

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

A BILL

To lower health care costs for Americans.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents.

TITLE I—GENERAL PROVISIONS

Sec. 101. Minimum monthly premium payments.

Sec. 102. Requiring biometric and ID verification.

Sec. 103. Facilitating enrollment in and payment into Healthcare Affordability
Accounts.

Sec. 104. Healthcare Affordability Accounts.

Sec. 105. Extension of temporary enhanced premium credits.

- Sec. 106. Special rules relating to coverage of abortion services.
- Sec. 107. Special rules relating to credit for plans covering abortion services.
- Sec. 108. Reporting of health insurance coverage.
- Sec. 109. Exclusion of gender transition procedures from coverage under qualified health plans.
- Sec. 110. Funding cost sharing reduction payments.
- Sec. 111. Waivers for State innovation.

TITLE II—HOSPITAL TRANSPARENCY REQUIREMENTS

- Sec. 201. Strengthening hospital price transparency requirements.
- Sec. 202. Increasing price transparency of clinical diagnostic laboratory tests.
- Sec. 203. Imaging transparency.
- Sec. 204. Ambulatory surgical center price transparency requirements.
- Sec. 205. Strengthening health coverage transparency requirements.
- Sec. 206. Increasing group health plan access to health data.
- Sec. 207. Oversight of administrative service providers.
- Sec. 208. State preemption only in event of conflict.
- Sec. 209. Requirement for explanation of benefits.
- Sec. 210. Provision of itemized bills.

1 **TITLE I—GENERAL PROVISIONS**

2 **SEC. 101. MINIMUM MONTHLY PREMIUM PAYMENTS.**

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

6 “(4) LIMITATION.—Notwithstanding para-
 7 graphs (2) and (3), in no case shall the premium as-
 8 sistance amount with respect to any coverage month
 9 exceed the excess (if any) of the amount determined
 10 under paragraph (2)(A) over—

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

14 “(B) in the case of a taxpayer whose
 15 household income (expressed as a percent of the

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

3 “(C) in the case of a taxpayer whose
 4 household income (expressed as a percent of the
 5 poverty line) is not less than 300 percent, and
 6 less than 400 percent, \$30, and

7 “(D) in the case of a taxpayer whose
 8 household income (expressed as a percent of the
 9 poverty line) is not less than 400 percent,
 10 \$40.”.

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

14 **SEC. 102. REQUIRING BIOMETRIC AND ID VERIFICATION.**

15 Section 1411(b)(1) of Patient Protection and Afford-
 16 able Care Act (42 U.S.C. 18081(b)(1)) is amended—

17 (1) in subparagraph (A), by striking “; and”
 18 and inserting a semicolon;

19 (2) by redesignating subparagraph (B) as sub-
 20 paragraph (C); and

21 (3) by inserting after subparagraph (A) the fol-
 22 lowing:

23 “(B) government-issued photo identifica-
 24 tion for each enrollee over the age of 18, and
 25 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”;

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

3 “(8) ENROLLMENT IN HEALTHCARE AFFORD-
4 ABILITY ACCOUNTS.—The Secretary shall establish a
5 procedure for notifying qualified individuals who
6 purchase qualified health plans and who are eligible
7 for a premium tax credit under section 36B of the
8 Internal Revenue Code of 1986 of the need to enroll
9 in a Healthcare Affordability Account described in
10 section 223(i) of such Code, in order to receive such
11 credit, for plan years beginning after December 31,
12 2026, and before January 1, 2032.”; and

13 (3) in subsection (d)(4)(G), by inserting “, and,
14 for plan years beginning after December 31, 2026,
15 and before January 1, 2032, make available to any
16 individual qualifying for such a tax credit, a link to
17 the application on the website of the Department of
18 the Treasury for enrollment in a Healthcare Afford-
19 ability Account described in section 223(i) of the In-
20 ternal Revenue Code of 1986” before the semicolon
21 at the end.

22 (b) PAYMENT OF PREMIUM TAX CREDITS INTO
23 HEALTHCARE AFFORDABILITY ACCOUNTS.—Section
24 1412 of the Patient Protection and Affordable Care Act
25 (42 U.S.C. 18082) is amended—

1 (1) in subsection (a)(3)—

2 (A) by striking “the Secretary of the
3 Treasury makes advance payments” and insert-
4 ing “the Secretary of the Treasury—

5 “(A) except as provided in subparagraph
6 (B), makes advance payments”;

7 (B) by striking the period at the end and
8 inserting “, and”; and

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

11 “(B) in the case of a plan year beginning
12 after December 31, 2026, and before January
13 1, 2032, makes advance payments—

14 “(i) of such premium tax credit into
15 the Healthcare Affordability Account main-
16 tained under section 223(i) of the Internal
17 Revenue Code of 1986 for each individual
18 eligible for such credit; and

19 “(ii) of such cost-sharing reductions
20 to the issuers of the qualified health plans
21 in order to reduce the premiums payable
22 by individuals eligible for such cost-sharing
23 reductions.”; and

24 (2) in subsection (c)(2)—

1 (A) by striking “The Secretary” and in-
 2 serting “Except as provided in subparagraph
 3 (C), the Secretary”; and

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

6 “(C) PAYMENT OF PREMIUM TAX CREDIT
 7 INTO HEALTHCARE AFFORDABILITY AC-
 8 COUNTS.—In the case of plan years beginning
 9 after December 31, 2026, and before January
 10 1, 2031, the Secretary of the Treasury shall
 11 make the advance payment under this section
 12 of any premium tax credit allowed under section
 13 36B of the Internal Revenue Code of 1986 to
 14 the Healthcare Affordability Account of the ap-
 15 plicable individual on a monthly basis (or such
 16 other periodic basis as the Secretary may pro-
 17 vide).”.

18 **SEC. 104. HEALTHCARE AFFORDABILITY ACCOUNTS.**

19 (a) IN GENERAL.—Section 223 of the Internal Rev-
 20 enue Code of 1986 is amended by adding at the end the
 21 following new subsection:

22 “(i) HEALTHCARE AFFORDABILITY ACCOUNTS.—For
 23 purposes of this section—

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

4 “(2) HEALTHCARE AFFORDABILITY AC-
5 COUNT.—The term ‘Healthcare Affordability Ac-
6 count’ means a health savings account, determined
7 as provided in this subsection.

8 “(3) TREATMENT OF TRANSFERRED CONTRIBU-
9 TIONS.—Amounts transferred to a Healthcare Af-
10 fordability Account pursuant to section 1412 of the
11 Patient Protection and Affordable Care Act shall not
12 be taken into account in determining the deduction
13 allowed by subsection (a).

14 “(4) ACCOUNT MUST BE ONLY HSA OF INDIV-
15 VIDUAL.—

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

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

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

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

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

12 “(A) gender transition procedures, or

13 “(B) abortion.

14 “(7) DEFINITIONS.—For purposes of paragraph
 15 (6)—

16 “(A) GENDER TRANSITION PROCEDURE.—

17 “(i) IN GENERAL.—The term ‘gender
 18 transition procedure’ means any hormonal
 19 or surgical intervention for the purpose of
 20 gender transition, including—

21 “(I) gonadotropin-releasing hor-
 22 mone (GnRH) agonists or other pu-
 23 berty-blocking or suppressing drugs to
 24 stop or delay normal puberty;

- 1 “(II) testosterone, estrogen, pro-
- 2 gesterone, or other androgens to an
- 3 individual at doses that are
- 4 supraphysiologic to what would nor-
- 5 mally be produced endogenously in a
- 6 healthy individual of the same age
- 7 and sex;
- 8 “(III) castration;
- 9 “(IV) orchiectomy;
- 10 “(V) scrotoplasty;
- 11 “(VI) implantation of erection or
- 12 testicular prostheses;
- 13 “(VII) vasectomy;
- 14 “(VIII) hysterectomy;
- 15 “(IX) oophorectomy;
- 16 “(X) ovariectomy;
- 17 “(XI) reconstruction of the fixed
- 18 part of the urethra with or without a
- 19 metoidioplasty or a phalloplasty;
- 20 “(XII) metoidioplasty;
- 21 “(XIII) penectomy;
- 22 “(XIV) phalloplasty;
- 23 “(XV) vaginoplasty;
- 24 “(XVI) clitoroplasty;
- 25 “(XVII) vaginectomy;

- 1 “(XVIII) vulvoplasty;
- 2 “(XIX) reduction
- 3 thyrochondroplasty;
- 4 “(XX) chondrolaryngoplasty;
- 5 “(XXI) mastectomy;
- 6 “(XXII) tubal ligation;
- 7 “(XXIII) sterilization;
- 8 “(XXIV) any plastic, cosmetic, or
- 9 aesthetic surgery that feminizes or
- 10 masculinizes the facial or other phys-
- 11 iological features of an individual;
- 12 “(XXV) any placement of chest
- 13 implants to create feminine breasts;
- 14 “(XXVI) any placement of fat or
- 15 artificial implants in the gluteal re-
- 16 gion;
- 17 “(XXVII) augmentation
- 18 mammoplasty;
- 19 “(XXVIII) liposuction;
- 20 “(XXIX) lipofilling;
- 21 “(XXX) voice surgery;
- 22 “(XXXI) hair reconstruction;
- 23 “(XXXII) pectoral implants; and

1 “(XXXIII) the removal of any
 2 otherwise healthy or non-diseased
 3 body part or tissue.

4 “(ii) EXCLUSIONS.—The term ‘gender
 5 transition procedure’ does not include the
 6 following when furnished to an individual
 7 by a health care provider with the consent
 8 of such individual or, if applicable, such in-
 9 dividual’s parents or legal guardian:

10 “(I) Services to individuals born
 11 with a medically verifiable disorder of
 12 sex development, including an indi-
 13 vidual with external sex characteris-
 14 ties that are irresolvably ambiguous,
 15 such as an individual born with 46
 16 XX chromosomes with virilization, an
 17 individual born with 46 XY chro-
 18 mosomes with undervirilization, or an
 19 individual born having both ovarian
 20 and testicular tissue.

21 “(II) Services provided when a
 22 physician has otherwise diagnosed a
 23 disorder of sexual development in
 24 which the physician has determined
 25 through genetic or biochemical testing

1 that the individual does not have nor-
2 mal sex chromosome structure, sex
3 steroid hormone production, or sex
4 steroid hormone action for a healthy
5 individual of the same sex and age.

6 “(III) The treatment of any in-
7 fection, injury, disease, or disorder
8 that has been caused by or exacer-
9 bated by the performance of gender
10 transition procedures, whether or not
11 the gender transition procedure was
12 performed in accordance with State
13 and Federal law or whether or not
14 funding for the gender transition pro-
15 cedure is permissible under this sec-
16 tion.

17 “(IV) Any procedure undertaken
18 because the individual suffers from a
19 physical disorder, physical injury, or
20 physical illness (but not mental, be-
21 havioral, or emotional distress or a
22 mental, behavioral, or emotional dis-
23 order) that would, as certified by a
24 physician, place the individual in im-
25 minent danger of death or impairment

1 of major bodily function, unless the
2 procedure is performed.

3 “(V) Puberty suppression or
4 blocking prescription drugs for the
5 purpose of normalizing puberty for a
6 minor experiencing precocious pu-
7 berty.

8 “(VI) Male circumcision.

9 “(B) GENDER TRANSITION.—The term
10 ‘gender transition’ means the process in which
11 an individual goes from identifying with or pre-
12 senting as his or her sex to identifying with or
13 presenting a self-proclaimed identity that does
14 not correspond with or is different from his or
15 her sex, and may be accompanied with social,
16 legal, or physical changes.

17 “(C) SEX.—The term ‘sex’, when referring
18 to an individual’s sex, means to refer to either
19 male or female, as biologically determined.

20 “(D) FEMALE.—The term ‘female’, when
21 used to refer to a natural person, means an in-
22 dividual who naturally has, had, will have, or
23 would have, but for a congenital anomaly, his-
24 torical accident, or intentional or unintentional
25 disruption, the reproductive system that at

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

3 “(E) MALE.—The term ‘male’, when used
4 to refer to a natural person, means an indi-
5 vidual who naturally has, had, will have, or
6 would have, but for a congenital anomaly, his-
7 torical accident, or intentional or unintentional
8 disruption, the reproductive system that at
9 some point produces, transports, and utilizes
10 sperm for fertilization.

11 “(F) ABORTION.—

12 “(i) IN GENERAL.—The term ‘abor-
13 tion’ means—

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

17 “(II) pre-viable delivery not de-
18 scribed in clause (ii), and

19 “(III) post-viable delivery with
20 intentional death of the fetus.

21 “(ii) EXCLUSIONS.—Such term does
22 not include—

23 “(I) separation of the mother
24 and her embryo or fetus to prevent
25 the mother’s death or immediate irre-

1 versible bodily harm, which cannot be
 2 mitigated in any other way,
 3 “(II) treatment of ectopic or
 4 molar pregnancy,
 5 “(III) treatment of miscarriage,
 6 or
 7 “(IV) any service described in
 8 clause (i) in the case of a pregnancy
 9 which is the result of an act of rape
 10 or incest.”.

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

14 **SEC. 105. EXTENSION OF TEMPORARY ENHANCED PRE-**
 15 **MIUM CREDITS.**

16 (a) IN GENERAL.—Clause (iii) of section
 17 36B(b)(3)(A) of the Internal Revenue Code of 1986 is
 18 amended—

19 (1) by striking “January 1, 2026” and insert-
 20 ing “January 1, 2032”, and

21 (2) by striking “2025” in the heading and in-
 22 serting “2031”.

23 (b) HOUSEHOLD INCOME LIMITATION.—Section
 24 36B(c)(1)(E) of the Internal Revenue Code of 1986 is
 25 amended—

1 (1) by striking “RULE FOR 2021 THROUGH
2 2025.—In the case of” and inserting the following:

3 “RULES FOR 2021 THROUGH 2031.—

4 “(i) IN GENERAL.—In the case of”,
5 and

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

8 “(ii) SPECIAL RULE FOR 2027
9 THROUGH 2031.—In the case of any tax-
10 able year beginning after December 31,
11 2026, and before January 1, 2032, sub-
12 paragraph (A) shall be applied by sub-
13 stituting ‘700 percent’ for ‘400 percent’.”.

14 (c) PHASEDOWN OF ENHANCED AMOUNTS.—Sub-
15 paragraph (A) of section 36B(b)(3) of the Internal Rev-
16 enue Code of 1986 is amended by adding at the end the
17 following new clause:

18 “(iv) PHASEDOWN OF ENHANCED
19 AMOUNTS.—

20 “(I) IN GENERAL.—In the case
21 of a taxable year beginning after De-
22 cember 31, 2027, the premium assist-
23 ance amount determined under this
24 subsection (without regard to this
25 clause) shall be reduced by an amount

1 equal to the phasedown percentage of
2 the enhanced amount.

3 “(II) ENHANCED AMOUNT.—For
4 purposes of subclause (I), the term
5 ‘enhanced amount’ means the excess,
6 if any, of the premium assistance
7 amount determined under this sub-
8 section (without regard to this clause)
9 over the premium assistance amount
10 which would be so determined if
11 clause (iii) did not apply for the tax-
12 able year.

13 “(III) PHASEDOWN PERCENT-
14 AGE.—For purposes of subclause (I),
15 the phasedown percentage is—

16 “(aa) 20 percent, in the case
17 of a taxable year beginning after
18 December 31, 2027, and before
19 January 1, 2029,

20 “(bb) 40 percent, in the case
21 of a taxable year beginning after
22 December 31, 2028, and before
23 January 1, 2030,

24 “(cc) 60 percent, in the case
25 of a taxable year beginning after

1 December 31, 2029, and before
2 January 1, 2031, and
3 “(dd) 80 percent, in the case
4 of a taxable year beginning after
5 December 31, 2030, and before
6 January 1, 2032.”.

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

10 **SEC. 106. SPECIAL RULES RELATING TO COVERAGE OF**
11 **ABORTION SERVICES.**

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

15 (1) in paragraph (2)—

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

18 “(A) PROHIBITION ON THE USE OF FED-
19 ERAL FUNDS.—If a qualified health plan pro-
20 vides coverage of services described in para-
21 graph (1)(B)(i), the issuer of the plan shall not
22 use any amount attributable to any cost-sharing
23 reduction under section 1402 of the Patient
24 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.

1 “(B) DISCLOSURES.—

2 “(i) IN GENERAL.—The issuer of a
3 plan described in subparagraph (A) shall
4 include the coverage of services described
5 in paragraph (1)(B)(i) as part of the sum-
6 mary of benefits and coverage explanation
7 for the plan, as applicable.

8 “(ii) COMPARATIVE INFORMATION.—
9 If one or more plans described in subpara-
10 graph (A) are offered through an Ex-
11 change in a State, the Exchange shall in-
12 clude in any standardized format for pre-
13 senting health benefits plan options to po-
14 tential enrollees, comparative information
15 on plan coverage of such services.”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall apply with respect to plan years begin-
18 ning after December 31, 2026.

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

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

24 “(F) SPECIAL RULE FOR ABORTION COV-
25 ERAGE.—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

1 such coverage (calculated as de-
 2 scribed in subsection (b)(2)(B) of
 3 such section), and

4 “(cc) the amount (if any) of
 5 any advance payment under sec-
 6 tion 1412 of the Patient Protec-
 7 tion and Affordable Care Act of
 8 any premium tax credit under
 9 section 36B with respect to such
 10 coverage, and”.

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

14 **SEC. 109. EXCLUSION OF GENDER TRANSITION PROCE-**
 15 **DURES FROM COVERAGE UNDER QUALIFIED**
 16 **HEALTH PLANS.**

17 (a) IN GENERAL.—Section 1301(a)(1) of the Patient
 18 Protection and Affordable Care Act (42 U.S.C.
 19 18021(a)(1)) is amended—

20 (1) in subparagraph (B), by striking “and”
 21 after the semicolon;

22 (2) in subparagraph (C)(iv), by striking the pe-
 23 riod at the end and inserting “; and”; and

24 (3) by adding at the end the following:

1 “(D) does not provide coverage for gender
2 transition procedures.”.

3 (b) DEFINITION OF GENDER TRANSITION PROCE-
4 DURE.—Section 1301 of the Patient Protection and Af-
5 fordable Care Act (42 U.S.C. 18021) is amended by add-
6 ing at the end the following:

7 “(c) DEFINITIONS RELATING TO GENDER TRANSI-
8 TION PROCEDURES.—

9 “(1) GENDER TRANSITION PROCEDURE.—

10 “(A) IN GENERAL.—For purposes of sub-
11 section (a)(1)(D), the term ‘gender transition
12 procedure’ means any hormonal or surgical
13 intervention for the purpose of gender transi-
14 tion, including—

15 “(i) gonadotropin-releasing hormone
16 (GnRH) agonists or other puberty-blocking
17 or suppressing drugs to stop or delay nor-
18 mal puberty;

19 “(ii) testosterone, estrogen, progester-
20 one, or other androgens to an individual at
21 doses that are supraphysiologic to what
22 would normally be produced endogenously
23 in a healthy individual of the same age and
24 sex;

25 “(iii) castration;

- 1 “(iv) orchiectomy;
- 2 “(v) scrotoplasty;
- 3 “(vi) implantation of erection or tes-
- 4 ticular prostheses;
- 5 “(vii) vasectomy;
- 6 “(viii) hysterectomy;
- 7 “(ix) oophorectomy;
- 8 “(x) ovariectomy;
- 9 “(xi) reconstruction of the fixed part
- 10 of the urethra with or without a
- 11 metoidioplasty or a phalloplasty;
- 12 “(xii) metoidioplasty;
- 13 “(xiii) penectomy;
- 14 “(xiv) phalloplasty;
- 15 “(xv) vaginoplasty;
- 16 “(xvi) clitoroplasty;
- 17 “(xvii) vaginectomy;
- 18 “(xviii) vulvoplasty;
- 19 “(xix) reduction thyrochondroplasty;
- 20 “(xx) chondrolaryngoplasty;
- 21 “(xxi) mastectomy;
- 22 “(xxii) tubal ligation;
- 23 “(xxiii) sterilization;
- 24 “(xxiv) any plastic, cosmetic, or aes-
- 25 thetic surgery that feminizes or

1 masculinizes the facial or other physio-
 2 logical features of an individual;

3 “(xxv) any placement of chest im-
 4 plants to create feminine breasts;

5 “(xxvi) any placement of fat or artifi-
 6 cial implants in the gluteal region;

7 “(xxvii) augmentation mammoplasty;

8 “(xxviii) liposuction;

9 “(xxix) lipofilling;

10 “(xxx) voice surgery;

11 “(xxxi) hair reconstruction;

12 “(xxxii) pectoral implants; and

13 “(xxxiii) the removal of any otherwise
 14 healthy or non-diseased body part or tis-
 15 sue.

16 “(B) EXCLUSIONS.—For purposes of sub-
 17 section (a)(1)(D), the term ‘gender transition
 18 procedure’ does not include the following when
 19 furnished to an individual by a health care pro-
 20 vider with the consent of such individual or, if
 21 applicable, such individual’s parents or legal
 22 guardian:

23 “(i) Services to individuals born with
 24 a medically verifiable disorder of sex devel-
 25 opment, including an individual with exter-

1 nal sex characteristics that are irresolvably
2 ambiguous, such as an individual born with
3 46 XX chromosomes with virilization, an
4 individual born with 46 XY chromosomes
5 with undervirilization, or an individual
6 born having both ovarian and testicular
7 tissue.

8 “(ii) Services provided when a physi-
9 cian has otherwise diagnosed a disorder of
10 sexual development in which the physician
11 has determined through genetic or bio-
12 chemical testing that the individual does
13 not have normal sex chromosome struc-
14 ture, sex steroid hormone production, or
15 sex steroid hormone action for a healthy
16 individual of the same sex and age.

17 “(iii) The treatment of any infection,
18 injury, disease, or disorder that has been
19 caused by or exacerbated by the perform-
20 ance of gender transition procedures,
21 whether or not the gender transition proce-
22 dure was performed in accordance with
23 State and Federal law or whether or not
24 funding for the gender transition proce-
25 dure 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.

1 “(B) GENDER TRANSITION.—The term
2 ‘gender transition’ means the process in which
3 an individual goes from identifying with or pre-
4 senting as his or her sex to identifying with or
5 presenting a self-proclaimed identity that does
6 not correspond with or is different from his or
7 her sex, and may be accompanied with social,
8 legal, or physical changes.

9 “(C) MALE.—The term ‘male’, when used
10 to refer to a natural person, means an indi-
11 vidual who naturally has, had, will have, or
12 would have, but for a congenital anomaly, his-
13 torical accident, or intentional or unintentional
14 disruption, the reproductive system that at
15 some point produces, transports, and utilizes
16 sperm for fertilization.

17 “(D) SEX.—The term ‘sex’, when referring
18 to an individual’s sex, means to refer to either
19 male or female, as biologically determined.”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply with respect to plan years begin-
22 ning on or after January 1, 2026.

1 **SEC. 110. FUNDING COST SHARING REDUCTION PAYMENTS.**

2 Section 1402 of the Patient Protection and Afford-
3 able Care Act (42 U.S.C. 18071) is amended by adding
4 at the end the following new subsection:

5 “(h) FUNDING.—

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

11 “(2) LIMITATION.—

12 “(A) IN GENERAL.—The amounts appro-
13 priated under paragraph (1) may not be used
14 for purposes of making payments under this
15 section for a qualified health plan that provides
16 health benefit coverage that includes coverage
17 of abortion.

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

1 **SEC. 111. WAIVERS FOR STATE INNOVATION.**

2 (a) STREAMLINING THE STATE APPLICATION PROC-
3 ESS.—Section 1332 of the Patient Protection and Afford-
4 able Care Act (42 U.S.C. 18052) is amended—

5 (1) in subsection (a)(1)(C), by striking “the
6 law” and inserting “a law or has in effect a certifi-
7 cation”; and

8 (2) in subsection (b)(2)—

9 (A) in the paragraph heading, by inserting
10 “OR CERTIFY” after “LAW”;

11 (B) in subparagraph (A)—

12 (i) by striking “A law” and inserting
13 the following:

14 “(i) LAWS.—A law”; and

15 (ii) by adding at the end the fol-
16 lowing:

17 “(ii) CERTIFICATIONS.—A certifi-
18 cation described in this paragraph is a doc-
19 ument, signed by the Governor of the
20 State, that certifies that such Governor
21 has the authority under existing Federal
22 and State law to take action under this
23 section, including implementation of the
24 State plan under subsection (a)(1)(B).”;
25 and

26 (C) in subparagraph (B)—

1 (i) in the subparagraph heading, by
 2 striking “OF OPT OUT”; and

3 (ii) by striking “may repeal a law”
 4 and all that follows through the period at
 5 the end and inserting the following: “may
 6 terminate the authority provided under the
 7 waiver with respect to the State by—

8 “(i) repealing a law described in sub-
 9 paragraph (A)(i); or

10 “(ii) terminating a certification de-
 11 scribed in subparagraph (A)(ii), through a
 12 certification for such termination signed by
 13 the Governor of the State.”.

14 (b) GIVING STATES MORE FUNDING FLEXIBILITY,
 15 TO ESTABLISH REINSURANCE, INVISIBLE HIGH-RISK
 16 POOLS, INSURANCE STABILITY FUNDS, AND OTHER PRO-
 17 GRAMS.—

18 (1) STATE GRANTS UNDER WAIVERS.—Section
 19 1332(a) of the Patient Protection and Affordable
 20 Care Act (42 U.S.C. 18052(a)) is amended—

21 (A) in paragraph (3)—

22 (i) in the first sentence—

23 (I) by inserting “or would qualify
 24 for a reduced portion of” after “would
 25 not qualify for”;

1 (II) by inserting “, or the State
2 would not qualify for or would qualify
3 for a reduced portion of basic health
4 program funds under section 1331,”
5 after “subtitle E”;

6 (III) by inserting “, or basic
7 health program funds the State would
8 have received,” after “this title”; and

9 (IV) by inserting “or for imple-
10 menting the basic health program es-
11 tablished under section 1331” before
12 the period;

13 (ii) in the second sentence, by insert-
14 ing before the period “, and with respect to
15 participation in the basic health program
16 and funds provided to such other States
17 under section 1331”; and

18 (iii) by adding after the second sen-
19 tence the following: “A State may request
20 that all of, or any portion of, such aggre-
21 gate amount of such credits, reductions, or
22 funds be paid to the State as described in
23 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

1 with the allocation methodology under subpara-
2 graph (A), for the following purposes:

3 “(i) For fiscal year 2027, for adminis-
4 trative costs of the State associated with
5 preparing and submitting information de-
6 scribed in subsection (a)(1)(B) that in-
7 cludes an invisible high-risk pool or rein-
8 surance program that meets the require-
9 ments of subsection (g)(2), or costs associ-
10 ated with the establishment of such invis-
11 ible high-risk pool or reinsurance program.

12 “(ii) For each of fiscal years 2028,
13 2029, and 2030, for the establishment or
14 maintenance of invisible high-risk pools
15 and reinsurance programs that meet the
16 requirements of subsection (g)(2) and for
17 which the State has received a waiver
18 under this section.

19 “(C) BUDGET NEUTRALITY.—Funds
20 awarded to a State under a grant awarded
21 under subparagraph (B) shall not be taken into
22 account for purposes of determining under
23 paragraph (1) whether the State waiver is
24 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-

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

12 (B) REQUIRED USE FOR MARKET STA-
 13 BILIZATION PAYMENTS TO ISSUERS.—The Sec-
 14 retary shall use any allocation for a State made
 15 pursuant to clause (i) to provide incentives to
 16 appropriate entities to enter into arrangements
 17 with the State to help stabilize premiums for
 18 health insurance coverage in the individual mar-
 19 ket in such State by providing payments to
 20 such appropriate entities using payment param-
 21 eters and a methodology determined by the Sec-
 22 retary.

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

1 (1) in subsection (a)(1)(C), by striking “sub-
 2 section (b)(2)” and inserting “subsection (b)(3”;
 3 and

4 (2) in subsection (b)—

5 (A) in paragraph (1)—

6 (i) in subparagraph (B), by striking
 7 “at least as affordable” and inserting “of
 8 comparable affordability, including for low-
 9 income individuals, individuals with serious
 10 health needs, and other vulnerable popu-
 11 lations,”; and

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

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

16 “(ii) will not increase the Federal deficit
 17 over the term of the 10-year budget plan sub-
 18 mitted under subsection (a)(1)(B)(ii).”;

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

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

24 “(2) BUDGETARY EFFECT.—

1 “(A) IN GENERAL.—In determining wheth-
 2 er a State plan submitted under subsection (a)
 3 meets the deficit neutrality requirements of
 4 paragraph (1)(D), the Secretary may take into
 5 consideration the direct budgetary effect of the
 6 provisions of such plan on sources of Federal
 7 funding other than the funding described in
 8 subsection (a)(3).

9 “(B) LIMITATION.—A determination made
 10 by the Secretary under subparagraph (A)—

11 “(i) shall not be construed to affect
 12 any waiver process or standards or terms
 13 and conditions in effect on the date of en-
 14 actment of the Lowering Health Care
 15 Costs for Americans Act under title XI,
 16 XVIII, XIX, or XXI of the Social Security
 17 Act, or any other Federal law relating to
 18 the provision of health care items or serv-
 19 ices; and

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

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

4 (1) in paragraph (1) by striking “180” and in-
 5 serting “120”; and

6 (2) by adding at the end the following:

7 “(3) EXPEDITED DETERMINATION.—

8 “(A) IN GENERAL.—With respect to any
 9 application under subsection (a)(1) submitted
 10 on or after the date of enactment of the Low-
 11 ering Health Care Costs for Americans Act or
 12 any such application submitted prior to such
 13 date of enactment and under review by the Sec-
 14 retary on such date of enactment, the Secretary
 15 shall make a determination on such application,
 16 using the criteria for approval otherwise appli-
 17 cable under this section, not later than 45 days
 18 after the receipt of such application, and shall
 19 allow the public notice and comment at the
 20 State and Federal levels described under sub-
 21 section (a)(5) to occur concurrently if such
 22 State application—

23 “(i) is submitted in response to an ur-
 24 gent situation, with respect to areas in the
 25 State that the Secretary determines are at

1 risk for excessive premium increases or
 2 having no health plans offered in the appli-
 3 cable health insurance market for the cur-
 4 rent or following plan year;

5 “(ii) is for a waiver that is the same
 6 or substantially similar to a waiver that
 7 the Secretary already has approved for an-
 8 other State; or

9 “(iii) is for a waiver that includes an
 10 invisible high-risk pool or reinsurance pro-
 11 gram described in subparagraph (A), (B),
 12 or (D) of subsection (g)(2).

13 “(B) APPROVAL.—

14 “(i) URGENT SITUATIONS.—

15 “(I) PROVISIONAL APPROVAL.—A
 16 waiver approved under the expedited
 17 determination process under subpara-
 18 graph (A)(i) shall be in effect for a
 19 period of 3 years, unless the State re-
 20 quests a shorter duration.

21 “(II) FULL APPROVAL.—Subject
 22 to the requirements for approval oth-
 23 erwise applicable under this section,
 24 not later than 1 year before the expi-
 25 ration of a provisional waiver period

1 described in subclause (I) with respect
2 to an application described in sub-
3 paragraph (A)(i), the Secretary shall
4 make a determination on whether to
5 extend the approval of such waiver for
6 the full term of the waiver requested
7 by the State, for a total approval pe-
8 riod not to exceed 6 years. The Sec-
9 retary may request additional infor-
10 mation as the Secretary determines
11 appropriate to make such determina-
12 tion.

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

17 “(C) GAO STUDY.—Not later than 5 years
18 after the date of enactment of the Lowering
19 Health Care Costs for Americans Act, the
20 Comptroller General of the United States shall
21 conduct a review of all waivers approved pursu-
22 ant to subparagraph (A)(ii) to evaluate whether
23 such waivers met the requirements of sub-
24 section (b)(1) and whether the applications

1 should have qualified for such expedited proc-
2 ess.”.

3 (e) PROVIDING CERTAINTY FOR STATE-BASED RE-
4 FORMS.—Section 1332(e) of the Patient Protection and
5 Affordable Care Act (42 U.S.C. 18052(e)) is amended by
6 striking “No waiver” and all that follows through the pe-
7 riod at the end and inserting the following: “A waiver
8 under this section—

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

11 “(2) may be renewed, subject to the State meet-
12 ing the criteria for approval otherwise applicable
13 under this section, for unlimited additional 6-year
14 periods upon application by the State; and

15 “(3) may not be suspended or terminated, in
16 whole or in part, by the Secretary at any time before
17 the date of expiration of the waiver period (including
18 any renewal period under paragraph (2)), unless the
19 Secretary determines that the State materially failed
20 to comply with the terms and conditions of the waiv-
21 er.”.

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

25 (1) by adding at the end the following:

1 “(f) GUIDANCE AND REGULATIONS.—

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

4 “(A) issue guidance, not later than 60
5 days after the date of enactment of the Low-
6 ering Health Care Costs for Americans Act,
7 that includes initial examples of model State
8 plans that meet the requirements for approval
9 under this section; and

10 “(B) periodically review the guidance
11 issued under subparagraph (A) and, when ap-
12 propriate, issue additional examples of model
13 State plans that meet the requirements for ap-
14 proval under this section, which may include—

15 “(i) State plans establishing reinsur-
16 ance or invisible high-risk pool arrange-
17 ments for purposes of covering the cost of
18 high-risk individuals;

19 “(ii) State plans expanding insurer
20 participation, access to affordable health
21 plans, network adequacy, and health plan
22 options over the entire applicable health in-
23 surance market in the State;

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

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

5 “(iv) State plans allowing for signifi-
 6 cant variation in health plan benefit de-
 7 sign; or

8 “(v) any other State plan as the Sec-
 9 retary determines appropriate.

10 “(2) RESCISSION OF PREVIOUS REGULATIONS
 11 AND GUIDANCE.—Beginning on the date of enact-
 12 ment of the Lowering Health Care Costs for Ameri-
 13 cans Act, the regulations promulgated and the guid-
 14 ance issued under this section prior to the date of
 15 enactment of the Lowering Health Care Costs for
 16 Americans Act shall have no force or effect.”; and

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

19 (A) in subparagraph (A), by inserting “, as
 20 applicable” before the period; and

21 (B) in subparagraph (B), by striking “Not
 22 later than 180 days after the date of enactment
 23 of this Act, the Secretary shall” and inserting
 24 “The Secretary may”.

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

6 “(g) INVISIBLE HIGH-RISK POOLS AND REINSUR-
 7 ANCE PROGRAMS.—

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

14 “(A) Amounts received through a grant de-
 15 scribed in subsection (a)(4)(B).

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

20 “(2) PROGRAM DESIGN.—An invisible high-risk
 21 pool or reinsurance program described in this para-
 22 graph is a program that meets any of the following:

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

1 who experience higher than average health costs
 2 as determined by the State, and are enrolled in
 3 health insurance coverage offered in the indi-
 4 vidual market, cede risk to the pool, without af-
 5 fecting the premium paid by the designated in-
 6 dividuals or their terms of coverage. With re-
 7 spect to such pool, the State, or an entity oper-
 8 ating the pool on behalf of the State, shall es-
 9 tablish—

10 “(i) the premium amount the ceding
 11 issuer shall pay to the reinsurance pool;

12 “(ii) the applicable attachment points
 13 or coinsurance percentages if the ceding
 14 issuer retains any portion of the risk under
 15 ceded policies; and

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

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

1 program that operated in the State in accord-
 2 ance with section 1341.

3 “(C) A reinsurance program established by
 4 the State not otherwise described in this para-
 5 graph.

6 “(D) A program based on another State’s
 7 reinsurance program—

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

11 “(ii) which was implemented prior to
 12 September 1, 2025, and which the Sec-
 13 retary determines meets the requirements
 14 of subparagraph (A).”.

15 (h) APPLICABILITY.—The amendments made by this
 16 Act to section 1332 of the Patient Protection and Afford-
 17 able Care Act (42 U.S.C. 18052)—

18 (1) with respect to applications for waivers
 19 under such section 1332 submitted after the date of
 20 enactment of this Act and applications for such
 21 waivers submitted prior to such date of enactment
 22 and under review by the Secretary on the date of en-
 23 actment, shall take effect on the date of enactment
 24 of this Act; and

1 (2) with respect to applications for waivers ap-
2 proved under such section 1332 before the date of
3 enactment of this Act, shall not require reconsider-
4 ation of whether such applications meet the require-
5 ments of such section 1332, except that, at the re-
6 quest of a State, the Secretary shall recalculate the
7 amount of funding provided under subsection (a)(3)
8 of such section.

9 (i) CLARIFYING BUDGET NEUTRALITY.—Section
10 1332(a)(1)(B) of the Patient Protection and Affordable
11 Care Act (42 U.S.C. 18052(a)(1)(B)) is amended—

12 (1) in clause (i), by inserting “, including, as
13 applicable, a description of the State’s plan to use
14 any amounts awarded to the State under paragraph
15 (4) to support an invisible high-risk pool or reinsur-
16 ance program consistent with subsection (g) and
17 such information about such program as the Sec-
18 retary may require” before the semicolon; and

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

1 **TITLE II—HOSPITAL TRANS-**
 2 **PARENCY REQUIREMENTS**

3 **SEC. 201. STRENGTHENING HOSPITAL PRICE TRANS-**
 4 **PARENCY REQUIREMENTS.**

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

8 “(e) STANDARD HOSPITAL CHARGES.—

9 “(1) IN GENERAL.—

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

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

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

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

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

13 “(B) STANDARD CHARGES DESCRIBED.—

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

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

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

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

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

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

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

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

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

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

17 “(C) UNIFORM METHOD AND FORMAT.—

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

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

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

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

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

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

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

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

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

“(5) ENFORCEMENT.—

“(A) IN GENERAL.—In the case of a hospital that fails to comply with the requirements of this subsection, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination, which shall include a request for a corrective action plan to comply with such requirements.

“(B) CIVIL MONETARY PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 without regard to whether such parent, sub-
2 sidiary, or other affiliated provider or supplier
3 operates under separate licensure, certification,
4 or designation.

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

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

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

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

24 (b) EFFECTIVE DATE.—

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

4 (2) CONTINUED APPLICABILITY OF RULES FOR
5 PREVIOUS YEARS.—Nothing in the amendment made
6 by this section may be construed as affecting the ap-
7 plicability of the regulations codified at part 180 of
8 title 45, Code of Federal Regulations, before Janu-
9 ary 1, 2026.

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

17 **SEC. 202. INCREASING PRICE TRANSPARENCY OF CLINICAL**
18 **DIAGNOSTIC LABORATORY TESTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 “(4) INCLUSION OF ANCILLARY SERVICES.—

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

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

3 “(5) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

24 “(F) THIRD PARTY PAYER.—The term
25 ‘third party payer’ means an entity that is, by

1 statute, contract, or agreement, legally respon-
 2 sible for payment of a claim for a health care
 3 item or service.

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

8 **SEC. 203. IMAGING TRANSPARENCY.**

9 Section 2718 of the Public Health Service Act (42
 10 U.S.C. 300gg–18), as amended by section 202, is further
 11 amended by adding at the end the following:

12 “(g) IMAGING SERVICES PRICE TRANSPARENCY.—

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

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

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

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

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

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

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

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

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

1 quired to determine and disclose the negotiated
2 charge.

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

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

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

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

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

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

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

19 “(5) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

16 **SEC. 204. AMBULATORY SURGICAL CENTER PRICE TRANS-**
 17 **PARENCY REQUIREMENTS.**

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

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

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

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

“(2) REQUIREMENT DESCRIBED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(C) UNIFORM METHOD AND FORMAT.—

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

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

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

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

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

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

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

14 “(5) ENFORCEMENT.—

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

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

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

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

5 “(B) CIVIL MONETARY PENALTY.—

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

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

1 violations occurring in 2027 or a subse-
2 quent year, the Secretary may through no-
3 tice and comment rulemaking increase the
4 limitation on the per day amount of any
5 penalty applicable to a specified ambula-
6 tory surgical center under clause (i).

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

16 “(iv) NO AUTHORITY TO WAIVE OR
17 REDUCE PENALTY.—The Secretary shall
18 not grant or extend any waiver, delay, toll-
19 ing, or other mitigation of a civil monetary
20 penalty for violation of this subsection.

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

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

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

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

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

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

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

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

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

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

1 **SEC. 205. STRENGTHENING HEALTH COVERAGE TRANS-**
 2 **PARENCY REQUIREMENTS.**

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

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

8 “(i) IN GENERAL.—The Exchange”;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(I) is based on an internet website;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 vider (identified by national provider
2 identifier) that is a participating pro-
3 vider with respect to such item or
4 service, other than such a rate in ef-
5 fect with a provider—

6 “(aa) that has submitted no
7 claims; and

8 “(bb) expects to receive no
9 claims in the then applicable cal-
10 endar year for such item or serv-
11 ice to such plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(DD) The place of
5 service code.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the health plan also shall disclose such al-
 2 gorithm, percentage, formula, or criteria as
 3 set forth in its contract and any other
 4 terms, schedules, exhibits, data, or other
 5 information referenced in any such con-
 6 tract as shall be required to determine and
 7 disclose the negotiated rate.

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

16 “(H) ENFORCEMENT.—

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

22 “(ii) NOTIFICATION AND REQUEST
 23 FOR CORRECTIVE ACTION.—In the case of
 24 a health plan that fails to comply with the
 25 requirements of this subsection, not later

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

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

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

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

3 (c) EFFECTIVE DATE.—

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

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

16 **SEC. 206. INCREASING GROUP HEALTH PLAN ACCESS TO**
 17 **HEALTH DATA.**

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

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

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

1 rangement, between a group health plan (as that
 2 term is defined in section 733(a) of this title) and
 3 party in interest, including a health care provider
 4 (which for purposes of this subparagraph, includes a
 5 health care facility), network or association of pro-
 6 viders, service provider offering access to a network
 7 of providers, third-party administrator, or pharmacy
 8 benefit manager (collectively referred to as ‘Covered
 9 Service Providers’), is reasonable within the meaning
 10 of this paragraph unless such contract or arrange-
 11 ment—

12 “(i) allows the responsible plan fiduciary
 13 (as that term is defined in subparagraph
 14 (B)(ii)(I)(ee)) access to all claims and encoun-
 15 ter information or data, and any documentation
 16 supporting claim payments, including, but not
 17 limited to, medical records and policy docu-
 18 ments, or information or data described in sec-
 19 tion 724(a)(1)(B) to—

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

23 “(II) determine the accuracy or rea-
 24 sonableness of payment; and

25 “(ii) does not—

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

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

12 “(III) limit the disclosure of pricing
13 terms for value-based payment arrange-
14 ments or capitated payment arrangements,
15 including—

16 “(aa) payment calculations and
17 formulas;

18 “(bb) quality measures;

19 “(cc) contract terms;

20 “(dd) payment amounts;

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

23 “(ff) other payment methodolo-
24 gies used by an entity, including a
25 health care provider (including a

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

6 “(IV) limit the disclosure of overpay-
7 ments and overpayment recovery terms;

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

12 “(VI) otherwise limit or unduly delay
13 the group health plan, the plan sponsor,
14 the plan administrator, or a business asso-
15 ciate of such plan from accessing claims
16 and encounter information or data in a
17 daily batch;

18 “(VII) limit the disclosure of fees
19 charged to the group health plan related to
20 plan administration and claims processing,
21 including renegotiation fees, access fees,
22 repricing fees, or enhanced review fees;

23 “(VIII) limit the right of the group
24 health plan, the plan sponsor, or the plan

1 administrator to request action on any sus-
2 pect claim payments; or

3 “(IX) limit public disclosure of de-
4 identified or aggregate information.

5 “(D)(i) Covered Service Providers shall provide
6 information or data under this paragraph in a man-
7 ner consistent with the privacy and security regula-
8 tions promulgated under the Health Insurance Port-
9 ability and Accountability Act (referred to in this
10 subparagraph as ‘HIPAA’).

11 “(ii) A group health plan that receives a disclo-
12 sure from a party in interest pursuant to subpara-
13 graph (B) or (C) shall comply with the privacy and
14 security regulations promulgated under HIPAA.

15 “(iii) Nothing in this subparagraph shall be
16 construed to modify the requirements for the cre-
17 ation, receipt, maintenance, or transmission of pro-
18 tected health information under the HIPAA privacy
19 regulation (as defined in section 1180(b)(3) of the
20 Social Security Act) as they apply directly or indi-
21 rectly to an entity pursuant to this paragraph.

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

1 security requirements on Covered Service Providers or
2 plan sponsors.

3 “(E) A group health plan receiving information
4 or data under this paragraph may disclose such in-
5 formation only in a manner that is consistent with
6 the Health Insurance Portability and Accountability
7 Act (HIPAA) and the privacy and security regula-
8 tions promulgated thereunder, regardless of their di-
9 rect or indirect applicability to the plan or any enti-
10 ties that could be or are business associates.

11 “(F) Information made available under this sec-
12 tion shall conform to the following standards:

13 “(i) All claims from a healthcare provider
14 shall be made to the group health plan in ac-
15 cordance with transaction standards adopted by
16 regulation under HIPAA, as follows:

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

20 “(II) Pharmacy claims shall be in the
21 National Council for Prescription Drug
22 Programs (NCPDP) format or any subse-
23 quent standard.

24 “(III) The files shall be unmodified
25 copies of the files sent from the provider.

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

6 “(ii) All claim payment (or EFT, electronic
7 funds transfer) and electronic remittance advice
8 (ERA) notices sent by a Covered Service Pro-
9 vider shall be made available to the group
10 health plan as ASC X12N 835 files in accord-
11 ance with standards adopted by regulation
12 under HIPAA. The files shall be unmodified
13 copies of the files sent by the Covered Service
14 Provider to the healthcare provider. Files shall
15 be accessible at no cost to the group health
16 plan.

17 “(iii) The contractual terms containing cal-
18 culation formulae, pricing methodologies, and
19 other information used to determine the dollar
20 value of reimbursement.

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

1 “(G) The Secretary shall implement subpara-
2 graphs (C) through (F) through notice and comment
3 rulemaking in accordance with section 553 of title 5,
4 United States Code.”.

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

9 “(13) In the case of an agreement between a group
10 health plan (as defined in section 733(a)), the plan spon-
11 sor of such plan (as defined in section 3(16)(B)), or the
12 plan administrator of such plan (as defined in section
13 3(16)(A)) and a health care provider (which, for purposes
14 of this paragraph, includes a health care facility), network
15 or association of providers, service provider offering access
16 to a network or association of providers, third-party ad-
17 ministrator, or pharmacy benefit manager, that violates
18 the provisions of section 724, the Secretary may assess
19 a civil penalty against such provider, network or associa-
20 tion, service provider offering access to a network or asso-
21 ciation of providers, third-party administrator, pharmacy
22 benefit manager, or other service provider in the amount
23 of \$10,000 for each day during which such violation con-
24 tinues. Such penalty shall be in addition to other penalties
25 as may be prescribed by law.”.

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

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

6 “(1) unduly delays or limits a group health plan
 7 (as defined in section 733(a)), the plan sponsor of
 8 such plan (as defined in section 3(16)(B)), or the
 9 plan administrator of such plan (as defined in sec-
 10 tion 3(16)(A)) from accessing the claims and en-
 11 counter information or data described in section
 12 724(a)(1)(B); or

13 “(2) violates the requirements of section
 14 408(b)(2)(C).”.

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

19 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
 20 ITY INFORMATION.—Section 724(a)(3) of the Employee
 21 Retirement Income Security Act of 1974 (29 U.S.C.
 22 1185m(a)(3)) is amended to read as follows:

23 “(3) ATTESTATION.—

24 “(A) IN GENERAL.—Subject to subpara-
 25 graph (C), a group health plan or health insur-

1 ance issuer offering group health insurance cov-
2 erage shall annually submit to the Secretary an
3 attestation that such plan or issuer of such cov-
4 erage is in compliance with the requirements of
5 this subsection. Such attestation shall also in-
6 clude a statement verifying that—

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

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

22 “(B) LIMITATION ON SUBMISSION.—Sub-
23 ject to clause (ii), a group health plan or issuer
24 offering group health insurance coverage may
25 not enter into an agreement with a third-party

1 administrator or other service provider to sub-
2 mit the attestation required under subpara-
3 graph (A).

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

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

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

23 “(iii) a description of any response by
24 the third-party administrator or other serv-
25 ice provider with respect to efforts to com-

1 ply with the attestation requirement under
 2 subparagraph (A), including the name of
 3 the third-party administrator or other serv-
 4 ice provider.”.

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

10 **SEC. 207. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
 11 **VIDERS.**

12 (a) ERISA AMENDMENTS.—

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

17 **“SEC. 726. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
 18 **VIDERS.**

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

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

14 “(b) REQUIRED DISCLOSURES.—

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

23 “(A) The information described in section
 24 724(a)(1)(B).

1 “(B) Any contractual and subcontractual
2 calculation methodologies, pricing or fee sched-
3 ules, or other formulae used to determine reim-
4 bursement amounts to providers and sub-
5 contractors, including methodologies, schedules,
6 fee structures, and any applied adjustments or
7 modifiers, with such information provided in a
8 manner sufficiently detailed to enable the group
9 health plan or health insurance issuer to accu-
10 rately assess, verify, and ensure compliance
11 with the terms of any contractual and sub-
12 contractual agreement governing the reimburse-
13 ment amounts.

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

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

1 arrangements, and all other remuneration that
2 has been paid or is expected to be paid for ad-
3 ministrative and other services.

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

16 “(2) PRIVACY REQUIREMENTS.—

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

1 Health Act of 2009, and section 1180 of the
2 Social Security Act, and shall restrict the use
3 and disclosure of such information according to
4 such privacy, security, and breach notification
5 regulations. An entity that receives a disclosure
6 from a party in interest pursuant to subpara-
7 graph (B) or (C) shall comply with the privacy
8 and security regulations promulgated under
9 HIPAA.

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

16 “(C) RULE OF CONSTRUCTION.—Nothing
17 in this section shall be construed to modify the
18 requirements for the creation, receipt, mainte-
19 nance, or transmission of protected health in-
20 formation under the HIPAA privacy regulations
21 (45 CFR parts 160 and 164, subparts A and
22 E).

23 “(3) DISCLOSURE AND REDISCLOSURE.—

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

4 “(i) to the entity from which the in-
5 formation was received or to that entity’s
6 business associates or to the group health
7 plan’s business associates as defined in
8 section 160.103 of title 45, Code of Fed-
9 eral Regulations (or successor regulations);
10 or

11 “(ii) as permitted by the HIPAA Pri-
12 vacy Rule (45 CFR parts 160 and 164,
13 subparts A and E).

14 “(B) AVAILABILITY OF INFORMATION.—To
15 the extent the information required by this sub-
16 section is made available to the health insur-
17 ance issuer offering group health insurance in
18 connection with a group health plan, the health
19 insurance issuer shall make such information
20 available, at the same time, in the same format,
21 and at no cost, to the group health plan.

22 “(C) FAILURE TO PROVIDE.—The obliga-
23 tion to provide information pursuant to this
24 subsection shall exist notwithstanding the pres-
25 ence of any formal data-sharing agreement be-

1 tween the parties. Failure to provide the re-
 2 quired information as specified shall constitute
 3 a violation of this Act and the Secretary shall
 4 initiate enforcement action under section 502
 5 within 90 days of becoming aware of a violation
 6 of this section, except that nothing in this sec-
 7 tion shall be construed to limit the Secretary's
 8 existing authority under the Act.

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

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

16 “(i) Institutional, professional, and
 17 dental claims and adjustments to these
 18 claims shall be in ASC X12N 837 format,
 19 as transmitted by the provider, or, in the
 20 case of paper claims, converted to the ASC
 21 X12N 837 electronic format.

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

1 of paper claims, converted to the NCPDP
2 electronic format.

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

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

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

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

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

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

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

19 (2) PENALTY.—

20 (A) IN GENERAL.—Section 502(c) of the
 21 Employee Retirement Income Security Act of
 22 1974 (29 U.S.C. 1132(c)), as amended by sec-
 23 tion 206, is further amended by adding at the
 24 end the following new paragraph:

1 “(14) The Secretary may assess a civil penalty
 2 against any person of \$100,000 per day for each violation
 3 by any person of section 726.”.

4 (B) TECHNICAL AMENDMENT.—Paragraph
 5 (6) of section 502(a) of the Employee Retirement
 6 Income Security Act of 1974 (29 U.S.C.
 7 1132(a)) is amended by striking “or (9)” and
 8 inserting “(9), (13), or (14)”.

9 (b) PHSA AMENDMENTS.—

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

13 **“SEC. 2799A-11. OVERSIGHT OF ADMINISTRATIVE SERVICE**
 14 **PROVIDERS.**

15 “(a) IN GENERAL.—For plan years beginning on or
 16 after the date that is 1 year after the date of enactment
 17 of this section, no agreement between a group health plan
 18 that is a self-funded, non-Federal governmental plan, as
 19 defined in section 2791(d)(8)(C), and a health care pro-
 20 vider, network or association of providers, third-party ad-
 21 ministrator, service provider offering access to a network
 22 of providers, pharmacy benefit managers, or any other
 23 third party (each referred to in this section as a ‘health
 24 plan service provider’) is permissible if such agreement
 25 limits (or delays beyond the applicable reporting period de-

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

5 “(b) REQUIRED DISCLOSURES.—

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

14 “(A) The information described in section
 15 2799A–9(a)(1)(B).

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

1 tial and subcontractual agreement governing
2 the reimbursement amounts.

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

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

18 “(E) All payment data and reconciliation
19 information related to alternative compensation
20 arrangements including accountable care orga-
21 nizations, value-based programs, shared savings
22 programs, incentive compensation, bundled pay-
23 ments, capitation arrangements, performance
24 payments, and any other reimbursement or pay-
25 ment models, where the group health plan paid

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

4 “(2) PRIVACY REQUIREMENTS.—

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

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

1 title 45, Code of Federal Regulations (or a suc-
 2 cessor regulation), and a plan sponsor shall act
 3 in accordance with the terms of the agreement
 4 described in such section.

5 “(C) RULE OF CONSTRUCTION.—Nothing
 6 in this section shall be construed to modify the
 7 requirements for the creation, receipt, mainte-
 8 nance, or transmission of protected health in-
 9 formation under the HIPAA privacy regulations
 10 (parts 160 and 164 of title 45, Code of Federal
 11 Regulations).

12 “(3) DISCLOSURE AND REDISCLOSURE.—

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

17 “(i) to the entity from which the in-
 18 formation was received or to that entity’s
 19 business associates as defined in section
 20 160.103 of title 45, Code of Federal Regu-
 21 lations (or successor regulations); or

22 “(ii) as permitted by the HIPAA Pri-
 23 vacy Rule (45 CFR parts 160 and 164,
 24 subparts A and E).

1 “(B) RULE OF CONSTRUCTION.—Nothing
2 in this section shall be construed to prevent a
3 group health plan that is a self-funded, non-
4 Federal governmental plan, or a health plan
5 service provider providing services with respect
6 to such a plan, from placing reasonable restric-
7 tions on the public disclosure of the information
8 described in paragraph (1), except that such
9 plan or entity may not restrict disclosure of
10 such information to the Department of Health
11 and Human Services, the Department of Labor,
12 the Department of the Treasury, or the Comp-
13 troller General of the United States.

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

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

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

9 “(i) Institutional, professional, and
10 dental claims and adjustments to these
11 claims shall be provided to the group
12 health plan that is a self-funded, non-Fed-
13 eral governmental plan in the ASC X12N
14 837 format.

15 “(ii) Prescription drug claims shall be
16 in the National Council for Prescription
17 Drug Programs (NCPDP) format.

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

1 “(B) All claim payment (or EFT, elec-
2 tronic funds transfer) and electronic remittance
3 advice (ERA) information sent by a health plan
4 service provider shall be provided to the group
5 health plan or health insurance issuer in the
6 ASC X12N 835 format, in accordance with
7 standards adopted under HIPAA at section
8 162.1602 of title 45, Code of Federal Regula-
9 tions, unmodified from the form in which it was
10 transmitted to the healthcare provider. Such in-
11 formation shall be provided at no cost to the
12 group health plan.

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

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

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

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

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

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

19 **SEC. 208. STATE PREEMPTION ONLY IN EVENT OF CON-**
20 **FLICT.**

21 The provisions of sections 201 through 204 (includ-
22 ing the amendments made by such sections) shall not su-
23 perseede any provision of State law which establishes, im-
24 plements, or continues in effect any requirement or prohi-
25 bition related to health care price transparency, including

1 hospital, clinical diagnostic laboratory tests, imaging serv-
 2 ices, and ambulatory surgical center, except to the extent
 3 that such requirement or prohibition prevents the applica-
 4 tion of a requirement or prohibition of such sections (or
 5 amendment). Nothing in this section shall be construed
 6 to affect group health plans established under the Em-
 7 ployee Retirement Income Security Act of 1974, or alter
 8 the application of section 514 of such Act (29 U.S.C.
 9 1144).

10 **SEC. 209. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

11 (a) PHSA AMENDMENTS.—

12 (1) EMERGENCY SERVICES.—Section 2799A–
 13 1(f)(1)(C) of the Public Health Service Act (42
 14 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
 15 follows:

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

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

5 “(g) EXPLANATION OF BENEFITS.—

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

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

24 “(B) An itemized explanation of benefits
 25 that includes the following:

1 “(i) A plain language description of
2 each item or service.

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

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

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

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

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

22 “(2) FORMAT.—If applicable, the notification
23 described in paragraph (1) may be provided in con-
24 junction with, or as part of, a notice of a claim de-
25 termination or other communication required by sec-

1 tion 2719(a) (42 U.S.C. 300gg–19(a)), or regula-
2 tions thereunder.

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

7 (b) IRC AMENDMENTS.—

8 (1) EMERGENCY SERVICES.—Section
9 9816(f)(1)(C) of the Internal Revenue Code of 1986
10 is amended to read as follows:

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

20 (2) EXPLANATION OF BENEFITS.—Section
21 9816 of the Internal Revenue Code of 1986 is
22 amended by adding at the end the following:

23 “(g) EXPLANATION OF BENEFITS.—

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

1 shall, within 45 days of receiving any request for
2 payment for an item or service under the plan, pro-
3 vide to the participant or beneficiary (through mail
4 or electronic means, as requested by the participant
5 or beneficiary) a notification (in clear and under-
6 standable language and utilizing substantially the
7 same format as the advanced explanation of benefits
8 required by subsection (f) to enable comparison) in-
9 cluding the following:

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

14 “(B) An itemized explanation of benefits
15 that includes the following:

16 “(i) A plain language description of
17 each item or service.

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

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

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

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

3 “(v) The amount that the participant
4 or beneficiary has incurred toward meeting
5 the limit of the financial responsibility (in-
6 cluding with respect to deductibles and
7 out-of-pocket maximums) under the plan
8 (as of the date of such notification).

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

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

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

20 (c) ERISA AMENDMENTS.—

21 (1) EMERGENCY SERVICES.—Section
22 716(f)(1)(C) of the Employee Retirement Income
23 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is
24 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

1 explanation of benefits required by subsection (f) to
2 enable comparison) including the following:

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

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

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

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

16 “(iii) The amount the plan or cov-
17 erage is responsible for paying for each
18 item or service.

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

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

1 cluding with respect to deductibles and
 2 out-of-pocket maximums) under the plan
 3 or coverage (as of the date of such notifi-
 4 cation).

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

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

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

15 **SEC. 210. PROVISION OF ITEMIZED BILLS.**

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

19 **“SEC. 2799B-10. PROVIDER REQUIREMENTS FOR ITEMIZED**
 20 **BILLS.**

21 “(a) REQUIREMENTS.—

22 “(1) ITEMIZED BILL AND OTHER INFORMATION
 23 REQUIRED.—

24 “(A) IN GENERAL.—A health care provider
 25 or health care facility that requests payment

1 from an individual after providing a health care
2 item or service to the patient shall include with
3 such request a written, itemized bill of the cost
4 of each reasonably expected item or service the
5 health care provider or health care facility pro-
6 vided to the individual, including telehealth vis-
7 its or visits by other electronic means. The
8 health care provider or health care facility shall
9 provide the itemized bill not later than 30 days
10 after the health care provider or health care fa-
11 cility received a final payment on the provided
12 service or supply from a third party.

13 “(B) REQUIRED INFORMATION.—For each
14 item or service provided by the health care pro-
15 vider or facility or for which the health care
16 provider or facility is billing the individual, the
17 itemized bill must include—

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

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

1 “(iii) the price and billed amount, if
2 different, of each distinct health care item
3 or service or if the provider or facility is
4 offering binding, all-in prices for bundled
5 items and services, the total binding price
6 for bundled items and services and billed
7 amount;

8 “(iv) any payments made to the
9 health care provider or health care facility
10 by or on behalf of the individual (including
11 payments by any health plan or insurance)
12 for any health care item or service covered
13 in the itemized bill;

14 “(v) information about the availability
15 of language-assistance services for individ-
16 uals with limited English proficiency
17 (LEP);

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

1 “(vii) information about the health
 2 care provider’s or health care facility’s
 3 charity care policies and instructions on
 4 how to apply for charity care.

5 “(2) COLLECTIONS ACTIONS.—

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

9 “(i) for any provided health care item
 10 or service unless the health care provider
 11 or health care facility has complied with
 12 paragraph (1); or

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

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

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

12 “(b) FAILURE TO COMPLY.—

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

18 “(2) PRESUMPTION IN FAVOR OF INDI-
19 VIDUAL.—If a health care provider or health care fa-
20 cility fails to comply with the requirements of this
21 section, the presumption shall be that charges were
22 substantially in excess of the good faith estimate (as
23 set forth in section 2799B–6) for the purpose of any
24 patient-provider dispute, including in accordance

1 with section 2799B–7 and regulations promulgated
2 thereunder.

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

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