

119TH CONGRESS  
1ST SESSION

# S. 2355

To amend the Public Health Service Act to provide for hospital and insurer price transparency.

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## IN THE SENATE OF THE UNITED STATES

JULY 17, 2025

Mr. MARSHALL (for himself, Mr. HICKENLOOPER, Mr. GRASSLEY, Ms. HASSAN, Mr. SHEEHY, and Ms. ERNST) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend the Public Health Service Act to provide for hospital and insurer price transparency.

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

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “Patients Deserve Price  
5       Tags Act”.

1 **SEC. 2. STRENGTHENING HOSPITAL PRICE TRANSPARENCY**  
 2 **REQUIREMENTS.**

3 (a) IN GENERAL.—Section 2718(e) of the Public  
 4 Health Service Act (42 U.S.C. 300gg–18(e)) is amended  
 5 to read as follows:

6 “(e) STANDARD HOSPITAL CHARGES.—

7 “(1) IN GENERAL.—

8 “(A) DISCLOSURE OF STANDARD  
 9 CHARGES.—Each hospital shall, in accordance  
 10 with a method and format established by the  
 11 Secretary under subparagraph (C), on a month-  
 12 ly basis compile and make public (without sub-  
 13 scription and free of charge)—

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

18 “(ii) hospital standard charge infor-  
 19 mation, including the information de-  
 20 scribed in subparagraph (B), in a con-  
 21 sumer-friendly format (as specified by the  
 22 Secretary), that includes—

23 “(I) as many of the Centers for  
 24 Medicare & Medicaid Services-speci-  
 25 fied shoppable services that are fur-  
 26 nished by the hospital, and as many

1 additional hospital-selected shoppable  
 2 services (or all such additional serv-  
 3 ices, if such hospital furnishes fewer  
 4 than 300 shoppable services) as may  
 5 be necessary for a combined total of  
 6 at least 300 shoppable services  
 7 through December 31, 2026, after  
 8 which the hospital's prices shall in-  
 9 clude all shoppable services; and

10 “(II) with respect to each Cen-  
 11 ters for Medicare & Medicaid Serv-  
 12 ices-specified shoppable service that is  
 13 not furnished by the hospital, an indi-  
 14 cation that such service is not so fur-  
 15 nished.

16 “(B) STANDARD CHARGES DESCRIBED.—

17 For purposes of subparagraph (A), standard  
 18 charges means:

19 “(i) A plain language description of  
 20 each item or service, accompanied by any  
 21 applicable billing codes, including modi-  
 22 fiers, using commonly recognized billing  
 23 code sets, including the Current Proce-  
 24 dural Terminology code, the Healthcare  
 25 Common Procedure Coding System code,

1 the diagnosis-related group, the National  
2 Drug Code, and other nationally recog-  
3 nized identifier.

4 “(ii) The gross charge, expressed as a  
5 dollar amount, for each such item or serv-  
6 ice, when provided in, as applicable, the in-  
7 patient setting and outpatient department  
8 setting.

9 “(iii) The discounted cash price ex-  
10 pressed as a dollar amount, for each such  
11 item or service when provided in, as appli-  
12 cable, the inpatient setting and outpatient  
13 department setting (or, in the case no dis-  
14 counted cash price is available for an item  
15 or service, the minimum cash price accept-  
16 ed by the hospital from self-pay individuals  
17 for such item or service, expressed as a  
18 dollar amount, as well as, with respect to  
19 prices made public pursuant to subpara-  
20 graph (A)(ii), a link to a consumer-friendly  
21 document that clearly explains the hos-  
22 pital’s charity care policy). The hospital  
23 shall accept the discounted cash price as  
24 payment in full from any patient that

1 chooses to pay in cash without regard to  
2 the patient's coverage.

3 “(iv) The payer-specific negotiated  
4 charges, expressed as a dollar amount and  
5 clearly associated with the name of the ap-  
6 plicable third party payer and name of  
7 each plan, that apply to each such item or  
8 service when provided in, as applicable, the  
9 inpatient setting and outpatient depart-  
10 ment setting. If the charges are based on  
11 an algorithm, percentage of another  
12 amount, or other formula or criteria, the  
13 hospital also shall disclose such algorithm,  
14 percentage, formula, or criteria as set forth  
15 in its contract and any other terms, sched-  
16 ules, exhibits, data, or other information  
17 referenced in any such contract as shall be  
18 required to determine and disclose the ne-  
19 gotiated charge.

20 “(v) The de-identified maximum and  
21 minimum negotiated charges for each such  
22 item or service, expressed as a non-zero  
23 dollar amount.

24 “(vi) Any other additional information  
25 the Secretary may require for the purpose

1 of improving the accuracy of, or enabling  
2 consumers to easily understand and com-  
3 pare, standard charges and prices for an  
4 item or service, except information that is  
5 duplicative of any other reporting require-  
6 ment under this subsection. In the case of  
7 standard charges and prices for an item or  
8 service included as part of a bundled, per  
9 diem, episodic, or other similar arrange-  
10 ment, the information described in this  
11 subparagraph shall be made available as  
12 determined appropriate by the Secretary.

13 “(C) UNIFORM METHOD AND FORMAT.—

14 Not later than January 1, 2026, the Secretary  
15 shall establish a standard, uniform method and  
16 format for hospitals to use in compiling and  
17 making public standard charges pursuant to  
18 subparagraph (A)(i) and a standard, uniform  
19 method and format for such hospitals to use in  
20 compiling and making public prices pursuant to  
21 subparagraph (A)(ii). Such methods and for-  
22 mats shall—

23 “(i) in the case of such method and  
24 format for making public standard charges  
25 pursuant to subparagraph (A)(i), ensure

1           that such charges are made available in a  
2           machine-readable spreadsheet format;

3           “(ii) meet such standards as deter-  
4           mined appropriate by the Secretary in  
5           order to ensure the accessibility and  
6           usability of such charges and prices; and

7           “(iii) be updated as determined appro-  
8           priate by the Secretary, in consultation  
9           with stakeholders.

10          “(2) NO DEEMED COMPLIANCE.—The avail-  
11          ability of a price estimator tool shall not be consid-  
12          ered to deem compliance with or otherwise vitiate  
13          the requirements of paragraph (1)(A)(ii) or any  
14          other requirements of this section. Furthermore, the  
15          use of an estimator tool shall not be used for pur-  
16          poses of compliance with any provisions in this Sec-  
17          tion.

18          “(3) MONITORING COMPLIANCE.—The Sec-  
19          retary shall, in consultation with the Inspector Gen-  
20          eral of the Department of Health and Human Serv-  
21          ices, establish a process to monitor compliance with  
22          this subsection. Such process shall ensure that each  
23          hospital’s compliance with this subsection is re-  
24          viewed not less frequently than once every year.

1           “(4) ATTESTATION.—A senior official from  
 2           each hospital (the Chief Executive Officer, Chief Fi-  
 3           nancial Officer, or an official of equivalent seniority)  
 4           shall attest to the accuracy and completeness of the  
 5           disclosures made in accordance with the hospital  
 6           price transparency requirements set forth in this  
 7           regulation. Such attestation shall be deemed to be  
 8           material to payment from the Federal Government  
 9           to the hospital.

10           “(5) ENFORCEMENT.—

11           “(A) IN GENERAL.—In the case of a hos-  
 12           pital that fails to comply with the requirements  
 13           of this subsection, not later than 30 days after  
 14           the date on which the Secretary determines  
 15           such failure exists, the Secretary shall submit  
 16           to such hospital a notification of such deter-  
 17           mination, which shall include a request for a  
 18           corrective action plan to comply with such re-  
 19           quirements.

20           “(B) CIVIL MONETARY PENALTY.—

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



1 graph (A) and fails to comply with the re-  
2 quirements of this subsection by the date  
3 that is 45 days after such request is made  
4 shall be subject to a civil monetary penalty  
5 of an amount specified by the Secretary for  
6 each day (beginning with the day on which  
7 the Secretary first determined that such  
8 hospital was not complying with such re-  
9 quirements) during which such failure was  
10 ongoing. Such amount shall not exceed—

11 “(I) in the case of a hospital with  
12 30 or fewer beds, \$300 per day;

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

22 “(III) in the case of a hospital  
23 with more than 100 beds but fewer  
24 than 301 beds, \$17.50 per bed per  
25 day (or, in the case of such a hospital

1 that has been noncompliant with such  
2 requirements for a 1-year period or  
3 longer, beginning with the first day  
4 following such 1-year period, \$20 per  
5 bed per day);

6 “(IV) in the case of a hospital  
7 with more than 300 beds but fewer  
8 than 501 beds, \$20 per bed per day  
9 (or, in the case of such a hospital that  
10 has been noncompliant with such re-  
11 quirements for a 1-year period or  
12 longer, beginning with the first day  
13 following such 1-year period, \$25 per  
14 bed per day); and

15 “(V) in the case of a hospital  
16 with more than 500 beds, \$25 per bed  
17 per day (or, in the case of such a hos-  
18 pital that has been noncompliant with  
19 such requirements for a 1-year period  
20 or longer, beginning with the first day  
21 following such 1-year period, \$35 per  
22 bed per day).

23 “(ii) INCREASE AUTHORITY.—In ap-  
24 plying this subparagraph with respect to  
25 violations occurring in 2027 or a subse-

1           quent year, the Secretary may through no-  
2           tice and comment rulemaking increase—

3                   “(I) the limitation on the per day  
4                   amount of any penalty applicable to a  
5                   hospital under clause (i)(I);

6                   “(II) the limitations on the per  
7                   bed per day amount of any penalty  
8                   applicable under any of subclauses  
9                   (II) through (V) of clause (i); and

10                   “(III) the limitation on the in-  
11                   crease of any penalty applied under  
12                   clause (iii) pursuant to the amounts  
13                   specified in subclause (II) of such  
14                   clause.

15                   “(iii)     PERSISTENT     NONCOMPLI-  
16                   ANCE.—

17                   “(I) IN GENERAL.—In the case  
18                   of a hospital that the Secretary has  
19                   determined to be knowingly and will-  
20                   fully noncompliant with the provisions  
21                   of this subsection two or more times  
22                   during a 1-year period, the Secretary  
23                   may increase any penalty otherwise  
24                   applicable under this subparagraph by  
25                   the amount specified in subclause (II)

1 with respect to such hospital and may  
2 require such hospital to complete such  
3 additional corrective actions plans as  
4 the Secretary may specify.

5 “(II) SPECIFIED AMOUNT.—For  
6 purposes of subclause (I), the amount  
7 specified in this subclause is, with re-  
8 spect to a hospital—

9 “(aa) with more than 30  
10 beds but fewer than 101 beds, an  
11 amount that is not less than  
12 \$500,000 and not more than  
13 \$1,000,000;

14 “(bb) with more than 100  
15 beds but fewer than 301 beds, an  
16 amount that is greater than  
17 \$1,000,000 and not more than  
18 \$2,000,000;

19 “(cc) with more than 300  
20 beds but fewer than 501 beds, an  
21 amount that is greater than  
22 \$2,000,000 and not more than  
23 \$4,000,000; and

24 “(dd) with more than 500  
25 beds, and amount that is not less

1                   than \$5,000,000 and not more  
2                   than \$10,000,000.

3                   “(iv) PROVISION OF TECHNICAL AS-  
4                   SISTANCE.—The Secretary may, to the ex-  
5                   tent practicable, provide technical assist-  
6                   ance relating to compliance with the provi-  
7                   sions of this section to hospitals requesting  
8                   such assistance.

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

17                  “(C) NO WAIVER.—The Secretary shall not  
18                  grant or extend any waiver, delay, tolling, or  
19                  other mitigation of a civil monetary penalty for  
20                  violation of this subsection.

21                  “(6) DEFINITIONS.—For purposes of this sub-  
22                  section:

23                  “(A) DISCOUNTED CASH PRICE.—The  
24                  term ‘discounted cash price’ means the min-  
25                  imum charge, exclusive of any hospital or third-

1 party payer assistance, that the hospital accepts  
2 from an individual who pays cash, or cash  
3 equivalent, for a hospital-furnished item or  
4 service, without regard to patient coverage, as  
5 payment in full.

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

10 “(C) HOSPITAL.—The term ‘hospital’  
11 means a hospital (as defined in section 1861(e)  
12 of the Social Security Act), a critical access  
13 hospital (as defined in section 1861(mmm)(1)  
14 of the Social Security Act), or a rural emer-  
15 gency hospital (as defined in section 1861(kkk)  
16 of the Social Security Act), together with any  
17 parent, subsidiary, or other affiliated provider  
18 or supplier of health care items and services  
19 without regard to whether such parent, sub-  
20 sidiary, or other affiliated provider or supplier  
21 operates under separate licensure, certification,  
22 or designation.

23 “(D) PAYER-SPECIFIC NEGOTIATED  
24 CHARGE.—The term ‘payer-specific negotiated  
25 charge’ means the charge that a hospital has

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

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

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

13 “(7) RULEMAKING.—The Secretary shall imple-  
14 ment this subsection through notice and comment  
15 rulemaking in accordance with section 553 of title 5,  
16 United States Code.”.

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—The amendment made by  
19 subsection (a) shall apply beginning January 1,  
20 2026.

21 (2) CONTINUED APPLICABILITY OF RULES FOR  
22 PREVIOUS YEARS.—Nothing in the amendment made  
23 by this section may be construed as affecting the ap-  
24 plicability of the regulations codified at part 180 of

1 title 45, Code of Federal Regulations, before Janu-  
 2 ary 1, 2025.

3 (c) CONTINUED APPLICABILITY OF STATE LAW.—

4 The provisions of this Act shall not supersede any provi-  
 5 sion of State law that establishes, implements, or con-  
 6 tinues in effect any requirement or prohibition related to  
 7 health care price transparency, except to the extent that  
 8 such requirement or prohibition prevents the application  
 9 of a requirement or prohibition of this Act.

10 **SEC. 3. INCREASING PRICE TRANSPARENCY OF CLINICAL**  
 11 **DIAGNOSTIC LABORATORY TESTS.**

12 Section 2718 of the Public Health Service Act (42  
 13 U.S.C. 300gg–18) is amended by adding at the end the  
 14 following:

15 “(f) CLINICAL DIAGNOSTIC LABORATORY PRICE  
 16 TRANSPARENCY.—

17 “(1) IN GENERAL.—Beginning July 1, 2027, an  
 18 applicable laboratory shall—

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



1           “(B) ensure that such information is up-  
2           dated not less frequently than monthly, if there  
3           have been any changes to such information.

4           “(2) INFORMATION DESCRIBED.—For purposes  
5           of paragraph (1), the information described in this  
6           paragraph is, with respect to an applicable labora-  
7           tory and a specified clinical diagnostic laboratory  
8           test, the following:

9           “(A) A plain language description of each  
10          item or service, accompanied by any applicable  
11          billing codes, including modifiers, using com-  
12          monly recognized billing code sets, including the  
13          Current Procedural Terminology code, the  
14          Healthcare Common Procedure Coding System  
15          code, the diagnosis-related group, the National  
16          Drug Code, and other nationally recognized  
17          identifier.

18          “(B) The gross charge expressed as a dol-  
19          lar amount, for each such item or service.

20          “(C) The discounted cash price expressed  
21          as a dollar amount, for each such item or serv-  
22          ice (or, in the case no discounted cash price is  
23          available for an item or service, the minimum  
24          cash price accepted by the laboratory from self-  
25          pay individuals for such item or service when

1 provided in such settings for the previous three  
2 years, expressed as a dollar amount, as well as,  
3 with respect to prices made public pursuant to  
4 subparagraph (A)(ii), a link to a consumer-  
5 friendly document that clearly explains the lab-  
6 oratory's charity care policy). The laboratory  
7 shall accept the discounted or minimum cash  
8 price as payment in full from any patient that  
9 chooses to pay in cash without regard to the pa-  
10 tient's coverage.

11 “(D) The payer-specific negotiated  
12 charges, expressed as a dollar amount and  
13 clearly associated with the name of the applica-  
14 ble third party payer and name of each plan,  
15 that apply to each such item or service when  
16 provided in, as applicable, the inpatient setting  
17 and outpatient department setting. If the  
18 charges are based on an algorithm, percentage  
19 of another amount, or other formula or criteria,  
20 the clinical diagnostic laboratory also shall dis-  
21 close such algorithm, percentage, formula, or  
22 criteria as set forth in its contract and any  
23 other terms, schedules, exhibits, data, or other  
24 information referenced in any such contract as

1 shall be required to determine and disclose the  
2 negotiated charge.

3 “(E) The de-identified maximum and min-  
4 imum negotiated charges for each such item or  
5 service, expressed as a non-zero dollar amount.

6 “(F) Any other additional information the  
7 Secretary may require for the purpose of im-  
8 proving the accuracy of, or enabling consumers  
9 to easily understand and compare, standard  
10 charges and prices for an item or service, ex-  
11 cept information that is duplicative of any other  
12 reporting requirement under this subsection. In  
13 the case of standard charges and prices for an  
14 item or service included as part of a bundled,  
15 per diem, episodic, or other similar arrange-  
16 ment, the information described in this sub-  
17 paragraph shall be made available as deter-  
18 mined appropriate by the Secretary.

19 “(3) UNIFORM METHOD AND FORMAT.—Not  
20 later than January 1, 2027, the Secretary shall es-  
21 tablish a standard, uniform method and format for  
22 applicable laboratories to use in compiling and mak-  
23 ing public information pursuant to paragraph (1).  
24 Such method and format shall—

1           “(A) include a machine-readable spread-  
2           sheet format containing the information de-  
3           scribed in paragraph (2) for all items and serv-  
4           ices furnished by each laboratory;

5           “(B) meet such standards as determined  
6           appropriate by the Secretary in order to ensure  
7           the accessibility and usability of such informa-  
8           tion; and

9           “(C) be updated as determined appropriate  
10          by the Secretary, in consultation with stake-  
11          holders.

12          “(4) INCLUSION OF ANCILLARY SERVICES.—  
13          Any price or rate for a specified clinical diagnostic  
14          laboratory test available to be furnished by an appli-  
15          cable laboratory made publicly available in accord-  
16          ance with paragraph (1) shall include the price or  
17          rate for any ancillary item or service (including spec-  
18          imen collection services, specimen transport, cen-  
19          trifugation, aliquoting, labeling, requisition proc-  
20          essing, and standard result reporting services) that  
21          would customarily and routinely be furnished by  
22          such laboratory as part of such test, as specified by  
23          the Secretary.

24          “(5) ENFORCEMENT.—

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

4                   “(i) not later than 30 days after such  
5                   determination, the Secretary shall notify  
6                   such laboratory of such determination; and

7                   “(ii) if such laboratory continues to  
8                   fail to comply with such paragraph after  
9                   the date that is 90 days after such notifi-  
10                  cation is sent, the Secretary may impose a  
11                  civil monetary penalty in an amount not to  
12                  exceed \$300 for each day (beginning with  
13                  the day on which the Secretary first deter-  
14                  mined that such laboratory was failing to  
15                  comply with such paragraph) during which  
16                  such failure is ongoing.

17           “(B) INCREASE AUTHORITY.—In applying  
18           this paragraph with respect to violations occur-  
19           ring in 2028 or a subsequent year, the Sec-  
20           retary may through notice and comment rule-  
21           making increase the per day limitation on civil  
22           monetary penalties under subparagraph (A)(ii).

23           “(C) APPLICATION OF CERTAIN PROVI-  
24           SIONS.—The provisions of section 1128A of the  
25           Social Security Act (other than subsections (a)

1           and (b) of such section) shall apply to a civil  
 2           monetary penalty imposed under this paragraph  
 3           in the same manner as such provisions apply to  
 4           a civil monetary penalty imposed under sub-  
 5           section (a) of such section.

6           “(6) PROVISION OF TECHNICAL ASSISTANCE.—  
 7           The Secretary shall, to the extent practicable, pro-  
 8           vide technical assistance relating to compliance with  
 9           the provisions of this subsection to applicable labora-  
 10          tories requesting such assistance.

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

12                 “(A) APPLICABLE LABORATORY.—The  
 13                 term ‘applicable laboratory’ means a ‘labora-  
 14                 tory’ as such term is defined in section 493.2,  
 15                 of title 42, Code of Federal Regulations (or a  
 16                 successor regulation), except that such term  
 17                 does not include a laboratory with respect to  
 18                 which standard charges and prices for specified  
 19                 clinical diagnostic laboratory tests furnished by  
 20                 such laboratory are made available by a hos-  
 21                 pital pursuant to subsection (e) of this section.

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

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

5           “(D) PAYER-SPECIFIC NEGOTIATED  
6 CHARGE.—The term ‘payer-specific negotiated  
7 charge’ means the charge that an applicable  
8 laboratory has negotiated with a third party  
9 payer for an item or service.

10           “(E) SPECIFIED CLINICAL DIAGNOSTIC  
11 LABORATORY TEST.—The term ‘specified clin-  
12 ical diagnostic laboratory test’ means a clinical  
13 diagnostic laboratory test that is included on  
14 the list of shoppable services specified by the  
15 Centers for Medicare & Medicaid Services (as  
16 described in subsection (e) of this section),  
17 other than such a test that is only available to  
18 be furnished by a single provider of services or  
19 supplier.

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

1           “(8) RULEMAKING.—The Secretary shall imple-  
 2           ment this subsection through notice and comment  
 3           rulemaking in accordance with section 553 of title 5,  
 4           United States Code.”.

5   **SEC. 4. IMAGING TRANSPARENCY.**

6           Section 2718 of the Public Health Service Act (42  
 7   U.S.C. 300gg–18), as amended by section 3, is further  
 8   amended by adding at the end the following:

9           “(g) IMAGING SERVICES PRICE TRANSPARENCY.—

10           “(1) IN GENERAL.—Beginning July 1, 2027,  
 11           each provider of services or supplier that furnishes  
 12           a specified imaging service, other than such a pro-  
 13           vider or supplier with respect to which standard  
 14           charges and prices for such services furnished by  
 15           such provider or supplier are made available by a  
 16           hospital pursuant to subsection (e), shall—

17           “(A) make publicly available (in accord-  
 18           ance with paragraph (3)) on an internet website  
 19           the information described in paragraph (2) with  
 20           respect to each such service that such provider  
 21           of services or supplier furnishes; and

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

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



1 paragraph is, with respect to a provider of services  
2 or supplier and a specified imaging service, the fol-  
3 lowing:

4 “(A) A plain language description of each  
5 item or service, accompanied by any applicable  
6 billing codes, including modifiers, using com-  
7 monly recognized billing code sets, including the  
8 Current Procedural Terminology code, the  
9 Healthcare Common Procedure Coding System  
10 code, the diagnosis-related group, the National  
11 Drug Code, and other nationally recognized  
12 identifier.

13 “(B) The gross charge expressed as a dol-  
14 lar amount, for each such item or service.

15 “(C) The discounted cash price expressed  
16 as a dollar amount, for each such item or serv-  
17 ice (or, in the case no discounted cash price is  
18 available for an item or service, the minimum  
19 cash price accepted by the provider of services  
20 or supplier from self-pay individuals for such  
21 item or service when provided in such settings  
22 for the previous three years, expressed as a dol-  
23 lar amount, as well as, with respect to prices  
24 made public pursuant to subparagraph (A)(ii),  
25 a link to a consumer-friendly document that

1 clearly explains the provider of services or sup-  
2 plier's charity care policy). The provider of  
3 services or supplier shall accept the discounted  
4 or minimum cash price as payment in full from  
5 any patient that chooses to pay in cash without  
6 regard to the patient's coverage.

7 “(D) The payer-specific negotiated  
8 charges, expressed as a dollar amount and  
9 clearly associated with the name of the applica-  
10 ble third party payer and name of each plan,  
11 that apply to each such item or service when  
12 provided in, as applicable, the inpatient setting  
13 and outpatient department setting. If the  
14 charges are based on an algorithm, percentage  
15 of another amount, or other formula or criteria,  
16 the provider or supplier also shall disclose such  
17 algorithm, percentage, formula, or criteria as  
18 set forth in its contract and any other terms,  
19 schedules, exhibits, data, or other information  
20 referenced in any such contract as shall be re-  
21 quired to determine and disclose the negotiated  
22 charge.

23 “(E) The de-identified maximum and min-  
24 imum negotiated charges for each such item or  
25 service, expressed as a non-zero dollar amount.

1           “(F) Any other additional information the  
2           Secretary may require for the purpose of im-  
3           proving the accuracy of, or enabling consumers  
4           to easily understand and compare, standard  
5           charges and prices for an item or service, ex-  
6           cept information that is duplicative of any other  
7           reporting requirement under this subsection. In  
8           the case of standard charges and prices for an  
9           item or service included as part of a bundled,  
10          per diem, episodic, or other similar arrange-  
11          ment, the information described in this sub-  
12          paragraph shall be made available as deter-  
13          mined appropriate by the Secretary.

14          “(3) UNIFORM METHOD AND FORMAT.—Not  
15          later than January 1, 2027, the Secretary shall es-  
16          tablish a standard, uniform method and format for  
17          providers of services and suppliers to use in making  
18          public information described in paragraph (2). Any  
19          such method and format shall—

20                 “(A) include a machine-readable spread-  
21                 sheet format containing the information de-  
22                 scribed in paragraph (2) for all items and serv-  
23                 ices furnished by each provider of services and  
24                 supplier described in paragraph (1);

1           “(B) meet such standards as determined  
2           appropriate by the Secretary in order to ensure  
3           the accessibility and usability of such informa-  
4           tion; and

5           “(C) be updated as determined appropriate  
6           by the Secretary, in consultation with stake-  
7           holders.

8           “(4) MONITORING COMPLIANCE.—The Sec-  
9           retary shall, through notice and comment rule-  
10          making and in consultation with the Inspector Gen-  
11          eral of the Department of Health and Human Serv-  
12          ices, establish a process to monitor compliance with  
13          this subsection.

14          “(5) ENFORCEMENT.—

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

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

23                   “(ii) upon request of the Secretary,  
24                   such provider or supplier shall submit to  
25                   the Secretary, not later than 45 days after

1 the date of such request, a corrective ac-  
2 tion plan to comply with such paragraph;  
3 and

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

20 “(B) INCREASE AUTHORITY.—In applying  
21 this paragraph with respect to violations occur-  
22 ring in 2027 or a subsequent year, the Sec-  
23 retary may through notice and comment rule-  
24 making increase the amount of the civil mone-  
25 tary penalty under subparagraph (A)(iii).

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

9           “(D) NO AUTHORITY TO WAIVE OR RE-  
10          DUCE PENALTY.—The Secretary shall not grant  
11          or extend any waiver, delay, tolling, or other  
12          mitigation of a civil monetary penalty for viola-  
13          tion of this subsection.

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

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

1           “(6) SPECIFIED IMAGING SERVICE DEFINED.—  
 2           the term ‘specified imaging service’ means an imag-  
 3           ing service that is a Centers for Medicare & Med-  
 4           icaid Services-specified shoppable service (as de-  
 5           scribed in subsection (e)).

6           “(7) RULEMAKING.—The Secretary shall imple-  
 7           ment this subsection through notice and comment  
 8           rulemaking in accordance with section 553 of title 5,  
 9           United States Code.”.

10 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**  
 11 **PARENCY REQUIREMENTS.**

12           Section 2718 of the Public Health Service Act (42  
 13 U.S.C. 300gg–18), as amended by section 4, is further  
 14 amended by adding at the end the following:

15           “(h) AMBULATORY SURGERY CENTER TRANS-  
 16 PARENCY.—

17           “(1) IN GENERAL.—Beginning July 1, 2027,  
 18           each specified ambulatory surgical center shall com-  
 19           ply with the price transparency requirement de-  
 20           scribed in paragraph (2).

21           “(2) REQUIREMENT DESCRIBED.—

22           “(A) IN GENERAL.—A specified ambula-  
 23           tory surgical center, in accordance with a meth-  
 24           od and format established by the Secretary  
 25           under subparagraph (C), shall compile and

1 make public (without subscription and free of  
2 charge), for each year—

3 “(i) one or more lists, in a machine-  
4 readable format specified by the Secretary,  
5 of the ambulatory surgical center’s stand-  
6 ard charges (including the information de-  
7 scribed in subparagraph (B)) for each item  
8 and service furnished by such surgical cen-  
9 ter;

10 “(ii) information in a consumer-  
11 friendly format (as specified by the Sec-  
12 retary) on the ambulatory surgical center’s  
13 prices (including the information described  
14 in subparagraph (B)) for as many of the  
15 Centers for Medicare & Medicaid Services-  
16 specified shoppable services included on the  
17 list described in subsection (e) that are  
18 furnished by such surgical center, and as  
19 many additional ambulatory surgical cen-  
20 ter-selected shoppable services (or all such  
21 additional services, if such surgical center  
22 furnishes fewer than 300 shoppable serv-  
23 ices) as may be necessary for a combined  
24 total of at least 300 shoppable services;  
25 and



1 “(iii) with respect to each Centers for  
 2 Medicare & Medicaid Services-specified  
 3 shoppable service (as described in clause  
 4 (ii)) that is not furnished by the ambula-  
 5 tory surgical center, an indication that  
 6 such service is not so furnished.

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

13 “(i) A description of each item or  
 14 service, accompanied by the Healthcare  
 15 Common Procedure Coding System code,  
 16 the national drug code, or other identifier  
 17 used or approved by the Centers for Medi-  
 18 care & Medicaid Services.

19 “(ii) The gross charge, expressed as a  
 20 dollar amount, for each such item or serv-  
 21 ice.

22 “(iii) The discounted cash price, ex-  
 23 pressed as a dollar amount, for each such  
 24 item or service (or, in the case no dis-  
 25 counted cash price is available for an item

1 or service, the minimum cash price accept-  
2 ed by the specified ambulatory surgical  
3 center from self-pay individuals for such  
4 item or service when provided in such set-  
5 tings for the previous three years, ex-  
6 pressed as a dollar amount, as well as,  
7 with respect to prices made public pursu-  
8 ant to subparagraph (A)(ii), a link to a  
9 consumer-friendly document that clearly  
10 explains the provider of services or sup-  
11 plier's charity care policy). The specified  
12 ambulatory surgical center shall accept the  
13 discounted cash price as payment in full  
14 from any patient that chooses to pay in  
15 cash without regard to the patient's cov-  
16 erage.

17 “(iv) The payer-specific negotiated  
18 charges, expressed as a dollar amount and  
19 clearly associated with the name of the ap-  
20 plicable third party payer and name of  
21 each plan, that apply to each such item or  
22 service when provided in, as applicable, the  
23 inpatient setting and outpatient depart-  
24 ment setting. If the charges are based on  
25 an algorithm, percentage of another

1 amount, or other formula or criteria, the  
2 ambulatory surgical center also shall dis-  
3 close such algorithm, percentage, formula,  
4 or criteria as set forth in its contract and  
5 any other terms, schedules, exhibits, data,  
6 or other information referenced in any  
7 such contract as shall be required to deter-  
8 mine and disclose the negotiated charge.

9 “(v) The de-identified maximum and  
10 minimum negotiated charges for each such  
11 item or service, expressed as a non-zero  
12 dollar amount.

13 “(vi) Any other additional information  
14 the Secretary may require for the purpose  
15 of improving the accuracy of, or enabling  
16 consumers to easily understand and com-  
17 pare, standard charges and prices for an  
18 item or service, except information that is  
19 duplicative of any other reporting require-  
20 ment under this subsection.

21 “(C) UNIFORM METHOD AND FORMAT.—

22 Not later than January 1, 2027, the Secretary  
23 shall establish a standard, uniform method and  
24 format for specified ambulatory surgical centers  
25 to use in making public standard charges pur-

1           suant to subparagraph (A)(i) and a standard,  
 2           uniform method and format for such centers to  
 3           use in making public prices pursuant to sub-  
 4           paragraph (A)(ii). Any such method and format  
 5           shall—

6                   “(i) in the case of such charges made  
 7                   public by an ambulatory surgical center,  
 8                   ensure that such charges are made avail-  
 9                   able in a machine-readable format;

10                   “(ii) meet such standards as deter-  
 11                   mined appropriate by the Secretary in  
 12                   order to ensure the accessibility and  
 13                   usability of such charges and prices; and

14                   “(iii) be updated as determined appro-  
 15                   priate by the Secretary, in consultation  
 16                   with stakeholders.

17           “(3) NO DEEMED COMPLIANCE.—The avail-  
 18           ability of a price estimator tool shall not be consid-  
 19           ered to deem compliance with or otherwise vitiate  
 20           the requirements of this subsection (aa). Further-  
 21           more, the use of an estimator tool shall not be used  
 22           for purposes of compliance with any provisions in  
 23           this subsection.

24           “(4) MONITORING COMPLIANCE.—The Sec-  
 25           retary shall, in consultation with the Inspector Gen-

1       eral of the Department of Health and Human Serv-  
 2       ices, establish a process to monitor compliance with  
 3       this subsection. Such process shall ensure that each  
 4       specified ambulatory surgical center’s compliance  
 5       with this subsection is reviewed not less frequently  
 6       than once every year.

7               “(5) ENFORCEMENT.—

8               “(A) IN GENERAL.—In the case of a speci-  
 9       fied ambulatory surgical center that fails to  
 10      comply with the requirements of this sub-  
 11      section—

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

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

23              “(B) CIVIL MONETARY PENALTY.—

24              “(i) IN GENERAL.—A specified ambu-  
 25      latory surgical center that has received a

1 notification under subparagraph (A)(i) and  
2 fails to comply with the requirements of  
3 this subsection by the date that is 90 days  
4 after such notification (or, in the case of  
5 an ambulatory surgical center that has  
6 submitted a corrective action plan de-  
7 scribed in subparagraph (A)(ii) in response  
8 to a request so described, by the date that  
9 is 90 days after such submission) shall be  
10 subject to a civil monetary penalty of an  
11 amount specified by the Secretary for each  
12 day (beginning with the day on which the  
13 Secretary first determined that such hos-  
14 pital was not complying with such require-  
15 ments) during which such failure is ongo-  
16 ing (not to exceed \$300 per day).

17 “(ii) INCREASE AUTHORITY.—In ap-  
18 plying this subparagraph with respect to  
19 violations occurring in 2027 or a subse-  
20 quent year, the Secretary may through no-  
21 tice and comment rulemaking increase the  
22 limitation on the per day amount of any  
23 penalty applicable to a specified ambula-  
24 tory surgical center under clause (i).

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

10                   “(iv) NO AUTHORITY TO WAIVE OR  
 11                   REDUCE PENALTY.—The Secretary shall  
 12                   not grant or extend any waiver, delay, toll-  
 13                   ing, or other mitigation of a civil monetary  
 14                   penalty for violation of this subsection.

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

20                   “(7) DEFINITIONS.—For purposes of this sec-  
 21                   tion:

22                   “(A) DISCOUNTED CASH PRICE.—The  
 23                   term ‘discounted cash price’ means the charge  
 24                   that applies to an individual who pays cash, or

1 cash equivalent, for a item or service furnished  
2 by an ambulatory surgical center.

3 “(B) GROSS CHARGE.—The term ‘gross  
4 charge’ means the charge for an individual item  
5 or service that is reflected on a specified sur-  
6 gical center’s chargemaster, absent any dis-  
7 counts.

8 “(C) GROUP HEALTH PLAN; GROUP  
9 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
10 HEALTH INSURANCE COVERAGE.—The terms  
11 ‘group health plan’, ‘group health insurance  
12 coverage’, and ‘individual health insurance cov-  
13 erage’ have the meaning given such terms in  
14 section 2791 of the Public Health Service Act.

15 “(D) PAYER-SPECIFIC NEGOTIATED  
16 CHARGE.—The term ‘payer-specific negotiated  
17 charge’ means the charge that a specified sur-  
18 gical center has negotiated with a third party  
19 payer for an item or service.

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



“(F) SPECIFIED AMBULATORY SURGICAL CENTER.—The term ‘specified ambulatory surgical center’ means an ambulatory surgical center with respect to which a hospital (or any person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in a hospital) is a person with an ownership or control interest (as so defined).

“(G) THIRD PARTY PAYER.—The term ‘third party payer’ means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

“(8) RULEMAKING.—The Secretary shall implement this subsection through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.”.

**SEC. 6. STRENGTHENING HEALTH COVERAGE TRANSPARENCY REQUIREMENTS.**

(a) TRANSPARENCY IN COVERAGE.—Section 1311(e)(3)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

(1) by striking “The Exchange” and inserting the following:

“(i) IN GENERAL.—The Exchange”;

1 (2) in clause (i), as inserted by paragraph (1)—

2 (A) by striking “participating provider”  
3 and inserting “provider”;

4 (B) by inserting “shall include the infor-  
5 mation specified in clause (ii) and” after “such  
6 information”;

7 (C) by striking “an Internet website” and  
8 inserting “a self-service tool that meets the re-  
9 quirements of clause (iii)”; and

10 (D) by striking “and such other” and all  
11 that follows through the period and inserting  
12 “or, at the option such individual, through a  
13 paper or phone disclosure (as selected by such  
14 individual and provided at no cost to such indi-  
15 vidual) that meets such requirements as the  
16 Secretary may specify.”; and

17 (3) by adding at the end the following new  
18 clauses:

19 “(ii) SPECIFIED INFORMATION.—For  
20 purposes of clause (i), the information  
21 specified in this clause is, with respect to  
22 benefits available under a health plan for  
23 an item or service furnished by a health  
24 care provider, the following:

1           “(I) If such provider is a partici-  
2           pating provider with respect to such  
3           item or service, the in-network rate  
4           (as defined in subparagraph (F)) for  
5           such item or service.

6           “(II) If such provider is not de-  
7           scribed in subclause (I), the maximum  
8           allowed dollar amount for such item  
9           or service.

10          “(III) The amount of cost shar-  
11          ing (including deductibles, copay-  
12          ments, and coinsurance) that the indi-  
13          vidual will incur for such item or serv-  
14          ice (which, in the case such item or  
15          service is to be furnished by a pro-  
16          vider described in subclause (II), shall  
17          be calculated using the maximum  
18          amount described in such subclause).

19          “(IV) The amount the individual  
20          has already accumulated with respect  
21          to any deductible or out of pocket  
22          maximum under the plan (broken  
23          down, in the case separate deductibles  
24          or maximums apply to separate indi-  
25          viduals enrolled in the plan, by such

1 separate deductibles or maximums, in  
2 addition to any cumulative deductible  
3 or maximum).

4 “(V) In the case such plan im-  
5 poses any frequency or volume limita-  
6 tions with respect to such item or  
7 service (excluding medical necessity  
8 determinations), the amount that such  
9 individual has accrued towards such  
10 limitation with respect to such item or  
11 service.

12 “(VI) Any prior authorization,  
13 concurrent review, step therapy, fail  
14 first, or similar requirements applica-  
15 ble to coverage of such item or service  
16 under such plan.

17 “(iii) SELF-SERVICE TOOL.—For pur-  
18 poses of clause (i), a self-service tool estab-  
19 lished by a health plan meets the require-  
20 ments of this clause if such tool—

21 “(I) is based on an internet  
22 website;

23 “(II) provides for real-time re-  
24 sponses to requests described in such  
25 clause;

1           “(III) is updated in a manner  
2           such that information provided  
3           through such tool is timely and accu-  
4           rate;

5           “(IV) allows such a request to be  
6           made with respect to an item or serv-  
7           ice furnished by—

8                   “(aa) a specific provider  
9                   that is a participating provider  
10                  with respect to such item or serv-  
11                  ice;

12                  “(bb) all providers that are  
13                  participating providers with re-  
14                  spect to such plan and such item  
15                  or service; or

16                  “(cc) a provider that is not  
17                  described in item (bb);

18           “(V) provides that such a request  
19           may be made with respect to an item  
20           or service through use of—

21                   “(aa) the billing code for  
22                   such item or service; or

23                   “(bb) through use of a de-  
24                   scriptive term for such item or  
25                   service to produce a list of billing

1 code options from which the indi-  
 2 vidual selects to indicate the sub-  
 3 ject matter items or services; and  
 4 “(VI) holds a member harmless  
 5 for the amount of any difference in  
 6 excess of the amount of the individ-  
 7 ual’s responsibility generated by the  
 8 self-service tool and the amount ulti-  
 9 mately billed or charged to the indi-  
 10 vidual.”.

11 (b) DISCLOSURE OF ADDITIONAL INFORMATION.—  
 12 Section 1311(e)(3) of the Patient Protection and Afford-  
 13 able Care Act (42 U.S.C. 18031(e)(3)) is amended by add-  
 14 ing at the end the following new subparagraphs:

15 “(E) RATE AND PAYMENT INFORMA-  
 16 TION.—

17 “(i) IN GENERAL.—Not later than  
 18 January 1, 2027, and every month there-  
 19 after, each health plan shall submit to the  
 20 Exchange, the Secretary, the State insur-  
 21 ance commissioner, and make available to  
 22 the public, the rate and payment informa-  
 23 tion described in clause (ii) in accordance  
 24 with clause (iii).

1           “(ii) RATE AND PAYMENT INFORMA-  
2           TION DESCRIBED.—For purposes of clause  
3           (i), the rate and payment information de-  
4           scribed in this clause is, with respect to a  
5           health plan, the following:

6                   “(I) With respect to each item or  
7                   service for which benefits are available  
8                   under such plan (expressed as a dollar  
9                   amount), including prescription drugs,  
10                  identified by CPT, HCPCS, DRG,  
11                  NDC, or other applicable nationally  
12                  recognized identifier, including any  
13                  applicable code modifiers, and accom-  
14                  panied by a brief description of the  
15                  item or service, the in-network rate in  
16                  effect as of the date of the submission  
17                  of such information with each pro-  
18                  vider (identified by national provider  
19                  identifier) that is a participating pro-  
20                  vider with respect to such item or  
21                  service, other than such a rate in ef-  
22                  fect with a provider—

23                   “(aa) that has submitted no  
24                   claims; and

1 “(bb) expects to receive no  
2 claims in the then applicable cal-  
3 endar year for such item or serv-  
4 ice to such plan.

5 “(II) With respect to each drug  
6 (identified by National Drug Code, J-  
7 code, or other commonly recognized  
8 billing code used for drugs) for which  
9 benefits are available under such plan:

10 “(aa) The in-network rate  
11 (expressed as a dollar amount),  
12 including the individual and total  
13 amounts for any bundled rates,  
14 in effect as of the first day of the  
15 month in which such information  
16 is made public with each provider  
17 that is a participating provider  
18 with respect to such drug.

19 “(bb) The historical net  
20 price paid by such plan (net of  
21 rebates, discounts, and price con-  
22 cessions) (expressed as a dollar  
23 amount) for such drug dispensed  
24 or administered during the 90-  
25 day period beginning 180 days



1 before such date of submission to  
2 each provider that was a partici-  
3 pating provider with respect to  
4 such drug, broken down by each  
5 such provider (identified by na-  
6 tional provider identifier), other  
7 than such an amount paid to a  
8 provider that has submitted no  
9 claims for such drug to such  
10 plan.

11 “(III) With respect to each item  
12 or service for which benefits are avail-  
13 able under such plan (expressed as a  
14 dollar amount), identified by CPT,  
15 DRG, HCPCS, NDC, or other appli-  
16 cable nationally recognized identifier,  
17 including any applicable code modi-  
18 fiers, and accompanied by a brief de-  
19 scription of the item or service, the  
20 amount billed or charged by the pro-  
21 vider, and the amount allowed by the  
22 plan, for each such item or service  
23 furnished during the 90-day period  
24 beginning 180 days before such date  
25 of submission by each provider that

1 was not a participating provider with  
2 respect to such item or service, broken  
3 down by each such provider (identified  
4 by national provider identifier), other  
5 than items and services with respect  
6 to which no claims for such item or  
7 service were submitted to such plan  
8 during such period.

9 “(iii) MANNER OF SUBMISSION.—Rate  
10 and payment information required to be  
11 submitted and made available under this  
12 subparagraph shall be so submitted and so  
13 made available as follows:

14 “(I) Information shall be con-  
15 tained in 3 separate machine-readable  
16 files corresponding to the information  
17 described in each of subclauses (I)  
18 through (III) of clause (ii) that meet  
19 such requirements as specified by the  
20 Secretary through rulemaking, in con-  
21 sultation with the Secretaries of  
22 Labor and the Treasury to apply com-  
23 parable requirements to group health  
24 plans and to entities providing benefit  
25 management or other third-party ad-

1           ministration services on a contractual  
2           basis with a group health plan.

3                   “(II) Requirements specified by  
4           the Secretary through rulemaking  
5           shall ensure that:

6                           “(aa) Such files are limited  
7                           to an appropriate size, are made  
8                           available in a widely available  
9                           format that allows for informa-  
10                          tion contained in such files to be  
11                          compared across health plans,  
12                          and are accessible to individuals  
13                          at no cost and without the need  
14                          to establish a user account or  
15                          provider other credentials.

16                          “(bb) The rates, amounts,  
17                          and prices to be disclosed include  
18                          contractual terms containing cal-  
19                          culation formulae, pricing meth-  
20                          odologies, and other information  
21                          necessary to determine the dollar  
22                          value of reimbursement.

23                          “(cc) Each such file includes  
24                          each of the following data ele-  
25                          ments:

1                   “(AA) A numerical  
2                   identifier for the group  
3                   health plan and/or health in-  
4                   surance issuer (such as a  
5                   Health Insurance Oversight  
6                   System identifier).

7                   “(BB) A plain-language  
8                   description of the item or  
9                   service (including, for drugs,  
10                  the proprietary and non-  
11                  proprietary name assigned).

12                  “(CC) The billing code,  
13                  including any applicable  
14                  modifiers, associated with  
15                  such item or service, includ-  
16                  ing the Healthcare Common  
17                  Procedure Coding System  
18                  code, diagnosis-related  
19                  group, national drug code,  
20                  or other commonly recog-  
21                  nized code set.

22                  “(DD) The place of  
23                  service code.

24                  “(EE) The National  
25                  Provider Identifier or pro-

1                    vider   Tax   Identification  
2                    Number.

3                    “(III) The rate and payment in-  
4                    formation disclosed under subclauses  
5                    (I) through (III) of clause (ii) shall be  
6                    separately delineated for each item or  
7                    service, regardless of whether such  
8                    item or service is reimbursed as a part  
9                    of a bundle, episode, or other group-  
10                  ing of items and services.

11                  “(IV) An officer or executive of  
12                  competent authority shall attest to the  
13                  accuracy and completeness of infor-  
14                  mation submitted and made available  
15                  under this subparagraph. Such attes-  
16                  tation shall be subject to enforcement  
17                  under subparagraph (H) and, where  
18                  applicable, shall be deemed material  
19                  to payments from the Federal Govern-  
20                  ment received by the group health  
21                  plan or health insurance issuer.

22                  “(V) Regulations promulgated  
23                  pursuant to this section shall provide  
24                  that:

1           “(aa) The Secretary shall  
2           audit the three machine-readable  
3           files required by subparagraph  
4           (E)(ii) posted by no fewer than  
5           20 group health plans or health  
6           insurance issuers.

7           “(bb) The Secretary of  
8           Labor shall audit the three ma-  
9           chine-readable files required by  
10          subparagraph (E)(ii) posted by  
11          no fewer than 200 group health  
12          plans or service providers fur-  
13          nishing third-party administrator  
14          services to a group health plan.

15          “(cc) Findings, conclusions,  
16          and enforcement actions taken  
17          based on audits of the machine-  
18          readable files shall be reported  
19          annually to Congress no later  
20          than July 1 of the calendar year  
21          during which the files were au-  
22          dited. Such report to Congress  
23          shall be accessible to the public.

24          “(iv) USER GUIDE.—Each health plan  
25          shall make available to the public instruc-

tions written in plain language explaining how individuals may search for information described in clause (ii) in files submitted in accordance with clause (iii).

“(F) DEFINITIONS.—In this paragraph:

“(i) PARTICIPATING PROVIDER.—The term ‘participating provider’ has the meaning given such term in section 2799A–1 of the Public Health Service Act.

“(ii) IN-NETWORK RATE.—The term ‘in-network rate’ means, with respect to a 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 in effect between such plan and such provider for such item or service. If the rate is based on an algorithm, percentage of another amount, or other formula or criteria, the health plan also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such con-

tract as shall be required to determine and disclose the negotiated rate.

“(G) APPLICABILITY TO ACCOUNTABLE CARE ORGANIZATIONS.—An applicable ACO participating in the Medicare Shared Savings Program, as defined in Section 1899 of the Social Security Act (42 U.S.C. 1395jjj), shall be subject to the requirements of this paragraph as if such applicable ACO is a group health plan or health insurance issuer.

“(H) ENFORCEMENT.—

“(i) IN GENERAL.—Each year, the Secretary shall audit the three machine-readable files required by subparagraph (E)(ii) posted by no fewer than 20 group health plans or health insurance issuers.

“(ii) NOTIFICATION AND REQUEST FOR CORRECTIVE ACTION.—In the case of a health plan that fails to comply with the requirements of this subsection, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such health plan a notification of such determination, which shall include a request for a correc-



1           tive action plan to comply with such re-  
2           quirements.

3           “(iii) CIVIL MONETARY PENALTY.—A  
4           health plan that has received a request for  
5           a corrective action plan under clause (ii)  
6           and fails to comply with the requirements  
7           of this subsection by the date that is 90  
8           days after such request is made shall be  
9           subject to a civil monetary penalty of an  
10          amount specified by the Secretary for each  
11          day (beginning with the day on which the  
12          Secretary first determined that such lab-  
13          oratory was failing to comply with such  
14          paragraph) during which such failure was  
15          ongoing. Such amount shall not exceed  
16          \$300 per member per day or \$10,000,000,  
17          whichever is lesser.

18          “(I) RULEMAKING.—The Secretary shall  
19          implement subparagraphs (E) through (H)  
20          through notice and comment rulemaking in ac-  
21          cordance with section 553 of title 5, United  
22          States Code.”.

23          (c) EFFECTIVE DATE.—

1           (1) IN GENERAL.—The amendments made by  
2       subsections (a) and (b) shall apply beginning Janu-  
3       ary 1, 2026.

4           (2) CONTINUED APPLICABILITY OF RULES FOR  
5       PREVIOUS YEARS.—Nothing in the amendments  
6       made by this section may be construed as affecting  
7       the applicability of the rule entitled “Transparency  
8       in Coverage” published by the Department of the  
9       Treasury, the Department of Labor, and the De-  
10      partment of Health and Human Services on Novem-  
11      ber 12, 2020 (85 Fed. Reg. 72158) before January  
12      1, 2026.

13 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**  
14 **HEALTH DATA.**

15       (a) GROUP HEALTH PLAN ACCESS TO INFORMA-  
16      TION.—

17           (1) IN GENERAL.—Paragraph (2) of section  
18       408(b) of the Employee Retirement Income Security  
19       Act of 1974 (29 U.S.C. 1108(b)) is amended by  
20       adding at the end the following new subparagraphs:

21               “(C) No contract or arrangement for serv-  
22       ices, and no extension or renewal of such con-  
23       tract or arrangement, between a group health  
24       plan (as that term is defined in section 733(a)  
25       of this title) and party in interest, including a

1 health care provider (which for purposes of this  
 2 subparagraph, includes a health care facility),  
 3 network or association of providers, service pro-  
 4 vider offering access to a network of providers,  
 5 third-party administrator, or pharmacy benefit  
 6 manager (collectively referred to as ‘Covered  
 7 Service Providers’), is reasonable within the  
 8 meaning of this paragraph unless such contract  
 9 or arrangement—

10 “(i) allows the responsible plan fidu-  
 11 ciary (as that term is defined in subpara-  
 12 graph (B)(ii)(I)(ee)) access to all claims  
 13 and encounter information or data, and  
 14 any documentation supporting claim pay-  
 15 ments, including, but not limited to, med-  
 16 ical records and policy documents, or infor-  
 17 mation or data described in section  
 18 724(a)(1)(B) to—

19 “(I) enable such entity to comply  
 20 with the terms of the plan and any  
 21 applicable law; and

22 “(II) determine the accuracy or  
 23 reasonableness of payment; and

24 “(ii) does not—

1 “(I) unreasonably limit or delay  
2 access, as determined by the Secretary  
3 but in any event not longer than 15  
4 days, to such information or data;

5 “(II) limit the volume of claims  
6 and encounter information or data  
7 that the group health plan, the plan  
8 sponsor, the plan administrator, or a  
9 business associate of such plan may  
10 access during an audit or pursuant to  
11 any request for such information or  
12 data;

13 “(III) limit the disclosure of pric-  
14 ing terms for value-based payment ar-  
15 rangements or capitated payment ar-  
16 rangements, including—

17 “(aa) payment calculations  
18 and formulas;

19 “(bb) quality measures;

20 “(cc) contract terms;

21 “(dd) payment amounts;

22 “(ee) measurement periods  
23 for all incentives; and

24 “(ff) other payment meth-  
25 odologies used by an entity, in-

1 including a health care provider  
2 (including a health care facility),  
3 network or association of pro-  
4 viders, service provider offering  
5 access to a network of providers,  
6 third-party administrator, or  
7 pharmacy benefit manager;

8 “(IV) limit the disclosure of over-  
9 payments and overpayment recovery  
10 terms;

11 “(V) limit the right of the group  
12 health plan, the plan sponsor, or the  
13 plan administrator of such plan to se-  
14 lect an auditor or define audit scope  
15 or frequency;

16 “(VI) otherwise limit or unduly  
17 delay the group health plan, the plan  
18 sponsor, the plan administrator, or a  
19 business associate of such plan from  
20 accessing claims and encounter infor-  
21 mation or data in a daily batch;

22 “(VII) limit the disclosure of fees  
23 charged to the group health plan re-  
24 lated to plan administration and  
25 claims processing, including renegoti-

1           ation fees, access fees, repricing fees,  
2           or enhanced review fees;

3           “(VIII) limit the right of the  
4           group health plan, the plan sponsor,  
5           or the plan administrator to request  
6           action on any suspect claim payments;  
7           or

8           “(IX) limit public disclosure of  
9           de-identified or aggregate information.

10          “(D)(i) Covered Service Providers shall  
11          provide information or data under this para-  
12          graph in a manner consistent with the privacy  
13          and security regulations promulgated under the  
14          Health Insurance Portability and Accountability  
15          Act (referred to in this subparagraph as  
16          ‘HIPAA’).

17          “(ii) A group health plan that receives a  
18          disclosure from a party in interest pursuant to  
19          subparagraph (B) or (C) shall comply with the  
20          privacy and security regulations promulgated  
21          under HIPAA.

22          “(iii) Nothing in this subparagraph shall  
23          be construed to modify the requirements for the  
24          creation, receipt, maintenance, or transmission  
25          of protected health information under the

1 HIPAA privacy regulation (as defined in section  
2 1180(b)(3) of the Social Security Act) as they  
3 apply directly or indirectly to an entity pursu-  
4 ant to this paragraph.

5 “(iv) This subparagraph shall not be read  
6 to abridge or limit the disclosure requirements  
7 under this paragraph or to impose additional  
8 privacy or security requirements on Covered  
9 Service Providers or plan sponsors.

10 “(E) A group health plan receiving infor-  
11 mation or data under this paragraph may dis-  
12 close such information only in a manner that is  
13 consistent with the Health Insurance Port-  
14 ability and Accountability Act (HIPAA) and the  
15 privacy and security regulations promulgated  
16 thereunder, regardless of their direct or indirect  
17 applicability to the plan or any entities that  
18 could be or are business associates.

19 “(F) Information made available under  
20 this section shall conform to the following  
21 standards:

22 “(i) All claims from a healthcare pro-  
23 vider shall be made to the group health  
24 plan in accordance with transaction stand-

ards adopted by regulation under HIPAA,  
as follows:

“(I) Institutional, professional,  
and dental claims shall be in ASC  
X12N 837 format or any subsequent  
standard.

“(II) Pharmacy claims shall be in  
the National Council for Prescription  
Drug Programs (NCPDP) format or  
any subsequent standard.

“(III) The files shall be unmodi-  
fied copies of the files sent from the  
provider. In the event that paper  
claims are sent by the provider, they  
shall be converted to the appropriate  
standard electronic format. Files shall  
be accessible to the plan at no cost to  
the group health plan.

“(ii) All claim payment (or EFT, elec-  
tronic funds transfer) and electronic remit-  
tance advice (ERA) notices sent by a Cov-  
ered Service Provider shall be made avail-  
able to the group health plan as ASC  
X12N 835 files in accordance with stand-  
ards adopted by regulation under HIPAA.



1           The files shall be unmodified copies of the  
2           files sent by the Covered Service Provider  
3           to the healthcare provider. Files shall be  
4           accessible at no cost to the group health  
5           plan.

6           “(iii) The contractual terms con-  
7           taining calculation formulae, pricing meth-  
8           odologies, and other information used to  
9           determine the dollar value of reimburse-  
10          ment.

11          “(iv) All non-claim costs shall be  
12          itemized and made available to the group  
13          health plan in real time through a web-  
14          based portal, through an API, and through  
15          a downloadable CSV file.

16          “(G) The Secretary shall implement sub-  
17          paragraphs (C) through (F) through notice and  
18          comment rulemaking in accordance with section  
19          553 of title 5, United States Code.”.

20          (2) CIVIL ENFORCEMENT.—Subsection (c) of  
21          section 502 of such Act (29 U.S.C. 1132) is amend-  
22          ed by adding at the end the following new para-  
23          graph:

24                 “(13) In the case of an agreement between a  
25          group health plan (as defined in section 733(a)), the

1 plan sponsor of such plan (as defined in section  
 2 3(16)(B)), or the plan administrator of such plan  
 3 (as defined in section 3(16)(A)) and a health care  
 4 provider (which, for purposes of this paragraph, in-  
 5 cludes a health care facility), network or association  
 6 of providers, service provider offering access to a  
 7 network or association of providers, third-party ad-  
 8 ministrator, or pharmacy benefit manager, that vio-  
 9 lates the provisions of section 724, the Secretary  
 10 may assess a civil penalty against such provider, net-  
 11 work or association, service provider offering access  
 12 to a network or association of providers, third-party  
 13 administrator, pharmacy benefit manager, or other  
 14 service provider in the amount of \$10,000 for each  
 15 day during which such violation continues. Such  
 16 penalty shall be in addition to other penalties as  
 17 may be prescribed by law.”.

18 (3) EXISTING PROVISIONS VOID.—Section 410  
 19 of such Act (29 U.S.C. 1110) is amended by adding  
 20 at the end the following:

21 “(c) Any provision in an agreement or instrument  
 22 shall be void as against public policy if such provision—  
 23 “(1) unduly delays or limits a group health plan  
 24 (as defined in section 733(a)), the plan sponsor of  
 25 such plan (as defined in section 3(16)(B)), or the

1 plan administrator of such plan (as defined in sec-  
 2 tion 3(16)(A)) from accessing the claims and en-  
 3 counter information or data described in section  
 4 724(a)(1)(B); or

5 “(2) violates the requirements of section  
 6 408(b)(2)(C).”.

7 (4) TECHNICAL AMENDMENT.—Clause (i) of  
 8 section 408(b)(2)(B) of such Act is amended by  
 9 striking “this clause” and inserting “this para-  
 10 graph”.

11 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-  
 12 ITY INFORMATION.—Section 724(a)(3) of the Employee  
 13 Retirement Income Security Act of 1974 (29 U.S.C.  
 14 1185m(a)(3)) is amended to read as follows:

15 “(3) ATTESTATION.—

16 “(A) IN GENERAL.—Subject to subpara-  
 17 graph (C), a group health plan or health insur-  
 18 ance issuer offering group health insurance cov-  
 19 erage shall annually submit to the Secretary an  
 20 attestation that such plan or issuer of such cov-  
 21 erage is in compliance with the requirements of  
 22 this subsection. Such attestation shall also in-  
 23 clude a statement verifying that—

24 “(i) the information or data described  
 25 under subparagraphs (A) and (B) of para-

graph (1) is available upon request and provided to the group health plan, the plan sponsor, the plan administrator, or the business associate of such plan, or the issuer in a timely manner; and

“(ii) there are no terms in the agreement under such paragraph (1) that directly or indirectly restrict or unduly delay a group health plan, the plan sponsor, the plan administrator, a business associate of such plan, or the issuer from auditing, reviewing, or otherwise accessing such information.

“(B) LIMITATION ON SUBMISSION.—Subject to clause (ii), a group health plan or issuer offering group health insurance coverage may not enter into an agreement with a third-party administrator or other service provider to submit the attestation required under subparagraph (A).

“(C) EXCEPTION.—In the case of a group health plan or issuer offering group health insurance coverage that is unable to obtain the information or data needed to submit the attestation required under subparagraph (A), such

1 plan or issuer may submit a written statement  
2 in lieu of such attestation that includes—

3 “(i) an explanation of why such plan  
4 or issuer was unsuccessful in obtaining  
5 such information or data, including wheth-  
6 er such plan, the plan sponsor, or the plan  
7 administrator or issuer was limited or pre-  
8 vented from auditing, reviewing, or other-  
9 wise accessing such information or data;

10 “(ii) a description of the efforts made  
11 by the group health plan, the plan sponsor,  
12 or the plan administrator to remove any  
13 gag clause provisions from the agreement  
14 under paragraph (1); and

15 “(iii) a description of any response by  
16 the third-party administrator or other serv-  
17 ice provider with respect to efforts to com-  
18 ply with the attestation requirement under  
19 subparagraph (A), including the name of  
20 the third-party administrator or other serv-  
21 ice provider.”.

22 (c) EFFECTIVE DATE.—The amendments made by  
23 subsections (a) and (b) shall apply with respect to a plan  
24 beginning with the first plan year that begins on or after

1 the date that is 1 year after the date of enactment of this  
2 Act.

3 **SEC. 8. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**  
4 **VIDERS.**

5 (a) ERISA AMENDMENTS.—

6 (1) IN GENERAL.—Subpart B of part 7 of sub-  
7 title B of the Employee Retirement Income Security  
8 Act of 1974 (29 U.S.C. 1021 et seq.) is amended by  
9 adding at the end the following:

10 **“SEC. 726. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**  
11 **VIDERS.**

12 “(a) IN GENERAL.—For plan years beginning on or  
13 after the date that is 2 years after the date of enactment  
14 of this section, no agreement between a group health plan  
15 (as defined in section 733(a)), the plan sponsor of such  
16 plan (as defined in section 3(16)(B)), the plan adminis-  
17 trator of such plan (as defined in section 3(16)(A)), or  
18 a business associate of such plan (as defined in section  
19 160.103 of title 45, Code of Federal Regulations), (or  
20 health insurance issuer offering group health insurance  
21 coverage in connection with such a plan), and a health  
22 care provider, network or association of providers, third-  
23 party administrator, service provider offering access to a  
24 network of providers, pharmacy benefit managers, or any  
25 other third party (each referred to as a ‘health plan service

1 provider’) is permissible if such agreement limits (or  
 2 delays beyond the applicable reporting period described in  
 3 subsection (b)(1)) the disclosure of information to group  
 4 health plans in such a manner that prevents such plan,  
 5 issuer, or entity from providing the information described  
 6 in subsection (b).

7 “(b) REQUIRED DISCLOSURES.—

8 “(1) CONTENTS AND FREQUENCY.—With re-  
 9 spect to plan years beginning on or after the date  
 10 that is 2 years after the date of enactment of this  
 11 section, not less frequently than quarterly, a health  
 12 plan service provider shall provide to the group  
 13 health plan or health insurance issuer the following  
 14 information at no cost to the group health plan or  
 15 health insurance issuer:

16 “(A) The information described in section  
 17 724(a)(1)(B).

18 “(B) Any contractual and subcontractual  
 19 calculation methodologies, pricing or fee sched-  
 20 ules, or other formulae used to determine reim-  
 21 bursement amounts to providers and sub-  
 22 contractors, including methodologies, schedules,  
 23 fee structures, and any applied adjustments or  
 24 modifiers, with such information provided in a  
 25 manner sufficiently detailed to enable the group

1 health plan or health insurance issuer to accu-  
2 rately assess, verify, and ensure compliance  
3 with the terms of any contractual and sub-  
4 contractual agreement governing the reimburse-  
5 ment amounts.

6 “(C) The total amount received or ex-  
7 pected to be received by the health plan service  
8 provider or its subcontractors in provider or  
9 supplier rebates, fees, alternative discounts, and  
10 all other remuneration including amounts held  
11 in escrow or variance accounts that has been  
12 paid or is to be paid for claims incurred and  
13 administrative services including data sales or  
14 network payments.

15 “(D) The total amount paid or expected to  
16 be paid by the health plan service provider or  
17 to subcontractors in rebates, fees, contractual  
18 arrangements, and all other remuneration that  
19 has been paid or is expected to be paid for ad-  
20 ministrative and other services.

21 “(E) All payment data and reconciliation  
22 information related to alternative compensation  
23 arrangements including accountable care orga-  
24 nizations, value-based programs, shared savings  
25 programs, incentive compensation, bundled pay-



1           ments, capitation arrangements, performance  
2           payments, and any other reimbursement or pay-  
3           ment models, where the group health plan or  
4           health insurance issuer paid fees, incurred obli-  
5           gations, or made payments in connection with  
6           the group health plan related to such arrange-  
7           ments.

8           “(2) PRIVACY REQUIREMENTS.—

9                 “(A) IN GENERAL.—Health plan service  
10           providers shall provide the information or data  
11           under paragraph (1) consistent with the pri-  
12           vacy, security, and breach notification regula-  
13           tions at parts 160 and 164 of title 45, Code of  
14           Federal Regulations, promulgated under sub-  
15           title F of the Health Insurance Portability and  
16           Accountability Act of 1996, subtitle D of the  
17           Health Information Technology for Clinical  
18           Health Act of 2009, and section 1180 of the  
19           Social Security Act, and shall restrict the use  
20           and disclosure of such information according to  
21           such privacy, security, and breach notification  
22           regulations. An entity that receives a disclosure  
23           from a party in interest pursuant to subpara-  
24           graph (B) or (C) shall comply with the privacy

1 and security regulations promulgated under  
2 HIPAA.

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

9 “(C) RULE OF CONSTRUCTION.—Nothing  
10 in this section shall be construed to modify the  
11 requirements for the creation, receipt, mainte-  
12 nance, or transmission of protected health in-  
13 formation under the HIPAA privacy regulations  
14 (45 C.F.R. parts 160 and 164, subparts A and  
15 E).

16 “(3) DISCLOSURE AND REDISCLOSURE.—

17 “(A) IN GENERAL.—A group health plan  
18 receiving information under paragraph (1) may  
19 disclose such information only—

20 “(i) to the entity from which the in-  
21 formation was received or to that entity’s  
22 business associates or to the group health  
23 plan’s business associates as defined in  
24 section 160.103 of title 45, Code of Fed-

1                   eral Regulations (or successor regulations);

2                   or

3                   “(ii) as permitted by the HIPAA Pri-  
4                   vacy Rule (45 C.F.R. parts 160 and 164,  
5                   subparts A and E).

6                   “(B) AVAILABILITY OF INFORMATION.—To  
7                   the extent the information required by this sub-  
8                   section is made available to the health insur-  
9                   ance issuer offering group health insurance in  
10                  connection with a group health plan, the health  
11                  insurance issuer shall make such information  
12                  available, at the same time, in the same format,  
13                  and at no cost, to the group health plan.

14                  “(C) FAILURE TO PROVIDE.—The obliga-  
15                  tion to provide information pursuant to this  
16                  subsection shall exist notwithstanding the pres-  
17                  ence of any formal data-sharing agreement be-  
18                  tween the parties. Failure to provide the re-  
19                  quired information as specified shall constitute  
20                  a violation of this Act and the Secretary shall  
21                  initiate enforcement action under section 502  
22                  within 90 days of becoming aware of a violation  
23                  of this section, except that nothing in this sec-  
24                  tion shall be construed to limit the Secretary’s  
25                  existing authority under the Act.

1           “(4) DATA FORMAT STANDARDS.—All data and  
2           information provided pursuant to this subsection  
3           shall comply with the following standards:

4                   “(A) All claims from a healthcare provider  
5                   shall be made to the group health plan in ac-  
6                   cordance with transactions standards adopted  
7                   under HIPAA, as follows:

8                           “(i) Institutional, professional, and  
9                           dental claims and adjustments to these  
10                          claims shall be in ASC X12N 837 format,  
11                          as transmitted by the provider, or, in the  
12                          case of paper claims, converted to the ASC  
13                          X12N 837 electronic format.

14                          “(ii) Prescription drug claims shall be  
15                          in the National Council for Prescription  
16                          Drug Programs (NCPDP) format, as  
17                          transmitted by the provider, or in the case  
18                          of paper claims, converted to the NCPDP  
19                          electronic format.

20                          “(iii) Such data shall be provided at  
21                          no cost to the group health plan.

22                          “(B) All claim payment (or EFT, elec-  
23                          tronic funds transfer) and electronic remittance  
24                          advice (ERA) information sent by a health plan  
25                          service provider shall be provided to the group

1 health plan or health insurance issuer in the  
2 ASC X12N 835 format in accordance with  
3 transaction standards adopted under HIPAA,  
4 unmodified from the form in which it was  
5 transmitted to the healthcare provider. Such in-  
6 formation shall be provided at no cost to the  
7 group health plan or health insurance issuer.

8 “(C) The Secretary may modify the stand-  
9 ards set forth in this paragraph as necessary to  
10 align with any changes adopted by the Sec-  
11 retary of Health and Human Services pursuant  
12 to the authority provided under section 1173 of  
13 the Social Security Act (42 U.S.C. 1320d-2).

14 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any  
15 provision in an agreement between a group health plan,  
16 the plan sponsor, the plan administrator, or a business  
17 associate of such plan or a health insurance issuer and  
18 a health plan service provider that unduly delays or limits  
19 a group health plan’s or health insurance issuer’s access  
20 to information described in this section or that restricts  
21 the format or timing of the provision of such information  
22 in a manner that is inconsistent with the requirements of  
23 this section shall be prohibited and, if a group health plan  
24 or health insurance issuer enters into such agreement,  
25 shall be deemed void as against public policy.

1       “(d) PENALTIES FOR NON-COMPLIANCE.—Any fail-  
 2       ure by a health plan service provider to comply with the  
 3       requirements of this section shall result in the imposition  
 4       of a civil penalty of \$100,000 for each day the violation  
 5       continues, in addition to any other penalties prescribed by  
 6       law.

7       “(e) REGULATIONS.—The Secretary shall implement  
 8       this section through notice and comment rulemaking in  
 9       accordance with section 553 of title 5, United States  
 10      Code.”.

11               (2) PENALTY.—

12                       (A) IN GENERAL.—Section 502(a) of the  
 13       Employee Retirement Income Security Act of  
 14       1974 (29 U.S.C. 1132(a)) is amended by add-  
 15       ing at the end the following new paragraph:

16               “(14) The Secretary may assess a civil penalty  
 17       against any person of \$100,000 per day for each vio-  
 18       lation by any person of section 726.”.

19                       (B) TECHNICAL AMENDMENT.—Paragraph  
 20       (6) of section 502(a) of the Employee Retire-  
 21       ment Income Security Act of 1974 (29 U.S.C.  
 22       1132(a)) is amended by striking “or (9)” and  
 23       inserting it with the phrase “(9), (13), or  
 24       (14)”.

25               (b) PHSA AMENDMENTS.—

1           (1) IN GENERAL.—Part D of title XXVII of the  
 2       Public Health Service Act (42 U.S.C. 300gg–111 et  
 3       seq.) is amended by adding at the end the following:

4       **“SEC. 2799A–11. OVERSIGHT OF ADMINISTRATIVE SERVICE**  
 5                               **PROVIDERS.**

6       “(a) IN GENERAL.—For plan years beginning on or  
 7       after the date that is 1 year after the date of enactment  
 8       of this section, no agreement between a group health plan  
 9       that is a self-funded, non-Federal governmental plan, as  
 10      defined in section 2791(d)(8)(C) (42 U.S.C. 300gg–  
 11      91(d)(8)(C)), and a health care provider, network or asso-  
 12      ciation of providers, third-party administrator, service pro-  
 13      vider offering access to a network of providers, pharmacy  
 14      benefit managers, or any other third party (each referred  
 15      to in this section as a ‘health plan service provider’) is  
 16      permissible if such agreement limits (or delays beyond the  
 17      applicable reporting period described in subsection (b)(1))  
 18      the disclosure of information to group health plans in such  
 19      a manner that prevents such plan, issuer, or entity from  
 20      providing the information described in subsection (b).

21      “(b) REQUIRED DISCLOSURES.—

22               “(1) CONTENTS AND FREQUENCY.—With re-  
 23      spect to plan years beginning on or after the date  
 24      that is 1 year after the date of enactment of this  
 25      section, not less frequently than quarterly, a health

1 plan service provider shall provide to the group  
2 health plan that is a self-funded, non-Federal gov-  
3 ernmental plan the following information at no cost  
4 to the plan:

5 “(A) The information described in section  
6 2799A-9(a)(1)(B) (42 U.S.C. 300gg-  
7 119(a)(1)(B)).

8 “(B) Any contractual and subcontractual  
9 calculation methodologies, pricing or fee sched-  
10 ules, or other formulae used to determine reim-  
11 bursement amounts to providers and sub-  
12 contractors, including methodologies, schedules,  
13 fee structures, and any applied adjustments or  
14 modifiers, with such information provided in a  
15 manner sufficiently detailed to enable the group  
16 health plan to accurately assess, verify, and en-  
17 sure compliance with the terms of any contrac-  
18 tual and subcontractual agreement governing  
19 the reimbursement amounts.

20 “(C) The total amount received or ex-  
21 pected to be received by the health plan service  
22 provider or its subcontractors in provider or  
23 supplier rebates, fees, alternative discounts, and  
24 all other remuneration including amounts held  
25 in escrow or variance accounts that has been



1       paid or is to be paid for claims incurred and  
2       administrative services including data sales or  
3       network payments.

4               “(D) The total amount paid or expected to  
5       be paid by the health plan service provider or  
6       to subcontractors in rebates, fees, contractual  
7       arrangements, and all other remuneration that  
8       has been paid or is expected to be paid for ad-  
9       ministrative and other services.

10              “(E) All payment data and reconciliation  
11       information related to alternative compensation  
12       arrangements including accountable care orga-  
13       nizations, value-based programs, shared savings  
14       programs, incentive compensation, bundled pay-  
15       ments, capitation arrangements, performance  
16       payments, and any other reimbursement or pay-  
17       ment models, where the group health plan paid  
18       fees, incurred obligations, or made payments in  
19       connection with the group health plan related to  
20       such arrangements.

21              “(2) PRIVACY REQUIREMENTS.—

22              “(A) IN GENERAL.—Health plan service  
23       providers shall provide the information or data  
24       under paragraph (1) consistent with the pri-  
25       vacy, security, and breach notification regula-

tions at parts 160 and 164 of title 45, Code of Federal Regulations, promulgated under subtitle F of the Health Insurance Portability and Accountability Act of 1996, subtitle D of the Health Information Technology for Clinical Health Act of 2009, and section 1180 of the Social Security Act, and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations. An entity that receives a disclosure from a party in interest pursuant to subparagraph (B) or (C) shall comply with the privacy and security regulations promulgated under HIPAA.

“(B) RESTRICTIONS.—A group health plan that is a self-funded, non-Federal governmental plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

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

1 formation under the HIPAA privacy regulations  
2 (45 C.F.R. parts 160 and 164, subparts A and  
3 E).

4 “(3) DISCLOSURE AND REDISCLOSURE.—

5 “(A) IN GENERAL.—A group health plan  
6 that is a self-funded, non-Federal governmental  
7 plan receiving information under paragraph (1)  
8 may disclose such information only—

9 “(i) to the entity from which the in-  
10 formation was received or to that entity’s  
11 business associates as defined in section  
12 160.103 of title 45, Code of Federal Regu-  
13 lations (or successor regulations); or

14 “(ii) as permitted by the HIPAA Pri-  
15 vacy Rule (45 C.F.R. parts 160 and 164,  
16 subparts A and E).

17 “(B) RULE OF CONSTRUCTION.—Nothing  
18 in this section shall be construed to prevent a  
19 group health plan that is a self-funded, non-  
20 Federal governmental plan, or a health plan  
21 service provider providing services with respect  
22 to such a plan, from placing reasonable restric-  
23 tions on the public disclosure of the information  
24 described in paragraph (1), except that such  
25 plan or entity may not restrict disclosure of

1 such information to the Department of Health  
 2 and Human Services, the Department of Labor,  
 3 the Department of the Treasury, or the Comp-  
 4 troller General of the United States.

5 “(C) FAILURE TO PROVIDE.—The obliga-  
 6 tion to provide information pursuant to this  
 7 subsection shall exist notwithstanding the pres-  
 8 ence of any formal data-sharing agreement be-  
 9 tween the parties. Failure to provide the re-  
 10 quired information as specified shall constitute  
 11 a violation of this Act and the Secretary shall  
 12 initiate enforcement action under section  
 13 2723(b) (42 U.S.C. 300gg–22(b)) within 90  
 14 days of becoming aware of a violation of this  
 15 section, except that nothing in this section shall  
 16 be construed to limit the Secretary’s existing  
 17 authority under this Act.

18 “(4) DATA FORMAT STANDARDS.—All data and  
 19 information provided pursuant to this subsection  
 20 shall comply with the following standards:

21 “(A) All claims from a healthcare provider  
 22 shall be made to the group health plan in ac-  
 23 cordance with standards adopted under HIPAA  
 24 at section 162.1101 of title 45, Code of Federal  
 25 Regulations, as follows:

1                   “(i) Institutional, professional, and  
2                   dental claims and adjustments to these  
3                   claims shall be provided to the group  
4                   health plan that is a self-funded, non-Fed-  
5                   eral governmental plan in the ASC X12N  
6                   837 format.

7                   “(ii) Prescription drug claims shall be  
8                   in the National Council for Prescription  
9                   Drug Programs (NCPDP) format.

10                  “(iii) The files shall be unmodified  
11                  copies of the files sent from the provider.  
12                  In the event that paper claims are sent by  
13                  the provider, they shall be converted to the  
14                  appropriate standard electronic format.  
15                  Such data shall be provided at no cost to  
16                  the group health plan.

17                  “(B) All claim payment (or EFT, elec-  
18                  tronic funds transfer) and electronic remittance  
19                  advice (ERA) information sent by a health plan  
20                  service provider shall be provided to the group  
21                  health plan or health insurance issuer in the  
22                  ASC X12N 835 format, in accordance with  
23                  standards adopted under HIPAA at section  
24                  162.1602 of title 45, Code of Federal Regula-  
25                  tions, unmodified from the form in which it was

1 transmitted to the healthcare provider. Such in-  
2 formation shall be provided at no cost to the  
3 group health plan.

4 “(C) The Secretary may modify the stand-  
5 ards set forth in this paragraph as necessary to  
6 align with any changes adopted by the Sec-  
7 retary pursuant to the authority provided under  
8 section 1173 of the Social Security Act (42  
9 U.S.C. 1320d-2).

10 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any  
11 provision in an agreement that unduly delays or limits a  
12 group health plan that is a self-funded, non-Federal gov-  
13 ernmental plan’s access to information described in this  
14 section or that restricts the format or timing of the provi-  
15 sion of such information in a manner that is inconsistent  
16 with the requirements of this section shall be prohibited  
17 and, if a self-funded, non-Federal governmental plan en-  
18 ters into such agreement, shall be deemed void as against  
19 public policy.

20 “(d) REGULATIONS.—The Secretary shall implement  
21 this section through notice and comment rulemaking in  
22 accordance with section 553 of title 5, United States  
23 Code.”.

1           (2) PENALTY.—Section 2723(b) of the Public  
 2       Health Service Act (42 U.S.C. 300gg–22(b)) is  
 3       amended by adding at the end the following:

4           “(4) ENFORCEMENT AUTHORITY RELATING TO  
 5       HEALTH PLAN SERVICE PROVIDERS.—Notwith-  
 6       standing any provisions to the contrary, the Sec-  
 7       retary may assess a penalty against a health plan  
 8       service provider, as defined in section 2799A–11(a)  
 9       (42 U.S.C. 300gg–121(a)), of \$100,000 per day for  
 10      each violation of such section, pursuant to substan-  
 11      tially similar processes and procedures as those set  
 12      forth in section 2723(b)(2)(D) through (G) (42  
 13      U.S.C. 300gg–121(b)(2)(D) through (G)).”.

14 **SEC. 9. STATE PREEMPTION ONLY IN EVENT OF CONFLICT.**

15       The provisions of sections 2 through 5 (including the  
 16      amendments made by such sections) shall not supersede  
 17      any provision of State law which establishes, implements,  
 18      or continues in effect any requirement or prohibition re-  
 19      lated to health care price transparency, including hospital,  
 20      clinical diagnostic laboratory tests, imaging services, and  
 21      ambulatory surgical center, except to the extent that such  
 22      requirement or prohibition prevents the application of a  
 23      requirement or prohibition of such sections (or amend-  
 24      ment). Nothing in this section shall be construed to affect  
 25      group health plans established under the Employee Retire-

1 ment Income Security Act of 1974, or alter the application  
 2 of section 514 of such Act (29 U.S.C. 1144).

3 **SEC. 10. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

4 (a) PHSA AMENDMENTS.—

5 (1) EMERGENCY SERVICES.—Section 2799A–  
 6 1(f)(1)(C) of the Public Health Service Act (42  
 7 U.S.C. 300gg–111(f)(1)(C)) is amended to read as  
 8 follows:

9 “(C) A good faith estimate of the amount  
 10 the plan or coverage is responsible for paying  
 11 for items and services included in the estimate  
 12 described in subparagraph (B), including a  
 13 plain language description of each item or serv-  
 14 ice and all applicable billing codes for each item  
 15 or service, including modifiers, using standard  
 16 and commonly recognized billing code sets that  
 17 are clearly identified.”.

18 (2) EXPLANATION OF BENEFITS.—Section  
 19 2799A–1 of the Public Health Service Act (42  
 20 U.S.C. 300gg–111) is amended by adding at the end  
 21 the following:

22 “(g) EXPLANATION OF BENEFITS.—

23 “(1) IN GENERAL.—For plan years beginning  
 24 on or after January 1, 2026, each group health  
 25 plan, or a health insurance issuer offering group or



1 individual health insurance coverage shall, within 45  
2 days of receiving any request for payment for an  
3 item or service under the plan, provide to the partic-  
4 ipant, beneficiary, or enrollee (through mail or elec-  
5 tronic means, as requested by the participant, bene-  
6 ficiary, or enrollee) a notification (in clear and un-  
7 derstandable language and utilizing substantially the  
8 same format as the advanced explanation of benefits  
9 required by subsection (f) to enable comparison) in-  
10 cluding the following:

11 “(A) Whether or not the provider or facil-  
12 ity is a participating provider or a participating  
13 facility with respect to the plan or coverage  
14 with respect to the furnishing of such item or  
15 service.

16 “(B) An itemized explanation of benefits  
17 that includes the following:

18 “(i) A plain language description of  
19 each item or service.

20 “(ii) All applicable billing codes for  
21 each item or service, including modifiers,  
22 using standard and commonly recognized  
23 billing code sets that are clearly identified.

1                   “(iii) The amount the plan or cov-  
 2                   erage is responsible for paying for each  
 3                   item or service.

4                   “(iv) The amount of any cost-sharing  
 5                   for which the participant, beneficiary, or  
 6                   enrollee is responsible for each item or  
 7                   service (as of the date of such notification).

8                   “(v) The amount that the participant,  
 9                   beneficiary, or enrollee has incurred toward  
 10                  meeting the limit of the financial responsi-  
 11                  bility (including with respect to deductibles  
 12                  and out-of-pocket maximums) under the  
 13                  plan or coverage (as of the date of such  
 14                  notification).

15                  “(vi) The site of each item or service.

16                  “(2) FORMAT.—If applicable, the notification  
 17                  described in paragraph (1) may be provided in con-  
 18                  junction with, or as part of, a notice of a claim de-  
 19                  termination or other communication required by sec-  
 20                  tion 2719(a) (42 U.S.C. 300gg–19(a)), or regula-  
 21                  tions thereunder.

22                  “(h) REGULATIONS.—The Secretary shall implement  
 23                  this section through notice and comment rulemaking in  
 24                  accordance with section 553 of title 5, United States  
 25                  Code.”.

1 (b) IRC AMENDMENTS.—

2 (1) EMERGENCY SERVICES.—Section  
3 9816(f)(1)(C) of the Internal Revenue Code of 1986  
4 is amended to read as follows:

5 “(C) A good faith estimate of the amount  
6 the plan is responsible for paying for items and  
7 services included in the estimate described in  
8 subparagraph (B), including a plain language  
9 description of each item or service and all appli-  
10 cable billing codes for each item or service, in-  
11 cluding modifiers, using standard and com-  
12 monly recognized billing code sets that are  
13 clearly identified.”.

14 (2) EXPLANATION OF BENEFITS.—Section  
15 9816 of the Internal Revenue Code of 1986 is  
16 amended by adding at the end the following:

17 “(g) EXPLANATION OF BENEFITS.—

18 “(1) IN GENERAL.—For plan years beginning  
19 on or after January 1, 2026, each group health plan  
20 shall, within 45 days of receiving any request for  
21 payment for an item or service under the plan, pro-  
22 vide to the participant or beneficiary (through mail  
23 or electronic means, as requested by the participant  
24 or beneficiary) a notification (in clear and under-  
25 standable language and utilizing substantially the

1 same format as the advanced explanation of benefits  
2 required by subsection (f) to enable comparison) in-  
3 cluding the following:

4 “(A) Whether or not the provider or facil-  
5 ity is a participating provider or a participating  
6 facility with respect to the plan with respect to  
7 the furnishing of such item or service.

8 “(B) An itemized explanation of benefits  
9 that includes the following:

10 “(i) A plain language description of  
11 each item or service.

12 “(ii) All applicable billing codes for  
13 each item or service, including modifiers,  
14 using standard and commonly recognized  
15 billing code sets that are clearly identified.

16 “(iii) The amount the plan is respon-  
17 sible for paying for each item or service.

18 “(iv) The amount of any cost-sharing  
19 for which the participant or beneficiary is  
20 responsible for each item or service (as of  
21 the date of such notification).

22 “(v) The amount that the participant  
23 or beneficiary has incurred toward meeting  
24 the limit of the financial responsibility (in-  
25 cluding with respect to deductibles and

1 out-of-pocket maximums) under the plan  
 2 (as of the date of such notification).

3 “(vi) The site of each item or service.

4 “(2) FORMAT.—If applicable, the notification  
 5 described in paragraph (1) may be provided in con-  
 6 junction with, or as part of, a notice of a claim de-  
 7 termination or other communication required by sec-  
 8 tion 503 of the Employee Retirement Income Secu-  
 9 rity Act of 1974 or regulations thereunder.

10 “(h) REGULATIONS.—The Secretary shall implement  
 11 this section through notice and comment rulemaking in  
 12 accordance with section 553 of title 5, United States  
 13 Code.”.

14 (c) ERISA AMENDMENTS.—

15 (1) EMERGENCY SERVICES.—Section  
 16 716(f)(1)(C) of the Employee Retirement Income  
 17 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is  
 18 amended to read as follows:

19 “(C) A good faith estimate of the amount  
 20 the health plan is responsible for paying for  
 21 items and services included in the estimate de-  
 22 scribed in subparagraph (B), including a plain  
 23 language description of each item or service and  
 24 all applicable billing codes for each item or serv-  
 25 ice, including modifiers, using standard and

1 commonly recognized billing code sets that are  
2 clearly identified.”.

3 (2) EXPLANATION OF BENEFITS.—Section 716  
4 of the Employee Retirement Income Security Act of  
5 1974 (29 U.S.C. 1185e) is amended by adding at  
6 the end the following:

7 “(g) EXPLANATION OF BENEFITS.—

8 “(1) IN GENERAL.—For plan years beginning  
9 on or after January 1, 2026, each group health plan  
10 or health insurance issuer offering group health in-  
11 surance coverage shall, within 45 days of receiving  
12 any request for payment for an item or service  
13 under the plan, provide to the participant or bene-  
14 ficiary (through mail or electronic means, as re-  
15 quested by the participant or beneficiary) a notifica-  
16 tion (in clear and understandable language and uti-  
17 lizing substantially the same format as the advanced  
18 explanation of benefits required by subsection (f) to  
19 enable comparison) including the following:

20 “(A) Whether or not the provider or facil-  
21 ity is a participating provider or a participating  
22 facility with respect to the plan or coverage  
23 with respect to the furnishing of such item or  
24 service.

1 “(B) An itemized explanation of benefits  
2 that includes the following:

3 “(i) A plain language description of  
4 each item or service.

5 “(ii) All applicable billing codes for  
6 each item or service, including modifiers,  
7 using standard and commonly recognized  
8 billing code sets that are clearly identified.

9 “(iii) The amount the plan or cov-  
10 erage is responsible for paying for each  
11 item or service.

12 “(iv) The amount of any cost-sharing  
13 for which the participant or beneficiary is  
14 responsible for each item or service (as of  
15 the date of such notification).

16 “(v) The amount that the participant  
17 or beneficiary has incurred toward meeting  
18 the limit of the financial responsibility (in-  
19 cluding with respect to deductibles and  
20 out-of-pocket maximums) under the plan  
21 or coverage (as of the date of such notifi-  
22 cation).

23 “(vi) The site of each item or service.

24 “(2) FORMAT.—If applicable, the notification  
25 described in paragraph (1) may be provided in con-

1       junction with, or as part of, a notice of a claim de-  
 2       termination or other communication required by sec-  
 3       tion 503 or regulations thereunder.

4       “(h) REGULATIONS.—The Secretary shall implement  
 5       this section through notice and comment rulemaking in  
 6       accordance with section 553 of title 5, United States  
 7       Code.”.

8       **SEC. 11. PROVISION OF ITEMIZED BILLS.**

9       Part E of title XXVII of the Public Health Service  
 10      Act (42 U.S.C. 300gg–131 et seq.) is amended by adding  
 11      at the end the following:

12      **“SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED**  
 13                                   **BILLS.**

14      “(a) REQUIREMENTS.—

15                   “(1) ITEMIZED BILL AND OTHER INFORMATION  
 16      REQUIRED.—

17                           “(A) IN GENERAL.—A health care provider  
 18                   or health care facility that requests payment  
 19                   from an individual after providing a health care  
 20                   item or service to the patient shall include with  
 21                   such request a written, itemized bill of the cost  
 22                   of each reasonably expected item or service the  
 23                   health care provider or health care facility pro-  
 24                   vided to the individual, including telehealth vis-  
 25                   its or visits by other electronic means. The



1 health care provider or health care facility shall  
2 provide the itemized bill not later than 30 days  
3 after the health care provider or health care fa-  
4 cility received a final payment on the provided  
5 service or supply from a third party.

6 “(B) REQUIRED INFORMATION.—For each  
7 item or service provided by the health care pro-  
8 vider or facility or for which the health care  
9 provider or facility is billing the individual, the  
10 itemized bill must include—

11 “(i) a plain language description of  
12 each distinct health care item or service;

13 “(ii) all applicable billing codes for  
14 each distinct health care item or service,  
15 including modifiers, using standard and  
16 commonly recognized billing code sets that  
17 are clearly identified;

18 “(iii) the price and billed amount, if  
19 different, of each distinct health care item  
20 or service or if the provider or facility is  
21 offering binding, all-in prices for bundled  
22 items and services, the total binding price  
23 for bundled items and services and billed  
24 amount;

1           “(iv) any payments made to the  
 2           health care provider or health care facility  
 3           by or on behalf of the individual (including  
 4           payments by any health plan or insurance)  
 5           for any health care item or service covered  
 6           in the itemized bill;

7           “(v) information about the availability  
 8           of language-assistance services for individ-  
 9           uals with limited English proficiency  
 10          (LEP);

11          “(vi) the identification of an office or  
 12          individual at the health care provider or  
 13          health care facility, including phone num-  
 14          ber and email address, that shall be able to  
 15          discuss the specific details of the itemized  
 16          statement and be authorized to make ap-  
 17          propriate changes thereto; and

18          “(vii) information about the health  
 19          care provider’s or health care facility’s  
 20          charity care policies and instructions on  
 21          how to apply for charity care.

22          “(2) COLLECTIONS ACTIONS.—

23          “(A) IN GENERAL.—A health care provider  
 24          or health care facility shall not take any collec-  
 25          tions actions against an individual—

1 “(i) for any provided health care item  
2 or service unless the health care provider  
3 or health care facility has complied with  
4 paragraph (1); or

5 “(ii) with respect to any items or serv-  
6 ices for which the amount appearing on an  
7 itemized bill described above in paragraph  
8 (1) exceeds the amount disclosed pursuant  
9 to Federal health care price transparency  
10 regulations, including part 180 of title 45,  
11 Code of Federal Regulations, or provided  
12 in a good faith estimate that complies with  
13 section 2799B–6 of this Act and section  
14 149.610 of title 45, Code of Federal Regu-  
15 lations, or another good faith estimate pro-  
16 vided by a health care entity covered under  
17 this section but not otherwise covered  
18 under such section 2799B–6 unless the  
19 provider or facility documents that the ad-  
20 ditional items or services were medically  
21 necessary due to unforeseen complications  
22 or a patient-initiated change, and could not  
23 reasonably have been anticipated.

24 “(B) BURDEN OF PROOF.—The burden of  
25 proof under subparagraph (A)(ii) shall rest with

1           the provider, and absent the documentation de-  
2           scribed in such subparagraph, the good faith es-  
3           timate shall be binding.

4           “(b) FAILURE TO COMPLY.—

5                 “(1) PENALTIES.—The Secretary shall impose  
6           penalties on any health care provider or health care  
7           facility that fails to comply with the requirements of  
8           this section in an amount not to exceed \$10,000 for  
9           each instance of failure to comply.

10               “(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—If a health care provider or health care fa-  
11           cility fails to comply with the requirements of this  
12           section, the presumption shall be that charges were  
13           substantially in excess of the good faith estimate (as  
14           set forth in section 2799B–6) for the purpose of any  
15           patient-provider dispute, including in accordance  
16           with section 2799B–7 and regulations promulgated  
17           thereunder.

18               “(c) REGULATIONS.—The Secretary shall implement  
19           this section through notice and comment rulemaking in  
20           accordance with section 553 of title 5, United States  
21           Code.”.

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