

Calendar No. 522

119TH CONGRESS
2D SESSION**S. 2355**

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

IN THE SENATE OF THE UNITED STATES

JULY 17, 2025

Mr. MARSHALL (for himself, Mr. HICKENLOOPER, Mr. GRASSLEY, Ms. HASSAN, Mr. SHEEHY, Ms. ERNST, Ms. BALDWIN, Mr. MORENO, Mr. SCOTT of Florida, Mr. KIM, Mr. HUSTED, Ms. BLUNT ROCHESTER, Mr. TUBERVILLE, Ms. LUMMIS, Mr. COONS, Mr. MULLIN, Mr. BOOKER, Mr. WELCH, Mr. PETERS, Ms. WARREN, Mr. ARMSTRONG, Mr. KELLY, Mr. SCHMITT, Mr. FETTERMAN, and Mr. GALLEG0) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

JULY 27, 2026

Reported by Mr. CASSIDY, with an amendment

[Strike out all after the enacting clause and insert the part printed in *italie*]

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,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Patients Deserve Price
3 Tags Act”.

4 **SEC. 2. STRENGTHENING HOSPITAL PRICE TRANSPARENCY**
5 **REQUIREMENTS.**

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

9 “(e) **STANDARD HOSPITAL CHARGES.**—

10 “(1) **IN GENERAL.**—

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

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

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

1 “(I) as many of the Centers for
 2 Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many
 3 additional hospital-selected shoppable
 4 services (or all such additional services, if such hospital furnishes fewer
 5 than 300 shoppable services) as may
 6 be necessary for a combined total of
 7 at least 300 shoppable services
 8 through December 31, 2026, after
 9 which the hospital’s prices shall include all shoppable services; and

10 “(II) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is
 11 not furnished by the hospital, an indication that such service is not so furnished.

12 “(B) STANDARD CHARGES DESCRIBED.—

13 For purposes of subparagraph (A), standard
 14 charges means:

15 “(i) A plain language description of
 16 each item or service, accompanied by any
 17 applicable billing codes, including modi-

1 fiers, using commonly recognized billing
2 code sets, including the Current Proce-
3 dural Terminology code, the Healthcare
4 Common Procedure Coding System code,
5 the diagnosis-related group, the National
6 Drug Code, and other nationally recog-
7 nized identifier.

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

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

1 pital's charity care policy). The hospital
2 shall accept the discounted cash price as
3 payment in full from any patient that
4 chooses to pay in cash without regard to
5 the patient's coverage.

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

23 “(v) The de-identified maximum and
24 minimum negotiated charges for each such

1 item or service, expressed as a non-zero
2 dollar amount.

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

17 “(C) UNIFORM METHOD AND FORMAT.—

18 Not later than January 1, 2026, the Secretary
19 shall establish a standard, uniform method and
20 format for hospitals to use in compiling and
21 making public standard charges pursuant to
22 subparagraph (A)(i) and a standard, uniform
23 method and format for such hospitals to use in
24 compiling and making public prices pursuant to

1 subparagraph (A)(ii). Such methods and for-
2 mats shall—

3 “(i) in the case of such method and
4 format for making public standard charges
5 pursuant to subparagraph (A)(i), ensure
6 that such charges are made available in a
7 machine-readable spreadsheet format;

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

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

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

23 “(3) MONITORING COMPLIANCE.—The Sec-
24 retary shall, in consultation with the Inspector Gen-
25 eral of the Department of Health and Human Serv-

ices, establish a process to monitor compliance with this subsection. Such process shall ensure that each hospital's compliance with this subsection is reviewed not less frequently than once every year.

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

“(5) ENFORCEMENT.—

“(A) IN GENERAL.—In the case of a hospital 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 hospital a notification of such determination, which shall include a request for a corrective action plan to comply with such requirements.

“(B) CIVIL MONETARY PENALTY.—

1 “(i) IN GENERAL.—In addition to any
2 other enforcement actions or penalties that
3 may apply under another provision of law,
4 a hospital that has received a request for
5 a corrective action plan under subpara-
6 graph (A) and fails to comply with the re-
7 quirements of this subsection by the date
8 that is 45 days after such request is made
9 shall be subject to a civil monetary penalty
10 of an amount specified by the Secretary for
11 each day (beginning with the day on which
12 the Secretary first determined that such
13 hospital was not complying with such re-
14 quirements) during which such failure was
15 ongoing. Such amount shall not exceed—

16 “(I) in the case of a hospital with
17 30 or fewer beds, \$300 per day;

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

1 following such 1-year period, \$15 per
2 bed per day);

3 “(III) in the case of a hospital
4 with more than 100 beds but fewer
5 than 301 beds, \$17.50 per bed per
6 day (or, in the case of such a hospital
7 that has been noncompliant with such
8 requirements for a 1-year period or
9 longer, beginning with the first day
10 following such 1-year period, \$20 per
11 bed per day);

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

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

1 or longer, beginning with the first day
 2 following such 1-year period, \$35 per
 3 bed per day).

4 “(ii) INCREASE AUTHORITY.—In ap-
 5 plying this subparagraph with respect to
 6 violations occurring in 2027 or a subse-
 7 quent year, the Secretary may through no-
 8 tice and comment rulemaking increase—

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

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

16 “(III) the limitation on the in-
 17 crease of any penalty applied under
 18 clause (iii) pursuant to the amounts
 19 specified in subclause (II) of such
 20 clause.

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

23 “(I) IN GENERAL.—In the case
 24 of a hospital that the Secretary has
 25 determined to be knowingly and will-

1 fully noncompliant with the provisions
 2 of this subsection two or more times
 3 during a 1-year period; the Secretary
 4 may increase any penalty otherwise
 5 applicable under this subparagraph by
 6 the amount specified in subclause (H)
 7 with respect to such hospital and may
 8 require such hospital to complete such
 9 additional corrective actions plans as
 10 the Secretary may specify.

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

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

20 “(bb) with more than 100
 21 beds but fewer than 301 beds, an
 22 amount that is greater than
 23 \$1,000,000 and not more than
 24 \$2,000,000;

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

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

10 “(iv) PROVISION OF TECHNICAL AS-
 11 SISTANCE.—The Secretary may, to the ex-
 12 tent practicable, provide technical assist-
 13 ance relating to compliance with the provi-
 14 sions of this section to hospitals requesting
 15 such assistance.

16 “(v) APPLICATION OF CERTAIN PROVI-
 17 SIONS.—The provisions of section 1128A
 18 (other than subsections (a) and (b) of such
 19 section) shall apply to a civil monetary
 20 penalty imposed under this subparagraph
 21 in the same manner as such provisions
 22 apply to a civil monetary penalty imposed
 23 under subsection (a) of such section.

24 “(C) NO WAIVER.—The Secretary shall not
 25 grant or extend any waiver, delay, tolling, or

1 other mitigation of a civil monetary penalty for
 2 violation of this subsection.

3 ~~“(6) DEFINITIONS.—For purposes of this sub-~~
 4 ~~section:~~

5 ~~“(A) DISCOUNTED CASH PRICE.—The~~
 6 ~~term ‘discounted cash price’ means the min-~~
 7 ~~imum charge, exclusive of any hospital or third-~~
 8 ~~party payer assistance, that the hospital accepts~~
 9 ~~from an individual who pays cash, or cash~~
 10 ~~equivalent, for a hospital-furnished item or~~
 11 ~~service, without regard to patient coverage, as~~
 12 ~~payment in full.~~

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

17 ~~“(C) HOSPITAL.—The term ‘hospital’~~
 18 ~~means a hospital (as defined in section 1861(e)~~
 19 ~~of the Social Security Act), a critical access~~
 20 ~~hospital (as defined in section 1861(mmm)(1)~~
 21 ~~of the Social Security Act), or a rural emer-~~
 22 ~~gency hospital (as defined in section 1861(kkk)~~
 23 ~~of the Social Security Act), together with any~~
 24 ~~parent, subsidiary, or other affiliated provider~~
 25 ~~or supplier of health care items and services~~

without regard to whether such parent, subsidiary, or other affiliated provider or supplier operates under separate licensure, certification, or designation.

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

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

“(F) 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.

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

(b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendment made by
2 subsection (a) shall apply beginning January 1,
3 2026.

4 (2) CONTINUED APPLICABILITY OF RULES FOR
5 PREVIOUS YEARS.—Nothing in the amendment made
6 by this section may be construed as affecting the ap-
7 plicability of the regulations codified at part 180 of
8 title 45, Code of Federal Regulations, before Janu-
9 ary 1, 2025.

10 (c) CONTINUED APPLICABILITY OF STATE LAW.—
11 The provisions of this Act shall not supersede any provi-
12 sion of State law that establishes, implements, or con-
13 tinues in effect any requirement or prohibition related to
14 health care price transparency, except to the extent that
15 such requirement or prohibition prevents the application
16 of a requirement or prohibition of this Act.

17 **SEC. 3. INCREASING PRICE TRANSPARENCY OF CLINICAL**
18 **DIAGNOSTIC LABORATORY TESTS.**

19 Section 2718 of the Public Health Service Act (42
20 U.S.C. 300gg-18) is amended by adding at the end the
21 following:

22 “(f) CLINICAL DIAGNOSTIC LABORATORY PRICE
23 TRANSPARENCY.—

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

1 “(A) make publicly available on an internet
 2 website the information described in paragraph
 3 ~~(2)~~ with respect to each such specified clinical
 4 diagnostic laboratory test that such laboratory
 5 so furnishes; and

6 “(B) ensure that such information is up-
 7 dated not less frequently than monthly; if there
 8 have been any changes to such information.

9 ~~“(2) INFORMATION DESCRIBED.—~~For purposes
 10 of paragraph ~~(1)~~, the information described in this
 11 paragraph is, with respect to an applicable labora-
 12 tory and a specified clinical diagnostic laboratory
 13 test, the following:

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

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

1 “(C) The discounted cash price expressed
2 as a dollar amount, for each such item or serv-
3 ice (or, in the case no discounted cash price is
4 available for an item or service, the minimum
5 cash price accepted by the laboratory from self-
6 pay individuals for such item or service when
7 provided in such settings for the previous three
8 years, expressed as a dollar amount, as well as,
9 with respect to prices made public pursuant to
10 subparagraph (A)(ii), a link to a consumer-
11 friendly document that clearly explains the lab-
12 oratory’s charity care policy). The laboratory
13 shall accept the discounted or minimum cash
14 price as payment in full from any patient that
15 chooses to pay in cash without regard to the pa-
16 tient’s coverage.

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

1 the clinical diagnostic laboratory also shall dis-
2 close such algorithm, percentage, formula, or
3 criteria as set forth in its contract and any
4 other terms, schedules, exhibits, data, or other
5 information referenced in any such contract as
6 shall be required to determine and disclose the
7 negotiated charge.

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

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

24 “(3) UNIFORM METHOD AND FORMAT.—Not
25 later than January 1, 2027, the Secretary shall es-

1 establish a standard, uniform method and format for
2 applicable laboratories to use in compiling and mak-
3 ing public information pursuant to paragraph (1).
4 Such method and format shall—

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

9 “(B) meet such standards as determined
10 appropriate by the Secretary in order to ensure
11 the accessibility and usability of such informa-
12 tion; and

13 “(C) be updated as determined appropriate
14 by the Secretary, in consultation with stake-
15 holders.

16 “(4) INCLUSION OF ANCILLARY SERVICES.—

17 Any price or rate for a specified clinical diagnostic
18 laboratory test available to be furnished by an appli-
19 cable laboratory made publicly available in accord-
20 ance with paragraph (1) shall include the price or
21 rate for any ancillary item or service (including spec-
22 imen collection services, specimen transport, cen-
23 trifugation, aliquoting, labeling, requisition proe-
24 cessing, and standard result reporting services) that
25 would customarily and routinely be furnished by

1 such laboratory as part of such test, as specified by
 2 the Secretary.

3 ~~“(5) ENFORCEMENT.—~~

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

7 ~~“(i) not later than 30 days after such~~
 8 ~~determination, the Secretary shall notify~~
 9 ~~such laboratory of such determination; and~~

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

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

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

14 ~~“(7) DEFINITIONS.—In this subsection:~~

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

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

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

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

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

24 “(F) THIRD PARTY PAYER.—The term
 25 ‘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. 4. IMAGING TRANSPARENCY.

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

“(g) IMAGING SERVICES PRICE TRANSPARENCY.—

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

“(A) make publicly available (in accordance with paragraph (3)) on an internet website the information described in paragraph (2) with respect to each such service that such provider of services or supplier furnishes; and

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

3 ~~“(2) INFORMATION DESCRIBED.—~~For purposes
4 of paragraph (1), the information described in this
5 paragraph is, with respect to a provider of services
6 or supplier and a specified imaging service, the fol-
7 lowing:

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

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

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

1 for the previous three years, expressed as a dol-
2 lar amount, as well as, with respect to prices
3 made public pursuant to subparagraph (A)(ii),
4 a link to a consumer-friendly document that
5 clearly explains the provider of services or sup-
6 plier's charity care policy). The provider of
7 services or supplier shall accept the discounted
8 or minimum cash price as payment in full from
9 any patient that chooses to pay in cash without
10 regard to the patient'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 provider or supplier also shall disclose such
21 algorithm, percentage, formula, or criteria as
22 set forth in its contract and any other terms,
23 schedules, exhibits, data, or other information
24 referenced in any such contract as shall be re-

1 quired to determine and disclose the negotiated
2 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 ~~providers of services and suppliers to use in making~~
23 ~~public information described in paragraph (2). Any~~
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 provider of services and
 5 supplier described in paragraph (1);

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

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

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

19 “(5) ENFORCEMENT.—

20 “(A) IN GENERAL.—In the case that the
 21 Secretary determines that a provider of services
 22 or supplier is not in compliance with paragraph
 23 (1)—

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

1 such provider or supplier of such deter-
2 mination;

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

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

1 ~~“(B) INCREASE AUTHORITY.—~~In applying
 2 this paragraph with respect to violations occur-
 3 ring in 2027 or a subsequent year, the Sec-
 4 retary may through notice and comment rule-
 5 making increase the amount of the civil mone-
 6 tary penalty under subparagraph (A)(iii).

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

15 ~~“(D) NO AUTHORITY TO WAIVE OR RE-~~
 16 ~~DUCE PENALTY.—~~The Secretary shall not grant
 17 or extend any waiver, delay, tolling, or other
 18 mitigation of a civil monetary penalty for viola-
 19 tion of this subsection.

20 ~~“(E) PROVISION OF TECHNICAL ASSIST-~~
 21 ~~ANCE.—~~The Secretary shall, to the extent prac-
 22 ticable, provide technical assistance relating to
 23 compliance with the provisions of this sub-
 24 section to providers of services and suppliers re-
 25 questing such assistance.

1 “(F) CLARIFICATION OF NONAPPLICA-
 2 BILITY OF OTHER ENFORCEMENT PROVI-
 3 SIONS.—Notwithstanding any other provision of
 4 this title, this paragraph shall be the sole
 5 means of enforcing the provisions of this sub-
 6 section.

7 “(6) SPECIFIED IMAGING SERVICE DEFINED.—
 8 the term ‘specified imaging service’ means an imag-
 9 ing service that is a Centers for Medicare & Med-
 10 icaid Services-specified shoppable service (as de-
 11 scribed in subsection (e)).

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

16 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
 17 **PARENCY REQUIREMENTS.**

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

21 “(h) AMBULATORY SURGERY CENTER TRANS-
 22 PARENCY.—

23 “(1) IN GENERAL.—Beginning July 1, 2027,
 24 each specified ambulatory surgical center shall com-

ply with the price transparency requirement described in paragraph (2).

~~“(2) REQUIREMENT DESCRIBED.—~~

~~“(A) IN GENERAL.—A specified ambulatory surgical center, in accordance with a method and format established by the Secretary under subparagraph (C), shall compile and make public (without subscription and free of charge), for each year—~~

~~“(i) one or more lists, in a machine-readable format specified by the Secretary, of the ambulatory surgical center’s standard charges (including the information described in subparagraph (B)) for each item and service furnished by such surgical center;~~

~~“(ii) information in a consumer-friendly format (as specified by the Secretary) on the ambulatory surgical center’s prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-specified shoppable services included on the list described in subsection (c) that are furnished by such surgical center, and as~~

1 many additional ambulatory surgical cen-
 2 ter-selected shoppable services (or all such
 3 additional services, if such surgical center
 4 furnishes fewer than 300 shoppable serv-
 5 ices) as may be necessary for a combined
 6 total of at least 300 shoppable services;
 7 and

8 “(iii) with respect to each Centers for
 9 Medicare & Medicaid Services-specified
 10 shoppable service (as described in clause
 11 (ii)) that is not furnished by the ambula-
 12 tory surgical center, an indication that
 13 such service is not so furnished.

14 “(B) INFORMATION DESCRIBED.—For pur-
 15 poses of subparagraph (A), the information de-
 16 scribed in this subparagraph is, with respect to
 17 standard charges and prices made public by a
 18 specified ambulatory surgical center, the fol-
 19 lowing:

20 “(i) A description of each item or
 21 service, accompanied by the Healthcare
 22 Common Procedure Coding System code,
 23 the national drug code, or other identifier
 24 used or approved by the Centers for Medi-
 25 care & Medicaid Services.

1 “(ii) The gross charge, expressed as a
2 dollar amount, for each such item or serv-
3 ice.

4 “(iii) The discounted cash price, ex-
5 pressed as a dollar amount, for each such
6 item or service (or, in the case no dis-
7 counted cash price is available for an item
8 or service, the minimum cash price accept-
9 ed by the specified ambulatory surgical
10 center from self-pay individuals for such
11 item or service when provided in such set-
12 tings for the previous three years, ex-
13 pressed as a dollar amount, as well as,
14 with respect to prices made public pursu-
15 ant to subparagraph (A)(ii), a link to a
16 consumer-friendly document that clearly
17 explains the provider of services or sup-
18 plier’s charity care policy). The specified
19 ambulatory surgical center shall accept the
20 discounted cash price as payment in full
21 from any patient that chooses to pay in
22 cash without regard to the patient’s cov-
23 erage.

24 “(iv) The payer-specific negotiated
25 charges, expressed as a dollar amount and

1 clearly associated with the name of the ap-
2 plicable third party payer and name of
3 each plan; that apply to each such item or
4 service when provided in, as applicable, the
5 inpatient setting and outpatient depart-
6 ment setting. If the charges are based on
7 an algorithm, percentage of another
8 amount, or other formula or criteria, the
9 ambulatory surgical center also shall dis-
10 close such algorithm, percentage, formula,
11 or criteria as set forth in its contract and
12 any other terms, schedules, exhibits, data,
13 or other information referenced in any
14 such contract as shall be required to deter-
15 mine and disclose the negotiated charge.

16 “(v) The de-identified maximum and
17 minimum negotiated charges for each such
18 item or service, expressed as a non-zero
19 dollar amount.

20 “(vi) Any other additional information
21 the Secretary may require for the purpose
22 of improving the accuracy of, or enabling
23 consumers to easily understand and com-
24 pare, standard charges and prices for an
25 item or service, except information that is

1 duplicative of any other reporting require-
2 ment under this subsection.

3 ~~“(C) UNIFORM METHOD AND FORMAT.—~~

4 Not later than January 1, 2027, the Secretary
5 shall establish a standard, uniform method and
6 format for specified ambulatory surgical centers
7 to use in making public standard charges pur-
8 suant to subparagraph (A)(i) and a standard,
9 uniform method and format for such centers to
10 use in making public prices pursuant to sub-
11 paragraph (A)(ii). Any such method and format
12 shall—

13 ~~“(i) in the case of such charges made~~
14 ~~public by an ambulatory surgical center,~~
15 ~~ensure that such charges are made avail-~~
16 ~~able in a machine-readable format;~~

17 ~~“(ii) meet such standards as deter-~~
18 ~~mined appropriate by the Secretary in~~
19 ~~order to ensure the accessibility and~~
20 ~~usability of such charges and prices; and~~

21 ~~“(iii) be updated as determined appro-~~
22 ~~priate by the Secretary, in consultation~~
23 ~~with stakeholders.~~

24 ~~“(3) NO DEEMED COMPLIANCE.—The avail-~~
25 ~~ability of a price estimator tool shall not be consid-~~

1 ered to deem compliance with or otherwise vitiate
 2 the requirements of this subsection (aa). Further-
 3 more, the use of an estimator tool shall not be used
 4 for purposes of compliance with any provisions in
 5 this subsection.

6 “(4) MONITORING COMPLIANCE.—The Sec-
 7 retary shall, in consultation with the Inspector Gen-
 8 eral of the Department of Health and Human Serv-
 9 ices, establish a process to monitor compliance with
 10 this subsection. Such process shall ensure that each
 11 specified ambulatory surgical center’s compliance
 12 with this subsection is reviewed not less frequently
 13 than once every year.

14 “(5) ENFORCEMENT.—

15 “(A) IN GENERAL.—In the case of a speci-
 16 fied ambulatory surgical center that fails to
 17 comply with the requirements of this sub-
 18 section—

19 “(i) the Secretary shall notify such
 20 ambulatory surgical center of such failure
 21 not later than 30 days after the date on
 22 which the Secretary determines such fail-
 23 ure exists; and

24 “(ii) upon request of the Secretary,
 25 the ambulatory surgical center shall submit

1 to the Secretary, not later than 45 days
2 after the date of such request, a corrective
3 action plan to comply with such require-
4 ments.

5 “(B) CIVIL MONETARY PENALTY.—

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

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

violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to a specified ambulatory surgical center under clause (i).

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

~~“(iv) NO AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for violation of this subsection.~~

~~“(6) PROVISION OF TECHNICAL ASSISTANCE.—~~

The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to specified ambulatory surgical centers requesting such assistance.

1 “(7) DEFINITIONS.—For purposes of this sec-
2 tion:

3 “(A) DISCOUNTED CASH PRICE.—The
4 term ‘discounted cash price’ means the charge
5 that applies to an individual who pays cash, or
6 cash equivalent, for a item or service furnished
7 by an ambulatory surgical center.

8 “(B) GROSS CHARGE.—The term ‘gross
9 charge’ means the charge for an individual item
10 or service that is reflected on a specified sur-
11 gical center’s chargemaster, absent any dis-
12 counts.

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

20 “(D) PAYER-SPECIFIC NEGOTIATED
21 CHARGE.—The term ‘payer-specific negotiated
22 charge’ means the charge that a specified sur-
23 gical center has negotiated with a third party
24 payer for an item or service.

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

6 “(F) ~~SPECIFIED AMBULATORY SURGICAL~~
 7 ~~CENTER.~~—The term ‘specified ambulatory sur-
 8 gical center’ means an ambulatory surgical cen-
 9 ter with respect to which a hospital (or any per-
 10 son with an ownership or control interest (as
 11 defined in section 1124(a)(3) of the Social Se-
 12 curity Act) in a hospital) is a person with an
 13 ownership or control interest (as so defined).

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

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

1 **SEC. 6. STRENGTHENING HEALTH COVERAGE TRANS-**
 2 **PARENCY REQUIREMENTS.**

3 (a) TRANSPARENCY IN COVERAGE.—Section
 4 1311(e)(3)(C) of the Patient Protection and Affordable
 5 Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

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

8 “(i) IN GENERAL.—The Exchange”;

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

10 (A) by striking “participating provider”
 11 and inserting “provider”;

12 (B) by inserting “shall include the infor-
 13 mation specified in clause (ii) and” after “such
 14 information”;

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

18 (D) by striking “and such other” and all
 19 that follows through the period and inserting
 20 “or, at the option such individual, through a
 21 paper or phone disclosure (as selected by such
 22 individual and provided at no cost to such indi-
 23 vidual) that meets such requirements as the
 24 Secretary may specify.”; and

25 (3) by adding at the end the following new
 26 clauses:

1 “(ii) SPECIFIED INFORMATION.—For
 2 purposes of clause (i), the information
 3 specified in this clause is, with respect to
 4 benefits available under a health plan for
 5 an item or service furnished by a health
 6 care provider, the following:

7 “(I) If such provider is a partici-
 8 pating provider with respect to such
 9 item or service, the in-network rate
 10 (as defined in subparagraph (F)) for
 11 such item or service.

12 “(II) If such provider is not de-
 13 scribed in subclause (I), the maximum
 14 allowed dollar amount for such item
 15 or service.

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

1 “(IV) The amount the individual
2 has already accumulated with respect
3 to any deductible or out of pocket
4 maximum under the plan (broken
5 down, in the case separate deductibles
6 or maximums apply to separate indi-
7 viduals enrolled in the plan, by such
8 separate deductibles or maximums, in
9 addition to any cumulative deductible
10 or maximum).

11 “(V) In the case such plan im-
12 poses any frequency or volume limita-
13 tions with respect to such item or
14 service (excluding medical necessity
15 determinations), the amount that such
16 individual has accrued towards such
17 limitation with respect to such item or
18 service.

19 “(VI) Any prior authorization,
20 concurrent review, step therapy, fail
21 first, or similar requirements applica-
22 ble to coverage of such item or service
23 under such plan.

24 “(iii) SELF-SERVICE TOOL.—For pur-
25 poses of clause (i), a self-service tool estab-

lished by a health plan meets the requirements of this clause if such tool—

“(I) is based on an internet website;

“(II) provides for real-time responses to requests described in such clause;

“(III) is updated in a manner such that information provided through such tool is timely and accurate;

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

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

“(bb) all providers that are participating providers with respect to such plan and such item or service; or

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

1 “(V) provides that such a request
2 may be made with respect to an item
3 or service through use of—

4 “(aa) the billing code for
5 such item or service; or

6 “(bb) through use of a de-
7 scriptive term for such item or
8 service to produce a list of billing
9 code options from which the indi-
10 vidual selects to indicate the sub-
11 ject matter items or services; and

12 “(VI) holds a member harmless
13 for the amount of any difference in
14 excess of the amount of the individ-
15 ual’s responsibility generated by the
16 self-service tool and the amount ulti-
17 mately billed or charged to the indi-
18 vidual.”.

19 (b) DISCLOSURE OF ADDITIONAL INFORMATION.—

20 Section 1311(e)(3) of the Patient Protection and Afford-
21 able Care Act (42 U.S.C. 18031(e)(3)) is amended by add-
22 ing at the end the following new subparagraphs:

23 “(E) RATE AND PAYMENT INFORMA-
24 TION.—

1 “(i) IN GENERAL.—Not later than
 2 January 1, 2027, and every month there-
 3 after, each health plan shall submit to the
 4 Exchange, the Secretary, the State insur-
 5 ance commissioner, and make available to
 6 the public, the rate and payment informa-
 7 tion described in clause (ii) in accordance
 8 with clause (iii).

9 “(ii) RATE AND PAYMENT INFORMA-
 10 TION DESCRIBED.—For purposes of clause
 11 (i), the rate and payment information de-
 12 scribed in this clause is, with respect to a
 13 health plan, the following:

14 “(I) With respect to each item or
 15 service for which benefits are available
 16 under such plan (expressed as a dollar
 17 amount), including prescription drugs,
 18 identified by CPT, HCPCS, DRG,
 19 NDC, or other applicable nationally
 20 recognized identifier, including any
 21 applicable code modifiers, and accom-
 22 panied by a brief description of the
 23 item or service, the in-network rate in
 24 effect as of the date of the submission
 25 of such information with each pro-

vider (identified by national provider identifier) that is a participating provider with respect to such item or service, other than such a rate in effect with a provider—

“(aa) that has submitted no claims; and

“(bb) expects to receive no claims in the then applicable calendar year for such item or service to such plan.

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

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

1 “(bb) The historical net
2 price paid by such plan (net of
3 rebates, discounts, and price con-
4 cessions) (expressed as a dollar
5 amount) for such drug dispensed
6 or administered during the 90-
7 day period beginning 180 days
8 before such date of submission to
9 each provider that was a partici-
10 pating provider with respect to
11 such drug, broken down by each
12 such provider (identified by na-
13 tional provider identifier), other
14 than such an amount paid to a
15 provider that has submitted no
16 claims for such drug to such
17 plan.

18 “(III) With respect to each item
19 or service for which benefits are avail-
20 able under such plan (expressed as a
21 dollar amount), identified by CPT,
22 DRG, HCPCS, NDC, or other appli-
23 cable nationally recognized identifier,
24 including any applicable code modi-
25 fiers, and accompanied by a brief de-

1 scription of the item or service; the
 2 amount billed or charged by the pro-
 3 vider; and the amount allowed by the
 4 plan; for each such item or service
 5 furnished during the 90-day period
 6 beginning 180 days before such date
 7 of submission by each provider that
 8 was not a participating provider with
 9 respect to such item or service; broken
 10 down by each such provider (identified
 11 by national provider identifier); other
 12 than items and services with respect
 13 to which no claims for such item or
 14 service were submitted to such plan
 15 during such period.

16 “(iii) MANNER OF SUBMISSION.—Rate
 17 and payment information required to be
 18 submitted and made available under this
 19 subparagraph shall be so submitted and so
 20 made available as follows:

21 “(I) Information shall be con-
 22 tained in 3 separate machine-readable
 23 files corresponding to the information
 24 described in each of subclauses (I)
 25 through (III) of clause (ii) that meet

1 such requirements as specified by the
2 Secretary through rulemaking, in con-
3 sultation with the Secretaries of
4 Labor and the Treasury to apply com-
5 parable requirements to group health
6 plans and to entities providing benefit
7 management or other third-party ad-
8 ministration services on a contractual
9 basis with a group health plan.

10 “(H) Requirements specified by
11 the Secretary through rulemaking
12 shall ensure that:

13 “(aa) Such files are limited
14 to an appropriate size, are made
15 available in a widely available
16 format that allows for informa-
17 tion contained in such files to be
18 compared across health plans,
19 and are accessible to individuals
20 at no cost and without the need
21 to establish a user account or
22 provider other credentials.

23 “(bb) The rates, amounts,
24 and prices to be disclosed include
25 contractual terms containing cal-

1 calculation formulae, pricing meth-
2 odologies, and other information
3 necessary to determine the dollar
4 value of reimbursement.

5 “(cc) Each such file includes
6 each of the following data ele-
7 ments:

8 “(AA) A numerical
9 identifier for the group
10 health plan and/or health in-
11 surance issuer (such as a
12 Health Insurance Oversight
13 System identifier).

14 “(BB) A plain-language
15 description of the item or
16 service (including, for drugs,
17 the proprietary and non-
18 proprietary name assigned).

19 “(CC) The billing code,
20 including any applicable
21 modifiers, associated with
22 such item or service, includ-
23 ing the Healthcare Common
24 Procedure Coding System
25 code, diagnosis-related

1 group, national drug code,
 2 or other commonly recog-
 3 nized code set.

4 “(DD) The place of
 5 service code.

6 “(EE) The National
 7 Provider Identifier or pro-
 8 vider Tax Identification
 9 Number.

10 “(HH) The rate and payment in-
 11 formation disclosed under subclauses
 12 (I) through (III) of clause (ii) shall be
 13 separately delineated for each item or
 14 service, regardless of whether such
 15 item or service is reimbursed as a part
 16 of a bundle, episode, or other group-
 17 ing of items and services.

18 “(IV) An officer or executive of
 19 competent authority shall attest to the
 20 accuracy and completeness of infor-
 21 mation submitted and made available
 22 under this subparagraph. Such attes-
 23 tation shall be subject to enforcement
 24 under subparagraph (H) and, where
 25 applicable, shall be deemed material

1 to payments from the Federal Govern-
2 ment received by the group health
3 plan or health insurance issuer.

4 “(V) Regulations promulgated
5 pursuant to this section shall provide
6 that:

7 “(aa) The Secretary shall
8 audit the three machine-readable
9 files required by subparagraph
10 (E)(ii) posted by no fewer than
11 20 group health plans or health
12 insurance issuers.

13 “(bb) The Secretary of
14 Labor shall audit the three ma-
15 chine-readable files required by
16 subparagraph (E)(ii) posted by
17 no fewer than 200 group health
18 plans or service providers fur-
19 nishing third-party administrator
20 services to a group health plan.

21 “(cc) Findings, conclusions,
22 and enforcement actions taken
23 based on audits of the machine-
24 readable files shall be reported
25 annually to Congress no later

1 than July 1 of the calendar year
2 during which the files were au-
3 dited. Such report to Congress
4 shall be accessible to the public.

5 “(iv) USER GUIDE.—Each health plan
6 shall make available to the public instruc-
7 tions written in plain language explaining
8 how individuals may search for information
9 described in clause (ii) in files submitted in
10 accordance with clause (iii).

11 “(F) DEFINITIONS.—In this paragraph:

12 “(i) PARTICIPATING PROVIDER.—The
13 term ‘participating provider’ has the mean-
14 ing given such term in section 2799A–1 of
15 the Public Health Service Act.

16 “(ii) IN-NETWORK RATE.—The term
17 ‘in-network rate’ means, with respect to a
18 health plan and an item or service fur-
19 nished by a provider that is a participating
20 provider with respect to such plan and
21 item or service, the contracted rate in ef-
22 fect between such plan and such provider
23 for such item or service. If the rate is
24 based on an algorithm, percentage of an-
25 other 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 contract 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

1 than 30 days after the date on which the
 2 Secretary determines such failure exists;
 3 the Secretary shall submit to such health
 4 plan a notification of such determination;
 5 which shall include a request for a correc-
 6 tive action plan to comply with such re-
 7 quirements.

8 “(iii) CIVIL MONETARY PENALTY.—A
 9 health plan that has received a request for
 10 a corrective action plan under clause (ii)
 11 and fails to comply with the requirements
 12 of this subsection by the date that is 90
 13 days after such request is made shall be
 14 subject to a civil monetary penalty of an
 15 amount specified by the Secretary for each
 16 day (beginning with the day on which the
 17 Secretary first determined that such lab-
 18 oratory was failing to comply with such
 19 paragraph) during which such failure was
 20 ongoing. Such amount shall not exceed
 21 \$300 per member per day or \$10,000,000,
 22 whichever is lesser.

23 “(I) RULEMAKING.—The Secretary shall
 24 implement subparagraphs (E) through (H)
 25 through notice and comment rulemaking in ac-

1 cordance with section 552 of title 5, United
 2 States Code.”.

3 ~~(c) EFFECTIVE DATE.—~~

4 ~~(1) IN GENERAL.—~~The amendments made by
 5 subsections (a) and (b) shall apply beginning Janu-
 6 ary 1, 2026.

7 ~~(2) CONTINUED APPLICABILITY OF RULES FOR~~
 8 ~~PREVIOUS YEARS.—~~Nothing in the amendments
 9 made by this section may be construed as affecting
 10 the applicability of the rule entitled “Transparency
 11 in Coverage” published by the Department of the
 12 Treasury, the Department of Labor, and the De-
 13 partment of Health and Human Services on Novem-
 14 ber 12, 2020 (85 Fed. Reg. 72158) before January
 15 1, 2026.

16 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**
 17 **HEALTH DATA.**

18 ~~(a) GROUP HEALTH PLAN ACCESS TO INFORMA-~~
 19 ~~TION.—~~

20 ~~(1) IN GENERAL.—~~Paragraph (2) of section
 21 408(b) of the Employee Retirement Income Security
 22 Act of 1974 (29 U.S.C. 1108(b)) is amended by
 23 adding at the end the following new subparagraphs:

24 “(C) No contract or arrangement for serv-
 25 ices, and no extension or renewal of such con-

tract or arrangement, between a group health plan (as that term is defined in section 733(a) of this title) and party in interest, including a health care provider (which for purposes of this subparagraph, includes a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, or pharmacy benefit manager (collectively referred to as ‘Covered Service Providers’), is reasonable within the meaning of this paragraph unless such contract or arrangement—

“(i) allows the responsible plan fiduciary (as that term is defined in subparagraph (B)(ii)(I)(ee)) access to all claims and encounter information or data; and any documentation supporting claim payments, including, but not limited to, medical records and policy documents, or information or data described in section 724(a)(1)(B) to—

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

1 “(H) determine the accuracy or
2 reasonableness of payment; and

3 “(ii) does not—

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

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

16 “(III) limit the disclosure of prie-
17 ing terms for value-based payment ar-
18 rangements or capitated payment ar-
19 rangements, including—

20 “(aa) payment calculations
21 and formulas;

22 “(bb) quality measures;

23 “(cc) contract terms;

24 “(dd) payment amounts;

1 “(cc) measurement periods
2 for all incentives; and

3 “(ff) other payment meth-
4 odologies used by an entity, in-
5 cluding a health care provider
6 (including a health care facility),
7 network or association of pro-
8 viders, service provider offering
9 access to a network of providers,
10 third-party administrator, or
11 pharmacy benefit manager;

12 “(IV) limit the disclosure of over-
13 payments and overpayment recovery
14 terms;

15 “(V) limit the right of the group
16 health plan, the plan sponsor, or the
17 plan administrator of such plan to se-
18 lect an auditor or define audit scope
19 or frequency;

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

1 “(VII) limit the disclosure of fees
 2 charged to the group health plan re-
 3 lated to plan administration and
 4 claims processing, including renegoti-
 5 ation fees, access fees, repricing fees,
 6 or enhanced review fees;

7 “(VIII) limit the right of the
 8 group health plan, the plan sponsor,
 9 or the plan administrator to request
 10 action on any suspect claim payments;
 11 or

12 “(IX) limit public disclosure of
 13 de-identified or aggregate information.

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

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

1 “(iii) Nothing in this subparagraph shall
2 be construed to modify the requirements for the
3 creation, receipt, maintenance, or transmission
4 of protected health information under the
5 HIPAA privacy regulation (as defined in section
6 1180(b)(3) of the Social Security Act) as they
7 apply directly or indirectly to an entity pursu-
8 ant to this paragraph.

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

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

23 “(F) Information made available under
24 this section shall conform to the following
25 standards:

1 “(i) All claims from a healthcare pro-
2 vider shall be made to the group health
3 plan in accordance with transaction stand-
4 ards adopted by regulation under HIPAA,
5 as follows:

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

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

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

22 “(ii) All claim payment (or EFT, elec-
23 tronic funds transfer) and electronic remit-
24 tance advice (ERA) notices sent by a Cov-
25 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.
 The files shall be unmodified copies of the
 files sent by the Covered Service Provider
 to the healthcare provider. Files shall be
 accessible at no cost to the group health
 plan.

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

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

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

(2) CIVIL ENFORCEMENT.—Subsection (e) of
 section 502 of such Act (29 U.S.C. 1132) is amend-

ed by adding at the end the following new paragraph:

“(13) In the case of an agreement between a group health plan (as defined in section 733(a)), the plan sponsor of such plan (as defined in section 3(16)(B)), or the plan administrator of such plan (as defined in section 3(16)(A)) and a health care provider (which, for purposes of this paragraph, includes a health care facility), network or association of providers, service provider offering access to a network or association of providers, third-party administrator, or pharmacy benefit manager, that violates the provisions of section 724, the Secretary may assess a civil penalty against such provider, network or association, service provider offering access to a network or association of providers, third-party administrator, pharmacy benefit manager, or other service provider in the amount of \$10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.”.

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

1 “(c) Any provision in an agreement or instrument
2 shall be void as against public policy if such provision—

3 ~~“(1) unduly delays or limits a group health plan~~
4 ~~(as defined in section 733(a)), the plan sponsor of~~
5 ~~such plan (as defined in section 3(16)(B)), or the~~
6 ~~plan administrator of such plan (as defined in sec-~~
7 ~~tion 3(16)(A)) from accessing the claims and en-~~
8 ~~counter information or data described in section~~
9 ~~724(a)(1)(B); or~~

10 ~~“(2) violates the requirements of section~~
11 ~~408(b)(2)(C).”.~~

12 ~~(4) TECHNICAL AMENDMENT.—~~Clause (i) of
13 ~~section 408(b)(2)(B) of such Act is amended by~~
14 ~~striking “this clause” and inserting “this para-~~
15 ~~graph”.~~

16 ~~(b) UPDATED ATTESTATION FOR PRICE AND QUAL-~~
17 ~~ITY INFORMATION.—~~Section 724(a)(3) of the Employee
18 ~~Retirement Income Security Act of 1974 (29 U.S.C.~~
19 ~~1185m(a)(3)) is amended to read as follows:~~

20 ~~“(3) ATTESTATION.—~~

21 ~~“(A) IN GENERAL.—~~Subject to subpara-
22 ~~graph (C), a group health plan or health insur-~~
23 ~~ance issuer offering group health insurance cov-~~
24 ~~erage shall annually submit to the Secretary an~~
25 ~~attestation that such plan or issuer of such cov-~~

1 erage is in compliance with the requirements of
2 this subsection. Such attestation shall also in-
3 clude a statement verifying that—

4 “(i) the information or data described
5 under subparagraphs (A) and (B) of para-
6 graph (1) is available upon request and
7 provided to the group health plan, the plan
8 sponsor, the plan administrator, or the
9 business associate of such plan, or the
10 issuer in a timely manner; and

11 “(ii) there are no terms in the agree-
12 ment under such paragraph (1) that di-
13 rectly or indirectly restrict or unduly delay
14 a group health plan, the plan sponsor, the
15 plan administrator, a business associate of
16 such plan, or the issuer from auditing, re-
17 viewing, or otherwise accessing such infor-
18 mation.

19 “(B) LIMITATION ON SUBMISSION.—Sub-
20 ject to clause (ii), a group health plan or issuer
21 offering group health insurance coverage may
22 not enter into an agreement with a third-party
23 administrator or other service provider to sub-
24 mit the attestation required under subpara-
25 graph (A).

1 “(C) EXCEPTION.—In the case of a group
2 health plan or issuer offering group health in-
3 surance coverage that is unable to obtain the
4 information or data needed to submit the attes-
5 tation required under subparagraph (A), such
6 plan or issuer may submit a written statement
7 in lieu of such attestation that includes—

8 “(i) an explanation of why such plan
9 or issuer was unsuccessful in obtaining
10 such information or data, including wheth-
11 er such plan, the plan sponsor, or the plan
12 administrator or issuer was limited or pre-
13 vented from auditing, reviewing, or other-
14 wise accessing such information or data;

15 “(ii) a description of the efforts made
16 by the group health plan, the plan sponsor,
17 or the plan administrator to remove any
18 gag clause provisions from the agreement
19 under paragraph (1); and

20 “(iii) a description of any response by
21 the third-party administrator or other serv-
22 ice provider with respect to efforts to com-
23 ply with the attestation requirement under
24 subparagraph (A), including the name of

1 the third-party administrator or other serv-
 2 ice provider.”.

3 (c) ~~EFFECTIVE DATE.~~—The amendments made by
 4 subsections (a) and (b) shall apply with respect to a plan
 5 beginning with the first plan year that begins on or after
 6 the date that is 1 year after the date of enactment of this
 7 Act.

8 **SEC. 8. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
 9 **VIDERS.**

10 (a) ~~ERISA AMENDMENTS.~~—

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

15 **“SEC. 726. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
 16 **VIDERS.**

17 “(a) ~~IN GENERAL.~~—For plan years beginning on or
 18 after the date that is 2 years after the date of enactment
 19 of this section, no agreement between a group health plan
 20 (as defined in section 733(a)), the plan sponsor of such
 21 plan (as defined in section 3(16)(B)), the plan adminis-
 22 trator of such plan (as defined in section 3(16)(A)), or
 23 a business associate of such plan (as defined in section
 24 160.103 of title 45, Code of Federal Regulations), (or
 25 health insurance issuer offering group health insurance

1 coverage in connection with such a plan); and a health
 2 care provider; network or association of providers; third-
 3 party administrator; service provider offering access to a
 4 network of providers; pharmacy benefit managers; or any
 5 other third party (each referred to as a ‘health plan service
 6 provider’) is permissible if such agreement limits (or
 7 delays beyond the applicable reporting period described in
 8 subsection (b)(1)) the disclosure of information to group
 9 health plans in such a manner that prevents such plan;
 10 issuer; or entity from providing the information described
 11 in subsection (b):

12 “(b) REQUIRED DISCLOSURES.—

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

21 “(A) The information described in section
 22 724(a)(1)(B):

23 “(B) Any contractual and subcontractual
 24 calculation methodologies; pricing or fee sched-
 25 ules; or other formulae used to determine reim-

1 bursement amounts to providers and sub-
2 contractors, including methodologies, schedules,
3 fee structures, and any applied adjustments or
4 modifiers, with such information provided in a
5 manner sufficiently detailed to enable the group
6 health plan or health insurance issuer to accu-
7 rately assess, verify, and ensure compliance
8 with the terms of any contractual and sub-
9 contractual agreement governing the reimburse-
10 ment amounts.

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

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

1 “(E) All payment data and reconciliation
 2 information related to alternative compensation
 3 arrangements including accountable care orga-
 4 nizations, value-based programs, shared savings
 5 programs, incentive compensation, bundled pay-
 6 ments, capitation arrangements, performance
 7 payments, and any other reimbursement or pay-
 8 ment models, where the group health plan or
 9 health insurance issuer paid fees, incurred obli-
 10 gations, or made payments in connection with
 11 the group health plan related to such arrange-
 12 ments.

13 “(2) PRIVACY REQUIREMENTS.—

14 “(A) IN GENERAL.—Health plan service
 15 providers shall provide the information or data
 16 under paragraph (1) consistent with the pri-
 17 vacy, security, and breach notification regula-
 18 tions at parts 160 and 164 of title 45, Code of
 19 Federal Regulations, promulgated under sub-
 20 title F of the Health Insurance Portability and
 21 Accountability Act of 1996, subtitle D of the
 22 Health Information Technology for Clinical
 23 Health Act of 2009, and section 1180 of the
 24 Social Security Act, and shall restrict the use
 25 and disclosure of such information according to

1 such privacy, security, and breach notification
 2 regulations. An entity that receives a disclosure
 3 from a party in interest pursuant to subpara-
 4 graph (B) or (C) shall comply with the privacy
 5 and security regulations promulgated under
 6 HIPAA.

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

13 “(C) RULE OF CONSTRUCTION.—Nothing
 14 in this section shall be construed to modify the
 15 requirements for the creation, receipt, mainte-
 16 nance, or transmission of protected health in-
 17 formation under the HIPAA privacy regulations
 18 (45 C.F.R. parts 160 and 164, subparts A and
 19 E).

20 “(3) DISCLOSURE AND REDISCLOSURE.—

21 “(A) IN GENERAL.—A group health plan
 22 receiving information under paragraph (1) may
 23 disclose such information only—

24 “(i) to the entity from which the in-
 25 formation was received or to that entity’s

business associates or to the group health plan's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

“(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, subparts A and E).

“(B) AVAILABILITY OF INFORMATION.—To the extent the information required by this subsection is made available to the health insurance issuer offering group health insurance in connection with a group health plan, the health insurance issuer shall make such information available, at the same time, in the same format, and at no cost, to the group health plan.

“(C) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 502 within 90 days of becoming aware of a violation

1 of this section, except that nothing in this sec-
2 tion shall be construed to limit the Secretary's
3 existing authority under the Act.

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

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

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

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

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

1 “(B) All claim payment (or EFT, elec-
 2 tronic funds transfer) and electronic remittance
 3 advice (ERA) information sent by a health plan
 4 service provider shall be provided to the group
 5 health plan or health insurance issuer in the
 6 ASC X12N 835 format in accordance with
 7 transaction standards adopted under HIPAA,
 8 unmodified from the form in which it was
 9 transmitted to the healthcare provider. Such in-
 10 formation shall be provided at no cost to the
 11 group health plan or health insurance issuer.

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

18 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
 19 provision in an agreement between a group health plan,
 20 the plan sponsor, the plan administrator, or a business
 21 associate of such plan or a health insurance issuer and
 22 a health plan service provider that unduly delays or limits
 23 a group health plan’s or health insurance issuer’s access
 24 to information described in this section or that restricts
 25 the format or timing of the provision of such information

1 in a manner that is inconsistent with the requirements of
 2 this section shall be prohibited and, if a group health plan
 3 or health insurance issuer enters into such agreement,
 4 shall be deemed void as against public policy.

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

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

15 (2) ~~PENALTY.~~—

16 (A) ~~IN GENERAL.~~—Section 502(a) of the
 17 Employee Retirement Income Security Act of
 18 1974 (29 U.S.C. 1132(a)) is amended by add-
 19 ing at the end the following new paragraph:

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

23 (B) ~~TECHNICAL AMENDMENT.~~—Paragraph
 24 (6) of section 502(a) of the Employee Retirement
 25 ment Income Security Act of 1974 (29 U.S.C.

1 ~~1132(a))~~ is amended by striking “or (9)” and
 2 inserting it with the phrase “(9), (13), or
 3 (14)”.

4 **(b) PHSA AMENDMENTS.—**

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

8 **“SEC. 2799A–11. OVERSIGHT OF ADMINISTRATIVE SERVICE**
 9 **PROVIDERS.**

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

25 **“(b) REQUIRED DISCLOSURES.—**

1 “(1) CONTENTS AND FREQUENCY.—With re-
 2 spect to plan years beginning on or after the date
 3 that is 1 year after the date of enactment of this
 4 section, not less frequently than quarterly, a health
 5 plan service provider shall provide to the group
 6 health plan that is a self-funded, non-Federal gov-
 7 ernmental plan the following information at no cost
 8 to the plan:

9 “(A) The information described in section
 10 ~~2799A-9(a)(1)(B)~~ (42 U.S.C. ~~300gg-~~
 11 ~~119(a)(1)(B)~~).

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

24 “(C) The total amount received or ex-
 25 pected to be received by the health plan service

1 provider or its subcontractors in provider or
2 supplier rebates, fees, alternative discounts, and
3 all other remuneration including amounts held
4 in escrow or variance accounts that has been
5 paid or is to be paid for claims incurred and
6 administrative services including data sales or
7 network payments.

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

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

25 “(2) PRIVACY REQUIREMENTS.—

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

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

1 “(C) RULE OF CONSTRUCTION.—Nothing
 2 in this section shall be construed to modify the
 3 requirements for the creation, receipt, mainte-
 4 nance, or transmission of protected health in-
 5 formation under the HIPAA privacy regulations
 6 (45 C.F.R. parts 160 and 164, subparts A and
 7 E).

8 “(3) DISCLOSURE AND REDISCLOSURE.—

9 “(A) IN GENERAL.—A group health plan
 10 that is a self-funded, non-Federal governmental
 11 plan receiving information under paragraph (1)
 12 may disclose such information only—

13 “(i) to the entity from which the in-
 14 formation was received or to that entity’s
 15 business associates as defined in section
 16 160.103 of title 45, Code of Federal Regu-
 17 lations (or successor regulations); or

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

21 “(B) RULE OF CONSTRUCTION.—Nothing
 22 in this section shall be construed to prevent a
 23 group health plan that is a self-funded, non-
 24 Federal governmental plan, or a health plan
 25 service provider providing services with respect

1 to such a plan, from placing reasonable restric-
2 tions on the public disclosure of the information
3 described in paragraph (1), except that such
4 plan or entity may not restrict disclosure of
5 such information to the Department of Health
6 and Human Services, the Department of Labor,
7 the Department of the Treasury, or the Comp-
8 troller General of the United States.

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

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

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

6 “(i) Institutional, professional, and
 7 dental claims and adjustments to these
 8 claims shall be provided to the group
 9 health plan that is a self-funded, non-Fed-
 10 eral governmental plan in the ASC X12N
 11 837 format.

12 “(ii) Prescription drug claims shall be
 13 in the National Council for Prescription
 14 Drug Programs (NCPDP) format.

15 “(iii) The files shall be unmodified
 16 copies of the files sent from the provider.
 17 In the event that paper claims are sent by
 18 the provider, they shall be converted to the
 19 appropriate standard electronic format.
 20 Such data shall be provided at no cost to
 21 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 standards adopted under HIPAA at section
 4 ~~162.1602~~ of title 45, Code of Federal Regula-
 5 tions, unmodified from the form in which it was
 6 transmitted to the healthcare provider. Such in-
 7 formation shall be provided at no cost to the
 8 group health plan.

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

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

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

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

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

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

19 The provisions of sections 2 through 5 (including the
 20 amendments made by such sections) shall not supersede
 21 any provision of State law which establishes, implements,
 22 or continues in effect any requirement or prohibition re-
 23 lated to health care price transparency, including hospital,
 24 clinical diagnostic laboratory tests, imaging services, and
 25 ambulatory surgical center, except to the extent that such

1 requirement or prohibition prevents the application of a
 2 requirement or prohibition of such sections (or amend-
 3 ment). Nothing in this section shall be construed to affect
 4 group health plans established under the Employee Retire-
 5 ment Income Security Act of 1974, or alter the application
 6 of section 514 of such Act (29 U.S.C. 1144).

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

8 (a) PHSA AMENDMENTS.—

9 (1) EMERGENCY SERVICES.—Section 2799A—
 10 1(f)(1)(C) of the Public Health Service Act (42
 11 U.S.C. 300gg-111(f)(1)(C)) is amended to read as
 12 follows:

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

22 (2) EXPLANATION OF BENEFITS.—Section
 23 2799A-1 of the Public Health Service Act (42
 24 U.S.C. 300gg-111) is amended by adding at the end
 25 the following:

1 “(g) EXPLANATION OF BENEFITS.—

2 “(1) IN GENERAL.—For plan years beginning
3 on or after January 1, 2026, each group health
4 plan, or a health insurance issuer offering group or
5 individual health insurance coverage shall, within 45
6 days of receiving any request for payment for an
7 item or service under the plan, provide to the partic-
8 ipant, beneficiary, or enrollee (through mail or elec-
9 tronic means, as requested by the participant, bene-
10 ficiary, or enrollee) a notification (in clear and un-
11 derstandable language and utilizing substantially the
12 same format as the advanced explanation of benefits
13 required by subsection (f) to enable comparison) in-
14 cluding the following:

15 “(A) Whether or not the provider or facil-
16 ity is a participating provider or a participating
17 facility with respect to the plan or coverage
18 with respect to the furnishing of such item or
19 service.

20 “(B) An itemized explanation of benefits
21 that includes the following:

22 “(i) A plain language description of
23 each item or service.

24 “(ii) All applicable billing codes for
25 each item or service, including modifiers;

1 using standard and commonly recognized
 2 billing code sets that are clearly identified.

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

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

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

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

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

24 “(h) ~~REGULATIONS.~~—The Secretary shall implement
 25 this section through notice and comment rulemaking in

1 accordance with section 553 of title 5, United States
2 Code.”.

3 ~~(b) IRC AMENDMENTS.—~~

4 ~~(1) EMERGENCY SERVICES.—~~Section
5 9816(f)(1)(C) of the Internal Revenue Code of 1986
6 is amended to read as follows:

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

16 ~~(2) EXPLANATION OF BENEFITS.—~~Section
17 9816 of the Internal Revenue Code of 1986 is
18 amended by adding at the end the following:

19 “~~(g)~~ EXPLANATION OF BENEFITS.—

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

1 or beneficiary) a notification (in clear and under-
2 standable language and utilizing substantially the
3 same format as the advanced explanation of benefits
4 required by subsection (f) to enable comparison) in-
5 cluding the following:

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

10 “(B) An itemized explanation of benefits
11 that includes the following:

12 “(i) A plain language description of
13 each item or service.

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

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

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

24 “(v) The amount that the participant
25 or beneficiary has incurred toward meeting

1 the limit of the financial responsibility (in-
 2 cluding with respect to deductibles and
 3 out-of-pocket maximums) under the plan
 4 (as of the date of such notification).

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

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

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

16 (c) ~~ERISA AMENDMENTS.~~—

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

21 “(C) A good faith estimate of the amount
 22 the health plan is responsible for paying for
 23 items and services included in the estimate de-
 24 scribed in subparagraph (B), including a plain
 25 language description of each item or service and

all applicable billing codes for each item or service, including modifiers, using standard and commonly recognized billing code sets that are clearly identified.”.

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

“(g) EXPLANATION OF BENEFITS.—

“(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, each group health plan or health insurance issuer offering group health insurance coverage shall, within 45 days of receiving any request for payment for an item or service under the plan, provide to the participant or beneficiary (through mail or electronic means, as requested by the participant or beneficiary) a notification (in clear and understandable language and utilizing substantially the same format as the advanced explanation of benefits required by subsection (f) to enable comparison) including the following:

“(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage

1 with respect to the furnishing of such item or
2 service.

3 “(B) An itemized explanation of benefits
4 that includes the following:

5 “(i) A plain language description of
6 each item or service.

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

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

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

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

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

1 “(2) **FORMAT.**—If applicable, the notification
 2 described in paragraph (1) may be provided in con-
 3 junction with, or as part of, a notice of a claim de-
 4 termination or other communication required by sec-
 5 tion 503 or regulations thereunder.

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

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

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

14 **“SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED**
 15 **BILLS.**

16 “(a) **REQUIREMENTS.**—

17 “(1) **ITEMIZED BILL AND OTHER INFORMATION**
 18 **REQUIRED.**—

19 “(A) **IN GENERAL.**—A health care provider
 20 or health care facility that requests payment
 21 from an individual after providing a health care
 22 item or service to the patient shall include with
 23 such request a written, itemized bill of the cost
 24 of each reasonably expected item or service the
 25 health care provider or health care facility pro-

1 vided to the individual, including telehealth vis-
2 its or visits by other electronic means. The
3 health care provider or health care facility shall
4 provide the itemized bill not later than 30 days
5 after the health care provider or health care fa-
6 cility received a final payment on the provided
7 service or supply from a third party.

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

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

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

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

1 for bundled items and services and billed
2 amount;

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

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

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

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

24 “(2) COLLECTIONS ACTIONS.—

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

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

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

1 or a patient-initiated change, and could not
 2 reasonably have been anticipated.

3 ~~“(B) BURDEN OF PROOF.—~~The burden of
 4 proof under subparagraph (A)(ii) shall rest with
 5 the provider, and absent the documentation de-
 6 scribed in such subparagraph, the good faith es-
 7 timate shall be binding.

8 ~~“(b) FAILURE TO COMPLY.—~~

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

14 ~~“(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—~~If a health care provider or health care fa-
 15 cility fails to comply with the requirements of this
 16 section, the presumption shall be that charges were
 17 substantially in excess of the good faith estimate (as
 18 set forth in section 2799B-6) for the purpose of any
 19 patient-provider dispute, including in accordance
 20 with section 2799B-7 and regulations promulgated
 21 thereunder.
 22

23 ~~“(c) REGULATIONS.—~~The Secretary shall implement
 24 this section through notice and comment rulemaking in

1 accordance with section 553 of title 5, United States
2 Code.”.

3 **SECTION 1. SHORT TITLE.**

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

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

7 *Title XXVII of the Public Health Service Act is*
8 *amended by inserting after section 2718 (42 U.S.C. 300gg–*
9 *18) the following:*

10 **“SEC. 2718A. PROVIDER PRICE TRANSPARENCY.**

11 *“(a) DEFINITIONS.—In this section:*

12 *“(1) APPLICABLE IMAGING SERVICE PROVIDER.—*

13 *The term ‘applicable imaging provider’ means a pro-*
14 *vider of services or supplier who furnishes any imag-*
15 *ing services to patients, including an independent di-*
16 *agnostic testing facility, an outpatient diagnostic fa-*
17 *cility, and any other imaging center designated by*
18 *the Secretary, except that such term does not include*
19 *an imaging service provider with respect to which*
20 *standard charges for specified imaging service pro-*
21 *vider services furnished by such service provider are*
22 *made available by a hospital pursuant to subsection*
23 *(b) or specified ambulatory surgical center pursuant*
24 *to subsection (e).*

1 “(2) *APPLICABLE LABORATORY.*—The term ‘ap-
 2 plicable laboratory’ means a ‘laboratory’ as such term
 3 is defined in section 493.2, of title 42, Code of Federal
 4 Regulations (or a successor regulation), except that
 5 such term does not include a laboratory with respect
 6 to which standard charges for specified clinical diag-
 7 nostic laboratory tests furnished by such laboratory
 8 are made available by a hospital pursuant to sub-
 9 section (b) or specified ambulatory surgical center
 10 pursuant to subsection (e).

11 “(3) *DISCOUNTED CASH PRICE.*—

12 “(A) *IN GENERAL.*—The term ‘discounted
 13 cash price’ means the minimum charge expressed
 14 as a dollar amount, subject to subparagraph (B),
 15 that the applicable service provider subject to
 16 this section accepts from an individual who pays
 17 cash, or cash equivalent, for a furnished item or
 18 service, without regard to health insurance cov-
 19 erage, as payment in full.

20 “(B) *EXCLUSIONS.*—For purposes of sub-
 21 paragraph (A), the minimum charge described
 22 in such subparagraph, with respect to a fur-
 23 nished item or service, as applicable, shall be cal-
 24 culated without taking into account any finan-
 25 cial assistance, including assistance attributable

1 *to charity care (in the case of a hospital, as such*
 2 *term is used for purposes of hospital cost report-*
 3 *ing under title XVIII of the Social Security Act),*
 4 *or third-party assistance for such item or service.*

5 “(4) *EXTRAORDINARY COLLECTION ACTIONS.*—
 6 *The term ‘extraordinary collection action’ has the*
 7 *meaning given such term for purposes of section*
 8 *501(r) of the Internal Revenue Code of 1986.*

9 “(5) *GROSS CHARGE.*—*The term ‘gross charge’*
 10 *means the charge for an individual item or service*
 11 *that is reflected on a hospital’s chargemaster or simi-*
 12 *lar list of prices facilitated by any other provider, as*
 13 *defined by the Secretary, absent any discounts.*

14 “(6) *HOSPITAL.*—*The term ‘hospital’ means an*
 15 *institution in any State in which State or applicable*
 16 *local law provides for the licensing of hospitals, that*
 17 *is licensed as a hospital pursuant to such law or is*
 18 *approved, by the agency of such State or locality re-*
 19 *sponsible for licensing hospitals, as meeting the stand-*
 20 *ards established for such licensing. For purposes of*
 21 *this paragraph, the term ‘State’ includes each of the*
 22 *several States, the District of Columbia, Puerto Rico,*
 23 *the Virgin Islands, Guam, American Samoa, and the*
 24 *Northern Mariana Islands.*

1 “(7) *PAYER-SPECIFIC NEGOTIATED CHARGE.*—

2 *The term ‘payer-specific negotiated charge’ means the*
 3 *charge that a hospital has negotiated with a third-*
 4 *party payer for an item or service.*

5 “(8) *SHOPPABLE SERVICE.*—*The term ‘shoppable*
 6 *service’ means a service that can be scheduled by a*
 7 *healthcare consumer in advance. Such services are*
 8 *routinely provided in non-urgent situations that do*
 9 *not require immediate action or attention to the pa-*
 10 *tient, thus allowing patients to price shop and sched-*
 11 *ule a service at a time that is convenient for them.*

12 “(9) *SPECIFIED AMBULATORY SURGICAL CEN-*
 13 *TER.*—*The term ‘specified ambulatory surgical center’*
 14 *means any distinct entity that operates exclusively for*
 15 *the purpose of providing surgical services to patients*
 16 *not requiring hospitalization and in which the ex-*
 17 *pected duration of services would not exceed 24 hours*
 18 *following an admission, except that such term does*
 19 *not include a surgical center with respect to which*
 20 *standard charges for specified ambulatory surgical*
 21 *center services furnished by such surgical center are*
 22 *made available by a hospital pursuant to subsection*
 23 *(b).*

24 “(10) *SPECIFIED CLINICAL DIAGNOSTIC LABORA-*
 25 *TORY TEST.*—*The term ‘specified clinical diagnostic*

1 *laboratory test’ means any clinical diagnostic labora-*
 2 *tory test or service that is provided by the applicable*
 3 *laboratory, excluding advanced diagnostic laboratory*
 4 *tests (as defined in section 1834A(d)(5) of the Social*
 5 *Security Act).*

6 “(11) *SPECIFIED IMAGING SERVICE.*—*The term*
 7 *‘specified imaging service’ has the meaning given to*
 8 *the term ‘radiology and certain other imaging serv-*
 9 *ices’ for purposes of section 411.351 of title 42, Code*
 10 *of Federal Regulations (or successor regulations).*

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

15 “(b) *HOSPITAL PRICE TRANSPARENCY.*—

16 “(1) *IN GENERAL.*—*Beginning January 1 of the*
 17 *year that begins on or after the date that is 1 year*
 18 *after the date of enactment of the Patients Deserve*
 19 *Price Tags Act, each hospital shall, in accordance*
 20 *with a method and format established by the Sec-*
 21 *retary under paragraph (3), on a quarterly basis (if*
 22 *there have been any changes to the standard charges*
 23 *described in subparagraph (2) compile and make pub-*
 24 *licly available on an internet website (without sub-*
 25 *scription and free of charge)—*

1 “(A) all of the hospital’s standard charges
2 for each item and service furnished by such hos-
3 pital in a machine-readable format (or a suc-
4 cessor technology specified by the Secretary);

5 “(B) all of the hospital’s standard charges
6 in a consumer-friendly format (as specified by
7 the Secretary), that includes—

8 “(i) as many of the Centers for Medi-
9 care & Medicaid Services-specified
10 shoppable services that are furnished by the
11 hospital, and as many additional hospital-
12 selected shoppable services (or all such addi-
13 tional services, if such hospital furnishes
14 fewer than 300 shoppable services) as may
15 be necessary for a combined total of at least
16 300 shoppable services through the January
17 1 described in this subparagraph, after
18 which the hospital shall include all
19 shoppable services that the hospital fur-
20 nishes; and

21 “(ii) with respect to each Centers for
22 Medicare & Medicaid Services-specified
23 shoppable service that is not furnished by
24 the hospital, an indication that such service
25 is not so furnished; and

1 “(C) *the name and business address for each*
 2 *person or entity that, with respect to the hos-*
 3 *pital—*

4 “(i) *has an ownership or investment*
 5 *interest;*

6 “(ii) *has a controlling interest;*

7 “(iii) *is a management services organi-*
 8 *zation; or*

9 “(iv) *is a significant equity investor.*

10 “(2) *STANDARD CHARGES DEFINED.—For pur-*
 11 *poses of paragraph (1), the term ‘standard charges’*
 12 *means the following:*

13 “(A) *A plain language description of each*
 14 *item and service, accompanied by any applicable*
 15 *billing codes, including modifiers, using com-*
 16 *monly recognized billing code sets, including—*

17 “(i) *the Diagnosis Related Group;*

18 “(ii) *the Healthcare Common Proce-*
 19 *dure Coding System code;*

20 “(iii) *the National Drug Code; and*

21 “(iv) *other applicable identifiers as de-*
 22 *termined by the Secretary (or successor code*
 23 *sets).*

24 “(B) *The gross charge, expressed as a dollar*
 25 *amount, for each such item or service, when pro-*

1 *vided in, as applicable, the inpatient setting and*
2 *outpatient department setting.*

3 *“(C) The discounted cash price.*

4 *“(D) The payer-specific negotiated charges,*
5 *expressed as a dollar amount and clearly associ-*
6 *ated with the name of the applicable third-party*
7 *payer and name of each plan, that apply to each*
8 *such item or service when provided in, as appli-*
9 *cable, the inpatient setting and outpatient de-*
10 *partment setting. If the charges are based on an*
11 *algorithm, percentage of another amount, or*
12 *other formula or criteria, the hospital shall also*
13 *disclose such algorithm, percentage, formula, or*
14 *criteria as set forth in its contract and any other*
15 *information necessary to determine the nego-*
16 *tiated charge as a dollar amount.*

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

20 *“(F) The amount of any facility fee, as de-*
21 *finied by the Secretary, or add-on charges that*
22 *will be part of the final payment amount, in ad-*
23 *dition to any information that might help the*
24 *patient understand when a facility fee or add-on*

1 *charge may apply and how to avoid such*
2 *charges.*

3 “(G) *Any other additional information the*
4 *Secretary may require for the purpose of improv-*
5 *ing the accuracy of, or enabling consumers to*
6 *easily understand and compare, standard*
7 *charges for an item or service, except informa-*
8 *tion that is duplicative of any other reporting*
9 *requirement under this subsection. In the case of*
10 *standard charges for an item or service included*
11 *as part of a bundled, per diem, episodic, or other*
12 *similar arrangement, the information described*
13 *in this subparagraph shall be made available as*
14 *determined appropriate by the Secretary.*

15 “(3) *UNIFORM METHOD AND FORMAT.—The Sec-*
16 *retary shall establish a standard, uniform method and*
17 *format for hospitals to use in compiling and making*
18 *public information described in paragraph (1). Such*
19 *method and format shall—*

20 “(A) *include a machine-readable format (or*
21 *successor technology specified by the Secretary)*
22 *containing the information described in para-*
23 *graph (2) for all items and services furnished by*
24 *each hospital;*

1 “(B) meet such standards as determined ap-
 2 propriate by the Secretary in order to ensure the
 3 accessibility and usability of such charges; and

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

7 “(4) *NO DEEMED COMPLIANCE.*—Hospitals may
 8 offer a price estimator tool, but the availability of
 9 such a price estimator tool shall not be considered to
 10 deem compliance with or otherwise vitiate the require-
 11 ments of paragraph (1)(B) or any other requirements
 12 of this subsection.

13 “(5) *MONITORING COMPLIANCE.*—The Secretary
 14 shall, in consultation with the Inspector General of
 15 the Department of Health and Human Services, es-
 16 tablish a process to monitor compliance with this sub-
 17 section. Such process shall ensure that each hospital’s
 18 compliance with this subsection is reviewed not less
 19 frequently than once every year.

20 “(6) *ATTESTATION.*—A senior official from each
 21 hospital (the Chief Executive Officer, Chief Financial
 22 Officer, or an official of equivalent seniority) shall at-
 23 test to the accuracy and completeness of the disclo-
 24 sures, and any other attestations as required by the
 25 Secretary, made in accordance with the hospital price

1 *transparency requirements based on criteria estab-*
 2 *lished by the Secretary.*

3 “(7) *ENFORCEMENT.*—

4 “(A) *IN GENERAL.*—*In the case of a hos-*
 5 *pital that fails to comply with the requirements*
 6 *of this subsection, not later than 30 days after*
 7 *the date on which the Secretary determines such*
 8 *failure exists, the Secretary shall notify such hos-*
 9 *pital of such determination, which shall include*
 10 *a request for a corrective action plan if applica-*
 11 *ble to comply with such requirements.*

12 “(B) *CIVIL MONETARY PENALTY.*—

13 “(i) *IN GENERAL.*—*In addition to any*
 14 *other enforcement actions or penalties that*
 15 *may apply under another provision of law,*
 16 *a hospital that has received a request for a*
 17 *corrective action plan under subparagraph*
 18 *(A) and fails to comply with the require-*
 19 *ments of this subsection by the date that is*
 20 *90 days after such request is made shall be*
 21 *subject to a civil monetary penalty of an*
 22 *amount specified by the Secretary for each*
 23 *day (beginning on the day the hospital was*
 24 *first out of compliance, as determined by*
 25 *the Secretary) during which such failure*

1 *was ongoing. Such amount shall not ex-*
2 *ceed—*

3 *“(I) in the case of a specified hos-*
4 *pital with 30 or fewer beds, \$300 per*
5 *day (or, in the case of such a hospital*
6 *that has been noncompliant with such*
7 *requirements for a 1-year period or*
8 *longer, beginning with the first day fol-*
9 *lowing such 1-year period, \$400 per*
10 *day);*

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

20 *“(III) in the case of a specified*
21 *hospital with more than 100 beds but*
22 *fewer than 201 beds, \$17.50 per bed*
23 *per day (or, in the case of such a hos-*
24 *pital that has been noncompliant with*
25 *such requirements for a 1-year period*

1 or longer, beginning with the first day
 2 following such 1-year period, \$20 per
 3 bed per day);

4 “(IV) in the case of a specified
 5 hospital with more than 200 beds but
 6 fewer than 501 beds, \$20 per bed per
 7 day (or, in the case of such a hospital
 8 that has been noncompliant with such
 9 requirements for a 1-year period or
 10 longer, beginning with the first day fol-
 11 lowing such 1-year period, \$25 per bed
 12 per day); and

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

21 “(ii) INCREASE AUTHORITY.—In ap-
 22 plying this subparagraph with respect to
 23 hospitals that fail to comply in 2028 or a
 24 subsequent year, the Secretary may through
 25 notice and comment rulemaking increase—

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

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

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

13 “(iii) *PERSISTENT NONCOMPLIANCE.*—

14 “(I) *IN GENERAL.*—In the case of
15 a hospital that the Secretary has deter-
16 mined to be noncompliant with the
17 provisions of this subsection two or
18 more times during a 1-year period (as
19 determined by the Secretary), the Sec-
20 retary may increase any penalty other-
21 wise applicable under this subpara-
22 graph by the amount specified in sub-
23 clause (II) with respect to such hos-
24 pital and may require such hospital to
25 complete such additional corrective ac-

1 *tions plans as the Secretary may speci-*
2 *fy.*

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

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

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

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

22 “(dd) *with more than 500*
23 *beds, and amount that is not less*
24 *than \$5,000,000 and not more*
25 *than \$10,000,000.*

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

7 “(v) *APPLICATION OF CERTAIN PROVI-*
 8 *SIONS.—The provisions of section 1128A of*
 9 *the Social Security Act (other than sub-*
 10 *sections (a) and (b) of such section) shall*
 11 *apply to a civil monetary penalty imposed*
 12 *under this subparagraph in the same man-*
 13 *ner as such provisions apply to a civil mon-*
 14 *etary penalty imposed under subsection (a)*
 15 *of such section.*

16 “(C) *NO AUTHORITY TO WAIVE OR REDUCE*
 17 *PENALTY.—The Secretary shall not grant or ex-*
 18 *tend any waiver, delay, tolling, or other mitiga-*
 19 *tion of a civil monetary penalty for failing to*
 20 *comply with the requirements of this subsection*
 21 *except where the Secretary determines that im-*
 22 *posing the maximum civil monetary penalty, in-*
 23 *cluding penalties for persistent noncompliance,*
 24 *will disrupt hospital operations in a manner*
 25 *that impacts patient care. The Secretary may re-*

1 *quest documentation in such form and manner*
2 *as the Secretary may require in order to evalu-*
3 *ate impact on hospital operations.*

4 “(D) *PROHIBITION ON EXTRAORDINARY*
5 *COLLECTION.—In addition to civil monetary*
6 *penalties applicable under subparagraph (B)*
7 *and any other enforcement actions or penalties*
8 *that may apply under any other provision of*
9 *law, for a hospital that has received a request for*
10 *a corrective action plan under subparagraph (A)*
11 *and fails to comply with the requirements of this*
12 *subsection by the date that is 90 days after such*
13 *request, that hospital or any other person or en-*
14 *tity collecting on behalf of the hospital shall—*

15 “(i) *not take any extraordinary collec-*
16 *tion actions against any patient or patient*
17 *guarantor for debt incurred by any patient*
18 *on the date or dates of service when the hos-*
19 *pital was not in compliance with the re-*
20 *quirements of this subsection;*

21 “(ii) *cease any extraordinary collection*
22 *actions that have begun against any patient*
23 *or patient guarantor for debt incurred by*
24 *any patient on the date or dates of service*
25 *when the hospital was not in compliance*

1 *with the requirements of this subsection;*
 2 *and*

3 “(iii) *not take any extraordinary col-*
 4 *lection actions against any patient or pa-*
 5 *tient guarantor for debt incurred by any*
 6 *patient on the date or dates of service when*
 7 *the hospital was not in compliance with the*
 8 *requirements of this subsection after the hos-*
 9 *pital comes back into compliance with the*
 10 *requirements of this subsection.*

11 “(8) *RULEMAKING.—*

12 “(A) *IN GENERAL.—The Secretary shall im-*
 13 *plement this subsection through notice and com-*
 14 *ment rulemaking in accordance with section 553*
 15 *of title 5, United States Code.*

16 “(B) *OWNERSHIP INFORMATION.—In pro-*
 17 *mulgating regulations under this paragraph, the*
 18 *Secretary shall define the individuals and orga-*
 19 *nizations that must be disclosed under para-*
 20 *graph (1)(C) in a manner that harmonizes dis-*
 21 *closure requirements with requirements estab-*
 22 *lished under section 1124 of the Social Security*
 23 *Act and prioritizes the disclosure of individuals*
 24 *and organizations who’s ownership or manage-*
 25 *ment relationship with a hospital impacts oper-*

1 *ational, financial, or clinical decision making*
 2 *for such hospital.”.*

3 **SEC. 3. CLINICAL DIAGNOSTIC LABORATORY PRICE TRANS-**
 4 **PARENCY.**

5 *Section 2718A of the Public Health Service Act, as*
 6 *added by section 2, is amended by adding at the end the*
 7 *following:*

8 “(c) *CLINICAL DIAGNOSTIC LABORATORY PRICE*
 9 *TRANSPARENCY.—*

10 “(1) *IN GENERAL.—Beginning January 1 of the*
 11 *year that begins on or after the date that is 1 year*
 12 *after the date of enactment of the Patients Deserve*
 13 *Price Tags Act, an applicable laboratory shall, on a*
 14 *quarterly basis (if there have been any changes to the*
 15 *standard charges described in paragraph (2)) compile*
 16 *and make publicly available on an internet website*
 17 *(without subscription and free of charge)—*

18 “(A) *the standard charges described in*
 19 *paragraph (2) with respect to each specified clin-*
 20 *ical diagnostic laboratory test that such labora-*
 21 *tory so furnishes; and*

22 “(B) *the name and business address for*
 23 *each person or entity that, with respect to the*
 24 *laboratory—*

1 “(i) *has an ownership or investment*
2 *interest;*

3 “(ii) *has a controlling interest;*

4 “(iii) *is a management services organi-*
5 *zation; or*

6 “(iv) *is a significant equity investor.*

7 “(2) *STANDARD CHARGES DEFINED.—For pur-*
8 *poses of paragraph (1), the term ‘standard charges’*
9 *means, with respect to an applicable laboratory and*
10 *a specified clinical diagnostic laboratory test, the fol-*
11 *lowing:*

12 “(A) *A plain language description of each*
13 *item or service, accompanied by any applicable*
14 *billing codes (including modifiers that materi-*
15 *ally change the price for insurers or providers,*
16 *and that materially change out-of-pocket costs*
17 *for consumers) using commonly recognized bill-*
18 *ing code sets, including—*

19 “(i) *the Healthcare Common Procedure*
20 *Coding System code;*

21 “(ii) *the National Drug Code; or*

22 “(iii) *other applicable identifier as de-*
23 *termined by the Secretary (or successor code*
24 *sets).*

1 “(B) *The gross charge expressed as a dollar*
2 *amount, for each such test.*

3 “(C) *The discounted cash price.*

4 “(D) *The payer-specific negotiated charges,*
5 *expressed as a dollar amount and clearly associ-*
6 *ated with the name of the applicable third-party*
7 *payer and name of each plan, that apply to each*
8 *such test. If the charges are based on an algo-*
9 *rithm, percentage of another amount, or other*
10 *formula or criteria, the applicable laboratory*
11 *also shall disclose such algorithm, percentage,*
12 *formula, or criteria as set forth in its contract*
13 *and any other information necessary to deter-*
14 *mine the negotiated charge as a dollar amount.*

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

18 “(F) *Any other additional information the*
19 *Secretary may require for the purpose of improv-*
20 *ing the accuracy of, or enabling consumers to*
21 *easily understand and compare, standard*
22 *charges for an item or service, except informa-*
23 *tion that is duplicative of any other reporting*
24 *requirement under this section. In the case of*
25 *standard charges for an item or service included*

1 *as part of a bundled, per diem, episodic, or other*
2 *similar arrangement, the information described*
3 *in this subparagraph shall be made available as*
4 *determined appropriate by the Secretary.*

5 “(3) *UNIFORM METHOD AND FORMAT.*—*The Sec-*
6 *retary shall establish a standard, uniform method and*
7 *format for applicable laboratories to use in compiling*
8 *and making public information pursuant to para-*
9 *graph (1). Such method and format shall—*

10 *“(A) include a machine-readable format (or*
11 *a successor technology specified by the Secretary)*
12 *containing the information described in para-*
13 *graph (2) for all specified clinical diagnostic lab-*
14 *oratory tests furnished by each laboratory and*
15 *the ownership information described in para-*
16 *graph (1)(B);*

17 *“(B) meet such standards as determined ap-*
18 *propriate by the Secretary in order to ensure the*
19 *accessibility and usability of such information;*
20 *and*

21 *“(C) be updated as determined appropriate*
22 *by the Secretary, in consultation with stake-*
23 *holders.*

24 “(4) *MONITORING COMPLIANCE.*—*The Secretary*
25 *shall, in consultation with the Inspector General of*

1 *the Department of Health and Human Services, es-*
2 *tablish a process to monitor compliance with this sub-*
3 *section. Such process shall ensure that each applicable*
4 *laboratory's compliance with this subsection is re-*
5 *viewed not less frequently than once every year.*

6 “(5) *INCLUSION OF ANCILLARY SERVICES.—Any*
7 *charge for a specified clinical diagnostic laboratory*
8 *test furnished by an applicable laboratory made pub-*
9 *licly available in accordance with paragraph (1) shall*
10 *include the charge for any ancillary item or service*
11 *(such as specimen collection services, specimen trans-*
12 *port, centrifugation, aliquoting, labeling, requisition*
13 *processing, and standard result reporting services)*
14 *that would customarily and routinely be furnished by*
15 *such laboratory as part of such test, as specified by*
16 *the Secretary.*

17 “(6) *ATTESTATION.—A senior official from each*
18 *clinical diagnostic laboratory (the Chief Executive Of-*
19 *ficer, Chief Financial Officer, or an official of equiva-*
20 *lent seniority) shall attest to the accuracy and com-*
21 *pleteness of the disclosures, and any other attestations*
22 *as required by the Secretary, made in accordance*
23 *with the clinical laboratory price transparency re-*
24 *quirements based on criteria established by the Sec-*
25 *retary.*

1 “(7) *ENFORCEMENT.*—

2 “(A) *IN GENERAL.*—*In the case of an appli-*
3 *cable laboratory that fails to comply with the re-*
4 *quirements of this subsection—*

5 “(i) *the Secretary shall notify such lab-*
6 *oratory of such failure not later than 30*
7 *days after the date on which the Secretary*
8 *determines such failure exists; and*

9 “(ii) *upon request of the Secretary,*
10 *such laboratory shall submit to the Sec-*
11 *retary, not later than 45 days after the date*
12 *of such request, a corrective action plan to*
13 *comply with such requirements.*

14 “(B) *CIVIL MONETARY PENALTY.*—

15 “(i) *IN GENERAL.*—*An applicable lab-*
16 *oratory that has received a notification*
17 *under subparagraph (A)(i) and fails to*
18 *comply with the requirements of this sub-*
19 *section by the date that is 90 days after*
20 *such notification (or, in the case of an ap-*
21 *plicable laboratory that has submitted a*
22 *corrective action plan described in subpara-*
23 *graph (A)(ii) in response to a request so de-*
24 *scribed, by the date that is 90 days after*
25 *such submission) shall be subject to a civil*

1 *monetary penalty of an amount specified by*
 2 *the Secretary for each day (beginning with*
 3 *the day on which the Secretary first deter-*
 4 *mined that such laboratory was not com-*
 5 *plying with such requirements) during*
 6 *which such failure is ongoing (not to exceed*
 7 *\$300 per day).*

8 “(ii) *INCREASE AUTHORITY.*—*In ap-*
 9 *plying this subparagraph with respect to an*
 10 *applicable laboratory that fails to comply*
 11 *with the requirements of this subsection in*
 12 *2028 or a subsequent year, the Secretary*
 13 *may through notice and comment rule-*
 14 *making increase the limitation on the per*
 15 *day amount of any penalty applicable to an*
 16 *applicable laboratory under clause (i).*

17 “(iii) *APPLICATION OF CERTAIN PROVI-*
 18 *SIONS.*—*The provisions of section 1128A of*
 19 *the Social Security Act (other than sub-*
 20 *sections (a) and (b) of such section) shall*
 21 *apply to a civil monetary penalty imposed*
 22 *under this subparagraph in the same man-*
 23 *ner as such provisions apply to a civil mon-*
 24 *etary penalty imposed under subsection (a)*
 25 *of such section.*

1 “(iv) *NO AUTHORITY TO WAIVE OR RE-*
2 *DUCE PENALTY.—The Secretary shall not*
3 *grant or extend any waiver, delay, tolling,*
4 *or other mitigation of a civil monetary pen-*
5 *alty for failing to comply with the require-*
6 *ments of this subsection except where the*
7 *Secretary determines that imposing the*
8 *maximum civil monetary penalty will dis-*
9 *rupt applicable laboratory operations in a*
10 *manner that impacts patient care. The Sec-*
11 *retary may request documentation in such*
12 *form and manner as the Secretary may re-*
13 *quire in order to evaluate impact on appli-*
14 *cable laboratory operations.*

15 “(8) *PROVISION OF TECHNICAL ASSISTANCE.—*
16 *The Secretary shall, to the extent practicable, provide*
17 *technical assistance relating to compliance with the*
18 *provisions of this subsection to applicable laboratories*
19 *requesting such assistance.*

20 “(9) *RULEMAKING.—*

21 “(A) *IN GENERAL.—The Secretary shall im-*
22 *plement this subsection through notice and com-*
23 *ment rulemaking in accordance with section 553*
24 *of title 5, United States Code.*

1 “(B) *OWNERSHIP INFORMATION.*—*In pro-*
2 *mulgating regulations under this paragraph, the*
3 *Secretary shall define the individuals and orga-*
4 *nizations that must be disclosed under para-*
5 *graph (1)(C) in a manner that harmonizes dis-*
6 *closure requirements with requirements estab-*
7 *lished under section 1124 of the Social Security*
8 *Act and prioritizes the disclosure of individuals*
9 *and organizations who’s ownership or manage-*
10 *ment relationship with a hospital impacts oper-*
11 *ational, financial, or clinical decision making*
12 *for such hospital.”.*

13 **SEC. 4. IMAGING SERVICES PRICE TRANSPARENCY.**

14 *Section 2718A of the Public Health Service Act, as*
15 *amended by section 3, is further amended by adding at the*
16 *end the following:*

17 “(d) *IMAGING SERVICES PRICE TRANSPARENCY.*—

18 “(1) *IN GENERAL.*—*Beginning January 1 of the*
19 *year that begins on or after the date that is 1 year*
20 *after the date of enactment of the Patients Deserve*
21 *Price Tags Act, each applicable imaging service pro-*
22 *vider shall, on a quarterly basis (if there have been*
23 *any changes to the standard charges described in*
24 *paragraph (2)) compile and make publicly available*

1 on an internet website (without subscription and free
2 of charge)—

3 “(A) the standard charges described in
4 paragraph (2) with respect to each such specified
5 imaging service provided by such provider; and

6 “(B) the name and business address for
7 each person or entity that, with respect to the
8 imaging services provider—

9 “(i) has an ownership or investment
10 interest;

11 “(ii) has a controlling interest;

12 “(iii) is a management services organi-
13 zation; or

14 “(iv) is a significant equity investor.

15 “(2) STANDARD CHARGES DEFINED.—For pur-
16 poses of paragraph (1), the term ‘standard charges’,
17 with respect to an applicable imaging service pro-
18 vider and a specified imaging service, means the fol-
19 lowing:

20 “(A) A plain language description of each
21 item or service, accompanied by any applicable
22 billing codes (including modifiers that materi-
23 ally change the price for insurers or providers,
24 and that materially change out-of-pocket costs

1 *for consumers) using commonly recognized bill-*
 2 *ing code sets, including—*

3 *“(i) the Healthcare Common Procedure*
 4 *Coding System code;*

5 *“(ii) the National Drug Code; or*

6 *“(iii) other applicable identifier as de-*
 7 *termined by the Secretary (or successor code*
 8 *sets).*

9 *“(B) The gross charge expressed as a dollar*
 10 *amount, for each such item or service.*

11 *“(C) The discounted cash price.*

12 *“(D) The payer-specific negotiated charges,*
 13 *expressed as a dollar amount and clearly associ-*
 14 *ated with the name of the applicable third-party*
 15 *payer and name of each plan, that apply to each*
 16 *such service. If the charges are based on an algo-*
 17 *rithm, percentage of another amount, or other*
 18 *formula or criteria, the provider or supplier also*
 19 *shall disclose such algorithm, percentage, for-*
 20 *mula, or criteria as set forth in its contract and*
 21 *any other information necessary to determine the*
 22 *negotiated charge as a dollar amount.*

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 improv-
 3 ing the accuracy of, or enabling consumers to
 4 easily understand and compare, standard
 5 charges and prices for an item or service, except
 6 information that is duplicative of any other re-
 7 porting requirement under this subsection. In the
 8 case of standard charges for an item or service
 9 included as part of a bundled, per diem, epi-
 10 sodic, or other similar arrangement, the informa-
 11 tion described in this subparagraph shall be
 12 made available as determined appropriate by the
 13 Secretary.

14 “(3) UNIFORM METHOD AND FORMAT.—The Sec-
 15 retary shall establish a standard, uniform method and
 16 format for applicable imaging service providers to use
 17 in making public information described in paragraph
 18 (1). Any such method and format shall—

19 “(A) include a machine-readable format (as
 20 specified by the Secretary) containing the infor-
 21 mation described in paragraph (2) for all speci-
 22 fied imaging services furnished by each applica-
 23 ble imaging service provider and ownership in-
 24 formation described in paragraph (1)(B);

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

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

8 “(4) *MONITORING COMPLIANCE.*—The Secretary
 9 shall, in consultation with the Inspector General of
 10 the Department of Health and Human Services, es-
 11 tablish a process to monitor compliance with this sub-
 12 section.

13 “(5) *ATTESTATION.*—A senior official from each
 14 specified imaging service provider (the Chief Execu-
 15 tive Officer, Chief Financial Officer, or an official of
 16 equivalent seniority) shall attest to the accuracy and
 17 completeness of the disclosures, and any other attesta-
 18 tions as required by the Secretary, made in accord-
 19 ance with the imaging service provider price trans-
 20 parency requirements based on criteria established by
 21 the Secretary.

22 “(6) *ENFORCEMENT.*—

23 “(A) *IN GENERAL.*—In the case of a speci-
 24 fied imaging service provider that fails to com-
 25 ply with the requirements of this subsection—

1 “(i) the Secretary shall notify such im-
 2 aging service provider of such failure not
 3 later than 30 days after the date on which
 4 the Secretary determines such failure exists;
 5 and

6 “(ii) upon request of the Secretary,
 7 such imaging service provider shall submit
 8 to the Secretary, not later than 45 days
 9 after the date of such request, a corrective
 10 action plan to comply with such require-
 11 ments.

12 “(B) CIVIL MONETARY PENALTY.—

13 “(i) IN GENERAL.—A specified imag-
 14 ing service provider that has received a no-
 15 tification under subparagraph (A)(i) and
 16 fails to comply with the requirements of this
 17 subsection by the date that is 90 days after
 18 such notification (or, in the case of a speci-
 19 fied imaging service provider that has sub-
 20 mitted a corrective action plan described in
 21 subparagraph (A)(ii) in response to a re-
 22 quest so described, by the date that is 90
 23 days after such submission) shall be subject
 24 to a civil monetary penalty of an amount
 25 specified by the Secretary for each day (be-

1 *ginning with the day on which the Sec-*
2 *retary first determined that such imaging*
3 *service provider was not complying with*
4 *such requirements) during which such fail-*
5 *ure is ongoing (not to exceed \$300 per day).*

6 “(ii) *INCREASE AUTHORITY.—In ap-*
7 *plying this subparagraph with respect to a*
8 *specified imaging service provider that fails*
9 *to comply with the requirements of this sub-*
10 *section in 2028 or a subsequent year, the*
11 *Secretary may through notice and comment*
12 *rulemaking increase the limitation on the*
13 *per day amount of any penalty applicable*
14 *to a specified imaging service provider*
15 *under clause (i).*

16 “(iii) *APPLICATION OF CERTAIN PROVI-*
17 *SIONS.—The provisions of section 1128A of*
18 *the Social Security Act (other than sub-*
19 *sections (a) and (b) of such section) shall*
20 *apply to a civil monetary penalty imposed*
21 *under this subparagraph in the same man-*
22 *ner as such provisions apply to a civil mon-*
23 *etary penalty imposed under subsection (a)*
24 *of such section.*

1 “(iv) *NO AUTHORITY TO WAIVE OR RE-*
2 *DUCE PENALTY.*—*The Secretary shall not*
3 *grant or extend any waiver, delay, tolling,*
4 *or other mitigation of a civil monetary pen-*
5 *alty for failing to comply with the require-*
6 *ments of this subsection except where the*
7 *Secretary determines that imposing the*
8 *maximum civil monetary penalty will dis-*
9 *rupt specified imaging service provider op-*
10 *erations in a manner that impacts patient*
11 *care. The Secretary may request documenta-*
12 *tion in such form and manner as the Sec-*
13 *retary may require in order to evaluate im-*
14 *pact on specified imaging service provider*
15 *operations.*

16 “(7) *PROVISION OF TECHNICAL ASSISTANCE.*—
17 *The Secretary shall, to the extent practicable, provide*
18 *technical assistance relating to compliance with the*
19 *provisions of this subsection to providers of services*
20 *and suppliers requesting such assistance.*

21 “(8) *RULEMAKING.*—

22 “(A) *IN GENERAL.*—*The Secretary shall im-*
23 *plement this subsection through notice and com-*
24 *ment rulemaking in accordance with section 553*
25 *of title 5, United States Code.*

1 “(B) *OWNERSHIP INFORMATION.*—*In promulgating regulations under this paragraph, the*
2 *Secretary shall define the individuals and orga-*
3 *nizations that must be disclosed under para-*
4 *graph (1)(C) in a manner that harmonizes dis-*
5 *closure requirements with requirements estab-*
6 *lished under section 1124 of the Social Security*
7 *Act and prioritizes the disclosure of individuals*
8 *and organizations who’s ownership or manage-*
9 *ment relationship with a hospital impacts oper-*
10 *ational, financial, or clinical decision making*
11 *for such hospital.”.*

13 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
14 **PARENCY.**

15 *Section 2718A of the Public Health Service Act, as*
16 *amended by section 4, is further amended by adding at the*
17 *end the following:*

18 “(e) *AMBULATORY SURGICAL CENTER PRICE TRANS-*
19 *PARENCY.*—

20 “(1) *IN GENERAL.*—*Beginning January 1 of the*
21 *year that begins on or after the date that is 1 year*
22 *after the date of enactment of the Patients Deserve*
23 *Price Tags Act, each specified ambulatory surgical*
24 *center shall, on a quarterly basis (if there have been*
25 *any changes to the standard charges described in*

1 *paragraph (2)), compile and make publicly available*
 2 *on an internet website (without subscription and free*
 3 *of charge)—*

4 *“(A) the standard charges described in*
 5 *paragraph (2) with respect to each specified serv-*
 6 *ice furnished by such surgical center; and*

7 *“(B) the name and business address for*
 8 *each person or entity that, with respect to the*
 9 *ambulatory surgical center—*

10 *“(i) has an ownership or investment*
 11 *interest;*

12 *“(ii) has a controlling interest;*

13 *“(iii) is a management services organi-*
 14 *zation; or*

15 *“(iv) is a significant equity investor.*

16 *“(2) STANDARD CHARGES DEFINED.—For pur-*
 17 *poses of paragraph (1), the term ‘standard charges’*
 18 *with respect to standard charges and prices made*
 19 *public by a specified ambulatory surgical center*
 20 *means the following:*

21 *“(A) A plain language description of each*
 22 *item or service, accompanied by any applicable*
 23 *billing codes (including modifiers that materi-*
 24 *ally change the price for insurers or providers,*
 25 *and that materially change out-of-pocket costs*

1 *for consumers) using commonly recognized bill-*
 2 *ing code sets, including—*

3 *“(i) the Healthcare Common Procedure*
 4 *Coding System code;*

5 *“(ii) the National Drug Code; or*

6 *“(iii) other applicable identifier as de-*
 7 *termined by the Secretary (or successor code*
 8 *sets).*

9 *“(B) The gross charge, expressed as a dollar*
 10 *amount, for each such item or service.*

11 *“(C) The discounted cash price.*

12 *“(D) The payer-specific negotiated charges,*
 13 *expressed as a dollar amount and clearly associ-*
 14 *ated with the name of the applicable third party*
 15 *payer and name of each plan, that apply to each*
 16 *such item or service. If the charges are based on*
 17 *an algorithm, percentage of another amount, or*
 18 *other formula or criteria, the ambulatory sur-*
 19 *gical center also shall disclose such algorithm,*
 20 *percentage, formula, or criteria as set forth in its*
 21 *contract and any other information necessary to*
 22 *determine the negotiated charge as a dollar*
 23 *amount.*

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

4 “(F) *Any other additional information the*
5 *Secretary may require for the purpose of improv-*
6 *ing the accuracy of, or enabling consumers to*
7 *easily understand and compare, standard*
8 *charges and prices for an item or service. In the*
9 *case of standard charges for an item or service*
10 *included as part of a bundled, per diem, epi-*
11 *sodic, or other similar arrangement, the informa-*
12 *tion described in this subparagraph shall be*
13 *made available as determined appropriate by the*
14 *Secretary.*

15 “(3) *UNIFORM METHOD AND FORMAT.—The Sec-*
16 *retary shall establish a standard, uniform method and*
17 *format for specified ambulatory surgical centers to*
18 *use in compiling and making public information pur-*
19 *suant to paragraph (1). Such method and format*
20 *shall—*

21 “(A) *include a machine-readable format (or*
22 *a successor technology specified by the Secretary)*
23 *containing the information described in para-*
24 *graph (2) for all specified services furnished by*
25 *each ambulatory surgical center and for the own-*

1 *ership information described in paragraph*
 2 *(1)(B);*

3 *“(B) meet such standards as determined ap-*
 4 *propriate by the Secretary in order to ensure the*
 5 *accessibility and usability of such charges; and*

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

9 *“(4) MONITORING COMPLIANCE.—The Secretary*
 10 *shall, in consultation with the Inspector General of*
 11 *the Department of Health and Human Services, es-*
 12 *tablish a process to monitor compliance with this sub-*
 13 *section. Such process shall ensure that each specified*
 14 *ambulatory surgical center’s compliance with this*
 15 *subsection is reviewed not less frequently than once*
 16 *every year.*

17 *“(5) ATTESTATION.—A senior official from each*
 18 *specified ambulatory surgical center (the Chief Execu-*
 19 *tive Officer, Chief Financial Officer, or an official of*
 20 *equivalent seniority) shall attest to the accuracy and*
 21 *completeness of the disclosures, and any other attesta-*
 22 *tions as required by the Secretary, made in accord-*
 23 *ance with the ambulatory center price transparency*
 24 *requirements based on criteria established by the Sec-*
 25 *retary.*

“(6) *ENFORCEMENT.*—

“(A) *IN GENERAL.*—*In the case of a specified ambulatory surgical center that fails to comply with the requirements of this subsection—*

“(i) *the Secretary shall notify such ambulatory surgical center of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and*

“(ii) *upon request of the Secretary, such ambulatory surgical center shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such requirements.*

“(B) *CIVIL MONETARY PENALTY.*—

“(i) *IN GENERAL.*—*A specified ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of a specified ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a re-*

1 quest so described, by the date that is 90
 2 days after such submission) shall be subject
 3 to a civil monetary penalty of an amount
 4 specified by the Secretary for each day (be-
 5 ginning with the day on which the Sec-
 6 retary first determined that such ambula-
 7 tory surgical center was not complying with
 8 such requirements) during which such fail-
 9 ure is ongoing (not to exceed \$300 per day).

10 “(ii) *INCREASE AUTHORITY.*—In ap-
 11 plying this subparagraph with respect to a
 12 specified ambulatory surgical center that
 13 fails to comply with the requirements of this
 14 subsection in 2028 or a subsequent year, the
 15 Secretary may through notice and comment
 16 rulemaking increase the limitation on the
 17 per day amount of any penalty applicable
 18 to a specified ambulatory surgical center
 19 under clause (i).

20 “(iii) *APPLICATION OF CERTAIN PROVI-*
 21 *SIONS.*—The provisions of section 1128A of
 22 the Social Security Act (other than sub-
 23 sections (a) and (b) of such section) shall
 24 apply to a civil monetary penalty imposed
 25 under this subparagraph in the same man-

ner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

“(iv) *NO AUTHORITY TO WAIVE OR REDUCE PENALTY.*—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for failing to comply with the requirements of this subsection except where the Secretary determines that imposing the maximum civil monetary penalty will disrupt specified ambulatory surgical center operations in a manner that impacts patient care. The Secretary may request documentation in such form and manner as the Secretary may require in order to evaluate impact on specified ambulatory surgical center operations.

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

“(8) *RULEMAKING.*—

1 “(A) *IN GENERAL.*—*The Secretary shall im-*
2 *plement this subsection through notice and com-*
3 *ment rulemaking in accordance with section 553*
4 *of title 5, United States Code.*

5 “(B) *OWNERSHIP INFORMATION.*—*In pro-*
6 *mulgating regulations under this paragraph, the*
7 *Secretary shall define the individuals and orga-*
8 *nizations that must be disclosed under para-*
9 *graph (1)(C) in a manner that harmonizes dis-*
10 *closure requirements with requirements estab-*
11 *lished under section 1124 of the Social Security*
12 *Act and prioritizes the disclosure of individuals*
13 *and organizations who’s ownership or manage-*
14 *ment relationship with a hospital impacts oper-*
15 *ational, financial, or clinical decision making*
16 *for such hospital.*

17 “(f) *CONTINUED APPLICABILITY OF STATE LAW.*—*The*
18 *provisions of this section shall not supersede any provision*
19 *of State law that establishes, implements, or continues in*
20 *effect any requirement or prohibition related to health care*
21 *price transparency, except to the extent that such require-*
22 *ment or prohibition prevents the application of a require-*
23 *ment or prohibition of this section.”.*

1 **SEC. 6. STRENGTHENING HEALTH COVERAGE TRANS-**
 2 **PARENCY REQUIREMENTS.**

3 (a) *TRANSPARENCY IN COVERAGE.*—Section 2715A of
 4 the Public Health Service Act (42 U.S.C. 300gg-15a) is
 5 amended—

6 (1) by striking “A Group health” and inserting
 7 the following:

8 “(a) *IN GENERAL.*—A group health”; and

9 (2) by ending at the end the following:

10 “(b) *ADDITIONAL TRANSPARENCY REQUIREMENTS.*—

11 “(1) *SPECIFIED INFORMATION REQUIRED.*—

12 “(A) *IN GENERAL.*—A group health plan or
 13 health insurance issuer offering coverage in the
 14 individual or group market shall provide to each
 15 participant, beneficiary, or enrollee, at the time
 16 of enrollment in the plan or coverage, the infor-
 17 mation described in subparagraph (B).

18 “(B) *INFORMATION REQUIRED.*—For pur-
 19 poses of subparagraph (A), the information spec-
 20 ified in this subparagraph is, with respect to
 21 benefits available under the plan or coverage for
 22 an item or service furnished by a health care
 23 provider, the following (or other information as
 24 determined appropriate by the Secretary):

25 “(i) If such provider is an in-network
 26 provider with respect to such item or serv-

1 *ice, the in-network rate (as defined in para-*
2 *graph (5)) for such item or service.*

3 “(ii) *If such provider is not described*
4 *in clause (i), the out-of-network allowed*
5 *amount (as such term is defined for pur-*
6 *poses of section 147.210(a)(2)(xvii) of title*
7 *45, Code of Federal Regulation) for such*
8 *item or service that the plan or coverage*
9 *will pay without regard to the amount in*
10 *clause (iii).*

11 “(iii) *The amount of cost-sharing li-*
12 *ability (including deductibles, copayments,*
13 *and coinsurance) that the individual will*
14 *incur for such item or service based on the*
15 *information available to the plan or cov-*
16 *erage at the time the request is made*
17 *(which, in the case such item or service is*
18 *to be furnished by a provider described in*
19 *clause (ii), shall be calculated using the*
20 *maximum amount described in such*
21 *clause).*

22 “(iv) *The accumulated amounts with*
23 *respect to any deductible or out-of-pocket*
24 *maximum under the plan or coverage re-*
25 *flected in the plan’s or coverage’s records at*

1 the time the request is made (broken down,
2 in the case separate deductibles or maxi-
3 mums apply to separate individuals en-
4 rolled in the plan or coverage, by such sepa-
5 rate deductibles or maximums, in addition
6 to any cumulative deductible or maximum).

7 “(v) In the case such plan or coverage
8 imposes any frequency or volume limita-
9 tions with respect to such item or service
10 (excluding medical necessity determina-
11 tions), the amount that such individual has
12 accrued towards such limitation with re-
13 spect to such item or service reflected in the
14 plan’s or coverage’s records at the time the
15 request is made.

16 “(vi) Information about any utiliza-
17 tion management requirements, such as
18 prior authorization, concurrent review, step
19 therapy, fail first, or similar requirements
20 applicable to coverage of such item or serv-
21 ice under such plan or coverage, including
22 information regarding utilization manage-
23 ment practices and determinations, includ-
24 ing aggregate information related to ap-
25 proval and denial rates, associated

1 *timelines, and appeals, as determined ap-*
2 *propriate by the Secretary.*

3 “(C) *SELF-SERVICE TOOL* .—*For purposes*
4 *of subparagraph (A), a self-service tool estab-*
5 *lished by a health plan meets the requirements of*
6 *this subparagraph if such tool—*

7 *“(i) is based on an internet website;*

8 *“(ii) provides for real-time responses to*
9 *requests described in such subparagraph;*

10 *“(iii) is updated in a manner such*
11 *that the information is accurate based on*
12 *the information available to the plan or*
13 *coverage at the time the request is made;*

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

17 *“(I) a specific provider that is an*
18 *in-network provider with respect to*
19 *such item or service; or*

20 *“(II) all providers that are in-net-*
21 *work providers with respect to such*
22 *plan or coverage and such item or*
23 *service;*

1 “(v) provides that such a request may
2 be made for information with respect to an
3 item or service through use of—

4 “(I) the billing code for such item
5 or service; or

6 “(II) through use of a descriptive
7 term for such item or service; and

8 “(vi) is made available in plain lan-
9 guage, without subscription or other fee.

10 “(D) NONDUPLICATION.—A group health
11 plan or health insurance issuers shall be deemed
12 to be in compliance with this paragraph if such
13 plan or issuer has a tool in place under section
14 2799A–4.

15 “(2) RATE AND PAYMENT INFORMATION.—

16 “(A) IN GENERAL.—Beginning January 1
17 of the year that begins on or after the date that
18 is 1 year after the date of enactment of the Pa-
19 tients Deserve Price Tags Act, and every quarter
20 thereafter (if there have been any changes to the
21 rate and payment information described in sub-
22 paragraphs (B) and (C), each group health plan
23 or health insurance issuer offering coverage in
24 the group or individual market shall make avail-
25 able to the public, the rate and payment infor-

1 *mation described in subparagraph (B) in accord-*
2 *ance with subparagraph (C).*

3 *“(B) RATE AND PAYMENT INFORMATION DE-*
4 *SCRIBED.—For purposes of subparagraph (A),*
5 *the rate and payment information described in*
6 *this subparagraph is, with respect to a plan or*
7 *coverage, the following:*

8 *“(i) With respect to each item or serv-*
9 *ice for which benefits are available under*
10 *such plan or coverage, excluding those in-*
11 *cluded in clause (ii), identified by CPT,*
12 *HCPCS, DRG, or other applicable nation-*
13 *ally recognized identifier, including any ap-*
14 *plicable code modifiers, and accompanied*
15 *by a plain language description of the item*
16 *or service, the in-network rate (expressed as*
17 *a dollar amount or percentage of charges,*
18 *unless otherwise specified by the Secretary),*
19 *including the individual and total amounts*
20 *for any bundled rates, in effect as of the*
21 *date of the submission of such information*
22 *with each provider (identified by national*
23 *provider identifier) that is an in-network*
24 *provider with respect to such item or serv-*
25 *ice, other than such a rate in effect with a*

1 *provider that an issuer has determined*
2 *based on factors determined by the Sec-*
3 *retary (such as medical specialty) that it is*
4 *unlikely that the provider would be reim-*
5 *bursed for the item or service.*

6 *“(ii) With respect to each drug and*
7 *biologic (identified by National Drug Code,*
8 *J-code, or other commonly recognized bill-*
9 *ing code used for drugs) for which benefits*
10 *are available under such plan or coverage,*
11 *the in-network rate (expressed as a dollar*
12 *amount or percentage of charges, unless oth-*
13 *erwise specified by the Secretary) in effect*
14 *as of the first day of the quarter in which*
15 *such information is made public with each*
16 *pharmacy or other prescription drug dis-*
17 *perser that is an in-network pharmacy or*
18 *other prescription drug dispenser with re-*
19 *spect to such drug.*

20 *“(iii) With respect to each item or*
21 *service for which benefits are available*
22 *under such plan or coverage (expressed as a*
23 *dollar amount), identified by CPT, DRG,*
24 *HCPCS, or other applicable nationally rec-*
25 *ognized identifier, including any applicable*

1 *code modifiers, and accompanied by a brief*
2 *description of the item or service, the*
3 *amount billed or charged by the provider,*
4 *and the amount allowed by the plan or cov-*
5 *erage, for each such item or service fur-*
6 *nished during a representative lookback*
7 *window established by the Secretary by each*
8 *provider that was an out-of-network pro-*
9 *vider with respect to such item or service,*
10 *broken down by each such provider (identi-*
11 *fied by national provider identifier), other*
12 *than items and services with respect to*
13 *which not fewer than 11 claims for such*
14 *item or service were submitted to such plan*
15 *during such period.*

16 “(C) *MANNER OF SUBMISSION.*—*Rate and*
17 *payment information required to be submitted*
18 *and made available under this paragraph shall*
19 *be so submitted and so made available as follows:*

20 “(i) *Information shall be contained in*
21 *at least 3 separate machine-readable files*
22 *corresponding to the information described*
23 *in each of clauses (i) through (iii) of sub-*
24 *paragraph (B) that meet such requirements*
25 *as specified by the Secretary through rule-*

1 *making, in consultation with the Secretaries*
2 *of Labor and the Treasury, to apply com-*
3 *parable requirements to group health plans*
4 *and health insurance coverage and to enti-*
5 *ties providing benefit management or other*
6 *third-party administration services on a*
7 *contractual basis with a group health plan*
8 *or coverage.*

9 “(ii) *Requirements specified by the*
10 *Secretary through rulemaking (or subregu-*
11 *latory guidance) shall ensure the following:*

12 “(I) *Such files are made available*
13 *in a widely available format that al-*
14 *lows for information contained in such*
15 *files to be compared across plans and*
16 *coverage and are freely accessible to in-*
17 *dividuals at no cost and without the*
18 *need to establish a user account or pro-*
19 *vide other credentials.*

20 “(II) *Each such file includes each*
21 *of the following data elements:*

22 “(aa) *A numerical identifier*
23 *for the group health plan or*
24 *health insurance issuer (such as a*

1 *Health Insurance Oversight Sys-*
2 *tem identifier).*

3 “(bb) *A plain-language de-*
4 *scription of the item or service*
5 *(including, for drugs, the propri-*
6 *etary and nonproprietary name*
7 *assigned).*

8 “(cc) *The billing code, in-*
9 *cluding any applicable modifiers,*
10 *associated with such item or serv-*
11 *ice, including the Healthcare*
12 *Common Procedure Coding Sys-*
13 *tem code, diagnosis-related group,*
14 *national drug code, or other com-*
15 *monly recognized code set.*

16 “(dd) *The place of service*
17 *code.*

18 “(ee) *The National Provider*
19 *Identifier and provider Tax Iden-*
20 *tification Number.*

21 “(iii) *The rate and payment informa-*
22 *tion disclosed under clauses (i) through (iii)*
23 *of subparagraph (B) shall be separately de-*
24 *lineated for each item or service, regardless*
25 *of whether such item or service is reim-*

1 bursed as a part of a bundle, episode, or
2 other grouping of items and services.

3 “(iv) An officer or executive of com-
4 petent authority shall attest to the accuracy
5 and completeness of information submitted
6 and made available under this subpara-
7 graph. In the case of a plan or coverage
8 that relies on a third-party administrator
9 or other service provider to compile the in-
10 formation submitted and made available
11 under this subparagraph, such plan or cov-
12 erage may satisfy the requirement under
13 this clause by obtaining such an attestation
14 from the third-party administrator or other
15 service provider. Such attestation shall be
16 subject to enforcement under paragraph (6).

17 “(3) OWNERSHIP INFORMATION.—Beginning
18 January 1 of the year that begins on or after the date
19 that is 1 year after the date of enactment of the Pa-
20 tients Deserve Price Tags Act, and every quarter
21 thereafter (if there have been any changes in the re-
22 quired information), each group health plan or health
23 insurance issuer offering coverage in the individual or
24 group market shall submit to the Secretary, the appli-
25 cable State authority, and make available to the pub-

1 *lic, the name and business address of each person or*
 2 *entity that, with respect to such plan or coverage—*

3 *“(A) has an ownership or investment inter-*
 4 *est;*

5 *“(B) has a controlling interest;*

6 *“(C) is a management services organiza-*
 7 *tion; or*

8 *“(D) is a significant equity investor.*

9 *“(4) ENFORCEMENT.—*

10 *“(A) IN GENERAL.—Each year, the Sec-*
 11 *retary shall audit the machine-readable files re-*
 12 *quired by paragraph (2)(B) posted by not fewer*
 13 *than 50 group health plans or health insurance*
 14 *issuers for compliance with format and accessi-*
 15 *bility standards.*

16 *“(B) NOTIFICATION AND REQUEST FOR COR-*
 17 *RECTIVE ACTION.—In the case of a group health*
 18 *plan or health insurance issuer that fails to com-*
 19 *ply with the requirements of this paragraph, not*
 20 *later than 30 days after the date on which the*
 21 *Secretary determines such failure exists, the Sec-*
 22 *retary shall submit to such plan or issuer a noti-*
 23 *fication of such determination, which shall in-*
 24 *clude a request for a corrective action plan to*
 25 *comply with such requirements.*

1 “(C) *CIVIL MONETARY PENALTY.*—*A plan or*
 2 *issuer that has received a request for a corrective*
 3 *action plan under subparagraph (B) and fails to*
 4 *comply with the requirements of this paragraph*
 5 *by the date that is 30 days after such request is*
 6 *made shall be subject to a civil monetary penalty*
 7 *of an amount specified by the Secretary for each*
 8 *day (beginning with the day on which such*
 9 *health plan or health insurance issuer was fail-*
 10 *ing to comply with such paragraph) during*
 11 *which such failure was ongoing. Such amount*
 12 *shall not exceed \$300 per participant, bene-*
 13 *ficiary, or covered individual per day or*
 14 *\$10,000,000, whichever is lesser.*

15 “(5) *DEFINITIONS.*—*In this subsection:*

16 “(A) *IN-NETWORK PROVIDER.*—*The term*
 17 *‘in-network provider’ has the meaning given such*
 18 *term in section 54.9815-2715A1(a)(2)(xii) of title*
 19 *26, Code of Federal Regulations.*

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

1 *vider for such item or service. If the rate is based*
 2 *on an algorithm, percentage of another amount,*
 3 *or other formula or criteria, the health plan also*
 4 *shall disclose such algorithm, percentage, for-*
 5 *mula, or criteria as set forth in its contract and*
 6 *any other terms, schedules, exhibits, data, or*
 7 *other information referenced in any such con-*
 8 *tract as shall be required to determine and dis-*
 9 *close the negotiated rate.*

10 *“(6) RULEMAKING.—*

11 *“(A) IN GENERAL.—The Secretary shall im-*
 12 *plement this subsection through notice and com-*
 13 *ment rulemaking in accordance with section 553*
 14 *of title 5, United States Code. The Secretary*
 15 *may implement the manner of submission of*
 16 *data described in paragraph (2)(C) through sub-*
 17 *regulatory guidance.*

18 *“(B) REGULATIONS.—Regulations promul-*
 19 *gated pursuant to this subsection shall provide*
 20 *the following:*

21 *“(i) The Secretary shall annually*
 22 *audit the machine-readable files required by*
 23 *paragraph (2)(B) posted by not fewer than*
 24 *50 group health plans or health insurance*

1 *issuers for compliance with format and ac-*
2 *cessibility standards.*

3 “(ii) *The Secretary of Labor shall an-*
4 *nually audit the machine-readable files re-*
5 *quired by paragraph (2)(B) posted by not*
6 *fewer than 250 group health plans or serv-*
7 *ice providers furnishing third-party admin-*
8 *istrator services to a group health plan for*
9 *compliance with format and accessibility*
10 *standards.*

11 “(iii) *The Secretary of Health and*
12 *Human Services, in conjunction with the*
13 *Secretary of Labor and the Secretary of the*
14 *Treasury, shall annually issue a report to*
15 *Congress that includes findings, conclusions,*
16 *and enforcement actions taken based on au-*
17 *ditions of the machine-readable files. Such re-*
18 *port shall be provided no later than July 1*
19 *following the calendar year during which*
20 *the audits were completed. The Secretary of*
21 *Health and Human Services shall make*
22 *such report to Congress accessible to the*
23 *public.”.*

24 ***(b) EFFECTIVE DATE.—***

1 (1) *IN GENERAL.*—*The amendments made by*
 2 *subsections (a) and (b) shall apply beginning Janu-*
 3 *ary 1 of the year that begins on or after the date that*
 4 *is 1 year after the date of enactment of the Patients*
 5 *Deserve Price Tags Act.*

6 (2) *CONTINUED APPLICABILITY OF RULES FOR*
 7 *PREVIOUS YEARS.*—*Nothing in the amendments made*
 8 *by this section may be construed as affecting the ap-*
 9 *plicability of the rule entitled “Transparency in Cov-*
 10 *erage” published by the Department of the Treasury,*
 11 *the Department of Labor, and the Department of*
 12 *Health and Human Services on November 12, 2020*
 13 *(85 Fed. Reg. 72158), or amendments made to such*
 14 *rule that are applicable before the date of enactment*
 15 *of the Patients Deserve Price Tags Act.*

16 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**
 17 **HEALTH DATA.**

18 (a) *GROUP HEALTH PLAN ACCESS TO INFORMA-*
 19 *TION.*—

20 (1) *IN GENERAL.*—*Section 2799A-9 of the Public*
 21 *Health Service Act (42 U.S.C. 300gg-119) is amended*
 22 *by adding at the end the following:*

23 “(1) *GROUP HEALTH PLAN ACCESS TO INFORMA-*
 24 *TION.*—

“(A) *IN GENERAL.*—No contract or arrangement for services, and no extension or renewal of such contract or arrangement, between a group health plan that is offered by a specified large employer or that is a specified large plan (as such terms are defined in subparagraph (F)) and a health care provider (which for purposes of this subparagraph, includes a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, health insurance issuer offering group or individual health insurance coverage, or pharmacy benefit manager, or any entity acting as an intermediary between the group health plan and the health care provider, network association of providers, service provider offering access to a network or association of providers (including a licensed health insurance issuer or third-party administrator), or pharmacy benefit manager (collectively referred to in this subsection as ‘Covered Service Providers’), is reasonable within the meaning of this subsection unless such contract or arrangement—

“(i) allows the responsible plan fiduciary (as that term is defined in section

1 408(b)(2)(B)(ii)(I)(ee)) access to all claims
2 and encounter information or data, and
3 any documentation supporting claim pay-
4 ments, including, but not limited to, med-
5 ical records and policy documents, or infor-
6 mation or data described in subsection
7 (a)(1)(B) to—

8 “(I) comply with applicable law;

9 and

10 “(II) determine the accuracy or
11 reasonableness of claims payment; and

12 “(ii) does not—

13 “(I) unreasonably limit or delay
14 access, as determined by the Secretary
15 but in any event not longer than 15
16 days, after a request for access by a
17 plan fiduciary to such information or
18 data;

19 “(II) limit the volume of claims
20 and encounter information or data
21 that the group health plan, the plan
22 sponsor, the plan administrator, or a
23 business associate of such plan may ac-
24 cess during an audit or pursuant to

1 *any request for such information or*
2 *data;*

3 “(III) *limit the disclosure of pric-*
4 *ing terms for value-based payment ar-*
5 *rangements or capitated payment ar-*
6 *rangements, including—*

7 “(aa) *payment calculations*
8 *and formulas;*

9 “(bb) *quality measures;*

10 “(cc) *contract terms;*

11 “(dd) *payment amounts;*

12 “(ee) *measurement periods*
13 *for all incentives; and*

14 “(ff) *other payment meth-*
15 *odologies used by an entity, in-*
16 *cluding a health care provider*
17 *(including a health care facility),*
18 *network or association of pro-*
19 *viders, service provider offering*
20 *access to a network of providers,*
21 *third-party administrator, or*
22 *pharmacy benefit manager;*

23 “(IV) *limit the disclosure of over-*
24 *payments and overpayment recovery*
25 *terms;*

1 “(V) *limit the right of the group*
2 *health plan, the plan sponsor, or the*
3 *plan administrator of such plan to se-*
4 *lect an auditor or define audit scope or*
5 *frequency;*

6 “(VI) *otherwise limit or unduly*
7 *delay the group health plan, the plan*
8 *sponsor, the plan administrator, or a*
9 *business associate of such plan from*
10 *accessing claims and encounter infor-*
11 *mation or data;*

12 “(VII) *limit the disclosure of fees*
13 *charged to the group health plan re-*
14 *lated to plan administration and*
15 *claims processing, including renegoti-*
16 *ation fees, access fees, repricing fees, or*
17 *enhanced review fees;*

18 “(VIII) *limit the right of the*
19 *group health plan, the plan sponsor, or*
20 *the plan administrator to request ac-*
21 *tion on any suspect claim payments;*

22 “(IX) *limit public disclosure of*
23 *de-identified or aggregate information;*

24 “(X) *limit the disclosure of, with*
25 *respect to a provider that files claims*

1 *under such plan, whether a Covered*
 2 *Service Provider—*

3 “*(aa) has an ownership or*
 4 *investment interest;*

5 “*(bb) has a controlling inter-*
 6 *est;*

7 “*(cc) is a management serv-*
 8 *ices organization; or*

9 “*(dd) is a significant equity*
 10 *investor; or*

11 “*(XI) limit the disclosure of the*
 12 *name and address of each person or*
 13 *entity that, with respect to the health*
 14 *plan service provider—*

15 “*(aa) has an ownership or*
 16 *investment interest;*

17 “*(bb) has a controlling inter-*
 18 *est; or*

19 “*(cc) is a significant equity*
 20 *investor.*

21 “*(B) MANNER OF PROVIDING INFORMATION*
 22 *OR DATA.—*

23 “*(i) IN GENERAL.—A Covered Service*
 24 *Provider shall provide information or data*
 25 *under this subsection in a manner con-*

1 *sistent with the privacy regulations promul-*
 2 *gated under section 13402(a) of the Health*
 3 *Information Technology for Economic and*
 4 *Clinical Health Act (42 U.S.C. 17932(a))*
 5 *and consistent with the privacy regulations*
 6 *promulgated under the Health Insurance*
 7 *Portability and Accountability Act of 1996*
 8 *in part 160 and subparts A and E of part*
 9 *164 of title 45, Code of Federal Regulations*
 10 *(or successor regulations) (referred to in this*
 11 *paragraph as the ‘HIPAA privacy regula-*
 12 *tions’) and shall restrict the use and disclo-*
 13 *sure of such information according to such*
 14 *privacy regulations and such HIPAA pri-*
 15 *vacv regulations. A Covered Service Pro-*
 16 *vider shall not be required to disclose infor-*
 17 *mation or data under this subsection that*
 18 *could reasonably identify a participant or*
 19 *beneficiary through individually identifi-*
 20 *able health information (as such term is de-*
 21 *finad under HIPAA privacy regulations).*

22 *“(ii) ADDITIONAL REQUIREMENTS.—In*
 23 *carrying out this subsection, a Covered*
 24 *Service Provider shall comply with section*

1 164.504(f) of title 45, Code of Federal Regu-
 2 lations (or a successor regulation).

3 “(iii) *RULE OF CONSTRUCTION.*—

4 “(I) *IN GENERAL.*—Nothing in
 5 this subsection shall be construed to
 6 modify the requirements for the cre-
 7 ation, receipt, maintenance, or trans-
 8 mission of protected health information
 9 under the HIPAA privacy regulations.

10 “(II) *CIVIL RIGHTS LAWS.*—Noth-
 11 ing in this subsection shall be con-
 12 strued to affect the application of any
 13 Federal or State privacy or civil rights
 14 law, including the HIPAA privacy reg-
 15 ulations, the Genetic Information Non-
 16 discrimination Act of 2008 (Public
 17 Law 110–233) (including the amend-
 18 ments made by such Act), the Ameri-
 19 cans with Disabilities Act of 1990 (42
 20 U.S.C. 12101 et seq.), section 504 of
 21 the Rehabilitation Act of 1973 (29
 22 U.S.C. 794), section 1557 of the Pa-
 23 tient Protection and Affordable Care
 24 Act (42 U.S.C. 18116), title VI of the
 25 Civil Rights Act of 1964 (42 U.S.C.

1 2000d), and title VII of the Civil
2 Rights Act of 1964 (42 U.S.C. 2000e).

3 “(iv) WRITTEN NOTICE.—Each plan
4 year, a Covered Service Provider shall pro-
5 vide to each participant or beneficiary writ-
6 ten notice informing the participant or ben-
7 eficiary of the requirement that Covered
8 Service Providers respond to requests to
9 submit information or data under para-
10 graph (1), as applicable, which may include
11 incorporating such notification in plan doc-
12 uments provided to the participant or bene-
13 ficiary, or providing individual notifica-
14 tion.

15 “(v) CLARIFICATION REGARDING PUB-
16 LIC DISCLOSURE OF INFORMATION.—Noth-
17 ing in this subsection shall prevent a Cov-
18 ered Service Provider from placing reason-
19 able restrictions on the public disclosure of
20 the information or data described in para-
21 graph (1), except that such Provider may
22 not restrict disclosure of such report to the
23 Department of Health and Human Services,
24 the Department of Labor, or the Depart-
25 ment of the Treasury.

1 “(vi) *LIMITATION.*—*This paragraph*
2 *shall not be construed to abridge or limit*
3 *the disclosure requirements under this sub-*
4 *section or to impose additional privacy or*
5 *security requirements on Covered Service*
6 *Providers or plan sponsors.*

7 “(C) *LIMITATION ON DISCLOSURE.*—*A*
8 *group health plan receiving information or data*
9 *under this subsection may disclose such informa-*
10 *tion only in a manner that is consistent with*
11 *HIPAA and the privacy and security regulations*
12 *promulgated thereunder, regardless of their direct*
13 *or indirect applicability to the plan or any enti-*
14 *ties that could be or are business associates. A*
15 *group health plan (and any business associate or*
16 *other entity acting on behalf of such plan) may*
17 *use such information or data only for purposes*
18 *of plan administration and may not sell, license,*
19 *or otherwise commercially exploit such informa-*
20 *tion or data or provide such information or data*
21 *to any third party that may take such action.*

22 “(D) *REQUIREMENTS OF INFORMATION.*—
23 *Information made available under this sub-*
24 *section shall conform to the following standards:*

1 “(i) *All claims from a healthcare pro-*
2 *vider shall be made to the group health plan*
3 *in accordance with transaction standards*
4 *adopted by regulation under HIPAA, as fol-*
5 *lows:*

6 “(I) *Institutional, professional,*
7 *and dental claims shall be in ASC*
8 *X12N 837D format or any subsequent*
9 *standard as established by the Sec-*
10 *retary.*

11 “(II) *Pharmacy claims shall be in*
12 *the National Council for Prescription*
13 *Drug Programs (NCPDP) format or*
14 *any subsequent standard as established*
15 *by the Secretary.*

16 “(III) *The files shall be unmodi-*
17 *fied copies of the files sent from the*
18 *provider, or, upon request, delivered in*
19 *a machine readable format. In the*
20 *event that paper claims are sent by the*
21 *provider, they shall be converted to the*
22 *appropriate standard electronic for-*
23 *mat. Files shall be accessible to the*
24 *plan at no cost to the group health*
25 *plan.*

1 “(ii) *All claim payment (or EFT, elec-*
2 *tronic funds transfer) and electronic remit-*
3 *tance advice (ERA) notices sent by a Cov-*
4 *ered Service Provider shall be made avail-*
5 *able to the group health plan as ASC X12N*
6 *835 files (or any other format as identified*
7 *by the Secretary) in accordance with stand-*
8 *ards adopted by regulation under HIPAA.*
9 *The files shall be unmodified copies of the*
10 *files sent by the Covered Service Provider to*
11 *the healthcare provider. Files shall be acces-*
12 *sible at no cost to the group health plan.*

13 “(iii) *The contractual terms containing*
14 *payment calculations and formulas, pricing*
15 *methodologies, and other information used*
16 *to determine the dollar value of reimburse-*
17 *ment, in a format as specified by the Sec-*
18 *retary.*

19 “(iv) *All non-claim costs shall be*
20 *itemized and made available to the group*
21 *health plan as requested through a web-*
22 *based portal, through an application pro-*
23 *gram interface (API), through a*
24 *downloadable Comma-Separated Value*
25 *(CSV) file, and, as appropriate, through*

1 *other downloadable machine-readable file*
2 *types.*

3 “(E) *IMPLEMENTATION.*—*The Secretary*
4 *shall implement this subsection through notice*
5 *and comment rulemaking in accordance with*
6 *section 553 of title 5, United States Code.*

7 “(F) *DEFINITIONS.*—

8 “(i) *IN GENERAL.*—*The provisions of*
9 *sections 408 and 410 of the Employee Re-*
10 *tirement Income Security Act of 1974 shall*
11 *apply with respect to terms used under this*
12 *subsection.*

13 “(ii) *SPECIFIED LARGE EMPLOYER.*—
14 *In this subsection, the term ‘specified large*
15 *employer’ means, in connection with a*
16 *group health plan (including group health*
17 *insurance coverage offered in connection*
18 *with such a plan) established or maintained*
19 *by a single employer, with respect to a cal-*
20 *endar year or a plan year, as applicable,*
21 *an employer who employed an average of at*
22 *least 50 employees on business days during*
23 *the preceding calendar year or plan year*
24 *and who employs at least 1 employee on the*
25 *first day of the calendar year or plan year.*

1 “(iii) *SPECIFIED LARGE PLAN.*—In
 2 *this subsection, the term ‘specified large*
 3 *plan’ means a group health plan (including*
 4 *group health insurance coverage offered in*
 5 *connection with such a plan) established or*
 6 *maintained by a plan sponsor described in*
 7 *clause (ii) or (iii) of section 3(16)(B) of the*
 8 *Employee Retirement Income Security Act*
 9 *of 1974 that had an average of at least 50*
 10 *participants on business days during the*
 11 *preceding calendar year or plan year, as*
 12 *applicable.”.*

13 (2) *CIVIL ENFORCEMENT.*—

14 (A) *CIVIL ENFORCEMENT.*—Subsection (c)
 15 *of section 502 of such Act (29 U.S.C. 1132) is*
 16 *amended by adding at the end the following new*
 17 *paragraph:*

18 “(13)(A) *In the case of an agreement between a*
 19 *group health plan (as defined in section 733(a)), the*
 20 *plan sponsor of such plan (as defined in section*
 21 *3(16)(B)), or the plan administrator of such plan (as*
 22 *defined in section 3(16)(A)) and a health care pro-*
 23 *vider (which, for purposes of this paragraph, includes*
 24 *a health care facility), network or association of pro-*
 25 *viders, service provider offering access to a network or*

1 *association of providers, third-party administrator,*
 2 *or pharmacy benefit manager, that violates the provi-*
 3 *sions of section 724(b), the Secretary may assess a*
 4 *civil penalty against such provider, network or asso-*
 5 *ciation, service provider offering access to a network*
 6 *or association of providers, third-party adminis-*
 7 *trator, pharmacy benefit manager, or other service*
 8 *provider in the amount of up to \$10,000 for each day*
 9 *during which such violation continues. Such penalty*
 10 *shall be in addition to other penalties as may be pre-*
 11 *scribed by law.*

12 *“(B) Nothing in subparagraph (A) shall be con-*
 13 *strued to permit the Secretary to regulate health care*
 14 *providers acting in their capacity as medical organi-*
 15 *zations furnishing items and services to patients.”.*

16 *(B) EXISTING PROVISIONS VOID.—Section*
 17 *410 of such Act (29 U.S.C. 1110) is amended by*
 18 *adding at the end the following:*

19 *“(c) Any provision in an agreement or instrument*
 20 *shall be void as against public policy if such provision—*

21 *“(1) unduly delays or limits a group health plan*
 22 *(as defined in section 733(a)), the plan sponsor of*
 23 *such plan (as defined in section 3(16)(B)), or the*
 24 *plan administrator of such plan (as defined in section*
 25 *3(16)(A)) from accessing the claims and encounter in-*

1 *formation or data described in section 724(b)(1)(B);*
 2 *or*

3 *“(2) violates the requirements of section*
 4 *408(b)(2)(C).”.*

5 (C) *TECHNICAL AMENDMENTS.—Section*
 6 *408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2))*
 7 *is amended—*

8 *(i) in clause (i), by striking “this*
 9 *clause” and inserting “this paragraph”;*
 10 *and*

11 *(ii) by adding at the end the following:*

12 *“(xi) A contract or arrangement shall*
 13 *not be reasonable under this subparagraph*
 14 *if it fails to comply with section 724(b).”.*

15 (b) *UPDATED ATTESTATION FOR PRICE AND QUALITY*
 16 *INFORMATION.—Section 2799A-9(a)(4) of the Public Health*
 17 *Service Act (42 U.S.C. 300gg-119(a)(4)) is amended to read*
 18 *as follows:*

19 “(4) *ATTESTATION.—*

20 “(A) *IN GENERAL.—Subject to subpara-*
 21 *graph (C), a group health plan or health insur-*
 22 *ance issuer offering group health insurance cov-*
 23 *erage shall annually submit to the Secretary an*
 24 *attestation that such plan or issuer of such cov-*
 25 *erage is in compliance with the requirements of*

1 *this subsection. Such attestation shall also in-*
 2 *clude a statement verifying that—*

3 *“(i) the information or data described*
 4 *under subparagraphs (A) and (B) of para-*
 5 *graph (1) is available upon request and*
 6 *provided to the group health plan, the plan*
 7 *sponsor, the plan administrator, or the*
 8 *business associate of such plan, or the*
 9 *issuer, as applicable, in a timely manner;*
 10 *and*

11 *“(ii) there are no terms in the agree-*
 12 *ment under such paragraph (1) that di-*
 13 *rectly or indirectly restrict or unduly delay*
 14 *a group health plan, the plan sponsor, the*
 15 *plan administrator, a business associate of*
 16 *such plan, or the issuer from auditing, re-*
 17 *viewing, or otherwise accessing such infor-*
 18 *mation.*

19 *“(B) LIMITATION ON SUBMISSION.—A*
 20 *group health plan or issuer offering group health*
 21 *insurance coverage may not enter into an agree-*
 22 *ment with a third-party administrator or other*
 23 *service provider to submit the attestation re-*
 24 *quired under subparagraph (A).*

1 “(C) *EXCEPTION.*—*In the case of a group*
2 *health plan or health insurance issuer offering*
3 *group health insurance coverage that is unable to*
4 *obtain the information or data needed to submit*
5 *the attestation required under subparagraph (A),*
6 *such plan or issuer may submit a written state-*
7 *ment in lieu of such attestation that includes—*

8 “(i) *an explanation of why such plan*
9 *or issuer was unsuccessful in obtaining such*
10 *information or data, including whether such*
11 *plan, the plan sponsor, or the plan admin-*
12 *istrator or issuer was limited or prevented*
13 *from auditing, reviewing, or otherwise ac-*
14 *cessing such information or data;*

15 “(ii) *a description of the efforts made*
16 *by the group health plan, the plan sponsor,*
17 *or the plan administrator to remove any*
18 *gag clause provisions from the agreement*
19 *under paragraph (1); and*

20 “(iii) *a description of any response by*
21 *the third-party administrator or other serv-*
22 *ice provider with respect to efforts to com-*
23 *ply with the attestation requirement under*
24 *subparagraph (A), including the name of*

1 the third-party administrator or other serv-
2 ice provider.”.

3 (c) *EFFECTIVE DATE.*—The amendments made by sub-
4 sections (a) and (b) shall apply with respect to a plan be-
5 ginning with the first plan year that begins on or after the
6 date that is 1 year after the date of enactment of this Act.

7 **SEC. 8. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
8 **VIDERS.**

9 (a) *PHSA AMENDMENT.*—Part D of title XXVII of the
10 Public Health Service Act (42 U.S.C. 300gg–111 et seq.),
11 as amended by section 6701(a) of the Consolidated Appro-
12 priations Act, 2026, is amended by adding at the end the
13 following:

14 **“SEC. 2799A–12. OVERSIGHT OF ADMINISTRATIVE SERVICE**
15 **PROVIDERS.**

16 “(a) *IN GENERAL.*—For plan years beginning on or
17 after January 1 of the year that begins on or after the date
18 that is 1 year after the date of enactment of the Patients
19 Deserve Price Tags Act, no agreement between a group
20 health plan that is offered by a specified large employer
21 or that is a specified large plan (as such terms are defined
22 in section 2799A–11(f)) or a health insurance issuer offer-
23 ing individual or group health coverage (that makes an elec-
24 tion subject to subsection (b)(5)) and a health insurance
25 issuer that is operating as a third-party administrator, a

1 *health care provider, network or association of providers,*
 2 *third-party administrator, service provider offering access*
 3 *to a network of providers, pharmacy benefit managers, or*
 4 *any other third party (each referred to in this section as*
 5 *a 'health plan service provider') is permissible if such agree-*
 6 *ment limits (or delays beyond the applicable reporting pe-*
 7 *riod described in subsection (b)(1)) the disclosure of infor-*
 8 *mation to such group health plans and health insurance*
 9 *issuers in a manner that prevents any health plan service*
 10 *provider from providing the information described in sub-*
 11 *section (b)).*

12 “(b) *REQUIRED DISCLOSURES.*—

13 “(1) *CONTENTS AND FREQUENCY.*—*With respect*
 14 *to plan years beginning on or after the date that is*
 15 *1 year after the date of enactment of this section, not*
 16 *less frequently than quarterly, a health plan service*
 17 *provider shall provide to the group health or the*
 18 *health insurance issuer offering individual or group*
 19 *health insurance coverage the following information*
 20 *at no cost to the plan or issuer:*

21 “(A) *The information described in section*
 22 2799A–9(a)(1)(B) (42 U.S.C. 300gg–

23 119(a)(1)(B)).

24 “(B) *Any contractual and subcontractual*
 25 *calculation methodologies, pricing or fee sched-*

1 *ules, or other formulae used to determine reim-*
2 *bursement amounts to providers and subcontrac-*
3 *tors, including methodologies, schedules, fee*
4 *structures, and any applied adjustments or*
5 *modifiers, with such information provided in a*
6 *manner sufficiently detailed to enable the group*
7 *health plan or issuer to accurately assess, verify,*
8 *and ensure compliance with the terms of any*
9 *contractual and subcontractual agreement gov-*
10 *erning the reimbursement amounts.*

11 *“(C) The total amount received or expected*
12 *to be received by the health plan service provider*
13 *or its subcontractors in provider or supplier re-*
14 *bates, fees, alternative discounts, and all other*
15 *remuneration including amounts held in escrow*
16 *or variance accounts that has been paid or is to*
17 *be paid for claims incurred and administrative*
18 *services including data sales or network pay-*
19 *ments.*

20 *“(D) The total amount paid or expected to*
21 *be paid by the health plan service provider to its*
22 *subcontractors in rebates, fees, contractual ar-*
23 *rangements, and all other remuneration for ad-*
24 *ministrative and other services.*

1 “(E) All payment data, calculation meth-
 2 odologies, and reconciliation information related
 3 to alternative compensation arrangements, in-
 4 cluding accountable care organizations, value-
 5 based programs, shared savings programs, incen-
 6 tive compensation, bundled payments, capitation
 7 arrangements, performance payments, and any
 8 other reimbursement or payment models, where
 9 the group health plan paid fees, incurred obliga-
 10 tions, or made payments in connection with the
 11 group health plan or issuer related to such ar-
 12 rangements.

13 “(F) Whether, with respect to a provider
 14 that files claims under such plan or coverage, the
 15 health plan service provider—

16 “(i) has an ownership or investment
 17 interest;

18 “(ii) has a controlling interest;

19 “(iii) is a management services organi-
 20 zation; or

21 “(iv) is a significant equity investor.

22 “(G) The name and business address for
 23 each person or entity that, with respect to the
 24 health plan service provider—

1 “(i) *has an ownership or investment*
 2 *interest;*

3 “(ii) *has a controlling interest; or*

4 “(iii) *is a significant equity investor.*

5 “(2) *MANNER OF PROVIDING INFORMATION OR*
 6 *DATA.—*

7 “(A) *IN GENERAL.—A health plan service*
 8 *provider shall provide information or data under*
 9 *paragraph (1) in a manner consistent with the*
 10 *privacy regulations promulgated under section*
 11 *13402(a) of the Health Information Technology*
 12 *for Economic and Clinical Health Act (42*
 13 *U.S.C. 17932(a)) and consistent with the pri-*
 14 *vacy regulations promulgated under the Health*
 15 *Insurance Portability and Accountability Act of*
 16 *1996 in part 160 and subparts A and E of part*
 17 *164 of title 45, Code of Federal Regulations (or*
 18 *successor regulations) (referred to in this para-*
 19 *graph as the ‘HIPAA privacy regulations’) and*
 20 *shall restrict the use and disclosure of such infor-*
 21 *mation according to such privacy regulations*
 22 *and such HIPAA privacy regulations.*

23 “(B) *ADDITIONAL REQUIREMENTS.—In car-*
 24 *rying out this subsection, a health plan service*
 25 *provider shall comply with section 164.504(f) of*

1 *title 45, Code of Federal Regulations (or a suc-*
 2 *cessor regulation).*

3 “(C) *RULE OF CONSTRUCTION.*—

4 “(i) *IN GENERAL.*—*Nothing in this*
 5 *subsection shall be construed to modify the*
 6 *requirements for the creation, receipt, main-*
 7 *tenance, or transmission of protected health*
 8 *information under the HIPAA privacy reg-*
 9 *ulations.*

10 “(ii) *CIVIL RIGHTS LAWS.*—*Nothing in*
 11 *this subsection shall be construed to affect*
 12 *the application of any Federal or State pri-*
 13 *vacy or civil rights law, including the*
 14 *HIPAA privacy regulations, the Genetic In-*
 15 *formation Nondiscrimination Act of 2008*
 16 *(Public Law 110–233) (including the*
 17 *amendments made by such Act), the Ameri-*
 18 *cans with Disabilities Act of 1990 (42*
 19 *U.S.C. 12101 et seq.), section 504 of the Re-*
 20 *habilitation Act of 1973 (29 U.S.C. 794),*
 21 *section 1557 of the Patient Protection and*
 22 *Affordable Care Act (42 U.S.C. 18116), title*
 23 *VI of the Civil Rights Act of 1964 (42*
 24 *U.S.C. 2000d), and title VII of the Civil*
 25 *Rights Act of 1964 (42 U.S.C. 2000e).*

1 “(D) *WRITTEN NOTICE.*—*Each plan year, a*
 2 *health plan service provider shall provide to each*
 3 *participant or beneficiary written notice inform-*
 4 *ing the participant or beneficiary of the require-*
 5 *ment for health plan service providers to submit*
 6 *information or data under paragraph (1), as ap-*
 7 *plicable, which may include incorporating such*
 8 *notification in plan documents provided to the*
 9 *participant or beneficiary, or providing indi-*
 10 *vidual notification.*

11 “(E) *CLARIFICATION REGARDING PUBLIC*
 12 *DISCLOSURE OF INFORMATION.*—*Nothing in this*
 13 *subsection shall prevent a health plan service*
 14 *provider from placing reasonable restrictions on*
 15 *the public disclosure of the information or data*
 16 *described in paragraph (1), except that such pro-*
 17 *vider may not restrict disclosures under sub-*
 18 *section (b)(1) to the Department of Health and*
 19 *Human Services, the Department of Labor, or*
 20 *the Department of the Treasury.*

21 “(F) *LIMITATION.*—*This paragraph shall*
 22 *not be construed to abridge or limit the disclo-*
 23 *sure requirements under this subsection or to im-*
 24 *pose additional privacy or security requirements*

1 *on health plan service providers or plan spon-*
 2 *sors.*

3 “(3) *DISCLOSURE AND REDISCLOSURE.*—

4 “(A) *IN GENERAL.*—A group health plan or
 5 *health insurance issuer offering individual or*
 6 *group coverage receiving information under*
 7 *paragraph (1) may disclose such information*
 8 *only—*

9 “(i) *to the entity from which the infor-*
 10 *mation was received or to that entity’s busi-*
 11 *ness associates as defined in section 160.103*
 12 *of title 45, Code of Federal Regulations (or*
 13 *successor regulations); or*

14 “(ii) *as permitted by the HIPAA Pri-*
 15 *vacancy Rule (45 C.F.R. part 160 and sub-*
 16 *parts A and E of part 164).*

17 “(B) *AVAILABILITY OF INFORMATION.*—*To*
 18 *the extent the information required by this sub-*
 19 *section is made available to the health insurance*
 20 *issuer offering group health insurance coverage,*
 21 *the health insurance issuer shall make such in-*
 22 *formation available, at the same time, in the*
 23 *same format, and at no cost, to the group health*
 24 *plan.*

1 “(C) *LIMITATION ON USE OF INFORMA-*
2 *TION.—A group health plan or health insurance*
3 *issuer (and any business associate or other entity*
4 *acting on behalf of such plan) may use informa-*
5 *tion or data under this paragraph only for pur-*
6 *poses of plan administration and may not sell,*
7 *license, or otherwise commercially exploit such*
8 *information or data or provide such information*
9 *or data to any third party that may take such*
10 *action.*

11 “(D) *RULE OF CONSTRUCTION.—Nothing in*
12 *this section shall be construed to prevent a group*
13 *health plan, a health insurance issuer, or a*
14 *health plan service provider providing services*
15 *with respect to such a plan, from placing reason-*
16 *able restrictions on the public disclosure of the*
17 *information described in paragraph (1), except*
18 *that such plan or entity may not restrict disclo-*
19 *sure of such information to the Department of*
20 *Health and Human Services, the Department of*
21 *Labor, the Department of the Treasury, or the*
22 *Comptroller General of the United States.*

23 “(E) *FAILURE TO PROVIDE.—The obligation*
24 *to provide information pursuant to this sub-*
25 *section shall exist notwithstanding the presence*

1 *of any formal data-sharing agreement between*
 2 *the parties. Failure to provide the required infor-*
 3 *mation as specified shall constitute a violation of*
 4 *this Act and the Secretary shall initiate enforce-*
 5 *ment action under section 2723(b) (42 U.S.C.*
 6 *300gg-22(b)) within 90 days of becoming aware*
 7 *of a violation of this section, except that nothing*
 8 *in this section shall be construed to limit the*
 9 *Secretary's existing authority under this Act.*

10 *“(4) DATA FORMAT STANDARDS.—All data and*
 11 *information provided pursuant to this subsection*
 12 *shall comply with the following standards:*

13 *“(A) All claims from a healthcare provider*
 14 *shall be made to the group health plan in accord-*
 15 *ance with standards adopted under HIPAA as*
 16 *described in subpart K of part 162 of title 45,*
 17 *Code of Federal Regulations, as follows:*

18 *“(i) Institutional, professional, and*
 19 *dental claims and adjustments to these*
 20 *claims shall be provided to the group health*
 21 *plan or health insurance issuer in the ASC*
 22 *X12N 837 format.*

23 *“(ii) Prescription drug claims shall be*
 24 *in the National Council for Prescription*
 25 *Drug Programs (NCPDP) format.*

1 “(iii) *The files shall be unmodified*
2 *copies of the files sent from the provider. In*
3 *the event that paper claims are sent by the*
4 *provider, they shall be converted to the ap-*
5 *propriate standard electronic format. Such*
6 *data shall be provided at no cost to the*
7 *group health plan.*

8 “(B) *All claim payment (or EFT, electronic*
9 *funds transfer) and electronic remittance advice*
10 *(ERA) information sent by a health plan service*
11 *provider shall be provided to the group health*
12 *plan or health insurance issuer in the ASC*
13 *X12N 835 format, in accordance with standards*
14 *and operating rules adopted under HIPAA at*
15 *subpart P of part 162 of title 45, Code of Federal*
16 *Regulations, unmodified from the form in which*
17 *it was transmitted to the healthcare provider.*
18 *Such information shall be provided at no cost to*
19 *the group health plan.*

20 “(C) *The Secretary may modify the stand-*
21 *ards set forth in this paragraph as necessary to*
22 *align with any changes adopted by the Secretary*
23 *pursuant to the authority provided under section*
24 *1173 of the Social Security Act (42 U.S.C.*
25 *1320d-2).*

1 “(5) *OPT-IN FOR HEALTH INSURANCE COV-*
 2 *ERAGE.*—*In the case of a health insurance issuer of-*
 3 *fering coverage in the individual or group market,*
 4 *such issuer may, on an annual basis, for plan years*
 5 *beginning on or after the effective date of this section,*
 6 *elect to require a health plan service provider to sub-*
 7 *mit to such issuer a report that includes all of the in-*
 8 *formation described in paragraph (1).*

9 “(c) *PROHIBITED CONTRACTUAL PROVISIONS.*—*Any*
 10 *provision in an agreement that unduly delays or limits a*
 11 *group health plan or issuer’s access to information described*
 12 *in this section or that restricts the format or timing of the*
 13 *provision of such information in a manner that is incon-*
 14 *sistent with the requirements of this section shall be prohib-*
 15 *ited and, if a group health plan or issuer enters into such*
 16 *agreement, shall be deemed void as against public policy.*

17 “(d) *REGULATIONS.*—*The Secretary shall implement*
 18 *this section through notice and comment rulemaking in ac-*
 19 *cordance with section 553 of title 5, United States Code.”.*

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

23 “(4) *ENFORCEMENT AUTHORITY RELATING TO*
 24 *HEALTH PLAN SERVICE PROVIDERS.*—*Notwith-*
 25 *standing any provisions to the contrary, the Sec-*

1 retary may assess a penalty against a health plan
 2 service provider, as defined in section 2799A-12(a)
 3 (42 U.S.C. 300gg-121(a)), of \$100,000 per day for
 4 each violation of such section, pursuant to substan-
 5 tially similar processes and procedures as those set
 6 forth in section 2723(b)(2)(D) through (G) (42 U.S.C.
 7 300gg-121(b)(2)(D) through (G)).”.

8 (c) *ERISA AMENDMENTS.*—

9 (1) *IN GENERAL.*—Section 502(c) of the Em-
 10 ployee Retirement Income Security Act of 1974 (29
 11 U.S.C. 1132(c)) is amended by adding at the end the
 12 following new paragraph:

13 “(14) The Secretary may assess a civil penalty
 14 against any person of \$100,000 per day for each vio-
 15 lation by any person of section 727.”.

16 (2) *TECHNICAL AMENDMENT.*—Paragraph (6) of
 17 section 502(a) of the Employee Retirement Income
 18 Security Act of 1974 (29 U.S.C. 1132(a)) is amended
 19 by striking “or (9)” and inserting “(9), (13), or
 20 (14)”.

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

22 The provisions of section 2718A of the Public Health
 23 Service Act (as added and amended by this Act) shall not
 24 be construed to supersede any provision of State law which
 25 establishes, implements, or continues in effect any require-

1 *ment or prohibition related to health care price trans-*
 2 *parency, including for hospitals, clinical diagnostic labora-*
 3 *tories, provider of specified imaging services, and ambula-*
 4 *tory surgical centers (as such terms are defined in section*
 5 *2718A(a) of the Public Health Service Act), except to the*
 6 *extent that such requirement or prohibition prevents the ap-*
 7 *plication of a requirement or prohibition of such sections*
 8 *(or such amendments). Nothing in this section shall be con-*
 9 *strued to affect group health plans established under the*
 10 *Employee Retirement Income Security Act of 1974, or alter*
 11 *the application of section 514 of such Act (29 U.S.C. 1144).*

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

13 *(a) ADVANCED EXPLANATION OF BENEFITS.—Section*
 14 *2799A–1(f) of the Public Health Service Act (42 U.S.C.*
 15 *300gg–111(f)) is amended—*

16 *(1) in paragraph (1)—*

17 *(A) by striking subparagraph (C) and in-*
 18 *serting the following:*

19 *“(C) A good faith estimate of the amount*
 20 *the plan or coverage 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.”; and

3 (B) by adding at the end the following

4 “(I) A notification that the recipient may
 5 be held harmless, in certain circumstances, if the
 6 information in the advanced explanation of ben-
 7 efits does not match the amount the recipient is
 8 billed.”; and

9 (2) by adding at the end the following

10 “(3) *HOLD HARMLESS.*—

11 “(A) *IN GENERAL.*—For plan years begin-
 12 ning on or after the date that is 1 year after the
 13 date on which the Secretary implements this sec-
 14 tion, a participant, beneficiary, or enrollee shall
 15 be held harmless for any amount that is substan-
 16 tially in excess (as defined by the Secretary in
 17 a manner consistent with the process described
 18 in section 2799B–7) of the estimate generated by
 19 the advanced explanation of benefits.

20 “(B) *NO PATIENT RESPONSIBILITY FOR EX-*
 21 *CESS CHARGES.*—A group health plan or a
 22 health insurance issuer in the group or indi-
 23 vidual market shall not hold a participant, bene-
 24 ficiary, or enrollee responsible for excess charges
 25 described in this paragraph if such excess is the

1 *result of coverage or payment determinations*
 2 *that differ from projections made in the ad-*
 3 *vanced explanation of benefits at the time such*
 4 *explanation was generated.*

5 “(C) *SUBSTANTIAL EXCESS.*—A partici-
 6 *pant, beneficiary, or enrollee shall not be held*
 7 *harmless for excess amounts if such amounts re-*
 8 *fect the cost of medically necessary items or*
 9 *services furnished based on unforeseen cir-*
 10 *cumstances that could not have reasonably been*
 11 *anticipated by the provider or facility at the*
 12 *time the good faith estimate was generated or by*
 13 *the plan or issuer at the time the advanced ex-*
 14 *planation of benefits was generated.”.*

15 (b) *GOOD FAITH ESTIMATES.*—Section 2799B–6 of the
 16 *Public Health Service Act (42 U.S.C. 300gg–136) is amend-*
 17 *ed—*

18 (1) *by striking “Each health care” and inserting*
 19 *the following:*

20 “(a) *IN GENERAL.*—*Each health care*”; and

21 (2) *by adding at the end the following:*

22 “(b) *HOLD HARMLESS.*—

23 “(1) *IN GENERAL.*—*For plan years beginning on*
 24 *or after the date that is 1 year after the date on which*
 25 *the Secretary implements section 2799A–1(f), if an*

1 *individual enrolled in a group health plan or health*
2 *insurance coverage (and seeks to have a claim for an*
3 *item or service submitted to such plan or coverage) is*
4 *responsible for any amount that is substantially in*
5 *excess (as defined by the Secretary in a manner con-*
6 *sistent the process described in section 2799B-7) of*
7 *the estimate generated in the advanced explanation of*
8 *benefits described in section 2799A-1(f) because the*
9 *final charges for items and services were substantially*
10 *in excess of the good faith estimate provided to the*
11 *plan or coverage under this section, a provider shall*
12 *not bill the patient for amounts substantially in ex-*
13 *cess of the advanced explanation of benefits.*

14 “(2) *SUBSTANTIAL EXCESS.—An individual seek-*
15 *ing to have a claim for an item or service covered by*
16 *a group health plan or health insurance coverage*
17 *shall not be held harmless for excess amounts if such*
18 *amounts reflect the cost of medically necessary items*
19 *or services furnished based on unforeseen cir-*
20 *cumstances that could not have reasonably been an-*
21 *ticipated by the provider or facility at the time the*
22 *good faith estimate was generated or by the plan or*
23 *issuer at the time the advanced explanation of bene-*
24 *fits was generated.”.*

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

4 “(g) *EXPLANATION OF BENEFITS.*—

5 “(1) *IN GENERAL.*—For plan years beginning on
 6 January 1 of the year that begins on or after the date
 7 that is 1 year after the date of enactment of the Pa-
 8 tients Deserve Price Tags Act, each group health plan,
 9 or a health insurance issuer offering group or indi-
 10 vidual health insurance coverage shall, within 45
 11 days of receiving the information necessary to decide
 12 a claim for payment (as defined by the Secretary) for
 13 an item or service under the plan or coverage for
 14 which liability under the plan or coverage has been
 15 determined, provide to the participant, beneficiary, or
 16 enrollee (through mail or electronic means, as re-
 17 quested by the participant, beneficiary, or enrollee) a
 18 notification (in clear and understandable language
 19 and utilizing substantially the same format as the ad-
 20 vanced explanation of benefits required by subsection
 21 (f) to enable comparison when an advanced expla-
 22 nation of benefits is provided) including the following:

23 “(A) Whether or not the provider or facility
 24 is a participating provider or a participating

1 *facility with respect to the plan or coverage with*
2 *respect to the furnishing of such item or service.*

3 “(B) *An itemized explanation of benefits*
4 *that includes the following:*

5 “(i) *A plain language description of*
6 *each item or service.*

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

11 “(iii) *The amount the plan or coverage*
12 *is responsible for paying for each item or*
13 *service.*

14 “(iv) *The amount of any cost-sharing*
15 *for which the participant, beneficiary, or*
16 *enrollee is responsible for each item or serv-*
17 *ice (as of the date of such notification).*

18 “(v) *The amount that the participant,*
19 *beneficiary, or enrollee has incurred toward*
20 *meeting the limit of the financial responsi-*
21 *bility (including with respect to deductibles*
22 *and out-of-pocket maximums) under the*
23 *plan or coverage (as of the date of such no-*
24 *tification).*

1 “(vi) *The type of site of each item or*
2 *service, including office, facility, or emer-*
3 *gency room.*

4 “(vii) *If applicable, a description of*
5 *any discrepancies that exist between the*
6 *services outlined in a patient’s advanced ex-*
7 *planation of benefits and the explanation of*
8 *benefits.*

9 “(viii) *The amount of any facility fee*
10 *or other patient charges that were added to*
11 *the final payment amount, together with a*
12 *plain language explanation of the fee, if ap-*
13 *plicable.*

14 “(C) *If the provider or facility is a partici-*
15 *pating provider or facility with respect to the*
16 *plan or coverage with respect to the furnishing*
17 *of such item or service, the contracted rate under*
18 *such plan or coverage for such item or service.*

19 “(D) *The charges submitted by the provider*
20 *or facility for each item or service.*

21 “(E) *Information pertaining to plan type,*
22 *as defined the Secretary.*

23 “(2) *FORMAT.—If applicable, the notification de-*
24 *scribed in paragraph (1) may be provided in conjunc-*
25 *tion with, or as part of, a notice of a claim deter-*

1 mination or other communication required by section
 2 2719(a) (42 U.S.C. 300gg–19(a)), or regulations
 3 thereunder.

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

7 **SEC. 11. TRANSPARENCY IN BILLING.**

8 (a) *IN GENERAL.*—Part E of title XXVII of the Public
 9 Health Service Act (42 U.S.C. 300gg–131 et seq.) is amend-
 10 ed by adding at the end the following:

11 **“SEC. 2799B–10. PATIENT ACCESS TO COMPLETE BILLING**
 12 **INFORMATION.**

13 “(a) *REQUIREMENTS.*—

14 “(1) *NOTICE OF RIGHT OF ACCESS TO ITEMIZED*
 15 *BILLS; IN GENERAL.*—A health care provider or health
 16 care facility that requests payment from an indi-
 17 vidual for providing a health care item or service to
 18 the patient shall include with such request a written
 19 notice of the individual’s right to request an itemized
 20 bill as part of the individual’s designated record set
 21 under section 164,524 of title 45, Code of Federal
 22 Regulations (or a successor regulation).

23 “(2) *REQUIRED INFORMATION.*—A notice under
 24 paragraph (1) shall provide—

1 “(A) a phone number and internet website
2 where an individual can make a request for ac-
3 cess to their itemized bill;

4 “(B) information about the availability of
5 language-assistance services for individuals with
6 limited English proficiency (LEP); and

7 “(C) information about the health care pro-
8 vider’s or health care facility’s charity care poli-
9 cies and instructions on how to apply for charity
10 care.

11 “(3) COLLECTIONS ACTIONS.—

12 “(A) IN GENERAL.—A health care provider
13 or health care facility shall not bill or take any
14 collections actions against an individual—

15 “(i) for any provided health care item
16 or service unless the health care provider or
17 health care facility has complied with para-
18 graph (1) or section 13405(e)(4) of the
19 HITECH Act; or

20 “(ii) with respect to any items or serv-
21 ices for which the amount appearing on an
22 itemized bill described above in paragraph
23 (1) exceeds the amount disclosed pursuant
24 to Federal health care price transparency
25 regulations, including part 180 of title 45,

1 *Code of Federal Regulations, or provided in*
 2 *a good faith estimate that complies with*
 3 *section 2799B-6 of this Act and section*
 4 *149.610 of title 45, Code of Federal Regula-*
 5 *tions, or another good faith estimate pro-*
 6 *vided by a health care entity covered under*
 7 *this section but not otherwise covered under*
 8 *such section 2799B-6, unless the provider or*
 9 *facility documents that the additional items*
 10 *or services were medically necessary due to*
 11 *unforeseen complications or a patient-initi-*
 12 *ated change, and could not reasonably have*
 13 *been anticipated.*

14 “(B) *PROVIDER REQUIREMENT.*—*If a pro-*
 15 *vider fails to provide a documentation as re-*
 16 *quired under subparagraph (A)(ii) in the case of*
 17 *items or services, the good faith estimate de-*
 18 *scribed in such subparagraph with respect to*
 19 *such items or services shall be binding.*

20 “(b) *FAILURE TO COMPLY.*—

21 “(1) *PENALTIES.*—*The Secretary shall impose*
 22 *penalties on any health care provider or health care*
 23 *facility that fails to comply with the requirements of*
 24 *this section in an amount not to exceed \$10,000 for*
 25 *each instance of failure to comply.*

1 “(2) *PRESUMPTION IN FAVOR OF INDIVIDUAL.*—

2 *If a health care provider or health care facility fails*
 3 *to comply with the requirements of this section, the*
 4 *presumption shall be that charges were substantially*
 5 *in excess of the good faith estimate, as set forth in sec-*
 6 *tion 2799B–6, for the purpose of any patient-provider*
 7 *dispute, including in accordance with section 2799B–*
 8 *7 and regulations promulgated thereunder.*

9 “(c) *REGULATIONS.*—*The Secretary shall implement*
 10 *this section through notice and comment rulemaking in ac-*
 11 *cordance with section 553 of title 5, United States Code.”.*

12 (b) *STANDARDS FOR ACCESSING ITEMIZED BILLS.*—
 13 *Section 13405(e) of the HITECH Act (42 U.S.C. 17935(e))*
 14 *is amended—*

15 (1) *in paragraph (2), by striking “and” at the*
 16 *end;*

17 (2) *in paragraph (3), by striking the period and*
 18 *inserting “; and”; and*

19 (3) *by adding at the end, the following:*

20 “(4) *if the individual makes a request only for*
 21 *an itemized copy of a bill for services provided, the*
 22 *covered entity or business associate shall—*

23 “(A) *make such protected health informa-*
 24 *tion available within 30 days of such request;*

1 “(B) not impose any fee for providing such
2 individual a copy of their information; and

3 “(C) include in such itemized bill, a plain
4 language description of each distinct health care
5 item or service, all applicable billing codes for
6 each distinct item or service, including modi-
7 fiers, using standard and commonly recognized
8 billing code sets, the price and billed amount, if
9 different, of each distinct item or service.”.

10 **SEC. 12. TECHNICAL AMENDMENTS.**

11 (a) *ERISA*.—Section 715(a)(1) of the *Employee Re-*
12 *tirement Income Security Act of 1974* (29 U.S.C.
13 1185d(a)(1)) is amended by inserting “and parts D and
14 E of the *Public Health Service Act* (as amended by the *Pa-*
15 *tients Deserve Price Tags Act*)” after “*Affordable Care*
16 *Act*)”.

17 (b) *INTERNAL REVENUE CODE*.—Section 9815(a)(1) of
18 the *Internal Revenue Code of 1986* is amended by inserting
19 “and parts D and E of the *Public Health Service Act* (as
20 amended by the *Patients Deserve Price Tags Act*)” after
21 “*Affordable Care Act*)”.

22 **SEC. 13. IMPLEMENTATION AND ENFORCEMENT FUNDING.**

23 (a) *APPROPRIATION FOR SECRETARY OF LABOR*.—
24 There are authorized to be appropriated, such sums as may
25 be necessary for fiscal year 2026, and each subsequent fiscal

1 *year, to enable the Secretary of Labor to carry out this Act*
2 *and the amendments made by this Act, including enforce-*
3 *ment activities.*

4 **(b) APPROPRIATION FOR THE SECRETARY OF HEALTH**
5 **AND HUMAN SERVICES.**—*There are authorized to be appro-*
6 *priated, such sums as may be necessary for fiscal year 2026,*
7 *and each subsequent fiscal year, to enable the Secretary of*
8 *Health and Human Services to carry out the amendments*
9 *made by this Act, including implementation and enforce-*
10 *ment activities.*

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119TH CONGRESS
2^D Session

S. 2355

A BILL

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

JULY 27, 2026

Reported with an amendment