 spect to such plan during such plan year. Such file  
14 shall include the following:

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

1 by the geographic area in which such item or  
2 service is furnished.

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

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

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

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

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

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

1           “(d) ATTESTATION.—Each group health plan shall  
2 annually submit to the Secretary an attestation of such  
3 plan’s compliance with the provisions of this section. Such  
4 attestation shall include a link to the website (or other  
5 successor technology) where rate and payment information  
6 required to be made public under subsection (c) may be  
7 accessed.

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

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

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

4           “(2) with respect to each drug included on such  
5 list and each pharmacy with a contractual relation-  
6 ship for furnishing such drug under such plan, a  
7 specification of the difference (if any) between the  
8 specified payment amount for such drug so dis-  
9 pensed by such pharmacy and the specified reim-  
10 bursement amount for such drug so dispensed by  
11 such pharmacy.

12           “(g) DEFINITIONS.—In this section:

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

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

24           “(B) the specified payment amount for  
25 such drug so dispensed is less than the specified

1 reimbursement amount for such drug so dis-  
2 pensed.

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

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

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

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

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

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

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

“Sec. 9819. Transparency in coverage.”.

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

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

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

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

22           “(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, 2028.”; 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, 2028, 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            requirements 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) In the case such item or service is an  
10           applicable spread price drug dispensed by a  
11           pharmacy—

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

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

21                    “(iii) a plain language statement spec-  
22                    ified by the Secretary that explains the  
23                    concept of spread pricing and how such  
24                    item’s status as such an applicable spread  
25                    price drug may impact the amount such

1 plan or coverage pays for such drug and  
2 cost sharing amounts for such drug de-  
3 scribed in subparagraph (C); and

4 “(iv) except in the case of individual  
5 health insurance coverage, a plain lan-  
6 guage statement specified by the Secretary  
7 informing the participant or beneficiary of  
8 the participant’s or beneficiary’s ability to  
9 obtain a summary document relating to  
10 drug pricing information described in sec-  
11 tion 2799A–11(b)(2)(B)(ii).

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

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

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

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

1           “(D) 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) a provider located in a relevant  
11                   geographic region that is not a partici-  
12                   pating provider with respect to such item  
13                   or service;

14           “(E) 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                   “(F) 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           The Secretary may require such tool, as a condition  
25           of complying with subparagraph (E), to link multiple

1 billing codes to a single descriptive term if the Sec-  
2 retary determines that the billing codes to be so  
3 linked correspond to similar items and services.

4 “(c) RATE AND PAYMENT INFORMATION.—

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

4 “(ii) with respect to each such pro-  
5 vider, an indication of whether, during the  
6 1-year period beginning 18 months before  
7 the date such information is made public,  
8 such provider submitted a claim for such  
9 item or service to such plan or coverage;  
10 and

11 “(iii) in the case that such plan or  
12 coverage provides benefits for such item or  
13 service only when furnished by a specific  
14 type of provider, a specification of each  
15 type of provider that may furnish such  
16 item or service under such plan or cov-  
17 erage;

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

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

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

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

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

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

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

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

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

22 In the case that the Secretary finds a circumstance  
23 in which a specific dollar amount required to be  
24 made available pursuant to this subsection cannot be  
25 determined prospectively, the Secretary shall identify

1 an accurate proxy for such dollar amount and speci-  
2 fy through guidance such accurate proxy.

3 “(3) MANNER OF PUBLICATION.—

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

1 individuals at no cost and without the need to  
2 establish a user account or provide other cre-  
3 dentials.

4 “(B) TIMING.—Rate and payment infor-  
5 mation—

6 “(i) described in subparagraph (A) or  
7 (B) of paragraph (2) shall be made public  
8 on a quarterly basis; and

9 “(ii) described in subparagraph (C) of  
10 paragraph (2) shall be made public on a  
11 monthly basis.

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

23 “(5) SUMMARY.—For each plan year beginning  
24 on or after January 1, 2028, each group health plan  
25 and health insurance issuer offering group or indi-

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

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

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

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

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

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

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

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

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

22 “(d) ATTESTATION.—Each group health plan and  
23 health insurance issuer offering group or individual health  
24 insurance coverage shall annually submit to the Secretary  
25 an attestation of such plan’s or coverage’s compliance with

1 the provisions of this section. Such attestation shall in-  
2 clude a link to the website (or other successor technology)  
3 where rate and payment information required to be made  
4 public under subsection (c) may be accessed.

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

15 “(f) PBM DISCLOSURE OF APPLICABLE SPREAD  
16 PRICE DRUGS.—An entity providing pharmacy benefit  
17 management services on behalf of a group health plan or  
18 group or individual health insurance coverage shall dis-  
19 close to such plan or coverage, at such time and in such  
20 manner as specified by the Secretary to ensure that infor-  
21 mation provided under subsection (b) and rate and pay-  
22 ment information made public under subsection (c) is  
23 timely and accurate—

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

4           “(2) with respect to each drug included on such  
5 list and each pharmacy with a contractual relation-  
6 ship for furnishing such drug under such plan or  
7 coverage, a specification of the difference (if any) be-  
8 tween the specified payment amount for such drug  
9 so dispensed by such pharmacy and the specified re-  
10 imbursement amount for such drug so dispensed by  
11 such pharmacy.

12           “(g) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

16 (3) ERISA.—

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

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

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

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

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

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

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

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

12       “(b) COST-SHARING TRANSPARENCY.—

13               “(1) IN GENERAL.—For plan years beginning  
14 on or after January 1, 2028, a group health plan  
15 and a health insurance issuer offering group health  
16 insurance coverage shall provide a participant or  
17 beneficiary, in a timely manner upon request of the  
18 participant or beneficiary, information on the  
19 amount of cost-sharing (including deductibles, co-  
20 payments, and coinsurance) under the participant or  
21 beneficiary’s plan or coverage that the participant or  
22 beneficiary would be responsible for paying with re-  
23 spect to the furnishing of a specific item or service  
24 by a provider. At a minimum, such information shall  
25 include the information specified in paragraph (2)

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

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

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

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

1 with a notice that such participant or bene-  
2 ficiary may be liable for additional charges.

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

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

21 “(E) In the case such plan imposes any  
22 frequency or volume limitations with respect to  
23 such item or service (excluding medical neces-  
24 sity determinations), the amount that such par-

1            participant or beneficiary has accrued towards such  
2            limitation with respect to such item or service.

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

7            “(G) Any financial incentives (such as any  
8            credit, payment, or other benefit provided by  
9            such plan or issuer) available to the participant  
10           or beneficiary with respect to such item or serv-  
11           ice furnished by such provider known at the  
12           time such request is made.

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

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

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

1                   “(iii) a plain language statement spec-  
2                   fied by the Secretary that explains the  
3                   concept of spread pricing and how such  
4                   item’s status as such an applicable spread  
5                   price drug may impact the amount such  
6                   plan or coverage pays for such drug and  
7                   cost sharing amounts for such drug de-  
8                   scribed in subparagraph (C); and

9                   “(iv) a plain language statement spec-  
10                  fied by the Secretary informing the partic-  
11                  ipant or beneficiary of the participant’s or  
12                  beneficiary’s ability to obtain a summary  
13                  document relating to drug pricing informa-  
14                  tion described in section 726(b)(2)(B)(ii).

15                  “(3) SELF-SERVICE TOOL.—For purposes of  
16                  paragraph (1), a self-service tool established by a  
17                  group health plan or health insurance issuer offering  
18                  group health insurance coverage meets the require-  
19                  ments of this paragraph if such tool—

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

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

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

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

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

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

13                   “(iii) a provider located in a relevant  
14                   geographic region that is not a partici-  
15                   pating provider with respect to such item  
16                   or service;

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

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

1 usability of information provided through such  
2 tool.

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

8 “(c) RATE AND PAYMENT INFORMATION.—

9 “(1) IN GENERAL.—For plan years beginning  
10 on or after January 1, 2028, each group health plan  
11 and health insurance issuer offering group health in-  
12 surance coverage (other than a grandfathered health  
13 plan (as defined in section 1251(e) of the Patient  
14 Protection and Affordable Care Act)) shall make  
15 available to the public the rate and payment infor-  
16 mation described in paragraph (2) in accordance  
17 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 or  
22 group health insurance coverage, the 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 or coverage—

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;

7           “(ii) with respect to each such pro-  
8           vider, an indication of whether, during the  
9           1-year period beginning 18 months before  
10          the date such information is made public,  
11          such provider submitted a claim for such  
12          item or service to such plan or coverage;  
13          and

14          “(iii) in the case that such plan or  
15          coverage provides benefits for such item or  
16          service only when furnished by a specific  
17          type of provider, a specification of each  
18          type of provider that may furnish such  
19          item or service under such plan or cov-  
20          erage;

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, for each such item or serv-  
15                  ice furnished during the 6-month period begin-  
16                  ning 9 months before the date such information  
17                  is made public by a provider that was not a  
18                  participating provider with respect to such item  
19                  or service, broken down by each such provider,  
20                  other than such an amount with respect to an  
21                  item or service furnished by a provider that,  
22                  during such period, submitted fewer than 11  
23                  claims for such item or service to such plan or  
24                  coverage.

1 In the case that the Secretary finds a circumstance  
2 in which a specific dollar amount required to be  
3 made available pursuant to this subsection cannot be  
4 determined prospectively, the Secretary shall identify  
5 an accurate proxy for such dollar amount and speci-  
6 fy through guidance such accurate proxy.

7 “(3) MANNER OF PUBLICATION.—

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

1 available website that allows for information  
2 contained in such files to be compared across  
3 group health plans and group or individual  
4 health insurance coverage, and are accessible to  
5 individuals at no cost and without the need to  
6 establish a user account or provide other cre-  
7 dentials.

8 “(B) TIMING.—Rate and payment infor-  
9 mation—

10 “(i) described in subparagraph (A) or  
11 (B) of paragraph (2) shall be made public  
12 on a quarterly basis; and

13 “(ii) described in subparagraph (C) of  
14 paragraph (2) shall be made public on a  
15 monthly basis.

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

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

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

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

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

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

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

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

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

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 of such plan’s or coverage’s compliance with the provi-  
5 sions of this section. Such attestation shall include a link  
6 to the website (or other successor technology) where rate  
7 and payment information required to be made public  
8 under subsection (c) may be accessed.

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

19           “(f) PBM DISCLOSURE OF APPLICABLE SPREAD  
20 PRICE DRUGS.—An entity providing pharmacy benefit  
21 management services on behalf of a group health plan or  
22 group health insurance coverage shall disclose to such plan  
23 or coverage, at such time and in such manner as specified  
24 by the Secretary to ensure that information provided

1 under subsection (b) and rate and payment information  
2 made public under subsection (c) is timely and accurate—

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

6 “(2) with respect to each drug included on such  
7 list and each pharmacy with a contractual relation-  
8 ship for furnishing such drug under such plan or  
9 coverage, a specification of the difference (if any) be-  
10 tween the specified payment amount for such drug  
11 so dispensed by such pharmacy and the specified re-  
12 imbursement amount for such drug so dispensed by  
13 such pharmacy.

14 “(g) DEFINITIONS.—In this section:

15 “(1) APPLICABLE SPREAD PRICE DRUG.—The  
16 term ‘applicable spread price drug’ means, with re-  
17 spect to a group health plan or group health insur-  
18 ance coverage, a drug for which benefits are avail-  
19 able under such plan or coverage and with respect  
20 to which, at the time a disclosure described in sub-  
21 section (f) is required to be made by an entity pro-  
22 viding pharmacy benefit management services on be-  
23 half of such plan or coverage—

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

4           “(B) the specified payment amount for  
5           such drug so dispensed is less than the specified  
6           reimbursement amount for such drug so dis-  
7           pensed.

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

20          “(3) PARTICIPATING PROVIDER.—The term  
21          ‘participating provider’ means, with respect to an  
22          item or service and a group health plan or health in-  
23          surance issuer offering group health insurance cov-  
24          erage, a physician or other health care provider (as  
25          defined in paragraph (4)) who is acting within the

1 scope of practice of that provider’s license or certifi-  
2 cation under applicable State law and who has a  
3 contractual relationship with the plan or issuer, re-  
4 spectively, for furnishing such item or service under  
5 the plan or coverage, respectively.

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

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

1           “(6) SPECIFIED REIMBURSEMENT AMOUNT.—

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

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

          “Sec. 719. Transparency in coverage.”.

24           (b) APPLICATION PROGRAMMING INTERFACE RE-  
25           PORT.—Not later than January 1, 2026, and annually

1 thereafter, the Secretary of Health and Human Services  
2 shall, in consultation with the Office of the National Coor-  
3 dinator for Health Information Technology, Department  
4 of Labor, the Department of the Treasury, and stake-  
5 holders, submit to the House Committees on Education  
6 and the Workforce, Energy and Commerce, and Ways and  
7 Means, and the Senate Committees on Finance and  
8 Health, Education, Labor, and Pensions a report on the  
9 use of standards-based application programming inter-  
10 faces (in this subsection referred to as “APIs”) to facili-  
11 tate access to health care price transparency information  
12 and the interoperability of other medical information.  
13 Such report shall include an evaluation of the capacity of  
14 the Department of Health and Human Services, the De-  
15 partment of Labor, and the Department of the Treasury  
16 to regulate and implement standards related to APIs and  
17 recommendations for improving such capacity. Such re-  
18 port shall include the following:

19           (1) A description of current use, and proposed  
20           use, of APIs under Federal rules to facilitate inter-  
21           operability, including information related to capacity  
22           constraints within the agencies, barriers to adoption,  
23           privacy and security, administrative burdens and ef-  
24           ficiencies, care coordination, and levels of compli-  
25           ance.

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

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

8           (4) An analysis of the benefits and challenges  
9 of implementing standards-based APIs for price  
10 transparency data, including the ability for con-  
11 sumers to access rate and payment information and  
12 the amount of cost-sharing (including deductibles,  
13 copayments, and coinsurance) under the consumer's  
14 plan through third-party internet-based tools and  
15 applications.

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

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

1           (7) An analysis of the cost of API standards  
2           implementation on issuers, employers, and other pri-  
3           vate-sector entities.

4           (8) An analysis of the ability of State regu-  
5           lators to enforce API standards and the costs to the  
6           Federal Government and States to regulate and en-  
7           force API standards.

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

11         (c) PROVIDER TOOL REPORT.—

12           (1) IN GENERAL.—Not later than 1 year after  
13           the date of the enactment of this Act, The Secretary  
14           of Health and Human Services, acting through the  
15           Administrator of the Centers for Medicare & Med-  
16           icaid Services, shall, in consultation with stake-  
17           holders, conduct a study and submit to the House  
18           Committees on Education and the Workforce, En-  
19           ergy and Commerce, and Ways and Means, and the  
20           Senate Committees on Finance and Health, Edu-  
21           cation, Labor, and Pensions a report on the useful-  
22           ness and feasibility of the establishment of a pro-  
23           vider tool by a group health plan, or a health insur-  
24           ance issuer offering group or individual health insur-  
25           ance coverage, in facilitating the provision of infor-

1       mation made available pursuant to the amendments  
2       made by subsection (a). Such report shall include  
3       the following:

4               (A) A description of the feasibility of es-  
5               tablishing a requirement for the various types  
6               of plans and coverage to offer such a provider  
7               tool, including any challenges to establishing a  
8               provider tool using the same technology plat-  
9               form as the self-service tool described in such  
10              amendments.

11             (B) An evaluation on the usefulness of a  
12             provider tool to aid patient-decision making and  
13             how such tool would coordinate with other in-  
14             formation available to a patient and their pro-  
15             vider under other Federal requirements in place  
16             or under consideration.

17             (C) An evaluation of whether the informa-  
18             tion provided by such tool would be duplicative  
19             of the advanced explanation of benefits required  
20             under Federal law or any other existing require-  
21             ment.

22             (D) A description of the usability and ex-  
23             pected utilization of such tool among providers,  
24             including among different provider types.

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

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

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

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

8 (iii) care coordination and quality;

9 (iv) plan premiums;

10 (v) overall health care spending and  
11 utilization; and

12 (vi) health care access in rural areas.

13 (G) An analysis of the feasibility of a pro-  
14 vider tool to include additional functionality to  
15 facilitate and improve the administration of the  
16 requirements on providers to submit notifica-  
17 tions to such plan or coverage under section  
18 2799B–6 of the Public Health Service Act and  
19 the requirements on such plan or coverage to  
20 provide an advanced explanation of benefits to  
21 individuals under section 2799A–1(f) of such  
22 Act.

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

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

4 (J) An analysis of the burden and cost of  
5 the creation of a provider tool by plans and cov-  
6 erage on providers, issuers, employers, and  
7 other private-sector entities.

8 (K) An analysis of the ability of state reg-  
9 ulators to enforce provider tool standards and  
10 the costs to the Department and states to regu-  
11 late and enforce provider tool standards.

12 (2) DEFINITION.—The term “provider tool”  
13 means a tool designed to facilitate the provision of  
14 information made available pursuant to the amend-  
15 ments made by subsection (a) and established by a  
16 group health plan or a health insurance issuer offer-  
17 ing group or individual health insurance coverage  
18 that allows providers to access the information such  
19 plan or coverage must provide through the self-serv-  
20 ice tool described in such amendments to an indi-  
21 vidual with whom the provider is actively treating at  
22 the time of such request, upon the request of the  
23 provider, and with the consent of such individual.

24 (d) REPORTS.—

1           (1) COMPLIANCE.—Not later than January 1,  
2           2029, the Comptroller General of the United States  
3           shall submit to Congress a report containing—

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

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

9                   (C) recommendations relating to improving  
10                  such enforcement; and

11                  (D) recommendations relating to improving  
12                  public disclosure, and public awareness, of in-  
13                  formation required to be made available by  
14                  group health plans and health insurance issuers  
15                  pursuant to such amendments.

16           (2) PRICES.—Not later than January 1, 2029,  
17           and biennially thereafter, the Secretaries of Health  
18           and Human Services, Labor, and the Treasury shall  
19           jointly submit to Congress a report containing an as-  
20           sessment of differences in negotiated prices (and any  
21           trends in such prices) in the private market be-  
22           tween—

23                   (A) rural and urban areas;

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

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

4 (D) nonprofit and for-profit hospitals;

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

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

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

20 (f) CONTINUED APPLICABILITY OF RULES FOR PRE-  
21 VIOUS YEARS.—Nothing in the amendments made by sub-  
22 section (a) may be construed as affecting the applicability  
23 of the rule entitled “Transparency in Coverage” published  
24 by the Department of the Treasury, the Department of  
25 Labor, and the Department of Health and Human Serv-

- 1 ices on November 12, 2020 (85 Fed. Reg. 72158), for any
- 2 plan year beginning before January 1, 2028.