119TH CONGRESS
1ST SESSION

S. 3389

To lower health care costs for Americans.

IN THE SENATE OF THE UNITED STATES

DECEMBER 9, 2025

Mr. MARSHALL introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To lower health care costs for Americans.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Lowering Health Care Costs for Americans Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—GENERAL PROVISIONS

SEC. 101. MINIMUM MONTHLY PREMIUM PAYMENTS.

(a) IN GENERAL.—Section 36B(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(4) LIMITATION.—Notwithstanding paragraphs (2) and (3), in no case shall the premium assistance amount with respect to any coverage month exceed the excess (if any) of the amount determined under paragraph (2)(A) over—

''(A) in the case of a taxpayer whose household income (expressed as a percent of the poverty line) is less than 200 percent, $10,

''(B) in the case of a taxpayer whose household income (expressed as a percent of the

poverty line) is not less than 200 percent, and less than 300 percent, $20,

"(C) in the case of a taxpayer whose household income (expressed as a percent of the poverty line) is not less than 300 percent, and less than 400 percent, $30, and

"(D) in the case of a taxpayer whose household income (expressed as a percent of the poverty line) is not less than 400 percent, $40.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 102. REQUIRING BIOMETRIC AND ID VERIFICATION.

Section 1411(b)(1) of Patient Protection and Affordable Care Act (42 U.S.C. 18081(b)(1)) is amended—

(1) in subparagraph (A), by striking "; and" and inserting a semicolon;

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following:

"(B) government-issued photo identification for each enrollee over the age of 18, and any other documentation as the Administrator

of the Centers for Medicare & Medicaid Services may require for purposes of enrollment verification; and''.

SEC. 103. FACILITATING ENROLLMENT IN AND PAYMENT INTO HEALTHCARE AFFORDABILITY ACCOUNTS.

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

(1) in subsection (b)(1)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following:

''(C) in the case of plan years beginning after December 31, 2026, and before January 1, 2032, facilitates enrollment in Healthcare Affordability Accounts described in section 223(i) of the Internal Revenue Code of 1986, for qualified individuals who purchase qualified health plans and are eligible for premium tax credits under section 36B; and'';

(2) by adding at the end of subsection (c) the following:

''(8) ENROLLMENT IN HEALTHCARE AFFORDABILITY ACCOUNTS.—The Secretary shall establish a procedure for notifying qualified individuals who purchase qualified health plans and who are eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 of the need to enroll in a Healthcare Affordability Account described in section 223(i) of such Code, in order to receive such credit, for plan years beginning after December 31, 2026, and before January 1, 2032.''; and

(3) in subsection (d)(4)(G), by inserting '', and, for plan years beginning after December 31, 2026, and before January 1, 2032, make available to any individual qualifying for such a tax credit, a link to the application on the website of the Department of the Treasury for enrollment in a Healthcare Affordability Account described in section 223(i) of the Internal Revenue Code of 1986'' before the semicolon at the end.

(b) PAYMENT OF PREMIUM TAX CREDITS INTO HEALTHCARE AFFORDABILITY ACCOUNTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended—

(1) in subsection (a)(3)—

(A) by striking ''the Secretary of the Treasury makes advance payments'' and inserting ''the Secretary of the Treasury—

''(A) except as provided in subparagraph (B), makes advance payments'';

(B) by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(B) in the case of a plan year beginning after December 31, 2026, and before January 1, 2032, makes advance payments—

''(i) of such premium tax credit into the Healthcare Affordability Account maintained under section 223(i) of the Internal Revenue Code of 1986 for each individual eligible for such credit; and

''(ii) of such cost-sharing reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such cost-sharing reductions.''; and

(2) in subsection (c)(2)—

(A) by striking ''The Secretary'' and inserting ''Except as provided in subparagraph (C), the Secretary''; and

(B) by adding at the end the following new subparagraph:

''(C) PAYMENT OF PREMIUM TAX CREDIT INTO HEALTHCARE AFFORDABILITY ACCOUNTS.—In the case of plan years beginning after December 31, 2026, and before January 1, 2031, the Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the Healthcare Affordability Account of the applicable individual on a monthly basis (or such other periodic basis as the Secretary may provide).''.

SEC. 104. HEALTHCARE AFFORDABILITY ACCOUNTS.

(a) IN GENERAL.—Section 223 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(i) HEALTHCARE AFFORDABILITY ACCOUNTS.—For purposes of this section—

''(1) IN GENERAL.—In the case of a Healthcare Affordability Account, this section shall be applied as provided in paragraphs (3) through (7).

''(2) HEALTHCARE AFFORDABILITY ACCOUNT.—The term 'Healthcare Affordability Account' means a health savings account, determined as provided in this subsection.

''(3) TREATMENT OF TRANSFERRED CONTRIBUTIONS.—Amounts transferred to a Healthcare Affordability Account pursuant to section 1412 of the Patient Protection and Affordable Care Act shall not be taken into account in determining the deduction allowed by subsection (a).

''(4) ACCOUNT MUST BE ONLY HSA OF INDIVIDUAL.—

''(A) IN GENERAL.—An individual who has a Healthcare Affordability Account shall not be treated as an eligible individual with respect to any health savings account other than such Healthcare Affordability Account.

''(B) ROLLOVER OF EXISTING ACCOUNT PERMITTED.—An individual on whose behalf a Healthcare Affordability Account is established may roll over the balance of any other health savings account of the individual to such

Healthcare Affordability Account according to the rules of subsection (f)(5).

''(5) NO ROLLOVERS PERMITTED.—Except as provided in paragraph (4)(B), subsection (f)(5) shall not apply and no amount shall be contributed from a Healthcare Affordability Account to any health savings account other than a Healthcare Affordability Account.

''(6) RESTRICTION ON USE OF AMOUNTS.—No amounts in a Healthcare Affordability Account may be used to pay for any—

''(A) gender transition procedures, or

''(B) abortion.

''(7) DEFINITIONS.—For purposes of paragraph (6)—

''(A) GENDER TRANSITION PROCEDURE.—

''(i) IN GENERAL.—The term 'gender transition procedure' means any hormonal or surgical intervention for the purpose of gender transition, including—

''(I) gonadotropin-releasing hormone (GnRH) agonists or other puberty-blocking or suppressing drugs to stop or delay normal puberty;

"(II) testosterone, estrogen, progesterone, or other androgens to an individual at doses that are supraphysiologic to what would normally be produced endogenously in a healthy individual of the same age and sex;

"(III) castration;

"(IV) orchiectomy;

"(V) scrotoplasty;

"(VI) implantation of erection or testicular prostheses;

"(VII) vasectomy;

"(VIII) hysterectomy;

"(IX) oophorectomy;

"(X) ovariectomy;

"(XI) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

"(XII) metoidioplasty;

"(XIII) penectomy;

"(XIV) phalloplasty;

"(XV) vaginoplasty;

"(XVI) clitoroplasty;

"(XVII) vaginectomy;

‘‘(XVIII) vulvoplasty;

‘‘(XIX) reduction thyrochondroplasty;

‘‘(XX) chondrolaryngoplasty;

‘‘(XXI) mastectomy;

‘‘(XXII) tubal ligation;

‘‘(XXIII) sterilization;

‘‘(XXIV) any plastic, cosmetic, or aesthetic surgery that feminizes or masculinizes the facial or other physiological features of an individual;

‘‘(XXV) any placement of chest implants to create feminine breasts;

‘‘(XXVI) any placement of fat or artificial implants in the gluteal region;

‘‘(XXVII) augmentation mammoplasty;

‘‘(XXVIII) liposuction;

‘‘(XXIX) lipofilling;

‘‘(XXX) voice surgery;

‘‘(XXXI) hair reconstruction;

‘‘(XXXII) pectoral implants; and

''(XXXIII) the removal of any otherwise healthy or non-diseased body part or tissue.

''(ii) EXCLUSIONS.—The term 'gender transition procedure' does not include the following when furnished to an individual by a health care provider with the consent of such individual or, if applicable, such individual's parents or legal guardian:

''(I) Services to individuals born with a medically verifiable disorder of sex development, including an individual with external sex characteristics that are irresolvably ambiguous, such as an individual born with 46 XX chromosomes with virilization, an individual born with 46 XY chromosomes with undervirilization, or an individual born having both ovarian and testicular tissue.

''(II) Services provided when a physician has otherwise diagnosed a disorder of sexual development in which the physician has determined through genetic or biochemical testing

that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a healthy individual of the same sex and age.

''(III) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of gender transition procedures, whether or not the gender transition procedure was performed in accordance with State and Federal law or whether or not funding for the gender transition procedure is permissible under this section.

''(IV) Any procedure undertaken because the individual suffers from a physical disorder, physical injury, or physical illness (but not mental, behavioral, or emotional distress or a mental, behavioral, or emotional disorder) that would, as certified by a physician, place the individual in imminent danger of death or impairment

of major bodily function, unless the procedure is performed.

''(V) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for a minor experiencing precocious puberty.

''(VI) Male circumcision.

''(B) GENDER TRANSITION.—The term 'gender transition' means the process in which an individual goes from identifying with or presenting as his or her sex to identifying with or presenting a self-proclaimed identity that does not correspond with or is different from his or her sex, and may be accompanied with social, legal, or physical changes.

''(C) SEX.—The term 'sex', when referring to an individual's sex, means to refer to either male or female, as biologically determined.

''(D) FEMALE.—The term 'female', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historical accident, or intentional or unintentional disruption, the reproductive system that at

some point produces, transports, and utilizes eggs for fertilization.

''(E) MALE.—The term 'male', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historical accident, or intentional or unintentional disruption, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.

''(F) ABORTION.—

''(i) IN GENERAL.—The term 'abortion' means—

''(I) drugs or procedures used with the primary intent to end the life of the human being in the womb,

''(II) pre-viable delivery not described in clause (ii), and

''(III) post-viable delivery with intentional death of the fetus.

''(ii) EXCLUSIONS.—Such term does not include—

''(I) separation of the mother and her embryo or fetus to prevent the mother's death or immediate irre-

versible bodily harm, which cannot be mitigated in any other way,

"(II) treatment of ectopic or molar pregnancy,

"(III) treatment of miscarriage, or

"(IV) any service described in clause (i) in the case of a pregnancy which is the result of an act of rape or incest.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2026.

SEC. 105. EXTENSION OF TEMPORARY ENHANCED PREMIUM CREDITS.

(a) IN GENERAL.—Clause (iii) of section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended—

(1) by striking "January 1, 2026" and inserting "January 1, 2032", and

(2) by striking "2025" in the heading and inserting "2031".

(b) HOUSEHOLD INCOME LIMITATION.—Section 36B(c)(1)(E) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''RULE FOR 2021 THROUGH 2025.—In the case of'' and inserting the following: ''RULES FOR 2021 THROUGH 2031.—

''(i) IN GENERAL.—In the case of'', and

(2) by adding at the end the following new clause:

''(ii) SPECIAL RULE FOR 2027 THROUGH 2031.—In the case of any taxable year beginning after December 31, 2026, and before January 1, 2032, subparagraph (A) shall be applied by substituting '700 percent' for '400 percent'.''.

(c) PHASEDOWN OF ENHANCED AMOUNTS.—Subparagraph (A) of section 36B(b)(3) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iv) PHASEDOWN OF ENHANCED AMOUNTS.—

''(I) IN GENERAL.—In the case of a taxable year beginning after December 31, 2027, the premium assistance amount determined under this subsection (without regard to this clause) shall be reduced by an amount

equal to the phasedown percentage of the enhanced amount.

''(II) ENHANCED AMOUNT.—For purposes of subclause (I), the term 'enhanced amount' means the excess, if any, of the premium assistance amount determined under this subsection (without regard to this clause) over the premium assistance amount which would be so determined if clause (iii) did not apply for the taxable year.

''(III) PHASEDOWN PERCENTAGE.—For purposes of subclause (I), the phasedown percentage is—

''(aa) 20 percent, in the case of a taxable year beginning after December 31, 2027, and before January 1, 2029,

''(bb) 40 percent, in the case of a taxable year beginning after December 31, 2028, and before January 1, 2030,

''(cc) 60 percent, in the case of a taxable year beginning after

December 31, 2029, and before January 1, 2031, and

"(dd) 80 percent, in the case of a taxable year beginning after December 31, 2030, and before January 1, 2032.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 106. SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.

(a) IN GENERAL.—Section 1303(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18023(b)) is amended—

(1) in paragraph (2)—

(A) by amending subparagraph (A) to read as follows:

"(A) PROHIBITION ON THE USE OF FEDERAL FUNDS.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the

amount (if any) of the advance payment of the reduction under section 1412).'';

(B) in subparagraph (B)(i)(I), by striking ''credits and cost-sharing reductions described in subparagraph (A)'' and inserting ''cost-sharing reductions described in subparagraph (A) and premium tax credits under section 36B of the Internal Revenue Code of 1986, and the amount, if any, of the advance payment of such credit under section 1412''; and

(2) by amending paragraph (3) to read as follows:

''(3) RULES RELATING TO NOTICE.—

''(A) NOTICE.—A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall, at the time of enrollment, provide notice to enrollees—

''(i) that the plan includes such coverage;

''(ii) the amount of the premium charged for such coverage; and

''(iii) that such amount is not eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986.

''(B) DISCLOSURES.—

''(i) IN GENERAL.—The issuer of a plan described in subparagraph (A) shall include the coverage of services described in paragraph (1)(B)(i) as part of the summary of benefits and coverage explanation for the plan, as applicable.

''(ii) COMPARATIVE INFORMATION.—If one or more plans described in subparagraph (A) are offered through an Exchange in a State, the Exchange shall include in any standardized format for presenting health benefits plan options to potential enrollees, comparative information on plan coverage of such services.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to plan years beginning after December 31, 2026.

SEC. 107. SPECIAL RULES RELATING TO CREDIT FOR PLANS COVERING ABORTION SERVICES.

(a) IN GENERAL.—Paragraph (3) of section 36B(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(F) SPECIAL RULE FOR ABORTION COVERAGE.—If a qualified health plan offers cov-

erage of abortion (as defined in section 223(i)(7)(F)), the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such coverage shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2026.

SEC. 108. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subclause (II) of section 6055(b)(1)(B)(iii) of the Internal Revenue Code of 1986 is amended to read as follows:

''(II) in the case of a qualified health plan—

''(aa) the amount of the plan premium,

''(bb) if the plan provided coverage of services described in subsection (b)(1) of section 1303 of the Patient Protection and Affordable Care Act, the amount of the plan premium attributable to

such coverage (calculated as described in subsection (b)(2)(B) of such section), and

''(cc) the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any premium tax credit under section 36B with respect to such coverage, and''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2026.

SEC. 109. EXCLUSION OF GENDER TRANSITION PROCEDURES FROM COVERAGE UNDER QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—Section 1301(a)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(1)) is amended—

(1) in subparagraph (B), by striking ''and'' after the semicolon;

(2) in subparagraph (C)(iv), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

"(D) does not provide coverage for gender transition procedures.".

(b) DEFINITION OF GENDER TRANSITION PROCEDURE.—Section 1301 of the Patient Protection and Affordable Care Act (42 U.S.C. 18021) is amended by adding at the end the following:

"(c) DEFINITIONS RELATING TO GENDER TRANSITION PROCEDURES.—

"(1) GENDER TRANSITION PROCEDURE.—

"(A) IN GENERAL.—For purposes of subsection (a)(1)(D), the term 'gender transition procedure' means any hormonal or surgical intervention for the purpose of gender transition, including—

"(i) gonadotropin-releasing hormone (GnRH) agonists or other puberty-blocking or suppressing drugs to stop or delay normal puberty;

"(ii) testosterone, estrogen, progesterone, or other androgens to an individual at doses that are supraphysiologic to what would normally be produced endogenously in a healthy individual of the same age and sex;

"(iii) castration;

"(iv) orchiectomy;

"(v) scrotoplasty;

"(vi) implantation of erection or testicular prostheses;

"(vii) vasectomy;

"(viii) hysterectomy;

"(ix) oophorectomy;

"(x) ovariectomy;

"(xi) reconstruction of the fixed part of the urethra with or without a metoidioplasty or a phalloplasty;

"(xii) metoidioplasty;

"(xiii) penectomy;

"(xiv) phalloplasty;

"(xv) vaginoplasty;

"(xvi) clitoroplasty;

"(xvii) vaginectomy;

"(xviii) vulvoplasty;

"(xix) reduction thyrochondroplasty;

"(xx) chondrolaryngoplasty;

"(xxi) mastectomy;

"(xxii) tubal ligation;

"(xxiii) sterilization;

"(xxiv) any plastic, cosmetic, or aesthetic surgery that feminizes or

masculinizes the facial or other physiological features of an individual;

"(xxv) any placement of chest implants to create feminine breasts;

"(xxvi) any placement of fat or artificial implants in the gluteal region;

"(xxvii) augmentation mammoplasty;

"(xxviii) liposuction;

"(xxix) lipofilling;

"(xxx) voice surgery;

"(xxxi) hair reconstruction;

"(xxxii) pectoral implants; and

"(xxxiii) the removal of any otherwise healthy or non-diseased body part or tissue.

"(B) EXCLUSIONS.—For purposes of subsection (a)(1)(D), the term 'gender transition procedure' does not include the following when furnished to an individual by a health care provider with the consent of such individual or, if applicable, such individual's parents or legal guardian:

"(i) Services to individuals born with a medically verifiable disorder of sex development, including an individual with exter-

nal sex characteristics that are irresolvably ambiguous, such as an individual born with 46 XX chromosomes with virilization, an individual born with 46 XY chromosomes with undervirilization, or an individual born having both ovarian and testicular tissue.

''(ii) Services provided when a physician has otherwise diagnosed a disorder of sexual development in which the physician has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action for a healthy individual of the same sex and age.

''(iii) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of gender transition procedures, whether or not the gender transition procedure was performed in accordance with State and Federal law or whether or not funding for the gender transition procedure is permissible under this section.

''(iv) Any procedure undertaken because the individual suffers from a physical disorder, physical injury, or physical illness (but not mental, behavioral, or emotional distress or a mental, behavioral, or emotional disorder) that would, as certified by a physician, place the individual in imminent danger of death or impairment of major bodily function, unless the procedure is performed.

''(v) Puberty suppression or blocking prescription drugs for the purpose of normalizing puberty for a minor experiencing precocious puberty.

''(vi) Male circumcision.

''(2) RELATED TERMS.—For purposes of paragraph (1):

''(A) FEMALE.—The term 'female', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historical accident, or intentional or unintentional disruption, the reproductive system that at some point produces, transports, and utilizes eggs for fertilization.

''(B) GENDER TRANSITION.—The term 'gender transition' means the process in which an individual goes from identifying with or presenting as his or her sex to identifying with or presenting a self-proclaimed identity that does not correspond with or is different from his or her sex, and may be accompanied with social, legal, or physical changes.

''(C) MALE.—The term 'male', when used to refer to a natural person, means an individual who naturally has, had, will have, or would have, but for a congenital anomaly, historical accident, or intentional or unintentional disruption, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.

''(D) SEX.—The term 'sex', when referring to an individual's sex, means to refer to either male or female, as biologically determined.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2026.

SEC. 110. FUNDING COST SHARING REDUCTION PAYMENTS.

Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by adding at the end the following new subsection:

''(h) FUNDING.—

''(1) IN GENERAL.—There are appropriated out of any monies in the Treasury not otherwise appropriated such sums as may be necessary for purposes of making payments under this section for plan years beginning on or after January 1, 2026.

''(2) LIMITATION.—

''(A) IN GENERAL.—The amounts appropriated under paragraph (1) may not be used for purposes of making payments under this section for a qualified health plan that provides health benefit coverage that includes coverage of abortion.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to payments for a qualified health plan that provides coverage of abortion only if necessary to save the life of the mother or if the pregnancy is a result of an act of rape or incest.''.

SEC. 111. WAIVERS FOR STATE INNOVATION.

(a) STREAMLINING THE STATE APPLICATION PROCESS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) in subsection (a)(1)(C), by striking ''the law'' and inserting ''a law or has in effect a certification''; and

(2) in subsection (b)(2)—

(A) in the paragraph heading, by inserting ''OR CERTIFY'' after ''LAW'';

(B) in subparagraph (A)—

(i) by striking ''A law'' and inserting the following:

''(i) LAWS.—A law''; and

(ii) by adding at the end the following:

''(ii) CERTIFICATIONS.—A certification described in this paragraph is a document, signed by the Governor of the State, that certifies that such Governor has the authority under existing Federal and State law to take action under this section, including implementation of the State plan under subsection (a)(1)(B).''; and

(C) in subparagraph (B)—

(i) in the subparagraph heading, by striking ''OF OPT OUT''; and

(ii) by striking ''may repeal a law'' and all that follows through the period at the end and inserting the following: ''may terminate the authority provided under the waiver with respect to the State by—

''(i) repealing a law described in subparagraph (A)(i); or

''(ii) terminating a certification described in subparagraph (A)(ii), through a certification for such termination signed by the Governor of the State.''.

(b) GIVING STATES MORE FUNDING FLEXIBILITY, TO ESTABLISH REINSURANCE, INVISIBLE HIGH-RISK POOLS, INSURANCE STABILITY FUNDS, AND OTHER PROGRAMS.—

(1) STATE GRANTS UNDER WAIVERS.—Section 1332(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)) is amended—

(A) in paragraph (3)—

(i) in the first sentence—

(I) by inserting ''or would qualify for a reduced portion of'' after ''would not qualify for'';

(II) by inserting ", or the State would not qualify for or would qualify for a reduced portion of basic health program funds under section 1331," after "subtitle E";

(III) by inserting ", or basic health program funds the State would have received," after "this title"; and

(IV) by inserting "or for implementing the basic health program established under section 1331" before the period;

(ii) in the second sentence, by inserting before the period ", and with respect to participation in the basic health program and funds provided to such other States under section 1331"; and

(iii) by adding after the second sentence the following: "A State may request that all of, or any portion of, such aggregate amount of such credits, reductions, or funds be paid to the State as described in the first sentence.";

(B) by redesignating paragraphs (4), (5), and (6) as paragraphs (5), (6), and (7), respectively; and

(C) by inserting after paragraph (3) the following:

''(4) FEDERAL FUNDING FOR INVISIBLE HIGH-RISK POOL AND REINSURANCE PROGRAMS.—

''(A) ALLOCATIONS.—Not later than 45 days after the date of enactment of the Lowering Health Care Costs for Americans Act, the Secretary, in consultation with the National Association of Insurance Commissioners, shall specify an allocation methodology for determining the amount of funds appropriated under section 2(a)(2)(B) of the Lowering Health Care Costs for Americans Act for a fiscal year to be allocated for each State for purposes of subparagraph (B) and section 2(a)(2)(C) of the Lowering Health Care Costs for Americans Act.

''(B) STATE GRANTS.—From amounts appropriated under section 2(a)(2)(B) of the Lowering Health Care Costs for Americans Act for a fiscal year, the Secretary shall award grants to States for each of fiscal years 2027 through 2030, in amounts determined in accordance

with the allocation methodology under subparagraph (A), for the following purposes:

"(i) For fiscal year 2027, for administrative costs of the State associated with preparing and submitting information described in subsection (a)(1)(B) that includes an invisible high-risk pool or reinsurance program that meets the requirements of subsection (g)(2), or costs associated with the establishment of such invisible high-risk pool or reinsurance program.

"(ii) For each of fiscal years 2028, 2029, and 2030, for the establishment or maintenance of invisible high-risk pools and reinsurance programs that meet the requirements of subsection (g)(2) and for which the State has received a waiver under this section.

"(C) BUDGET NEUTRALITY.—Funds awarded to a State under a grant awarded under subparagraph (B) shall not be taken into account for purposes of determining under paragraph (1) whether the State waiver is budget neutral, or determining under subsection

(b)(1) whether the State waiver increases the Federal deficit.''.

(2) APPROPRIATIONS.—

(A) IN GENERAL.—There are authorized to be appropriated, and there are appropriated, to the Secretary of Health and Human Services, for the purposes described in section 1332(a)(4)(B) of the Patient Protection and Affordable Care Act and subparagraph (C), out of any funds in the Treasury not otherwise appropriated—

(i) $500,000,000 for fiscal year 2027; and

(ii) $5,000,000,000 for each of fiscal years 2028, 2029, and 2030.

(B) AVAILABLE UNTIL EXPENDED.—Amounts appropriated under this paragraph shall remain available until expended.

(3) DEFAULT FEDERAL SAFEGUARD.—

(A) IN GENERAL.—For purposes of plan year 2026, in the case of a State that does not, by a date specified by the Secretary of Health and Human Services (referred to in this paragraph as the ''Secretary''), in consultation with the National Association of Insurance Commis-

sioners, have in effect a waiver under section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) that includes an invisible high-risk pool or reinsurance program that meets the requirements of subsection (g)(2) of such section 1332, the Secretary shall, from amounts appropriated under subparagraph (B), use the allocation determined for the State under subsection (a)(4)(B) of such section 1332 for plan year 2026 for the purpose described in clause (ii) for such State.

(B) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—The Secretary shall use any allocation for a State made pursuant to clause (i) to provide incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual market in such State by providing payments to such appropriate entities using payment parameters and a methodology determined by the Secretary.

(c) ENSURING PATIENT ACCESS TO MORE FLEXIBLE HEALTH PLANS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) in subsection (a)(1)(C), by striking ''subsection (b)(2)'' and inserting ''subsection (b)(3)''; and

(2) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (B), by striking ''at least as affordable'' and inserting ''of comparable affordability, including for low-income individuals, individuals with serious health needs, and other vulnerable populations,''; and

(ii) by amending subparagraph (D) to read as follows:

''(D)(i) will not increase the Federal deficit over the term of the waiver; and

''(ii) will not increase the Federal deficit over the term of the 10-year budget plan submitted under subsection (a)(1)(B)(ii).'';

(B) by redesignating paragraph (2) (as amended by paragraph (1)) as paragraph (3); and

(C) by inserting after paragraph (1) the following:

''(2) BUDGETARY EFFECT.—

"(A) IN GENERAL.—In determining whether a State plan submitted under subsection (a) meets the deficit neutrality requirements of paragraph (1)(D), the Secretary may take into consideration the direct budgetary effect of the provisions of such plan on sources of Federal funding other than the funding described in subsection (a)(3).

"(B) LIMITATION.—A determination made by the Secretary under subparagraph (A)—

"(i) shall not be construed to affect any waiver process or standards or terms and conditions in effect on the date of enactment of the Lowering Health Care Costs for Americans Act under title XI, XVIII, XIX, or XXI of the Social Security Act, or any other Federal law relating to the provision of health care items or services; and

"(ii) shall be made without regard to any changes in policy with respect to any waiver process or provision of health care items or services described in clause (i).".

(d) PROVIDING EXPEDITED APPROVAL OF STATE WAIVERS.—Section 1332(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(d)) is amended—

(1) in paragraph (1) by striking ''180'' and inserting ''120''; and

(2) by adding at the end the following:

''(3) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—With respect to any application under subsection (a)(1) submitted on or after the date of enactment of the Lowering Health Care Costs for Americans Act or any such application submitted prior to such date of enactment and under review by the Secretary on such date of enactment, the Secretary shall make a determination on such application, using the criteria for approval otherwise applicable under this section, not later than 45 days after the receipt of such application, and shall allow the public notice and comment at the State and Federal levels described under subsection (a)(5) to occur concurrently if such State application—

''(i) is submitted in response to an urgent situation, with respect to areas in the State that the Secretary determines are at

risk for excessive premium increases or having no health plans offered in the applicable health insurance market for the current or following plan year;

''(ii) is for a waiver that is the same or substantially similar to a waiver that the Secretary already has approved for another State; or

''(iii) is for a waiver that includes an invisible high-risk pool or reinsurance program described in subparagraph (A), (B), or (D) of subsection (g)(2).

''(B) APPROVAL.—

''(i) URGENT SITUATIONS.—

''(I) PROVISIONAL APPROVAL.—A waiver approved under the expedited determination process under subparagraph (A)(i) shall be in effect for a period of 3 years, unless the State requests a shorter duration.

''(II) FULL APPROVAL.—Subject to the requirements for approval otherwise applicable under this section, not later than 1 year before the expiration of a provisional waiver period

described in subclause (I) with respect to an application described in subparagraph (A)(i), the Secretary shall make a determination on whether to extend the approval of such waiver for the full term of the waiver requested by the State, for a total approval period not to exceed 6 years. The Secretary may request additional information as the Secretary determines appropriate to make such determination.

''(ii) APPROVAL OF SAME OR SIMILAR APPLICATIONS.—An approval of a waiver under subparagraph (A)(ii) shall be subject to the terms of subsection (e).

''(C) GAO STUDY.—Not later than 5 years after the date of enactment of the Lowering Health Care Costs for Americans Act, the Comptroller General of the United States shall conduct a review of all waivers approved pursuant to subparagraph (A)(ii) to evaluate whether such waivers met the requirements of subsection (b)(1) and whether the applications

should have qualified for such expedited process.''.

(e) PROVIDING CERTAINTY FOR STATE-BASED REFORMS.—Section 1332(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(e)) is amended by striking ''No waiver'' and all that follows through the period at the end and inserting the following: ''A waiver under this section—

''(1) shall be in effect for a period of 6 years unless the State requests a shorter duration;

''(2) may be renewed, subject to the State meeting the criteria for approval otherwise applicable under this section, for unlimited additional 6-year periods upon application by the State; and

''(3) may not be suspended or terminated, in whole or in part, by the Secretary at any time before the date of expiration of the waiver period (including any renewal period under paragraph (2)), unless the Secretary determines that the State materially failed to comply with the terms and conditions of the waiver.''.

(f) GUIDANCE AND REGULATIONS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052) is amended—

(1) by adding at the end the following:

''(f) GUIDANCE AND REGULATIONS.—

''(1) IN GENERAL.—With respect to carrying out this section, the Secretary shall—

''(A) issue guidance, not later than 60 days after the date of enactment of the Lowering Health Care Costs for Americans Act, that includes initial examples of model State plans that meet the requirements for approval under this section; and

''(B) periodically review the guidance issued under subparagraph (A) and, when appropriate, issue additional examples of model State plans that meet the requirements for approval under this section, which may include—

''(i) State plans establishing reinsurance or invisible high-risk pool arrangements for purposes of covering the cost of high-risk individuals;

''(ii) State plans expanding insurer participation, access to affordable health plans, network adequacy, and health plan options over the entire applicable health insurance market in the State;

''(iii) waivers encouraging or requiring health plans in such State to deploy value-

based insurance designs which structure enrollee cost-sharing and other health plan design elements to encourage enrollees to consume high-value clinical services;

''(iv) State plans allowing for significant variation in health plan benefit design; or

''(v) any other State plan as the Secretary determines appropriate.

''(2) RESCISSION OF PREVIOUS REGULATIONS AND GUIDANCE.—Beginning on the date of enactment of the Lowering Health Care Costs for Americans Act, the regulations promulgated and the guidance issued under this section prior to the date of enactment of the Lowering Health Care Costs for Americans Act shall have no force or effect.''; and

(2) in subsection (a)(5) (as redesignated by paragraph (2)(A)(ii))—

(A) in subparagraph (A), by inserting '', as applicable'' before the period; and

(B) in subparagraph (B), by striking ''Not later than 180 days after the date of enactment of this Act, the Secretary shall'' and inserting ''The Secretary may''.

(g) INVISIBLE HIGH-RISK POOLS AND REINSURANCE PROGRAMS.—Section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052), as amended by paragraph (6), is further amended by adding at the end the following:

''(g) INVISIBLE HIGH-RISK POOLS AND REINSURANCE PROGRAMS.—

''(1) FUNDING.—With respect to a State that has received a waiver under this section to establish an invisible high-risk pool or reinsurance program described in paragraph (2), the State may fund such program, in whole or in part, using one or both of the following:

''(A) Amounts received through a grant described in subsection (a)(4)(B).

''(B) All of, or a portion of, the payments made to the State as described in subsection (a)(3), consistent with the information the State provides under subsection (a)(1)(B).

''(2) PROGRAM DESIGN.—An invisible high-risk pool or reinsurance program described in this paragraph is a program that meets any of the following:

''(A) An invisible high-risk pool, as defined by the State, under which health insurance issuers, with respect to designated individuals

who experience higher than average health costs as determined by the State, and are enrolled in health insurance coverage offered in the individual market, cede risk to the pool, without affecting the premium paid by the designated individuals or their terms of coverage. With respect to such pool, the State, or an entity operating the pool on behalf of the State, shall establish—

''(i) the premium amount the ceding issuer shall pay to the reinsurance pool;

''(ii) the applicable attachment points or coinsurance percentages if the ceding issuer retains any portion of the risk under ceded policies; and

''(iii) the mechanism by which high-risk individuals are designated for cession to the pool, which may include a list of designated high-cost health conditions.

''(B) A reinsurance program, as defined by the State, that assumes a portion of the risk for individuals who experience higher than average health costs, as determined by the State, in a manner substantially similar to the reinsurance

program that operated in the State in accordance with section 1341.

"(C) A reinsurance program established by the State not otherwise described in this paragraph.

"(D) A program based on another State's reinsurance program—

"(i) described in subparagraph (A), (B), or (C), for which an application has been approved under this subsection; or

"(ii) which was implemented prior to September 1, 2025, and which the Secretary determines meets the requirements of subparagraph (A).".

(h) APPLICABILITY.—The amendments made by this Act to section 1332 of the Patient Protection and Affordable Care Act (42 U.S.C. 18052)—

(1) with respect to applications for waivers under such section 1332 submitted after the date of enactment of this Act and applications for such waivers submitted prior to such date of enactment and under review by the Secretary on the date of enactment, shall take effect on the date of enactment of this Act; and

(2) with respect to applications for waivers approved under such section 1332 before the date of enactment of this Act, shall not require reconsideration of whether such applications meet the requirements of such section 1332, except that, at the request of a State, the Secretary shall recalculate the amount of funding provided under subsection (a)(3) of such section.

(i) CLARIFYING BUDGET NEUTRALITY.—Section 1332(a)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18052(a)(1)(B)) is amended—

(1) in clause (i), by inserting ", including, as applicable, a description of the State's plan to use any amounts awarded to the State under paragraph (4) to support an invisible high-risk pool or reinsurance program consistent with subsection (g) and such information about such program as the Secretary may require" before the semicolon; and

(2) in clause (ii), by inserting "over both the term of the proposed waiver and the term of the 10-year budget plan" after "Government".

TITLE II—HOSPITAL TRANSPARENCY REQUIREMENTS

SEC. 201. STRENGTHENING HOSPITAL PRICE TRANSPARENCY REQUIREMENTS.

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

''(e) STANDARD HOSPITAL CHARGES.—

''(1) IN GENERAL.—

''(A) DISCLOSURE OF STANDARD CHARGES.—Each hospital shall, in accordance with a method and format established by the Secretary under subparagraph (C), on a monthly basis compile and make public (without subscription and free of charge)—

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

''(ii) hospital standard charge information, including the information described in subparagraph (B), in a consumer-friendly format (as specified by the Secretary), that includes—

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

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

"(B) STANDARD CHARGES DESCRIBED.—For purposes of subparagraph (A), standard charges means:

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

fiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

''(ii) The gross charge, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

''(iii) The discounted cash price expressed as a dollar amount, for each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the hospital from self-pay individuals for such item or service, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the hos-

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

''(iv) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the hospital 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 charge.

''(v) The de-identified maximum and minimum negotiated charges for each such

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

''(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2026, the Secretary shall establish a standard, uniform method and format for hospitals to use in compiling and making public standard charges pursuant to subparagraph (A)(i) and a standard, uniform method and format for such hospitals to use in compiling and making public prices pursuant to

subparagraph (A)(ii). Such methods and formats shall—

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

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

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

"(2) NO DEEMED COMPLIANCE.—The availability of a price estimator tool shall not be considered to deem compliance with or otherwise vitiate the requirements of paragraph (1)(A)(ii) or any other requirements of this section. Furthermore, the use of an estimator tool shall not be used for purposes of compliance with any provisions in this Section.

"(3) MONITORING COMPLIANCE.—The Secretary shall, in consultation with the Inspector General 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.—

"(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of law, a hospital that has received a request for a corrective action plan under subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 45 days after such request is made shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

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

"(II) in the case of a hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day

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

''(III) in the case of a hospital with more than 100 beds but fewer than 301 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a hospital with more than 300 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

''(V) in the case of a hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period

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

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase—

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

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

''(III) the limitation on the increase of any penalty applied under clause (iii) pursuant to the amounts specified in subclause (II) of such clause.

''(iii) PERSISTENT NONCOMPLIANCE.—

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

fully noncompliant with the provisions of this subsection two or more times during a 1-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

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

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

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

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

"(iv) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary may, to the extent practicable, provide technical assistance relating to compliance with the provisions of this section to hospitals requesting such assistance.

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

"(C) NO WAIVER.—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) DEFINITIONS.—For purposes of this subsection:

''(A) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the minimum charge, exclusive of any hospital or third-party payer assistance, that the hospital accepts from an individual who pays cash, or cash equivalent, for a hospital-furnished item or service, without regard to patient coverage, as payment in full.

''(B) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.

''(C) HOSPITAL.—The term 'hospital' means a hospital (as defined in section 1861(e) of the Social Security Act), a critical access hospital (as defined in section 1861(mmm)(1) of the Social Security Act), or a rural emergency hospital (as defined in section 1861(kkk) of the Social Security Act), together with any parent, subsidiary, or other affiliated provider 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) IN GENERAL.—The amendment made by subsection (a) shall apply beginning January 1, 2026.

(2) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendment made by this section may be construed as affecting the applicability of the regulations codified at part 180 of title 45, Code of Federal Regulations, before January 1, 2026.

(c) CONTINUED APPLICABILITY OF STATE LAW.—The provisions of this title shall not supersede any provision of State law that establishes, implements, or continues in effect any requirement or prohibition related to health care price transparency, except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of this title.

SEC. 202. INCREASING PRICE TRANSPARENCY OF CLINICAL DIAGNOSTIC LABORATORY TESTS.

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

"(f) CLINICAL DIAGNOSTIC LABORATORY PRICE TRANSPARENCY.—

"(1) IN GENERAL.—Beginning July 1, 2027, an applicable laboratory shall—

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

''(B) ensure that such information is updated not less frequently than monthly, if there have been any changes to such information.

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to an applicable laboratory and a specified clinical diagnostic laboratory test, the following:

''(A) A plain language description of each item or service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

''(B) The gross charge expressed as a dollar amount, for each such item or service.

"(C) The discounted cash price expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the laboratory from self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the laboratory's charity care policy). The laboratory shall accept the discounted or minimum cash price as payment in full from any patient that chooses to pay in cash without regard to the patient's coverage.

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

the clinical diagnostic laboratory 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 charge.

''(E) The de-identified maximum and minimum negotiated charges for each such item or service, expressed as a non-zero dollar amount.

''(F) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

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

tablish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format shall—

"(A) include a machine-readable spreadsheet format containing the information described in paragraph (2) for all items and services furnished by each laboratory;

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

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

"(4) INCLUSION OF ANCILLARY SERVICES.—Any price or rate for a specified clinical diagnostic laboratory test available to be furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the price or rate for any ancillary item or service (including specimen collection services, specimen transport, centrifugation, aliquoting, labeling, requisition processing, and standard result reporting services) that would customarily and routinely be furnished by

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

''(5) ENFORCEMENT.—

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

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

''(ii) if such laboratory continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent, the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such laboratory was failing to comply with such paragraph) during which such failure is ongoing.

''(B) INCREASE AUTHORITY.—In applying this paragraph with respect to violations occurring in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (A)(ii).

''(C) 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 paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

''(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 applicable laboratories requesting such assistance.

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

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' means a 'laboratory' as such term is defined in section 493.2, of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by a hospital pursuant to subsection (e) of this section.

"(B) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

"(C) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on an applicable laboratory's chargemaster, absent any discounts.

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

"(E) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—The term 'specified clinical diagnostic laboratory test' means a clinical diagnostic laboratory test that is included on the list of shoppable services specified by the Centers for Medicare & Medicaid Services (as described in subsection (e) of this section), other than such a test that is only available to be furnished by a single provider of services or supplier.

"(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.

''(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. 203. IMAGING TRANSPARENCY.

Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended by section 202, 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

''(B) ensure that such information is updated not less frequently than annually.

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to a provider of services or supplier and a specified imaging service, the following:

''(A) A plain language description of each item or service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

''(B) The gross charge expressed as a dollar amount, for each such item or service.

''(C) The discounted cash price expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the provider of services or supplier from self-pay individuals for such item or service when provided in such settings

for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the provider of services or supplier's charity care policy). The provider of services or supplier shall accept the discounted or minimum cash price as payment in full from any patient that chooses to pay in cash without regard to the patient's coverage.

''(D) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the provider or supplier 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 re-

quired to determine and disclose the negotiated charge.

"(E) The de-identified maximum and minimum negotiated charges for each such item or service, expressed as a non-zero dollar amount.

"(F) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

"(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2027, the Secretary shall establish a standard, uniform method and format for providers of services and suppliers to use in making public information described in paragraph (2). Any such method and format shall—

''(A) include a machine-readable spreadsheet format containing the information described in paragraph (2) for all items and services furnished by each provider of services and supplier described in paragraph (1);

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

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

''(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection.

''(5) ENFORCEMENT.—

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

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

such provider or supplier of such determination;

''(ii) upon request of the Secretary, such provider or supplier shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such paragraph; and

''(iii) if such provider or supplier continues to fail to comply with such paragraph after the date that is 90 days after such notification is sent (or, in the case of such a provider or supplier that has submitted a corrective action plan described in clause (ii) in response to a request so described, after the date that is 90 days after such submission), the Secretary may impose a civil monetary penalty in an amount not to exceed $300 for each day (beginning with the day on which the Secretary first determined that such provider or supplier was failing to comply with such paragraph) during which such failure to comply or failure to submit is ongoing.

"(B) INCREASE AUTHORITY.—In applying this paragraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the amount of the civil monetary penalty under subparagraph (A)(iii).

"(C) 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 paragraph in the same manner as such provisions apply to a civil monetary penalty imposed under subsection (a) of such section.

"(D) 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.

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

''(F) CLARIFICATION OF NONAPPLICABILITY OF OTHER ENFORCEMENT PROVISIONS.—Notwithstanding any other provision of this title, this paragraph shall be the sole means of enforcing the provisions of this subsection.

''(6) SPECIFIED IMAGING SERVICE DEFINED.—The term 'specified imaging service' means an imaging service that is a Centers for Medicare & Medicaid Services-specified shoppable service (as described in subsection (e)).

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

SEC. 204. AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY REQUIREMENTS.

Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended by section 203, is further amended by adding at the end the following:

''(h) AMBULATORY SURGERY CENTER TRANSPARENCY.—

''(1) IN GENERAL.—Beginning July 1, 2027, 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 (e) that are furnished by such surgical center, and as

many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

''(iii) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service (as described in clause (ii)) that is not furnished by the ambulatory surgical center, an indication that such service is not so furnished.

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

''(i) A description of each item or service, accompanied by the Healthcare Common Procedure Coding System code, the national drug code, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

''(ii) The gross charge, expressed as a dollar amount, for each such item or service.

''(iii) The discounted cash price, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the specified ambulatory surgical center from self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the provider of services or supplier's charity care policy). The specified ambulatory surgical center shall accept the discounted cash price as payment in full from any patient that chooses to pay in cash without regard to the patient's coverage.

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

clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the ambulatory surgical center 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 charge.

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

''(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is

duplicative of any other reporting requirement under this subsection.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2027, the Secretary shall establish a standard, uniform method and format for specified ambulatory surgical centers to use in making public standard charges pursuant to subparagraph (A)(i) and a standard, uniform method and format for such centers to use in making public prices pursuant to subparagraph (A)(ii). Any such method and format shall—

''(i) in the case of such charges made public by an ambulatory surgical center, ensure that such charges are made available in a machine-readable format;

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

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

''(3) NO DEEMED COMPLIANCE.—The availability of a price estimator tool shall not be consid-

ered to deem compliance with or otherwise vitiate the requirements of this subsection (aa). Furthermore, the use of an estimator tool shall not be used for purposes of compliance with any provisions in this subsection.

''(4) MONITORING COMPLIANCE.—The Secretary shall, in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each specified ambulatory surgical center's compliance with this subsection is reviewed not less frequently than once every year.

''(5) 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, the 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 an ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure is ongoing (not to exceed $300 per day).

''(ii) INCREASE AUTHORITY.—In applying 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.

"(7) DEFINITIONS.—For purposes of this section:

"(A) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for a item or service furnished by an ambulatory surgical center.

"(B) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on a specified surgical center's chargemaster, absent any discounts.

"(C) GROUP HEALTH PLAN; GROUP HEALTH INSURANCE COVERAGE; INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms 'group health plan', 'group health insurance coverage', and 'individual health insurance coverage' have the meaning given such terms in section 2791 of the Public Health Service Act.

"(D) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that a specified surgical center 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) SPECIFIED AMBULATORY SURGICAL CENTER.—The term 'specified ambulatory surgical center' means an ambulatory surgical center with respect to which a hospital (or any person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in a hospital) is a person with an ownership or control interest (as so defined).

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

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

SEC. 205. STRENGTHENING HEALTH COVERAGE TRANSPARENCY REQUIREMENTS.

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

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

''(i) IN GENERAL.—The Exchange'';

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

(A) by striking ''participating provider'' and inserting ''provider'';

(B) by inserting ''shall include the information specified in clause (ii) and'' after ''such information'';

(C) by striking ''an Internet website'' and inserting ''a self-service tool that meets the requirements of clause (iii)''; and

(D) by striking ''and such other'' and all that follows through the period and inserting ''or, at the option such individual, through a paper or phone disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.''; and

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

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

''(I) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subparagraph (F)) for such item or service.

''(II) If such provider is not described in subclause (I), the maximum allowed dollar amount for such item or service.

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

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

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

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

''(iii) SELF-SERVICE TOOL.—For purposes 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);

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

''(aa) the billing code for such item or service; or

''(bb) through use of a descriptive term for such item or service to produce a list of billing code options from which the individual selects to indicate the subject matter items or services; and

''(VI) holds a member harmless for the amount of any difference in excess of the amount of the individual's responsibility generated by the self-service tool and the amount ultimately billed or charged to the individual.''.

(b) DISCLOSURE OF ADDITIONAL INFORMATION.—Section 1311(e)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)) is amended by adding at the end the following new subparagraphs:

''(E) RATE AND PAYMENT INFORMATION.—

"(i) IN GENERAL.—Not later than January 1, 2027, and every month thereafter, each health plan shall submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, the rate and payment information described in clause (ii) in accordance with clause (iii).

"(ii) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of clause (i), the rate and payment information described in this clause is, with respect to a health plan, the following:

"(I) With respect to each item or service for which benefits are available under such plan (expressed as a dollar amount), including prescription drugs, identified by CPT, HCPCS, DRG, NDC, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a brief description of the item or service, the in-network rate in effect as of the date of the submission 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.

"(II) 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.

''(bb) The historical net price paid by such plan (net of rebates, discounts, and price concessions) (expressed as a dollar amount) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that has submitted no claims for such drug to such plan.

''(III) With respect to each item or service for which benefits are available under such plan (expressed as a dollar amount), identified by CPT, DRG, HCPCS, NDC, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a brief de-

scription of the item or service, the amount billed or charged by the provider, and the amount allowed by the plan, for each such item or service furnished during the 90-day period beginning 180 days before such date of submission by each provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which no claims for such item or service were submitted to such plan during such period.

''(iii) MANNER OF SUBMISSION.—Rate and payment information required to be submitted and made available under this subparagraph shall be so submitted and so made available as follows:

''(I) Information shall be contained in 3 separate machine-readable files corresponding to the information described in each of subclauses (I) through (III) of clause (ii) that meet

such requirements as specified by the Secretary through rulemaking, in consultation with the Secretaries of Labor and the Treasury to apply comparable requirements to group health plans and to entities providing benefit management or other third-party administration services on a contractual basis with a group health plan.

''(II) Requirements specified by the Secretary through rulemaking shall ensure that:

''(aa) Such files are limited to an appropriate size, are made available in a widely available format that allows for information contained in such files to be compared across health plans, and are accessible to individuals at no cost and without the need to establish a user account or provider other credentials.

''(bb) The rates, amounts, and prices to be disclosed include contractual terms containing cal-

culation formulae, pricing methodologies, and other information necessary to determine the dollar value of reimbursement.

''(cc) Each such file includes each of the following data elements:

''(AA) A numerical identifier for the group health plan and/or health insurance issuer (such as a Health Insurance Oversight System identifier).

''(BB) A plain-language description of the item or service (including, for drugs, the proprietary and non-proprietary name assigned).

''(CC) The billing code, including any applicable modifiers, associated with such item or service, including the Healthcare Common Procedure Coding System code, diagnosis-related

group, national drug code, or other commonly recognized code set.

"(DD) The place of service code.

"(EE) The National Provider Identifier or provider Tax Identification Number.

"(III) The rate and payment information disclosed under subclauses (I) through (III) of clause (ii) shall be separately delineated for each item or service, regardless of whether such item or service is reimbursed as a part of a bundle, episode, or other grouping of items and services.

"(IV) An officer or executive of competent authority shall attest to the accuracy and completeness of information submitted and made available under this subparagraph. Such attestation shall be subject to enforcement under subparagraph (H) and, where applicable, shall be deemed material

to payments from the Federal Government received by the group health plan or health insurance issuer.

''(V) Regulations promulgated pursuant to this section shall provide that:

''(aa) 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.

''(bb) The Secretary of Labor shall audit the three machine-readable files required by subparagraph (E)(ii) posted by no fewer than 200 group health plans or service providers furnishing third-party administrator services to a group health plan.

''(cc) Findings, conclusions, and enforcement actions taken based on audits of the machine-readable files shall be reported annually to Congress no later

than July 1 of the calendar year during which the files were audited. Such report to Congress shall be accessible to the public.

''(iv) USER GUIDE.—Each health plan shall make available to the public instructions written in plain language explaining how individuals may search for information described in clause (ii) in files submitted in accordance with clause (iii).

''(F) DEFINITIONS.—In this paragraph:

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

''(ii) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service. If the rate is based on an algorithm, percentage of another amount, or other formula or criteria,

the health plan also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such 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

than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such health plan a notification of such determination, which shall include a request for a corrective action plan to comply with such requirements.

''(iii) CIVIL MONETARY PENALTY.—A health plan that has received a request for a corrective action plan under clause (ii) and fails to comply with the requirements of this subsection by the date that is 90 days after such request is made shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such laboratory was failing to comply with such paragraph) during which such failure was ongoing. Such amount shall not exceed $300 per member per day or $10,000,000, whichever is lesser.

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

cordance with section 553 of title 5, United States Code.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply beginning January 1, 2026.

(2) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by this section may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158), before January 1, 2026.

SEC. 206. INCREASING GROUP HEALTH PLAN ACCESS TO HEALTH DATA.

(a) GROUP HEALTH PLAN ACCESS TO INFORMATION.—

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

''(C) No contract or arrangement for services, and no extension or renewal of such contract or ar-

rangement, 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

"(II) determine the accuracy or reasonableness of payment; and

"(ii) does not—

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

''(II) limit the volume of claims and encounter information or data that the group health plan, the plan sponsor, the plan administrator, or a business associate of such plan may access during an audit or pursuant to any request for such information or data;

''(III) limit the disclosure of pricing terms for value-based payment arrangements or capitated payment arrangements, including—

''(aa) payment calculations and formulas;

''(bb) quality measures;

''(cc) contract terms;

''(dd) payment amounts;

''(ee) measurement periods for all incentives; and

''(ff) other payment methodologies used by an entity, including a health care provider (including 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;

''(IV) limit the disclosure of overpayments and overpayment recovery terms;

''(V) limit the right of the group health plan, the plan sponsor, or the plan administrator of such plan to select an auditor or define audit scope or frequency;

''(VI) otherwise limit or unduly delay the group health plan, the plan sponsor, the plan administrator, or a business associate of such plan from accessing claims and encounter information or data in a daily batch;

''(VII) limit the disclosure of fees charged to the group health plan related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees;

''(VIII) limit the right of the group health plan, the plan sponsor, or the plan

administrator to request action on any suspect claim payments; or

''(IX) limit public disclosure of de-identified or aggregate information.

''(D)(i) Covered Service Providers shall provide information or data under this paragraph in a manner consistent with the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act (referred to in this subparagraph as 'HIPAA').

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

''(iii) Nothing in this subparagraph shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulation (as defined in section 1180(b)(3) of the Social Security Act) as they apply directly or indirectly to an entity pursuant to this paragraph.

''(iv) This subparagraph shall not be read to abridge or limit the disclosure requirements under this paragraph or to impose additional privacy or se-

curity requirements on Covered Service Providers or plan sponsors.

''(E) A group health plan receiving information or data under this paragraph may disclose such information only in a manner that is consistent with the Health Insurance Portability and Accountability Act (HIPAA) and the privacy and security regulations promulgated thereunder, regardless of their direct or indirect applicability to the plan or any entities that could be or are business associates.

''(F) Information made available under this section shall conform to the following standards:

''(i) All claims from a healthcare provider shall be made to the group health plan in accordance with transaction standards adopted by regulation under HIPAA, as follows:

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

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

''(III) The files shall be unmodified copies of the files sent from the provider.

In the event that paper claims are sent by the provider, they shall be converted to the appropriate standard electronic format. Files shall be accessible to the plan at no cost to the group health plan.

''(ii) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) notices sent by a Covered Service Provider shall be made available to the group health plan as ASC X12N 835 files in accordance with standards 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 containing calculation formulae, pricing methodologies, and other information used to determine the dollar value of reimbursement.

''(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 subparagraphs (C) through (F) through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.''.

(2) CIVIL ENFORCEMENT.—Subsection (c) of section 502 of such Act (29 U.S.C. 1132) is amended 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:

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

''(1) unduly delays or limits 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)) from accessing the claims and encounter information or data described in section 724(a)(1)(B); or

''(2) violates the requirements of section 408(b)(2)(C).''.

(4) TECHNICAL AMENDMENT.—Clause (i) of section 408(b)(2)(B) of such Act is amended by striking ''this clause'' and inserting ''this paragraph''.

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

''(3) ATTESTATION.—

''(A) IN GENERAL.—Subject to subparagraph (C), a group health plan or health insur-

ance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection. Such attestation shall also include a statement verifying that—

"(i) the information or data described under subparagraphs (A) and (B) of paragraph (1) is available upon request and provided to the group health plan, the plan sponsor, the plan administrator, or the business associate of such plan, or the issuer in a timely manner; and

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

"(B) LIMITATION ON SUBMISSION.—Subject to clause (ii), a group health plan or issuer offering group health insurance coverage may not enter into an agreement with a third-party

administrator or other service provider to submit the attestation required under subparagraph (A).

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

''(i) an explanation of why such plan or issuer was unsuccessful in obtaining such information or data, including whether such plan, the plan sponsor, or the plan administrator or issuer was limited or prevented from auditing, reviewing, or otherwise accessing such information or data;

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

''(iii) a description of any response by the third-party administrator or other service provider with respect to efforts to com-

ply with the attestation requirement under subparagraph (A), including the name of the third-party administrator or other service provider.''.

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

SEC. 207. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

(a) ERISA AMENDMENTS.—

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

''SEC. 726. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of enactment of this section, no 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)), the plan administrator of such plan (as defined in section 3(16)(A)), or a business associate of such plan (as defined in section

160.103 of title 45, Code of Federal Regulations), (or health insurance issuer offering group health insurance coverage in connection with such a plan), and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from providing the information described in subsection (b).

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than quarterly, a health plan service provider shall provide to the group health plan or health insurance issuer the following information at no cost to the group health plan or health insurance issuer:

''(A) The information described in section 724(a)(1)(B).

''(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan or health insurance issuer to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

''(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider or to subcontractors in rebates, fees, contractual

arrangements, and all other remuneration that has been paid or is expected to be paid for administrative and other services.

''(E) All payment data and reconciliation information related to alternative compensation arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan or health insurance issuer paid fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—Health plan service providers shall provide the information or data under paragraph (1) consistent with the privacy, security, and breach notification regulations at parts 160 and 164 of title 45, Code of Federal Regulations, promulgated under subtitle F of the Health Insurance Portability and Accountability Act of 1996, subtitle D of the Health Information Technology for Clinical

Health Act of 2009, and section 1180 of the Social Security Act, and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations. An entity that receives a disclosure from a party in interest pursuant to subparagraph (B) or (C) shall comply with the privacy and security regulations promulgated under HIPAA.

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

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (45 CFR parts 160 and 164, subparts A and E).

''(3) DISCLOSURE AND REDISCLOSURE.—

"(A) IN GENERAL.—A group health plan receiving information under paragraph (1) may disclose such information only—

"(i) to the entity from which the information 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 CFR 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 be-

tween 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 of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under the Act.

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

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with transactions standards adopted under HIPAA, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be in ASC X12N 837 format, as transmitted by the provider, or, in the case of paper claims, converted to the ASC X12N 837 electronic format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format, as transmitted by the provider, or in the case

of paper claims, converted to the NCPDP electronic format.

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

"(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group health plan or health insurance issuer in the ASC X12N 835 format in accordance with transaction standards adopted under HIPAA, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan or health insurance issuer.

"(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary of Health and Human Services pursuant to the authority provided under section 1173 of the Social Security Act (42 U.S.C. 1320d–2).

"(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement between a group health plan, the plan sponsor, the plan administrator, or a business associate of such plan or a health insurance issuer and

a health plan service provider that unduly delays or limits a group health plan's or health insurance issuer's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a group health plan or health insurance issuer enters into such agreement, shall be deemed void as against public policy.

''(d) PENALTIES FOR NON-COMPLIANCE.—Any failure by a health plan service provider to comply with the requirements of this section shall result in the imposition of a civil penalty of $100,000 for each day the violation continues, in addition to any other penalties prescribed by law.

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

(2) PENALTY.—

(A) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)), as amended by section 206, is further amended by adding at the end the following new paragraph:

''(14) The Secretary may assess a civil penalty against any person of $100,000 per day for each violation by any person of section 726.''.

(B) TECHNICAL AMENDMENT.—Paragraph (6) of section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended by striking ''or (9)'' and inserting ''(9), (13), or (14)''.

(b) PHSA AMENDMENTS.—

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

''SEC. 2799A–11. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 1 year after the date of enactment of this section, no agreement between a group health plan that is a self-funded, non-Federal governmental plan, as defined in section 2791(d)(8)(C), and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to in this section as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period de-

scribed in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from providing the information described in subsection (b).

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 1 year after the date of enactment of this section, not less frequently than quarterly, a health plan service provider shall provide to the group health plan that is a self-funded, non-Federal governmental plan the following information at no cost to the plan:

''(A) The information described in section 2799A–9(a)(1)(B).

''(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan to accurately assess, verify, and ensure compliance with the terms of any contrac-

tual and subcontractual agreement governing the reimbursement amounts.

''(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider or to subcontractors in rebates, fees, contractual arrangements, and all other remuneration that has been paid or is expected to be paid for administrative and other services.

''(E) All payment data and reconciliation information related to alternative compensation arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan paid

fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—Health plan service providers shall provide the information or data under paragraph (1) consistent with the privacy, security, and breach notification regulations at parts 160 and 164 of title 45, Code of Federal Regulations, promulgated under subtitle F of the Health Insurance Portability and Accountability Act of 1996, subtitle D of the Health Information Technology for Clinical Health Act of 2009, and section 1180 of the Social Security Act, and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations. An entity that receives a disclosure from a party in interest pursuant to subparagraph (B) or (C) shall comply with the privacy and security regulations promulgated under HIPAA.

''(B) RESTRICTIONS.—A group health plan that is a self-funded, non-Federal governmental plan shall comply with section 164.504(f) of

title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (parts 160 and 164 of title 45, Code of Federal Regulations).

''(3) DISCLOSURE AND REDISCLOSURE.—

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

''(i) to the entity from which the information was received or to that entity'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 CFR parts 160 and 164, subparts A and E).

"(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan that is a self-funded, non-Federal governmental plan, or a health plan service provider providing services with respect to such a plan, from placing reasonable restrictions on the public disclosure of the information described in paragraph (1), except that such plan or entity may not restrict disclosure of such information to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or the Comptroller General of the United States.

"(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 2723(b) within 90 days of becoming aware of a violation of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under this Act.

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

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with standards adopted under HIPAA at section 162.1101 of title 45, Code of Federal Regulations, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be provided to the group health plan that is a self-funded, non-Federal governmental plan in the ASC X12N 837 format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format.

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

"(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group health plan or health insurance issuer in the ASC X12N 835 format, in accordance with standards adopted under HIPAA at section 162.1602 of title 45, Code of Federal Regulations, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan.

"(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary pursuant to the authority provided under section 1173 of the Social Security Act.

"(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement that unduly delays or limits a group health plan that is a self-funded, non-Federal governmental plan's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a self-funded, non-Federal governmental plan en-

ters into such agreement, shall be deemed void as against public policy.

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

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

''(4) ENFORCEMENT AUTHORITY RELATING TO HEALTH PLAN SERVICE PROVIDERS.—Notwithstanding any provisions to the contrary, the Secretary may assess a penalty against a health plan service provider, as defined in section 2799A–11(a), of $100,000 per day for each violation of such section, pursuant to substantially similar processes and procedures as those set forth in subparagraphs (D) through (G) of section 2723(b)(2).''.

SEC. 208. STATE PREEMPTION ONLY IN EVENT OF CONFLICT.

The provisions of sections 201 through 204 (including the amendments made by such sections) shall not supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition related to health care price transparency, including

hospital, clinical diagnostic laboratory tests, imaging services, and ambulatory surgical center, except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such sections (or amendment). Nothing in this section shall be construed to affect group health plans established under the Employee Retirement Income Security Act of 1974, or alter the application of section 514 of such Act (29 U.S.C. 1144).

SEC. 209. REQUIREMENT FOR EXPLANATION OF BENEFITS.

(a) PHSA AMENDMENTS.—

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

''(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain 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 2799A–1 of the Public Health Service Act (42 U.S.C. 300gg–111) 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 a health insurance issuer offering group or individual 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, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) 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 with respect to the furnishing of such item or service.

''(B) An itemized explanation of benefits that includes the following:

''(i) A plain language description of each item or service.

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

''(iii) The amount the plan or coverage is responsible for paying for each item or service.

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

''(v) The amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by sec-

tion 2719(a) (42 U.S.C. 300gg–19(a)), or regulations thereunder.

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

(b) IRC AMENDMENTS.—

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

''(C) A good faith estimate of the amount the plan is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain 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 9816 of the Internal Revenue Code of 1986 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

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 with respect to the furnishing of such item or service.

"(B) An itemized explanation of benefits that includes the following:

"(i) A plain language description of each item or service.

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

"(iii) The amount the plan is responsible for paying for each item or service.

"(iv) The amount of any cost-sharing for which the participant or beneficiary is

responsible for each item or service (as of the date of such notification).

''(v) The amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 503 of the Employee Retirement Income Security Act of 1974 or regulations thereunder.

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

(c) ERISA AMENDMENTS.—

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

''(C) A good faith estimate of the amount the health plan is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain 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 with respect to the furnishing of such item or service.

"(B) An itemized explanation of benefits that includes the following:

"(i) A plain language description of each item or service.

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

"(iii) The amount the plan or coverage is responsible for paying for each item or service.

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

"(v) The amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility (in-

cluding with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).

''(vi) The site of each item or service.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 503 or regulations thereunder.

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

SEC. 210. PROVISION OF ITEMIZED BILLS.

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

''SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED BILLS.

''(a) REQUIREMENTS.—

''(1) ITEMIZED BILL AND OTHER INFORMATION REQUIRED.—

''(A) IN GENERAL.—A health care provider or health care facility that requests payment

from an individual after providing a health care item or service to the patient shall include with such request a written, itemized bill of the cost of each reasonably expected item or service the health care provider or health care facility provided to the individual, including telehealth visits or visits by other electronic means. The health care provider or health care facility shall provide the itemized bill not later than 30 days after the health care provider or health care facility received a final payment on the provided service or supply from a third party.

''(B) REQUIRED INFORMATION.—For each item or service provided by the health care provider or facility or for which the health care provider or facility is billing the individual, the itemized bill must include—

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

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

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

''(iv) any payments made to the health care provider or health care facility by or on behalf of the individual (including payments by any health plan or insurance) for any health care item or service covered in the itemized bill;

''(v) information about the availability of language-assistance services for individuals with limited English proficiency (LEP);

''(vi) the identification of an office or individual at the health care provider or health care facility, including phone number and email address, that shall be able to discuss the specific details of the itemized statement and be authorized to make appropriate changes thereto; and

''(vii) information about the health care provider's or health care facility's charity care policies and instructions on how to apply for charity care.

''(2) COLLECTIONS ACTIONS.—

''(A) IN GENERAL.—A health care provider or health care facility shall not take any collections actions against an individual—

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

''(ii) with respect to any items or services for which the amount appearing on an itemized bill described above in paragraph (1) exceeds the amount disclosed pursuant to Federal health care price transparency regulations, including part 180 of title 45, Code of Federal Regulations, or provided in a good faith estimate that complies with section 2799B–6 of this Act and section 149.610 of title 45, Code of Federal Regulations, or another good faith estimate provided by a health care entity covered under this section but not otherwise covered

under such section 2799B–6 unless the provider or facility documents that the additional items or services were medically necessary due to unforeseen complications or a patient-initiated change, and could not reasonably have been anticipated.

''(B) BURDEN OF PROOF.—The burden of proof under subparagraph (A)(ii) shall rest with the provider, and absent the documentation described in such subparagraph, the good faith estimate shall be binding.

''(b) FAILURE TO COMPLY.—

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

''(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—If a health care provider or health care facility fails to comply with the requirements of this section, the presumption shall be that charges were substantially in excess of the good faith estimate (as set forth in section 2799B–6) for the purpose of any patient-provider dispute, including in accordance

with section 2799B–7 and regulations promulgated thereunder.

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

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