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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R. 9645

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

IN THE HOUSE OF REPRESENTATIVES

Mr. SMITH of Missouri introduced the following bill; which was referred to the Committee on _____

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Price Certainty for All Americans Act''.

SEC. 2. REQUIRING CERTAIN FACILITIES UNDER THE MEDICARE PROGRAM TO DISCLOSE CERTAIN INFORMATION RELATING TO CHARGES AND PRICES.

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

"SEC. 1899D. HEALTH CARE PROVIDER PRICE TRANSPARENCY.

"(a) HOSPITALS.—

"(1) IN GENERAL.—Beginning January 1, 2027, each specified hospital that receives payment under this title for furnishing items and services shall comply with the price transparency requirement described in paragraph (2).

"(2) REQUIREMENT DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a specified hospital, that such hospital—

"(i) in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge), and update not less frequently than annually (or at such greater fre-

quency as may be specified by the Secretary)—

"(I) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

"(II) information—

"(aa) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

"(bb) that includes, with respect to each Centers for Medi-

care & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished;

''(ii) post in a publicly accessible location of such hospital (in a form and manner specified by the Secretary) the discounted cash price, as applicable, expressed as a dollar amount, for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by the hospital when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for such service, the median cash price charged by the hospital to self-pay individuals for such service when provided in such settings for the previous three years, expressed as a dollar amount); and

''(iii) submit to the Secretary (in a form and manner specified by the Secretary and on an annual basis) an attestation, signed by the chief executive officer,

chief financial officer, or other comparable official (as specified by the Secretary) of such hospital, that all information made public pursuant to this subparagraph is complete and accurate.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a specified hospital, the following:

''(i) A plain language description (as specified by the Secretary) of each item or service, accompanied by, as applicable, commonly recognized billing code sets, including the Healthcare Common Procedure Coding System code, the diagnosis-related group, the national drug code, or other applicable identifier determined appropriate by the Secretary.

''(ii) For each such item or service when provided in, as applicable, the inpatient and outpatient department settings—

''(I) the gross charge, as applicable, expressed as a dollar amount;

''(II) each payer-specific negotiated charge in effect between such hospital and a third party payer, expressed as a dollar amount;

''(III) the deidentified maximum and minimum payer-specific negotiated charges in effect between such hospital and any third party payer; and

''(IV) the discounted cash price, as applicable, expressed as a dollar amount (or, in the case no discounted cash price is available for such item or service, the median cash price charged by the hospital (not including charity care) to self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount).

''(iii) With respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any slid-

ing scale payment structure employed for determining prices.

''(iv) Any other additional information the Secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service (which may include, in the case that charges described in clause (iii) for an item or service are unable to be expressed as a dollar amount, such information relating to past allowed charges for such item or service as may be specified by the Secretary), except information that is duplicative of any other reporting requirement under this subsection.

In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary

shall establish a standard, uniform method and format for specified hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i)(I) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to subparagraph (A)(i)(II). Such methods and formats—

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

''(I) standard charges pursuant to subparagraph (A)(i)(I), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary); and

''(II) prices pursuant to subparagraph (A)(i)(II), ensure that such prices are made available in a consumer-friendly format (as specified by the Secretary);

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

''(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

''(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(D) DEEMED COMPLIANCE WITH SHOPPABLE SERVICES REQUIREMENT FOR HOSPITALS WITH A PRICE ESTIMATOR TOOL.—

''(i) IN GENERAL.—Before the effective date of regulations implementing the provisions of sections 2799A–1(f) and 2799B–6 of the Public Health Service Act (relating to advanced explanations of benefits), including regulations on establishing data transfer standards to effectuate such provisions, a specified hospital shall be deemed to have compiled and made public information described in subparagraph (A)(i)(II) (relating to shoppable services) in accordance with a method and format specified by the Secretary under subparagraph (C) if such hospital maintains a price estimator tool described in clause (ii).

"(ii) PRICE ESTIMATOR TOOL DESCRIBED.—For purposes of clause (i), a price estimator tool described in this subparagraph is, with respect to a specified hospital, a tool that meets the following requirements:

"(I) Such tool allows an individual to immediately obtain a price estimate (taking into account whether such individual is covered under any plan, coverage, or program described in subclause (IV)(cc)) and the discounted cash price charged by a specified hospital for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by such hospital, and for each additional shoppable service as such hospital may select, such that price estimates are available through such tool for at least 300 shoppable services (or for all such services, if such hospital furnishes fewer than 300 shoppable services).

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

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

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

''(aa) The name of such individual.

''(bb) The date of birth of such individual.

''(cc) In the case such individual is covered under a group health plan, group or individual health insurance coverage, a Federal health care program, or the program established under chapter 89 of title 5, United States

Code, an identifying number assigned by such plan, coverage, or program to such individual.

''(dd) In the case of an individual described in item (cc), an indication as to whether such individual is the primary insured individual under such plan, coverage, or program (and, if such individual is not the primary insured individual, a description of the individual's relationship to such primary insured individual).

''(ee) Any other information specified by the Secretary.

''(V) Such tool contains a statement confirming the accuracy and completeness of information presented through such tool as of the date such request is made.

''(VI) Such tool meets any other requirement specified by the Secretary.

''(3) MONITORING COMPLIANCE.—The Secretary shall establish processes to monitor and as-

sess specified hospitals' compliance with this subsection. Such processes shall ensure that each specified hospital's compliance with this subsection is reviewed not less frequently than once every 3 years and include processes relating to the following:

''(A) The evaluation and analysis of complaints made by individuals or other entities relating to such hospitals' compliance with this subsection.

''(B) The use of audits to ensure such hospitals' compliance with this subsection.

''(C) The obtaining of additional information from such hospitals to determine such hospitals' compliance with this subsection (as determined appropriate by the Secretary).

''(4) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a specified hospital that fails to comply with the requirements of this subsection—

''(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a

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

''(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

''(I) the Secretary shall, not later than 60 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such hospital a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements; or

''(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—Subject to clause (vii), in addition to any other enforcement actions or penalties that may apply under another provision of Federal law, a specified hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 90 days after such request is made (or, if such hospital has submitted such a corrective action plan not later than 45 days after the date such request was made, by the date that is 90 days after the date of the submission of such corrective action plan), and a specified hospital with respect to which the Secretary has made a determination described

in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

''(I) in the case of a specified hospital with 30 or fewer beds, $342 per day;

''(II) in the case of a specified hospital with more than 30 beds but fewer than 550 beds, $11 per bed per day; and

''(III) in the case of a specified hospital with 550 beds or more, $6,277 per day.

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

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

''(II) the limitations on the per bed per day amount of any penalty applicable under clause (i)(II); and

''(III) the amounts specified in clause (iii)(II).

''(iii) PERSISTENT NONCOMPLIANCE.—

''(I) IN GENERAL.—In the case of a specified hospital (other than a specified hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection for two or more 6-month periods during any 3-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional

corrective actions plans as the Secretary may specify.

''(II) SPECIFIED AMOUNT.—For purposes of subclause (I), the amount specified in this subclause is, with respect to a specified hospital—

''(aa) with more than 30 beds but fewer than 101 beds, an amount that is not less than $500,000 and not more than $1,000,000;

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

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

''(dd) with more than 500 beds, and amount that is not less than $5,000,000 and not more than $10,000,000.

"(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

"(I) IN GENERAL.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a specified hospital located in a rural area (as defined by the Federal Office of Rural Health Policy for the purpose of rural health grant programs administered by such Office) or an underserved area if the Secretary determines that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

"(II) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under subclause (I) with respect to a specified hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more

than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a specified hospital during a 6-year period.

''(v) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to a specified hospital on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such hospital's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other unique or unexpected event).

''(vi) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provi-

sions of this subsection to specified hospitals requesting such assistance.

''(vii) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(C) PUBLICATION OF HOSPITAL PRICE TRANSPARENCY INFORMATION.—Beginning on January 1, 2028, the Secretary shall make publicly available on the website of the Centers for Medicare & Medicaid Services information with respect to compliance with the requirements of this subsection and enforcement activities undertaken by the Secretary under this subsection. Such information shall be updated in real time (if practicable) and include—

''(i) the number of reviews of compliance with this subsection undertaken by the Secretary;

''(ii) the number of notifications described in subparagraph (A)(i) sent by the Secretary;

''(iii) the identity of each specified hospital that was sent such a notification and a description of the nature of such hospital's noncompliance with this subsection;

''(iv) the amount of any civil monetary penalty imposed on such hospital under subparagraph (B);

''(v) whether such hospital subsequently came into compliance with this subsection;

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

''(I) the name of any specified hospital that received such a waiver or reduction;

''(II) the dollar amount of each such penalty so waived or reduced; and

''(III) the rationale for the granting of each such waiver or reduction, but only to the extent that such rationale does not make public commercially sensitive information; and

''(vii) any other information as determined by the Secretary.

''(b) CLINICAL DIAGNOSTIC LABORATORY SERVICES.—

''(1) IN GENERAL.—Beginning January 1, 2028, any applicable laboratory that receives payment under this title for furnishing any specified clinical diagnostic laboratory test under this title shall—

''(A) make publicly available, in accordance with a method and format established by the Secretary under paragraph (3), the information described in paragraph (2) with respect to each such specified clinical diagnostic laboratory test that such laboratory so furnishes;

''(B) update such information not less frequently than annually (or at such greater frequency as the Secretary may specify);

''(C) submit to the Secretary on an annual basis an attestation, signed by the chief execu-

tive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such laboratory, that all such information is complete and accurate; and

''(D) post in a publicly accessible location of such laboratory (in a form and manner specified by the Secretary) the discounted cash price, as applicable, expressed as a dollar amount, for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by the laboratory (or, in the case no discounted cash price is available for such service, the median cash price charged by the laboratory to self-pay individuals for such service for the previous three years, expressed as a dollar amount).

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

''(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for

applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format—

"(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(C)(ii));

"(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

"(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(4) INCLUSION OF ANCILLARY SERVICES.—Any price or charge for a specified clinical diagnostic laboratory test furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the price or charge (as applicable) for any ancillary item or service (such as specimen collection services) that would normally be furnished by such laboratory as part of such test, as specified by the Secretary.

"(5) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rule-

making, establish a process to monitor compliance with this subsection.

''(6) ENFORCEMENT.—

''(A) IN GENERAL.—In the case that the Secretary determines that an applicable laboratory is not in compliance with the requirements of paragraph (1)—

''(i) not later than 30 days after such determination, the Secretary shall notify such laboratory of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan (to be submitted not later than 45 days after such request is made)); and

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

''(I) the Secretary shall, not later than 90 days after such notification is sent, determine whether such laboratory is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such laboratory is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such laboratory a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements; or

''(bb) if the Secretary determines that such laboratory has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—An applicable laboratory that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of paragraph (1) by the date that is 90 days after such request is made, and an applicable laboratory with respect to

which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing.

''(C) INCREASE AUTHORITY.—In applying this paragraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (B).

''(D) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(E) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may waive or reduce any penalty otherwise applicable with respect to an applicable laboratory under this paragraph if the Secretary determines that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such laboratory.

''(ii) LIMITATION.—The Secretary may not elect to waive or reduce a penalty under clause (i) with respect to an applicable laboratory more than 3 times in a 10 year period.

''(F) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under subparagraph (E), the Secretary may waive any penalty with respect to an applicable laboratory on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such laboratory's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public

health emergency, or other unique or unexpected event).

''(7) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to applicable laboratories requesting such assistance.

''(8) DEFINITIONS.—In this subsection:

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' has the meaning given such term in section 414.502, of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by—

''(i) a specified hospital pursuant to subsection (a); or

''(ii) an ambulatory surgical center pursuant to subsection (d).

''(B) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—the term 'specified clinical diagnostic laboratory test' means a clinical diagnostic laboratory test that is included on the

list of shoppable services specified by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(A)(i)(II)), other than an advanced diagnostic laboratory test (as defined in section 1834A(d)(5)).

''(c) IMAGING SERVICES.—

''(1) IN GENERAL.—Beginning January 1, 2028, each provider of services and supplier that receives payment under this title for furnishing a specified imaging service, other than such a provider or supplier with respect to which standard charges and prices for such services furnished by such provider or supplier are made available by a specified hospital pursuant to subsection (a) or an ambulatory surgical center pursuant to subsection (d), shall—

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

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

''(C) submit to the Secretary on an annual basis an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such provider or supplier, that all such information is complete and accurate; and

''(D) post in a publicly accessible location of such provider or supplier (in a form and manner specified by the Secretary) the discounted cash price, as applicable, expressed as a dollar amount, for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by the provider or supplier (or, in the case no discounted cash price is available for such service, the median cash price charged by the provider or supplier to self-pay individuals for such service for the previous three years, expressed as a dollar amount).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a provider of services or supplier and a specified imaging service, the discounted cash price for such service (or, if no such price exists, the gross charge for such service).

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

''(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(C)(ii));

''(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; and

''(C) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rulemaking, establish a process to monitor compliance with this subsection.

''(5) ENFORCEMENT.—

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

or supplier is not in compliance with the requirements of paragraph (1)—

''(i) not later than 30 days after such determination, the Secretary shall notify such provider or supplier of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan (to be submitted not later than 45 days after such request is made)); and

''(ii) in the case of a provider of services or supplier that does not receive a request for a corrective action plan as part of a notification under clause (i)—

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

''(II) if the Secretary determines under subclause (I) that such provider or supplier is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such provider or supplier a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements; or

''(bb) if the Secretary determines that such provider or supplier has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—A provider of services or supplier that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of paragraph (1) by the date that is 90 days after such request is made, and a provider of services or supplier with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil

monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such provider or supplier was not complying with such requirements) during which such failure was ongoing.

''(C) INCREASE AUTHORITY.—In applying this paragraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase the amount of the civil monetary penalty under subparagraph (B).

''(D) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(E) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

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

a provider of services or supplier under this paragraph if the Secretary determines that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such provider or supplier.

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

''(F) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under subpargraph (E), the Secretary may waive any penalty with respect to a provider of services or supplier on a case-by-case basis if the Secretary determines that a circumstance exists interfering with such provider's or supplier's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other unique or unexpected event).

"(G) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to providers of services and suppliers requesting such assistance.

"(6) DEFINITION.—In this subsection, the term 'specified imaging service' means an imaging service that is included on the list of Centers for Medicare & Medicaid Services-specified shoppable services (as described in subsection (a)(i)(II)).

"(d) AMBULATORY SURGICAL CENTERS.—

"(1) IN GENERAL.—Beginning January 1, 2028, each ambulatory surgical center that receives payment under this title for furnishing items and services shall comply with the price transparency requirement described in paragraph (2).

"(2) REQUIREMENT DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this subsection is, with respect to an ambulatory surgical center, that such center—

"(i) in accordance with a method and format established by the Secretary under

subparagraph (C), compile and make public (without subscription and free of charge), and update not less frequently than annually (or at such greater frequency as may be specified by the Secretary)—

''(I) all of the ambulatory surgical center's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such surgical center;

''(II) information on the ambulatory surgical center's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services (as specified by the Secretary) that are furnished by such surgical center, and as many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be

necessary for a combined total of at least 300 shoppable services; and

''(III) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the ambulatory surgical center, an indication that such service is not so furnished;

''(ii) submit to the Secretary on an annual basis an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such center, that all information made public pursuant to this subparagraph is complete and accurate; and

''(iii) post in a publicly accessible location of such center (in a form and manner specified by the Secretary) the discounted cash price, as applicable, expressed as a dollar amount, for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by the center (or, in the case no discounted cash price is available for such service, the me-

dian cash price charged by the center to self-pay individuals for such service for the previous three years, expressed as a dollar amount).

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by an ambulatory surgical center, the following:

''(i) A plain language description (as specified by the Secretary) of each item or service, accompanied by, as applicable, commonly recognized billing code sets, including the Healthcare Common Procedure Coding System code, the national drug code, or other applicable identifier determined appropriate by the Secretary.

''(ii) For each such item or service—

''(I) the gross charge, as applicable, expressed as a dollar amount;

''(II) each payer-specific negotiated charge in effect between such center and a third party payer, expressed as a dollar amount;

''(III) the deidentified maximum and minimum payer-specific negotiated charges in effect between such center and any third party payer; and

''(IV) the discounted cash price, as applicable, expressed as a dollar amount (or, in the case no discounted cash price is available for an item or service, the median cash price charged to self-pay individuals (not including charity care) for such item or service for the previous three years, expressed as a dollar amount).

''(iii) Any other additional information the Secretary may require (in consultation with stakeholders) for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar ar-

rangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

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

''(i) shall, in the case of—

''(I) standard charges made public by an ambulatory surgical center under subparagraph (A)(i), ensure that such charges are made available in a machine-readable format (or successor technology); and

''(II) prices made public by an ambulatory surgical center under subparagraph (A)(ii), ensure that such prices are made available in a consumer-friendly format (as specified by the Secretary);

"(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (a)(2)(C)(ii));

"(iii) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges and prices; and

"(iv) shall be updated as determined appropriate by the Secretary, in consultation with stakeholders.

"(D) DEEMED COMPLIANCE WITH SHOPPABLE SERVICES REQUIREMENT FOR CENTERS WITH A PRICE ESTIMATOR TOOL.—

"(i) IN GENERAL.—Before the effective date of regulations implementing the provisions of sections 2799A–1(f) and 2799B–6 of the Public Health Service Act (relating to advanced explanations of benefits), including regulations on establishing data transfer standards to effectuate such provisions, a specified hospital shall be deemed to have compiled and made public information described in subparagraph (A)(i)(II) (relating to shoppable services)

in accordance with a method and format specified by the Secretary under subparagraph (C) if such hospital maintains a price estimator tool described in clause (ii).

''(ii) PRICE ESTIMATOR TOOL DESCRIBED.—For purposes of clause (i), a price estimator tool described in this subparagraph is, with respect to an ambulatory surgical center, a tool that meets the following requirements:

''(I) Such tool allows an individual to immediately obtain a price estimate (taking into account whether such individual is covered under any plan, coverage, or program described in subclause (IV)(cc)) and the discounted cash price charged by an ambulatory surgical center for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by such center, and for each additional shoppable service as such center may select, such that price estimates are available through such tool for at least 300 shoppable services (or

for all such services, if such hospital furnishes fewer than 300 shoppable services).

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

''(III) Such tool is prominently displayed on the public internet website of such center.

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

''(aa) The name of such individual.

''(bb) The date of birth of such individual.

''(cc) In the case such individual is covered under a group health plan, group or individual health insurance coverage, a Fed-

eral health care program, or the program established under chapter 89 of title 5, United States Code, an identifying number assigned by such plan, coverage, or program to such individual.

''(dd) In the case of an individual described in item (cc), an indication as to whether such individual is the primary insured individual under such plan, coverage, or program (and, if such individual is not the primary insured individual, a description of the individual's relationship to such primary insured individual).

''(ee) Any other information specified by the Secretary.

''(V) Such tool contains a statement confirming the accuracy and completeness of information presented through such tool as of the date such request is made.

''(VI) Such tool meets any other requirement specified by the Secretary.

''(3) MONITORING COMPLIANCE.—The Secretary shall establish processes to monitor and assess ambulatory surgical centers' compliance with this subsection. Such processes shall include processes relating to the following:

''(A) The evaluation and analysis of complaints made by individuals or other entities relating to such centers' compliance with this subsection.

''(B) The use of audits to ensure such centers' compliance with this subsection.

''(C) The obtaining of additional information from such centers to determine such centers' compliance with this subsection (as determined appropriate by the Secretary).

''(4) ENFORCEMENT.—

''(A) IN GENERAL.—In the case that the Secretary determines that an ambulatory surgical center is not in compliance with the requirements of paragraph (1)—

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

such center of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan (to be submitted not later than 45 days after such request is made)); and

''(ii) in the case of an ambulatory surgical center that does not receive a request for a corrective action plan as part of a notification under clause (i)—

''(I) the Secretary shall, not later than 90 days after such notification is sent, determine whether such center is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such center is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such center a request for a corrective action plan (to be submitted not later than 45 days after such request is made) to comply with such requirements; or

''(bb) if the Secretary determines that such center has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—An ambulatory surgical center that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of paragraph (1) by the date that is 90 days after such request is made, and an ambulatory surgical center with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such center was not complying with such requirements) during which such failure was ongoing.

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to failures to comply occurring in 2029 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty under clause (i).

''(iii) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to an ambulatory surgical center located in a rural or underserved area if the Secretary cer-

tifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such surgical center.

''(II) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under subclause (I) with respect to an ambulatory surgical center more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a surgical center more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to an ambulatory surgical center during a 6-year period.

''(v) HARDSHIP EXEMPTION.—Notwithstanding any limit on the waiver or reduction of a penalty under clause (iv), the Secretary may waive any penalty with respect to an ambulatory surgical center on a case-by-case basis if the Secretary determines that a circumstance exists inter-

fering with such center's ability to comply with the provisions of this subsection (such as a natural disaster (as defined in section 602(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act), a public health emergency, or other unique or unexpected event).

''(5) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to ambulatory surgical centers requesting such assistance.

''(e) ENSURING ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing this section, the Secretary shall through rulemaking ensure that a provider of services or supplier making public charges and prices pursuant to this section takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the provision of interpretation services or the provision of translations of charges and information.

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

''(1) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to

an individual who pays cash, or cash equivalent, for an item or service.

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

''(3) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that an applicable laboratory has negotiated with a third party payer for an item or service.

''(4) SHOPPABLE SERVICE.—The term 'shoppable service' means a service that can be scheduled by a health care consumer in advance and includes all ancillary items and services customarily furnished as part of such service.

''(5) SPECIFIED HOSPITAL.—The term 'specified hospital' means a hospital (as defined in section 1861(e)), a critical access hospital (as defined in section 1861(mmm)(1)), or a rural emergency hospital (as defined in section 1861(kkk)).

''(6) THIRD PARTY PAYER.—The term 'third party payer' means an entity that is, by statute, con-

tract, or agreement, legally responsible for payment of a claim for an item or service.''.

(b) CONFORMING AMENDMENT.—Section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)) is amended by adding at the end the following new sentence: ''The preceding provisions of this subsection shall not apply beginning on January 1, 2028.''.

SEC. 3. HEALTH COVERAGE PRICE TRANSPARENCY.

(a) PRICE TRANSPARENCY REQUIREMENTS.—

(1) IRC.—

(A) IN GENERAL.—Section 9819 of the Internal Revenue Code of 1986 is amended—

(i) in the header, by striking ''**MAINTENANCE OF PRICE COMPARISON TOOL**'' and inserting ''**TRANSPARENCY IN COVERAGE**'';

(ii) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2029.—

''(1) IN GENERAL.—A group health plan'';

(iii) in subsection (a), as inserted by clause (ii), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2029.''; and

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

''(b) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, a group health plan shall provide a participant or beneficiary, in a timely manner upon request of the participant or beneficiary, information on the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant or beneficiary's plan that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and provided at no cost to such partici-

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

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan furnished by a health care provider to a participant or beneficiary of such plan, the following:

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum allowed

amount or other dollar amount described in such subparagraph).

''(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to a participant and such participant's beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

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

''(G) Any financial incentives (such as any credit, payment, or other benefit provided by such plan) available to the participant or beneficiary with respect to such item or service fur-

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

''(H) Other information determined appropriate by the Secretary.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

"(ii) all providers that are participating providers with respect to such item or service; or

"(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;

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

"(G) meets any other requirement determined appropriate by the Secretary, including requirements to ensure the accessibility and usability of information provided through such tool.

"(c) RATE AND PAYMENT INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) or a church plan (as defined in section 414(e))) shall make available to the public

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

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such participating provider (other than a provider that is an excluded provider with respect to

such item or service), an indication of whether, during the 1-year period beginning 18 months before the date such information is made public, such provider submitted a claim for such item or service to such plan for which payment was made (in whole or in part) under such plan.

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a partici-

pating provider with respect to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 6-month period beginning

9 months before the date such information is made public by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than such an amount with respect to an item or service for which, during such period, fewer than 11 claims were made under such plan. In determining the number of claims made under such plan with respect to an item or service during such period for purposes of the preceding sentence, such number shall be deemed to include all claims for such item or service made during such period under all group health plans offered in the same insurance market (specified in subclause (I), (II), (III), of section 9816(a)(3)(E)(iv)) by the sponsor of the plan at issue.

In the case that a specific dollar amount for an in-network rate required to be made available pursuant to this subsection with respect to an item or service cannot be determined prospectively on the basis that such rate is determined as a percentage of the billed charges for such item or service, such percentage and the median amount recognized by such plan as payment for such item or service with respect to

claims for such item or service submitted by participating providers during the period described in subparagraph (A)(ii) shall be reported by such plan in lieu of such rate. Such plan shall identify that such median amount represents an estimate of such in-network rate for such item or service.

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance), including requirements relating to whether such information should be so made available on the plan or coverage level, with respect to individual provider networks, or aggregated in such manner as specified by the Secretary. Such requirements shall ensure that such files

are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely available format through a publicly available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials or undertake other steps as may be specified by the Secretary.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

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

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2029, each group health plan shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan with respect to such plan during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such

rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) ATTESTATION.— A group health plan shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan, of such plan's compliance with the provisions of this

section and that information made available under this section is true, accurate, and complete. Such attestation shall, except in the case of a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) or a church plan (as defined in section 414(e)), include a link to the website (or other successor technology) where rate and payment information required to be made public under subsection (c) may be accessed.

''(e) ACCESSIBILITY.—A group health plan shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan, a drug for which benefits are available under such plan and with respect to which, at the time rate and payment information is made public by such plan under subsection (c)—

"(A) a contract is in effect between an entity providing pharmacy benefit management services on behalf of such plan and a pharmacy for the dispensing of such drug under such plan; and

"(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

"(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

"(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice

of that provider's license or certification under applicable State law and who has a contractual relationship with the plan for furnishing such item or service under the plan.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan for the dispensing of such drug under such plan, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a phar-

macy to a participant or beneficiary of a group health plan where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan for the dispensing of such drug under such plan, the amount that such plan has agreed to pay to such entity for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such plan has agreed to pay such entity for such drug under any other compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.''.

(B) CLERICAL AMENDMENT.—The item relating to section 9819 of the table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended to read as follows:

''Sec. 9819. Transparency in coverage.''.

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

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

(B) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2029.—

''(1) IN GENERAL.—A group health plan'';

(C) in subsection (a), as inserted by subparagraph (B), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2029.''; and

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

''(b) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide a participant, beneficiary, or enrollee, in a timely manner upon request of the participant, beneficiary, or enrollee, information on the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant, beneficiary, or enrollee's plan or coverage that the participant, beneficiary, or enrollee would be responsible for paying with respect

to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant, beneficiary, or enrollee through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant, beneficiary, or enrollee, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group or individual health insurance coverage furnished by a health care provider to an individual enrolled under such plan or coverage, the following:

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar

amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such individual may be liable for additional charges.

''(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the individual will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the maximum allowed amount or other dollar amount described in such subparagraph).

''(D) The amount the individual has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to individuals enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such indi-

vidual has accrued towards such limitation with respect to such item or service.

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

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

''(H) Other information determined appropriate by the Secretary.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

''(ii) all providers that are participating providers with respect to such item or service; or

''(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;

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

''(G) meets any other requirement determined appropriate by the Secretary, including

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

''(c) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, each group health plan and health insurance issuer offering group or individual health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) and other than such an issuer offering group health insurance coverage in connection with a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986)) shall make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group or individual health insurance coverage, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan or coverage provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such participating provider (other than a provider that is an excluded provider with respect to such item or service), an indication of whether, during the 1-year period beginning 18 months before the date such information is made public, such provider submitted a claim for such item or service to such plan or coverage for which payment

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

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan or coverage (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration specified by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan or coverage during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan or coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

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

provider, other than such an amount with respect to an item or service for which, during such period, fewer than 11 claims were made under such plan or coverage. In determining the number of claims made under such plan or coverage with respect to an item or service during such period for purposes of the preceding sentence, such number shall be deemed to include all claims for such item or service made during such period under all group health plans and health insurance coverage offered in the same insurance market (specified in subclause (I), (II), (III), or (IV) of section 2799A–1(a)(3)(E)(iv)) by the sponsor or issuer (as applicable) of the plan or coverage at issue.

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

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

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance), including requirements relating to whether such information should be so made available on the plan or coverage level, with respect to individual provider networks, or aggregated in such manner as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not in-

clude disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

''(4) USER INSTRUCTIONS.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall make available to the public instructions written in plain language explaining how individuals may search for information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish through subregulatory guidance a template that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2029, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) ATTESTATION.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan or issuer, of such plan's or coverage's compliance with the provisions of this section and that information made available under this section is true, accurate, and complete. Such attestation shall, except in the case of a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) or in the case of such an issuer offering group health insurance coverage in connection with a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986), include a link to the website (or other successor technology) where rate and payment information required to be made public under subsection (c) may be accessed.

''(e) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable lan-

guage and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan or group or individual health insurance coverage, a drug for which benefits are available under such plan or coverage and with respect to which, at the time rate and payment information is made public by such plan under subsection (c)—

''(A) a contract is in effect between an entity providing pharmacy benefit management services on behalf of such plan or coverage and a pharmacy for the dispensing of such drug under such plan or coverage; and

''(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider

that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

''(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant, beneficiary, or enrollee of a group health plan

or group or individual health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant, beneficiary, or enrollee.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a pharmacy to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, the amount that such plan or coverage has agreed to pay to such entity for the ingre-

dient costs and any applicable dispensing fee for such drug (or the amount that such plan or coverage has agreed to pay such entity for such drug under any other compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant, beneficiary, or enrollee.''.

(3) ERISA.—

(A) IN GENERAL.—Section 719 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185h) is amended—

(i) in the header, by striking ''**MAINTENANCE OF PRICE COMPARISON TOOL**'' and inserting ''**TRANSPARENCY IN COVERAGE**'';

(ii) by striking ''A group health plan'' and inserting the following:

''(a) MAINTENANCE OF PRICE COMPARISON TOOL FOR PLAN YEARS BEFORE 2029.—

''(1) IN GENERAL.—A group health plan'';

(iii) in subsection (a), as inserted by clause (ii), by adding at the end the following new paragraph:

''(2) SUNSET.—Paragraph (1) shall not apply with respect to plan years beginning on or after January 1, 2029.''; and

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

''(b) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, a group health plan and a health insurance issuer offering group health insurance coverage shall provide a participant or beneficiary, in a timely manner upon request of the participant or beneficiary, information on the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant or beneficiary's plan or coverage that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and pro-

vided at no cost to such participant or beneficiary) that meets such requirements as the Secretary may specify.

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group health insurance coverage furnished by a health care provider to a participant or beneficiary of such plan or coverage, the following:

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

''(B) If such provider is not a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(C) The estimated amount of cost-sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by

a provider described in subparagraph (B), shall be calculated using the maximum allowed amount or other dollar amount described in such subparagraph).

''(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to a participant and such participant's beneficiaries enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(E) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

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

''(G) Any financial incentives (such as any credit, payment, or other benefit provided by

such plan or issuer) available to the participant or beneficiary with respect to such item or service furnished by such provider known at the time such request is made.

''(H) Other information determined appropriate by the Secretary.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(B) is made available in plain language at no cost;

''(C) provides for real-time responses to requests described in paragraph (1);

''(D) is updated in a manner such that information provided through such tool is timely and accurate at the time such request is made;

''(E) allows such a request to be made with respect to an item or service furnished by—

''(i) a specific provider that is a participating provider with respect to such item or service;

''(ii) all providers that are participating providers with respect to such item or service; or

''(iii) nonspecific providers located in a relevant geographic region that are not participating providers with respect to such item or service;

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

''(G) meets any other requirement determined appropriate by the Secretary, including requirements to ensure the accessibility and usability of information provided through such tool.

''(c) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2029, each group health plan and health insurance issuer offering group health insurance coverage (other than a grandfathered health

plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate and payment information described in this paragraph is, with respect to a group health plan or group health insurance coverage, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service (other than, in the case that such plan or coverage provides benefits for such item or service only when furnished by a specific type of provider, such a participating provider who is not such type of provider (referred to in this subparagraph as an 'excluded provider')); and

''(ii) with respect to each such participating provider (other than a provider that is an excluded provider with respect to such item or service), an indication of whether, during the 1-year period beginning 18 months before the date such information is made public, such provider submitted a claim for such item or service to such plan or coverage for which payment was made (in whole or in part) under such plan or coverage.

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

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug;

''(ii) the average amount paid by such plan or coverage (accounting for, in a manner determined appropriate by the Secretary, rebates, discounts, price concessions, and any other remuneration speci-

fied by the Secretary) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, unless fewer than 20 claims for such drug were submitted to such plan or coverage during such period; and

''(iii) in the case such drug is an applicable spread price drug dispensed by a pharmacy—

''(I) a specification that such drug is such an applicable spread price drug; and

''(II) for each pharmacy that has a contractual relationship for dispensing such drug under such plan or coverage, a specification of the difference (if any) between the specified payment amount for such drug so dispensed by such pharmacy and the specified reimbursement amount for such drug so dispensed by such pharmacy.

''(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 6-month period beginning 9 months before the date such information is made public by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than such an amount with respect to an item or service for which, during such period, fewer than 11 claims were made under such plan or coverage. In determining the number of claims made under such plan or coverage with respect to an item or service during such period for purposes of the preceding sentence, such number shall be deemed to include all claims for such item or service made during such period under all group health plans and health insurance coverage offered in the same insurance market (specified in subclause (I), (II), (III), or (IV) of section 716(a)(3)(E)(iv)) by the sponsor or issuer (as applicable) of the plan or coverage at issue.

In the case that a specific dollar amount for an in-network rate required to be made available pursuant to this subsection with respect to an item or service cannot be determined prospectively on the basis that such rate is determined as a percentage of the billed charges for such item or service, such percentage and the median amount recognized by such plan or coverage as payment for such item or service with respect to claims for such item or service submitted by participating providers during the period described in subparagraph (A)(ii) shall be reported by such plan or coverage in lieu of such rate. Such plan or coverage shall identify that such median amount represents an estimate of such in-network rate for such item or service.

''(3) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through separate machine-readable files (and any successor technology, as applicable, such as application programming interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through

(C) of paragraph (2) that meet such requirements as specified by the Secretary (which may be so specified through subregulatory guidance), including requirements relating to whether such information should be so made available on the plan or coverage level, with respect to individual provider networks, or aggregated in such manner as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely available format through a publicly available website that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

''(B) TIMING.—Rate and payment information described in paragraph (2) shall be made public on a quarterly basis.

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

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2029, each group health plan and health insurance issuer offering group health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not fur-

nished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

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

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

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such rate; and

''(ii) a list of the items and services included in such rate.

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

''(d) ATTESTATION.—Each group health plan and health insurance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation, signed by the chief executive officer, chief financial officer, or other comparable official (as specified by the Secretary) of such plan or issuer, of such plan's or coverage's compliance with the provisions of this section and that information made available under this section is true, accurate, and complete. Such attestation shall, except in the case of a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act), include a link to the website (or other successor technology) where rate and payment information required to be made public under subsection (c) may be accessed.

''(e) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group health insurance coverage shall take reasonable steps (as specified by the

Secretary) to ensure that information provided in response to a request described in subsection (b), and rate and payment information made public under subsection (c), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(f) DEFINITIONS.—In this section:

''(1) APPLICABLE SPREAD PRICE DRUG.—The term 'applicable spread price drug' means, with respect to a group health plan or group health insurance coverage, a drug for which benefits are available under such plan or coverage and with respect to which, at the time rate and payment information is made public by such plan under subsection (c)—

''(A) a contract is in effect between an entity providing pharmacy benefit management services on behalf of such plan or coverage and a pharmacy for the dispensing of such drug under such plan or coverage; and

''(B) the specified payment amount for such drug so dispensed is less than the specified reimbursement amount for such drug so dispensed.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.

''(3) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group health insurance coverage, a physician or other health care provider (as defined in paragraph (4)) who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

''(4) PROVIDER.—The term 'provider' includes a health care facility and a pharmacy.

''(5) SPECIFIED PAYMENT AMOUNT.—The term 'specified payment amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan or group health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the dispensing of such drug under such plan or coverage, the amount that such entity has agreed to pay such pharmacy for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such entity has agreed to pay such pharmacy for such drug under any other compensation structure specified by the Secretary) under such contract, taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.

''(6) SPECIFIED REIMBURSEMENT AMOUNT.—The term 'specified reimbursement amount' means, with respect to a drug to be dispensed by a pharmacy to a participant or beneficiary of a group health plan or group health insurance coverage where such pharmacy has in effect a contract with an entity providing pharmacy benefit management services on behalf of such plan or coverage for the

dispensing of such drug under such plan or coverage, the amount that such plan or coverage has agreed to pay to such entity for the ingredient costs and any applicable dispensing fee for such drug (or the amount that such plan or coverage has agreed to pay such entity for such drug under any other compensation structure specified by the Secretary), taking into account any cost sharing requirement applicable to such drug and participant or beneficiary.''.

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

''Sec. 719. Transparency in coverage.''.

(b) APPLICATION PROGRAMMING INTERFACE REPORT.—Not later than January 1, 2029, and annually thereafter, the Secretary of Health and Human Services shall, in consultation with the Office of the National Coordinator for Health Information Technology, Department of Labor, the Department of the Treasury, and stakeholders, submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the

use of standards-based application programming interfaces (in this subsection referred to as ''APIs'') to facilitate access to health care price transparency information and the interoperability of other medical information. Such report shall include an evaluation of the capacity of the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury to regulate and implement standards related to APIs and recommendations for improving such capacity. Such report shall include the following:

(1) A description of current use, and proposed use, of APIs under Federal rules to facilitate interoperability, including information related to capacity constraints within the agencies, barriers to adoption, privacy and security, administrative burdens and efficiencies, care coordination, and levels of compliance.

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

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

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

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

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

(7) An analysis of the cost of API standards implementation on issuers, employers, and other private-sector entities.

(8) An analysis of the ability of State regulators to enforce API standards and the costs to the Federal Government and States to regulate and enforce API standards.

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

(c) PROVIDER TOOL REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall, in consultation with stakeholders, conduct a study and submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the usefulness and feasibility of the establishment of a provider tool by a group health plan, or a health insurance issuer offering group or individual health insurance coverage, in facilitating the provision of information made available pursuant to the amendments made by subsection (a). Such report shall include the following:

(A) A description of the feasibility of establishing a requirement for the various types of plans and coverage to offer such a provider tool, including any challenges to establishing a

provider tool using the same technology platform as the self-service tool described in such amendments.

(B) An evaluation on the usefulness of a provider tool to aid patient-decision making and how such tool would coordinate with other information available to a patient and their provider under other Federal requirements in place or under consideration.

(C) An evaluation of whether the information provided by such tool would be duplicative of the advanced explanation of benefits required under Federal law or any other existing requirement.

(D) A description of the usability and expected utilization of such tool among providers, including among different provider types.

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

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

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

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

(iii) care coordination and quality;

(iv) plan premiums;

(v) overall health care spending and utilization; and

(vi) health care access in rural areas.

(G) An analysis of the feasibility of a provider tool to include additional functionality to facilitate and improve the administration of the requirements on providers to submit notifications to such plan or coverage under section 2799B–6 of the Public Health Service Act and the requirements on such plan or coverage to provide an advanced explanation of benefits to individuals under section 2799A–1(f) of such Act.

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

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

(J) An analysis of the burden and cost of the creation of a provider tool by plans and coverage on providers, issuers, employers, and other private-sector entities.

(K) An analysis of the ability of state regulators to enforce provider tool standards and the costs to the Department and states to regulate and enforce provider tool standards.

(2) DEFINITION.—The term ''provider tool'' means a tool designed to facilitate the provision of information made available pursuant to the amendments made by subsection (a) and established by a group health plan or a health insurance issuer offering group or individual health insurance coverage that allows providers to access the information such plan or coverage must provide through the self-service tool described in such amendments to an individual with whom the provider is actively treating at the time of such request, upon the request of the provider, and with the consent of such individual.

(d) REPORTS.—

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

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

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

(C) recommendations relating to improving such enforcement; and

(D) recommendations relating to improving public disclosure, and public awareness, of information required to be made available by group health plans and health insurance issuers pursuant to such amendments.

(2) PRICES.—Not later than January 1, 2029, and biennially thereafter, the Secretaries of Health and Human Services, Labor, and the Treasury shall jointly submit to Congress a report containing an assessment of differences in negotiated prices (and any trends in such prices) in the private market between—

(A) rural and urban areas;

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

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

(D) nonprofit and for-profit hospitals;

(E) nonprofit and for-profit insurers; and

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

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

(f) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by subsection (a) may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158), for any plan year beginning before January 1, 2029.

SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.

(a) PHSA.—

(1) IN GENERAL.—Part D of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2799A–12. INFORMATION ON PRESCRIPTION DRUGS.

''(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under such plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug

without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the enrollee under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(2) CONFORMING AMENDMENT.—Section 2729 of the Public Health Service Act (42 U.S.C. 300gg–29) is amended by adding at the end the following new subsection:

''(c) SUNSET.—The preceding provisions of this section shall not apply beginning on the date of the enactment of this subsection.''.

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following new section:

''SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.

''(a) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage shall—

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant or beneficiary in the plan or coverage from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under such plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 726 the following new item:

''Sec. 727. Information on prescription drugs.''.

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''SEC. 9827. INFORMATION ON PRESCRIPTION DRUGS.

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

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant or beneficiary in the plan from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan with respect to acquisition of the

drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such plan does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9827. Information on prescription drugs.''.

SEC. 5. VERTICAL INTEGRATION ACCOUNTABILITY.

(a) REQUIRED MA AND PDP REPORTING.—

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

''(6) REQUIRED DISCLOSURE OF CERTAIN INFORMATION RELATING TO HEALTH CARE PROVIDER OWNERSHIP.—

''(A) IN GENERAL.—For plan year 2028 and for every third plan year thereafter, each applicable MA organization offering an MA plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary—

''(i) the taxpayer identification number for each health care provider that was a specified health care provider with respect to such organization during such year;

''(ii) the total amount of incentive-based payments made with respect to such plan year to such specified health care providers that have in effect a financial risk arrangement with respect to such plan year;

''(iii) the total amount of recoupments collected with respect to such plan year from such specified health care providers that have in effect a financial risk arrangement with respect to such plan year;

''(iv) the total amount of incentive-based payments made with respect to such plan year to providers of services and suppliers not that are not specified health care providers and that have in effect a financial risk arrangement with respect to such plan year; and

''(v) the total amount of recoupments collected with respect to such plan year from such providers of services and suppliers that have in effect a financial risk arrangement with respect to such plan year.

''(B) DEFINITIONS.—For purposes of this paragraph:

''(i) APPLICABLE MA ORGANIZATION.—The term 'applicable MA organization' means, with respect to a plan year, an MA organization with at least 25,000 individuals enrolled across all Medicare Ad-

vantage plans offered by such organization during such plan year.

''(ii) SPECIFIED HEALTH CARE PROVIDER.—The term 'specified health care provider' means, with respect to an applicable MA organization and a plan year, a provider of services or supplier that—

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

''(II) has in effect a contract solely with such organization (or with an entity owned by, controlled by, or related under a common ownership structure with such organization (or that has in effect any comparable arrangement with such organization)) for furnishing items and services;

''(III) is a partner under a partnership (as defined in section 7701(a)(2) of the Internal Revenue Code of 1986) with such organization (or with any an entity owned by, controlled by, or related under a common

ownership structure with such organization); or

''(IV) through contract, ownership, or otherwise—

''(aa) directly or indirectly controls, is controlled by, or is under common ownership with such organization (or with an entity owned by, controlled by, or related under a common ownership structure with such organization);

''(bb) is part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986 with such organization (or with any such entity);

''(cc) is a participant in a lawful combination under which such provider or supplier shares substantial financial risk in connection with such organization's operations (or with the operations of any such entity); or

''(dd) part of an affiliated service group under section 414 of such Code with such organization (or with any such entity).''.

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

''(9) PROVISION OF INFORMATION RELATING TO PHARMACY OWNERSHIP.—

''(A) IN GENERAL.—For plan year 2028 and for every third plan year thereafter, each PDP sponsor offering a prescription drug plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary, the taxpayer identification number and National Provider Identifier for each pharmacy that was a specified pharmacy with respect to such plan during such year.

''(B) DEFINITION.—For purposes of this paragraph, the term 'specified pharmacy' means, with respect to a prescription drug plan offered by a PDP sponsor and a plan year, a pharmacy that—

''(i) is owned by, controlled by, or related under a common ownership structure with such sponsor;

''(ii) has in effect a contract solely with such sponsor (or with an entity owned by, controlled by, or related under a common ownership structure with such sponsor (or that has in effect any comparable arrangement with such sponsor)) for dispensing covered part D drugs;

''(iii) is a partner under a partnership (as defined in section 7701(a)(2) of the Internal Revenue Code of 1986) with such sponsor (or with any an entity owned by, controlled by, or related under a common ownership structure with such sponsor); or

''(iv) through contract, ownership, or otherwise—

''(I) directly or indirectly controls, is controlled by, or is under common ownership with such sponsor (or with an entity owned by, controlled by, or related under a common ownership structure with such sponsor);

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

''(III) is a participant in a lawful combination under which such provider or supplier shares substantial financial risk in connection with such sponsor's operations (or with the operations of any such sponsor); or

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

(b) REPORTS ON VERTICAL INTEGRATION UNDER MEDICARE.—

(1) IN GENERAL.—Not later than the first June 15 occurring on or after the date that is 2 years after the Secretary of Health and Human Services first makes available information submitted under sections 1857(e)(6) and 1860D–12(b)(9) of the Social Security Act (as added by paragraphs (1) and (2), respectively, of subsection (a)) to the Medicare Payment Advisory Commission, and again not later

than 4 years after the first report is submitted under this paragraph, the Medicare Payment Advisory Commission shall submit to Congress a report on the state of vertical integration in the health care sector during the applicable year with respect to entities participating in the Medicare program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) or part D of such title (42 U.S.C. 1395w–101 et seq.), including health care providers, pharmacies, prescription drug plan sponsors, Medicare Advantage organizations, and pharmacy benefit managers. Such report shall include, to the extent practicable—

(A) with respect to Medicare Advantage organizations, the evaluation described in paragraph (2);

(B) with respect to prescription drug plans, pharmacy benefit managers, and pharmacies, the comparisons and summary described in paragraph (3);

(C) an assessment of the Medicare Advantage organization and PDP sponsor integration information described in paragraph (4); and

(D) an analysis of the impact of such integration on health care access, price, quality, and outcomes.

(2) MEDICARE ADVANTAGE ORGANIZATIONS.—For purposes of paragraph (1)(A), the evaluation described in this paragraph is, with respect to Medicare Advantage organizations and an applicable year, an evaluation, taking into account patient acuity and the types of areas serviced by such organization, of—

(A) the average number of qualifying diagnoses made during such year with respect to enrollees of a Medicare Advantage plan offered by such organization who, during such year, received a health risk assessment from a specified health care provider, compared to the average number of such diagnoses made during such year with respect to enrollees of such plan who, during such year, did not receive such an assessment from such a provider;

(B) the average risk score for enrollees of a Medicare Advantage plan who received such an assessment from a specified health care provider during such year compared to the average risk score for enrollees of such plan who did not

receive such an assessment from such a provider during such year;

(C) any relationship between risk scores for such enrollees receiving such an assessment from such a provider during such year and incentive-based payments made to such providers;

(D) the average risk score for enrollees of such plan who received any item or service from a specified health care provider during such year compared to the average risk score for enrollees of such plan who did not receive any item or service from such a provider during such year;

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

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

(3) PRESCRIPTION DRUG PLANS.—For purposes of paragraph (1)(B), the comparisons and summary described in this paragraph are, with respect to pre-

scription drug plans and an applicable year, the following:

(A) For each covered part D drug for which benefits are available under such a plan, a comparison of information about payments submitted with respect to such plan under section 1860D–12(h)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1395w–112(h)(1)(C)(i)(I)) with respect to specified pharmacies with the same such information about payments submitted by such plan with respect to in-network pharmacies that are not specified pharmacies.

(B) Comparisons of the following:

(i) The total amount paid by pharmacy benefit managers to specified pharmacies for covered part D drugs and the total amount so paid to pharmacies that are not specified pharmacies for such drugs.

(ii) The total amount paid by such sponsors to specified pharmacy benefit managers as reimbursement for covered part D drugs and the total amount so paid to pharmacy benefit managers that are not

specified pharmacy benefit managers as such reimbursement.

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

(4) MEDICARE ADVANTAGE ORGANIZATION AND PDP SPONSOR INTEGRATION INFORMATION.—For purposes of paragraph (1)(C), the Medicare Advantage organization and PDP sponsor integration information described in this paragraph is information submitted under sections 1857(e)(6) and 1860D–12(b)(9) of the Social Security Act (as added by paragraphs (1) and (2), respectively, of subsection (a)) and section1860D–12(h) of such Act (42 U.S.C. 1395w–112(h)).

(5) DEFINITIONS.—In this subsection:

(A) APPLICABLE YEAR.—The term ''applicable year'' means—

(i) with respect to the first report submitted under paragraph (1), plan year 2028; and

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

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

(C) QUALIFYING DIAGNOSIS.—The term ''qualifying diagnosis'' means, with respect to an enrollee of a Medicare Advantage plan, a diagnosis that is taken into account in calculating a risk score for such enrollee under the risk adjustment methodology established by the Secretary pursuant to section 1853(a)(3) of the Social Security Act (42 U.S.C. 1305w–23(a)(3)).

(D) RISK SCORE.—The term ''risk score'' means, with respect to an enrollee of a Medicare Advantage plan, the score calculated for such individual using the methodology described in subparagraph (E).

(E) SPECIFIED HEALTH CARE PROVIDER.—The term ''specified health care provider'' means, with respect to a Medicare Ad-

vantage plan offered by a Medicare Advantage organization, a health care provider that—

(i) is owned by, controlled by, or related under a common ownership structure with such organization;

(ii) has in effect a contract solely with such organization (or with an entity owned by, controlled by, or related under a common ownership structure with such organization (or that has in effect any comparable arrangement with such organization)) for furnishing items and services;

(iii) is a partner under a partnership (as defined in section 7701(a)(2) of the Internal Revenue Code of 1986) with such organization (or with any an entity owned by, controlled by, or related under a common ownership structure with such organization); or

(iv) through contract, ownership, or otherwise—

(I) directly or indirectly controls, is controlled by, or is under common ownership with such organization (or with an entity owned by, controlled

by, or related under a common ownership structure with such organization);

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

(III) is a participant in a lawful combination under which such provider or supplier shares substantial financial risk in connection with such organization's operations (or with the operations of any such entity); or

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

(F) SPECIFIED PHARMACY.—The term ''specified pharmacy'' means, with respect to a prescription drug plan offered by a prescription drug plan sponsor, a pharmacy that—

(i) is owned by, controlled by, or related under a common ownership structure with such sponsor;

(ii) has in effect a contract solely with such sponsor (or with an entity owned by, controlled by, or related under a common ownership structure with such sponsor (or that has in effect any comparable arrangement with such sponsor)) for dispensing covered part D drugs;

(iii) is a partner under a partnership (as defined in section 7701(a)(2) of the Internal Revenue Code of 1986) with such sponsor (or with any an entity owned by, controlled by, or related under a common ownership structure with such sponsor); or

(iv) through contract, ownership, or otherwise—

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

(II) is part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986

with such sponsor (or with any such entity);

(III) is a participant in a lawful combination under which such provider or supplier shares substantial financial risk in connection with such sponsor's operations (or with the operations of any such entity); or

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

(G) SPECIFIED PHARMACY BENEFIT MANAGER.—The term ''specified pharmacy benefit manager'' means, with respect to a prescription drug plan offered by a prescription drug plan sponsor, a pharmacy benefit manager that—

(i) is owned by, controlled by, or related under a common ownership structure with such sponsor;

(ii) has in effect a contract solely with such sponsor (or with an entity owned by, controlled by, or related under a common ownership structure with such sponsor (or that has in effect any comparable arrange-

ment with such sponsor)) for furnishing pharmacy benefit management services;

(iii) is a partner under a partnership (as defined in section 7701(a)(2) of the Internal Revenue Code of 1986) with such sponsor (or with any an entity owned by, controlled by, or related under a common ownership structure with such sponsor); or

(iv) through contract, ownership, or otherwise—

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

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

(III) is a participant in a lawful combination under which such provider or supplier shares substantial financial risk in connection with such

sponsor's operations (or with the operations of any such entity); or

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

SEC. 6. IMPLEMENTATION FUNDING.

(a) IN GENERAL.—For the purposes described in subsection (b), there are appropriated, in addition to amounts otherwise available, out of amounts in the Treasury not otherwise appropriated—

(1) to the Secretary of Health and Human Services and the Secretary of the Treasury, $65,000,000 for fiscal year 2027, to remain available through fiscal year 2032; and

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

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

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

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

(3) Preparing, drafting, and publishing reports.

(4) Enforcement of such provisions.

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

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

(c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—Each Secretary described in subsection (a) shall annually submit, not later than September 1st of each year, to the Committees on Energy and Commerce, on Ways and Means, on Education and the Workforce, and on Appropriations of the House of Representatives and the Committees on Health, Education, Labor, and Pensions, on Finance, and on Appropriations of the Senate a report on funds expended pursuant to funds appropriated under this section.