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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R.

To promote price transparency in the health care sector.

IN THE HOUSE OF REPRESENTATIVES

Mr. GUTHRIE (for himself and Mr. PALLONE) introduced the following bill;
which was referred to the Committee on _____

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. SHORT TITLE.**

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

6 **SEC. 2. HOSPITAL PRICE TRANSPARENCY.**

7 (a) MEDICARE.—

8 (1) IN GENERAL.—Part E of title XVIII of the
9 Social Security Act (42 U.S.C. 1395x et seq.) is

1 amended by adding at the end the following new sec-
2 tion:

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

4 “(a) TRANSPARENCY REQUIREMENT.—

5 “(1) IN GENERAL.—Beginning January 1,
6 2028, each specified hospital that receives payment
7 under this title for furnishing items and services
8 shall comply with the price transparency require-
9 ment described in paragraph (2).

10 “(2) REQUIREMENT DESCRIBED.—

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

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

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

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

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

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

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

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

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

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

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

23 “(I) the discounted cash price, as
24 applicable, expressed as a dollar
25 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 “(C) UNIFORM METHOD AND FORMAT.—
13 Not later than January 1, 2028, the Secretary
14 shall establish a standard, uniform method and
15 format for specified hospitals to use in com-
16 piling and making public standard charges pur-
17 suant to subparagraph (A)(i) and a standard,
18 uniform method and format for such hospitals
19 to use in compiling and making public prices
20 pursuant to subparagraph (A)(ii). Such meth-
21 ods and formats—

22 “(i) shall, in the case of such method
23 and format for making public standard
24 charges pursuant to subparagraph (A)(i),
25 ensure that such charges are made avail-

1 able in a machine-readable format (or a
2 successor technology specified by the Sec-
3 retary);

4 “(ii) may be similar to any template
5 made available by the Centers for Medicare
6 & Medicaid Services as of the date of the
7 enactment of this subparagraph;

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

12 “(iv) shall be updated as determined
13 appropriate by the Secretary, in consulta-
14 tion with stakeholders.

15 “(3) MONITORING COMPLIANCE.—The Sec-
16 retary shall establish processes to monitor and as-
17 sess specified hospitals’ compliance with this sub-
18 section. Such processes shall include processes relat-
19 ing to the following:

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

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

1 “(C) The obtaining of additional informa-
2 tion from such hospitals to determine such hos-
3 pitals’ compliance with this subsection (as de-
4 termined appropriate by the Secretary).

5 “(4) ENFORCEMENT.—

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

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

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

23 “(I) the Secretary shall, not later
24 than 60 days after such notification is
25 sent, determine whether such hospital

1 is in compliance with such require-
2 ments; and

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

8 “(aa) submit to such hos-
9 pital a request for a corrective
10 action plan (to be submitted not
11 later than 45 days after such re-
12 quest is made) to comply with
13 such requirements; or

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

21 “(B) CIVIL MONETARY PENALTY.—

22 “(i) IN GENERAL.—Subject to clause
23 (vii), in addition to any other enforcement
24 actions or penalties that may apply under
25 another provision of Federal law, a speci-

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

22 “(I) in the case of a specified
23 hospital with 30 or fewer beds, \$300
24 per day (or, in the case of such a hos-
25 pital that has been noncompliant with

1 such requirements for a 1-year period
2 or longer, beginning with the first day
3 following such 1-year period, \$400 per
4 day);

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

14 “(III) in the case of a specified
15 hospital with more than 100 beds but
16 fewer than 201 beds, \$17.50 per bed
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, \$20 per
22 bed per day);

23 “(IV) in the case of a specified
24 hospital with more than 200 beds but
25 fewer than 501 beds, \$20 per bed per

1 day (or, in the case of such a hospital
2 that has been noncompliant with such
3 requirements for a 1-year period or
4 longer, beginning with the first day
5 following such 1-year period, \$25 per
6 bed per day); and

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

15 “(ii) INCREASE AUTHORITY.—In ap-
16 plying this subparagraph with respect to
17 violations occurring in 2029 or a subse-
18 quent year, the Secretary may through no-
19 tice and comment rulemaking increase—

20 “(I) the limitation on the per day
21 amount of any penalty applicable to a
22 specified hospital under clause (i)(I);

23 “(II) the limitations on the per
24 bed per day amount of any penalty

1 applicable under any of subclauses
2 (II) through (V) of clause (i); and

3 “(III) the amounts specified in
4 clause (iii)(II).

5 “(iii) PERSISTENT NONCOMPLI-
6 ANCE.—

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

23 “(II) SPECIFIED AMOUNT.—For
24 purposes of subclause (I), the amount

1 specified in this subclause is, with re-
2 spect to a specified hospital—

3 “(aa) with more than 30
4 beds but fewer than 101 beds, an
5 amount that is not less than
6 \$500,000 and not more than
7 \$1,000,000;

8 “(bb) with more than 100
9 beds but fewer than 301 beds, an
10 amount that is greater than
11 \$1,000,000 and not more than
12 \$2,000,000;

13 “(cc) with more than 300
14 beds but fewer than 501 beds, an
15 amount that is greater than
16 \$2,000,000 and not more than
17 \$4,000,000; and

18 “(dd) with more than 500
19 beds, and amount that is not less
20 than \$5,000,000 and not more
21 than \$10,000,000.

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

24 “(I) HOSPITALS LOCATED IN
25 RURAL OR UNDERSERVED AREAS.—

1 “(aa) IN GENERAL.—Sub-
2 ject to item (bb), the Secretary
3 may waive any penalty, or reduce
4 any penalty by not more than 75
5 percent, otherwise applicable
6 under this subparagraph with re-
7 spect to a specified hospital lo-
8 cated in a rural or underserved
9 area if the Secretary certifies
10 that imposition of such penalty
11 would result in an immediate
12 threat to access to care for indi-
13 viduals in the service area of
14 such hospital.

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

1 hibiting the Secretary from both
2 waiving and reducing a penalty
3 with respect to a specified hos-
4 pital during a 6-year period.

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

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

1 disaster (as defined in section 602(a) of
2 the Robert T. Stafford Disaster Relief and
3 Emergency Assistance Act), a public health
4 emergency, or other similar or unexpected
5 catastrophe or similar situation).

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

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

20 “(viii) NONDUPLICATION OF CERTAIN
21 PENALTIES.—

22 “(I) IN GENERAL.—The Sec-
23 retary may not subject a specified
24 hospital to a civil monetary penalty
25 under this subparagraph with respect

1 to noncompliance with the provisions
2 of this subsection for a period if the
3 Secretary has imposed a civil mone-
4 tary penalty on such hospital under
5 section 2718(f) of the Public Health
6 Service Act for failure to comply with
7 the provisions of such section for such
8 period.

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

18 “(C) PUBLICATION OF HOSPITAL PRICE
19 TRANSPARENCY INFORMATION.—Beginning on
20 January 1, 2028, the Secretary shall make pub-
21 licly available on the public website of the Cen-
22 ters for Medicare & Medicaid Services informa-
23 tion with respect to compliance with the re-
24 quirements of this subsection and enforcement
25 activities undertaken by the Secretary under

1 this subsection. Such information shall be up-
2 dated in real time (if practicable) and include—

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

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

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

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

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

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

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

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

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

12 “(vii) any other information as deter-
13 mined by the Secretary.

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

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

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

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

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

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

20 “(5) SPECIFIED HOSPITAL.—The term ‘speci-
21 fied hospital’ means a hospital (as defined in section
22 1861(e)), a critical access hospital (as defined in
23 section 1861(mmm)(1)), or a rural emergency hos-
24 pital (as defined in section 1861(kkk)).

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

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

12 (b) PHSA.—

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

17 “(f) HOSPITAL TRANSPARENCY REQUIREMENT.—

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

24 “(2) REQUIREMENT DESCRIBED.—

1 “(A) IN GENERAL.—For purposes of para-
2 graph (1), the price transparency requirement
3 described in this paragraph is, with respect to
4 a hospital, that such hospital, in accordance
5 with a method and format established by the
6 Secretary under subparagraph (C), compile and
7 make public (without subscription and free of
8 charge) for each year—

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

13 “(ii) information in a consumer-
14 friendly format (as specified by the Sec-
15 retary)—

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

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

4 “(II) that includes, with respect
5 to each Centers for Medicare & Med-
6 icaid Services-specified shoppable
7 service that is not furnished by the
8 hospital, an indication that such serv-
9 ice is not so furnished;

10 “(iii) each type 2 national provider
11 identifier associated with the hospital or a
12 unit of the hospital; and

13 “(iv) an attestation that all informa-
14 tion made public pursuant to this subpara-
15 graph is complete and accurate.

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

21 “(i) A plain language description (as
22 specified by the Secretary) of each item or
23 service, accompanied by, as applicable, the
24 Healthcare Common Procedure Coding
25 System code, the diagnosis-related group,

1 the national drug code, current procedure
2 terminology codes, or other identifier used
3 or approved by the Centers for Medicare &
4 Medicaid Services.

5 “(ii) The gross charge, as applicable,
6 expressed as a dollar amount (as specified
7 by the Secretary), for each such item or
8 service, when provided in, as applicable,
9 the inpatient setting and outpatient de-
10 partment setting.

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

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

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

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

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

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

20 “(vii) Any other additional informa-
21 tion the Secretary may require (in con-
22 sultation with stakeholders) for the pur-
23 pose of improving the accuracy of, or ena-
24 bling consumers to easily understand and
25 compare, standard charges and prices for

1 an item or service, except information that
2 is duplicative of any other reporting re-
3 quirement under this subsection.

4 “(C) UNIFORM METHOD AND FORMAT.—
5 Not later than January 1, 2028, the Secretary
6 shall establish a standard, uniform method and
7 format for hospitals to use in compiling and
8 making public standard charges pursuant to
9 subparagraph (A)(i) and a standard, uniform
10 method and format for such hospitals to use in
11 compiling and making public prices pursuant to
12 subparagraph (A)(ii). Such methods and for-
13 mats—

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

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

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

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

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

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

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

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

23 “(4) ENFORCEMENT.—

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

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

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

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

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

1 requirements, the Secretary shall ei-
2 ther—

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

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

16 “(B) CIVIL MONETARY PENALTY.—

17 “(i) IN GENERAL.—In addition to any
18 other enforcement actions or penalties that
19 may apply under another provision of Fed-
20 eral law, a hospital that has received a re-
21 quest for a corrective action plan under
22 clause (i) or (ii) of subparagraph (A) and
23 fails to comply with the requirements of
24 this subsection by the date that is 90 days
25 after such request is made (or, if such hos-

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

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

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

1 than 101 beds, \$12.50 per bed per
2 day (or, in the case of such a hospital
3 that has been noncompliant with such
4 requirements for a 1-year period or
5 longer, beginning with the first day
6 following such 1-year period, \$15 per
7 bed per day);

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

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

1 “(V) in the case of a hospital
2 with more than 500 beds, \$25 per bed
3 per day (or, in the case of such a hos-
4 pital that has been noncompliant with
5 such requirements for a 1-year period
6 or longer, beginning with the first day
7 following such 1-year period, \$35 per
8 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 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 hospital (other than a hospital
3 with 30 or fewer beds) that the Sec-
4 retary has determined to be knowingly
5 and willfully noncompliant with the
6 provisions of this subsection for two
7 or more 6-month periods during any
8 3-year period, the Secretary may in-
9 crease any penalty otherwise applica-
10 ble under this subparagraph by the
11 amount specified in subclause (II)
12 with respect to such hospital and may
13 require such hospital to complete such
14 additional corrective actions plans as
15 the Secretary may specify.

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

20 “(aa) with more than 30
21 beds but fewer than 101 beds, an
22 amount that is not less than
23 \$500,000 and not more than
24 \$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 hospital located in a

1 rural or underserved area if the
2 Secretary certifies that imposi-
3 tion of such penalty would result
4 in an immediate threat to access
5 to care for individuals in the
6 service area of such hospital.

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

22 “(II) REDUCTION IF HEARING
23 WAIVED.—The Secretary may reduce
24 any penalty otherwise applicable
25 under this subparagraph (as reduced,

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

8 “(v) PROVISION OF TECHNICAL AS-
9 SISTANCE.—The Secretary shall, to the ex-
10 tent practicable, provide technical assist-
11 ance relating to compliance with the provi-
12 sions of this subsection to hospitals re-
13 questing such assistance.

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

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

3 “(vii) APPLICATION OF CERTAIN PRO-
4 VISIONS.—The provisions of section 1128A
5 of the Social Security Act (other than sub-
6 sections (a) and (b) of such section) shall
7 apply to a civil monetary penalty imposed
8 under this subparagraph in the same man-
9 ner as such provisions apply to a civil mon-
10 etary penalty imposed under subsection (a)
11 of such section.

12 “(viii) NONDUPLICATION OF PEN-
13 ALTIES.—

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

1 “(II) PRIORITIZATION.—In the
2 case of a hospital that the Secretary
3 determines to be in violation of the
4 provisions of this subsection and of
5 section 1899D of the Social Security
6 Act, the Secretary shall impose pen-
7 alties as prescribed in this subsection
8 in lieu of any penalties prescribed in
9 such section 1899D.

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

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

23 “(ii) the number of notifications de-
24 scribed in subparagraph (A)(i) sent by the
25 Secretary;

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

5 “(iv) the amount of any civil monetary
6 penalty imposed on such hospital under
7 subparagraph (B);

8 “(v) whether such hospital subse-
9 quently came into compliance with this
10 subsection;

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

15 “(I) the name of any hospital
16 that received such a waiver or reduc-
17 tion;

18 “(II) the dollar amount of each
19 such penalty so waived or reduced;
20 and

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

1 “(vii) any other information as deter-
2 mined by the Secretary.

3 “(5) ENSURING ACCESSIBILITY THROUGH IM-
4 PLEMENTATION.—In implementing this subsection,
5 the Secretary shall through rulemaking ensure that
6 a hospital making public charges and prices pursu-
7 ant to this section takes reasonable steps (as speci-
8 fied by the Secretary) to ensure the accessibility of
9 such charges and information to individuals with
10 limited English proficiency. Such steps may include
11 the hospital’s provision of interpretation services or
12 the hospital’s provision of translations of charges
13 and information.

14 “(6) DEFINITIONS.—For purposes of this sub-
15 section:

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

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

1 “(C) PAYER-SPECIFIC NEGOTIATED
2 CHARGE.—The term ‘payer-specific negotiated
3 charge’ means the charge that a hospital has
4 negotiated with a third party payer for an item
5 or service.

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

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

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

19 (A) in subsection (b)(3), by inserting
20 “(other than the provisions of subsection (f))”
21 after “this section”; and

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

1 diagnostic laboratory test that such laboratory
2 so furnishes;

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

5 “(C) include on the website described in
6 subparagraph (A) an attestation that all such
7 information is complete and accurate.

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

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

20 “(A) may be similar to any template made
21 available by the Centers for Medicare & Med-
22 icaid Services (as described in section
23 1899D(a)(2)(C)(ii));

24 “(B) shall meet such standards as deter-
25 mined appropriate by the Secretary in order to

1 ensure the accessibility and usability of such in-
2 formation; and

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

6 “(4) INCLUSION OF ANCILLARY SERVICES.—

7 Any price or charge for a specified clinical diagnostic
8 laboratory test furnished by an applicable laboratory
9 made publicly available in accordance with para-
10 graph (1) shall include the price or charge (as appli-
11 cable) for any ancillary item or service (such as
12 specimen collection services) that would normally be
13 furnished by such laboratory as part of such test, as
14 specified by the Secretary.

15 “(5) ENFORCEMENT.—

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

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

22 “(ii) if such laboratory continues to
23 fail to comply with such paragraph after
24 the date that is 90 days after such notifi-
25 cation is sent, the Secretary may impose a

1 civil monetary penalty in an amount not to
2 exceed \$300 for each day (beginning with
3 the day on which the Secretary first deter-
4 mined that such laboratory was failing to
5 comply with such paragraph) during which
6 such failure is ongoing.

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

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

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

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

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

11 “(i) a specified hospital pursuant to
12 section 1899D;

13 “(ii) a hospital pursuant to section
14 2718(f) of the Public Health Service Act;
15 or

16 “(iii) an ambulatory surgical center
17 pursuant to section 1834(bb).

18 “(B) 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.

22 “(C) GROSS CHARGE.—The term ‘gross
23 charge’ means the charge for an individual item
24 or service that is reflected on an applicable lab-

1 oratory’s chargemaster (or similar list of
2 prices), absent any discounts.

3 “(D) SPECIFIED CLINICAL DIAGNOSTIC
4 LABORATORY TEST.—the term ‘specified clinical
5 diagnostic laboratory test’ means a clinical di-
6 agnostic laboratory test that is included on the
7 list of shoppable services specified by the Cen-
8 ters for Medicare & Medicaid Services (as de-
9 scribed in section 1899D(a)(2)(A)(ii)(I)), other
10 than an advanced diagnostic laboratory test (as
11 defined in section 1834A(d)(5)).

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

15 **SEC. 4. IMAGING PRICE TRANSPARENCY.**

16 Section 1899D of the Social Security Act, as added
17 by section 2, is amended—

18 (1) by redesignating subsections (b) and (c) as
19 subsections (c) and (d), respectively;

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

22 “(b) IMAGING SERVICES PRICE TRANSPARENCY.—

23 “(1) IN GENERAL.—Beginning January 1,
24 2028, each provider of services and supplier that re-
25 ceives payment under this title for furnishing a spec-

1 ified imaging service, other than such a provider or
2 supplier with respect to which standard charges and
3 prices for such services furnished by such provider
4 or supplier are made available by a specified hospital
5 pursuant to subsection (a), a hospital pursuant to
6 section 2718(f) of the Public Health Service Act, or
7 an ambulatory surgical center pursuant to section
8 1834(bb), shall—

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

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

16 “(C) include on the website described in
17 subparagraph (A) an attestation that all such
18 information is complete and accurate.

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

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

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

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

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

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

22 “(5) ENFORCEMENT.—

23 “(A) IN GENERAL.—In the case that the
24 Secretary determines that a provider of services

1 or supplier is not in compliance with paragraph
2 (1)—

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

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

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

1 was failing to comply with such paragraph)
2 during which such failure to comply or fail-
3 ure to submit is ongoing.

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

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

18 “(D) AUTHORITY TO WAIVE OR REDUCE
19 PENALTY.—

20 “(i) IN GENERAL.—Subject to clause
21 (ii), the Secretary may waive or reduce any
22 penalty otherwise applicable with respect to
23 a provider of services or supplier under
24 this subparagraph if the Secretary deter-
25 mines that imposition of such penalty

1 would result in an immediate threat to ac-
2 cess to care for individuals in the service
3 area of such provider or supplier.

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

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

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

21 (3) in subsection (d), as so redesignated by
22 paragraph (1), by adding at the end the following
23 new paragraph:

24 “(5) SPECIFIED IMAGING SERVICE.—the term
25 ‘specified imaging service’ means an imaging service

1 that is included on the list of Centers for Medicare
2 & Medicaid Services-specified shoppable services (as
3 described in subsection (a)(2)(A)(ii)(I)).”.

4 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
5 **PARENCY.**

6 Section 1834 of the Social Security Act (42 U.S.C.
7 1395m) is amended by adding at the end the following
8 new subsection:

9 “(bb) AMBULATORY SURGICAL CENTER PRICE
10 TRANSPARENCY.—

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

16 “(2) REQUIREMENT DESCRIBED.—

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

1 “(i) all of the ambulatory surgical
2 center’s standard charges (including the
3 information described in subparagraph
4 (B)) for each item and service furnished by
5 such surgical center;

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

21 “(iii) with respect to each Centers for
22 Medicare & Medicaid Services-specified
23 shoppable service that is not furnished by
24 the ambulatory surgical center, an indica-

1 tion that such service is not so furnished;
2 and

3 “(iv) an attestation that all standard
4 charges described in clause (i), information
5 described in clause (ii), and indications de-
6 scribed in clause (iii) are complete and ac-
7 curate.

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

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

21 “(ii) The gross charge, as applicable,
22 expressed as a dollar amount, for each
23 such item or service.

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

1 “(I) the discounted cash price, as
2 applicable, expressed as a dollar
3 amount; or

4 “(II) in the case no discounted
5 cash price is available for an item or
6 service, the median cash price charged
7 to self-pay individuals for such item
8 or service for the previous three years,
9 expressed as a dollar amount.

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

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

1 making public prices pursuant to subparagraph
2 (A)(ii). Any such method and format—

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

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

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

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

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

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

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

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

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

9 “(4) ENFORCEMENT.—

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

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

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

24 “(B) CIVIL MONETARY PENALTY.—

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

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

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

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

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

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

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

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

7 “(bb) LIMITATION ON AP-
8 PLICATION.—The Secretary may
9 not elect to waive a penalty
10 under item (aa) with respect to
11 an ambulatory surgical center
12 more than once in a 6-year pe-
13 riod and may not elect to reduce
14 such a penalty with respect to
15 such a center more than once in
16 such a period. Nothing in the
17 preceding sentence shall be con-
18 strued as prohibiting the Sec-
19 retary from both waiving and re-
20 ducing a penalty with respect to
21 an ambulatory surgical center
22 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 am-
4 bulatory surgical center that is the
5 subject of such penalty agrees to
6 waive any right of such center to a
7 hearing before an administrative law
8 judge with respect to the imposition of
9 such penalty.

10 “(5) PROVISION OF TECHNICAL ASSISTANCE.—

11 The Secretary shall, to the extent practicable, pro-
12 vide technical assistance relating to compliance with
13 the provisions of this subsection to ambulatory sur-
14 gical centers requesting such assistance.

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

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

22 “(B) GROSS CHARGE.—The term ‘gross
23 charge’ means the charge for an individual item
24 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. 6. 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 participant 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 “(3) MANNER OF PUBLICATION.—

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

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

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

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

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

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

24 “(5) SUMMARY.—For each plan year beginning
25 on or after January 1, 2028, each group health plan

1 shall make public a data file, in a manner that en-
2 sures that such file may be easily downloaded and
3 read by standard spreadsheet software and that
4 meets such requirements as established by the Sec-
5 retary, containing a summary of all rate and pay-
6 ment information made public by such plan with re-
7 spect to such plan during such plan year. Such file
8 shall include the following:

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

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

1 “(C) The name of such plan, a description
2 of the type of network of participating providers
3 used by such plan, and a description of whether
4 such plan is self-insured or fully-insured.

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

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

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

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

19 “(d) ATTESTATION.—Each group health plan shall
20 annually submit to the Secretary an attestation of such
21 plan’s compliance with the provisions of this section. Such
22 attestation shall include a link to the website (or other
23 successor technology) where rate and payment information
24 required to be made public under subsection (c) may be
25 accessed.

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

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

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

21 “(2) with respect to each drug included on such
22 list and each pharmacy with a contractual relation-
23 ship for furnishing such drug under such plan, a
24 specification of the difference (if any) between the
25 specified payment amount for such drug so dis-

1 pensed by such pharmacy and the specified reim-
2 bursement amount for such drug so dispensed by
3 such pharmacy.

4 “(g) DEFINITIONS.—In this section:

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

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

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

20 “(2) IN-NETWORK RATE.—The term ‘in-net-
21 work rate’ means, with respect to a group health
22 plan and an item or service furnished by a provider
23 that is a participating provider with respect to such
24 plan and item or service, the contracted rate (re-
25 flected as a dollar amount) in effect between such

1 plan and such provider for such item or service, re-
2 gardless of whether such rate is calculated based on
3 a set amount, a fee schedule, or an amount derived
4 from another amount, or a formula, or other meth-
5 od.

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

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

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

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

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

24 (B) CLERICAL AMENDMENT.—The item re-
25 lating to section 9819 of the table of sections

1 for subchapter B of chapter 100 of the Internal
2 Revenue Code of 1986 is amended to read as
3 follows:

“Sec. 9819. Transparency in coverage.”.

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

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

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

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

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

14 (C) in subsection (a), as inserted by sub-
15 paragraph (B), by adding at the end the fol-
16 lowing new paragraph:

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

20 (D) by adding at the end the following new
21 subsections:

22 “(b) COST-SHARING TRANSPARENCY.—

23 “(1) IN GENERAL.—For plan years beginning
24 on or after January 1, 2028, a group health plan
25

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

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

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

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

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

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

22 “(D) The amount the individual has al-
23 ready accumulated with respect to any deduct-
24 ible or out of pocket maximum under the plan
25 or coverage (broken down, in the case separate

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

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

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

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

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

1 “(i) a specification that such item or
2 service is such an applicable spread price
3 drug;

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

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

18 “(iv) except in the case of individual
19 health insurance coverage, a plain lan-
20 guage statement specified by the Secretary
21 informing the participant or beneficiary of
22 the participant’s or beneficiary’s ability to
23 obtain a summary document relating to
24 drug pricing information described in sec-
25 tion 2799A–11(b)(2)(B)(ii).

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

6 “(A) is based on an internet website (or
7 successor technology specified by the Sec-
8 retary);

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

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

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

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

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

23 “(iii) a provider located in a relevant
24 geographic region that is not a partici-

1 pating provider with respect to such item
2 or service;

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

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

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

18 “(c) RATE AND PAYMENT INFORMATION.—

19 “(1) IN GENERAL.—For plan years beginning
20 on or after January 1, 2028, each group health plan
21 and health insurance issuer offering group or indi-
22 vidual health insurance coverage (other than a
23 grandfathered health plan (as defined in section
24 1251(e) of the Patient Protection and Affordable
25 Care Act)) shall make available to the public the

1 rate and payment information described in para-
2 graph (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 or
7 group or individual health insurance coverage, the
8 following:

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

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

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

1 “(iii) in the case that such plan or
2 coverage provides benefits for such item or
3 service only when furnished by a specific
4 type of provider, a specification of each
5 type of provider that may furnish such
6 item or service under such plan or cov-
7 erage;

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

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

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

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

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

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

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

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

1 ice furnished during the 6-month period begin-
2 ning 9 months before the date such information
3 is made public by a provider that was not a
4 participating provider with respect to such item
5 or service, broken down by each such provider,
6 other than such an amount with respect to an
7 item or service furnished by a provider that,
8 during such period, submitted fewer than 11
9 claims for such item or service to such plan or
10 coverage.

11 “(3) MANNER OF PUBLICATION.—

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

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

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

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

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

20 “(4) USER INSTRUCTIONS.—Each group health
21 plan and health insurance issuer offering group or
22 individual health insurance coverage shall make
23 available to the public instructions written in plain
24 language explaining how individuals may search for
25 information described in paragraph (2) in files sub-

1 mitted in accordance with paragraph (3). The Sec-
2 retary shall develop and publish through subregu-
3 latory guidance a template that such a plan may use
4 in developing instructions for purposes of the pre-
5 ceding sentence.

6 “(5) SUMMARY.—For each plan year beginning
7 on or after January 1, 2028, each group health plan
8 and health insurance issuer offering group or indi-
9 vidual health insurance coverage shall make public a
10 data file, in a manner that ensures that such file
11 may be easily downloaded and read by standard
12 spreadsheet software and that meets such require-
13 ments as established by the Secretary, containing a
14 summary of all rate and payment information made
15 public by such plan or issuer with respect to such
16 plan or coverage during such plan year. Such file
17 shall include the following:

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

1 able under the plan or coverage, broken down
2 by the type of provider furnishing the item or
3 service and by the geographic area in which
4 such item or service is furnished.

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

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

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

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

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

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

1 paid for as part of a bundled rate, capitated
2 payment rate, or other alternative payment
3 model.

4 “(d) ATTESTATION.—Each group health plan and
5 health insurance issuer offering group or individual health
6 insurance coverage shall annually submit to the Secretary
7 an attestation of such plan’s or coverage’s compliance with
8 the provisions of this section. Such attestation shall in-
9 clude a link to the website (or other successor technology)
10 where rate and payment information required to be made
11 public under subsection (c) may be accessed.

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

22 “(f) PBM DISCLOSURE OF APPLICABLE SPREAD
23 PRICE DRUGS.—An entity providing pharmacy benefit
24 management services on behalf of a group health plan or
25 group or individual health insurance coverage shall dis-

1 close to such plan or coverage, at such time and in such
2 manner as specified by the Secretary to ensure that infor-
3 mation provided under subsection (b) and rate and pay-
4 ment information made public under subsection (c) is
5 timely and accurate—

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

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

17 “(g) DEFINITIONS.—In this section:

18 “(1) APPLICABLE SPREAD PRICE DRUG.—The
19 term ‘applicable spread price drug’ means, with re-
20 spect to a group health plan or group or individual
21 health insurance coverage, a drug for which benefits
22 are available under such plan or coverage and with
23 respect to which, at the time a disclosure described
24 in subsection (f) is required to be made by an entity

1 providing pharmacy benefit management services on
2 behalf of such plan or coverage—

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

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

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

22 “(3) PARTICIPATING PROVIDER.—The term
23 ‘participating provider’ means, with respect to an
24 item or service and a group health plan or health in-
25 surance issuer offering group or individual health in-

1 surance coverage, a physician or other health care
2 provider (as defined in paragraph (4)) who is acting
3 within the scope of practice of that provider’s license
4 or certification under applicable State law and who
5 has a contractual relationship with the plan or
6 issuer, respectively, for furnishing such item or serv-
7 ice under the plan or coverage, respectively.

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

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

1 requirement applicable to such drug and participant,
2 beneficiary, or enrollee.

3 “(6) SPECIFIED REIMBURSEMENT AMOUNT.—

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

21 (3) ERISA.—

22 (A) IN GENERAL.—Section 719 of the Em-
23 ployee Retirement Income Security Act of 1974
24 (29 U.S.C. 1185h) is amended—

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

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

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

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

10 (iii) in subsection (a), as inserted by
11 clause (ii), by adding at the end the fol-
12 lowing new paragraph:

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

16 (iv) by adding at the end the following
17 new subsections:

18 “(b) COST-SHARING TRANSPARENCY.—

19 “(1) IN GENERAL.—For plan years beginning
20 on or after January 1, 2028, a group health plan
21 and a health insurance issuer offering group health
22 insurance coverage shall provide a participant or
23 beneficiary, in a timely manner upon request of the
24 participant or beneficiary, information on the
25 amount of cost-sharing (including deductibles, co-

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

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

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

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

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

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

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

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

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

17 “(H) In the case such item or service is an
18 applicable spread price drug dispensed by a
19 pharmacy—

20 “(i) a specification that such item or
21 service is such an applicable spread price
22 drug;

23 “(ii) the amount of the difference (if
24 any) between the specified payment
25 amount for such drug so dispensed by such

1 pharmacy and the specified reimbursement
2 amount for such drug so dispensed by such
3 pharmacy;

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

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

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

23 “(A) is based on an internet website (or
24 successor technology specified by the Sec-
25 retary);

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

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

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

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

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

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

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

24 “(F) meets any other requirement deter-
25 mined appropriate by the Secretary, including

1 requirements to ensure the accessibility and
2 usability of information provided through such
3 tool.

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

9 “(c) RATE AND PAYMENT INFORMATION.—

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

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

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

4 “(i) the in-network rate (expressed as
5 a dollar amount) in effect as of the date on
6 which such information is made public
7 with each provider that is a participating
8 provider with respect to such item or serv-
9 ice;

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

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

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

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

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

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

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

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

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

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

6 “(3) MANNER OF PUBLICATION.—

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

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

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

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

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

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

1 “(5) SUMMARY.—For each plan year beginning
2 on or after January 1, 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 Retire-
21 ment 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, 2028, 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.