I

118TH CONGRESS
1ST SESSION

H. R. 4822

To improve price transparency with respect to certain health care services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2023

Mr. SMITH of Missouri introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve price transparency with respect to certain health care services, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Price Transparency Act of 2023''.

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

TITLE I—HEALTH CARE PRICE TRANSPARENCY FOR PATIENTS

SEC. 101. REQUIRING CERTAIN FACILITIES UNDER THE MEDICARE PROGRAM TO DISCLOSE CERTAIN INFORMATION RELATING TO CHARGES AND PRICES.

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

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

"(a) HOSPITAL PRICE TRANSPARENCY.—

"(1) IN GENERAL.—Beginning January 1, 2026, each specified hospital (as defined in paragraph (6)) that receives payment under this title for furnishing items and services shall comply with the

price transparency requirement described in paragraph (2).

''(2) REQUIREMENT DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this paragraph is, with respect to a specified hospital, that such hospital, in accordance with a method and format established by the Secretary under subparagraph (C), compile and make public (without subscription and free of charge) for each year—

''(i) one or more lists, in a format specified by the Secretary (which may be a machine-readable format), of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital; and

''(ii) information in a consumer-friendly format (as specified by the Secretary)—

''(I) on the hospital's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid

Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

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

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

''(i) A description of each item or service, accompanied by, as applicable, the Healthcare Common Procedure Coding System code, the diagnosis-related group,

the national drug code, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

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

''(iii) The discounted cash price, expressed as a dollar amount, for each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for an item or service, the median price charged by the hospital for such item or service when provided in such settings for the previous three years, expressed as a dollar amount).

''(iv) Any other information the Secretary may require for purposes of promoting public awareness of specified hospital standard charges or prices in advance of receiving an item or service from such a hospital, except information that is duplicative of any other reporting requirement

under this section. Such information may include any current payer-specific negotiated charges, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting.

''(C) METHOD AND FORMAT.—Not later than January 1, 2026, the Secretary shall establish one or more methods and formats for specified facilities to use in compiling and making public standard charges and prices (as applicable) pursuant to subparagraph (A). Any such method and format—

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

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

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

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

"(A) IN GENERAL.—With respect to each year until the effective date of regulations implementing the provisions of sections 2799A–1(f) and 2799B–6 of the Public Health Service Act (relating to advanced explanations of benefits), including regulations on establishing data transfer standards to effectuate such provisions, a specified hospital shall be deemed to have complied with the requirement described in paragraph (2)(A)(ii)(I) (relating to shoppable services) if such hospital maintains a price estimator tool described in subparagraph (B).

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

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

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

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

''(iv) Such tool does not require an individual seeking such an estimate to create an account or otherwise input personal information, except that such tool may re-

quire that such individual provide information specified by the Secretary, which may include the following:

''(I) The name of such individual.

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

''(III) In the case such individual is covered under a group health plan, group or individual health insurance coverage, a Federal health care program, or the program established under chapter 89 of title 5, United States Code, an identifying number assigned by such plan, coverage, or program to such individual.

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

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

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

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

''(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each specified hospital's compliance with this subsection is reviewed not less frequently than once every 3 years.

''(5) ENFORCEMENT.—

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

''(i) the Secretary shall notify such hospital of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

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

"(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of law, a specified hospital that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of such a hospital that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after the Secretary identifies the failure of such hospital to satisfactorily complete such corrective action plan) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each subsequent day during which such failure is ongoing. Such amount shall not exceed—

"(I) in the case of a specified hospital that is a hospital or critical access hospital with 30 or fewer beds, $300 per day; and

"(II) in the case of any specified hospital and except as provided in clause (iii), $2,000,000 for a 1-year period.

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

"(I) the limitation on the per day amount of any penalty applicable to a specified hospital that is a hospital or critical access hospital with 30 or fewer beds under clause (i)(I);

"(II) the limitation on the amount of any penalty applicable for a 1-year period under clause (i)(II); and

"(III) the limitation on the increase of any penalty applied under clause (iii).

"(iii) PERSISTENT NONCOMPLIANCE.—In the case of a specified hospital (other than a specified hospital that is a hospital or critical access hospital with 30 or fewer beds) that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection two or more times during a 1-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by not more than $1,000,000 and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

"(v) AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary may waive or reduce any penalty otherwise ap-

plicable with respect to a specified hospital under this subparagraph if the Secretary determines that imposition of such penalty would result in a significant hardship for such hospital (such as in the case of a hospital located in a rural or underserved area where imposition of such penalty may result in, or contribute to, a lack of access to care for individuals in such area).

''(C) PUBLICATION OF HOSPITAL PRICE TRANSPARENCY INFORMATION.—Beginning on January 1, 2026, the Secretary shall make publicly available on the public website of the Centers for Medicare & Medicaid Services information with respect to compliance with the requirements of this subsection and enforcement activities undertaken by the Secretary under this subsection. Such information shall be updated not less than annually and include, with respect to each year—

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

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

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

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

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

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

''(6) DEFINITIONS.—For purposes of this subsection:

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

"(B) FEDERAL HEALTH CARE PROGRAM.—The term 'Federal health care program' has the meaning given such term in section 1128B.

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

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

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

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

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

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

"(b) AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.—

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

"(2) REQUIREMENT DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this subsection is, with respect to an ambulatory surgical center, that such surgical center in accordance with a method and format established by the Secretary under sub-

paragraph (C)), compile and make public (without subscription and free of charge), for each year—

"(i) one or more lists, in a 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 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 that are furnished by such surgical center, and as many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services;

"(iii) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by

the ambulatory surgical center, an indication that such service is not so furnished; and

''(iv) any additional information specified by the Secretary.

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

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

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

''(iii) The discounted cash price, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item

or service, the gross charge for such item or service for the previous three years, expressed as a dollar amount).

''(iv) Any other information the Secretary may require that is not duplicative of any other reporting requirement under this subsection for purposes of promoting public awareness of ambulatory surgical center prices in advance of receiving an item or service from such an ambulatory surgical center, which may include any current payer-specific negotiated charges, clearly associated with the name of the third party payer and plan and expressed as a dollar amount, that applies to each such item or service.

''(C) METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish one or more methods and formats for ambulatory surgical centers to use in making public standard charges and prices (as applicable) pursuant to subparagraph (A). Any such method and format—

''(i) may be similar to any template made available by the Centers for Medicare

& Medicaid Services as of the date of the enactment of this paragraph;

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

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

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

"(A) IN GENERAL.—An ambulatory surgical center shall be deemed to have complied with the requirement described in subsection (b)(2)(A) (relating to shoppable services) if such surgical center maintains a price estimator tool described in subparagraph (B).

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

''(i) Such tool allows an individual to immediately obtain a price estimate (taking into account whether such individual is covered under any plan, coverage, or program described in clause (iv)(III)) for each Centers for Medicare & Medicaid Services-specified shoppable service that is furnished by such surgical center, and for each additional shoppable service as such surgical center may select, such that price estimates are available through such tool for at least 300 shoppable services (or for all such services, if such surgical center furnishes fewer than 300 shoppable services).

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

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

''(iv) Such tool does not require an individual seeking such an estimate to create an account or otherwise input personal information, except that such tool may re-

quire that such individual provide information specified by the Secretary, which may include the following:

"(I) The name of such individual.

"(II) The date of birth of such individual.

"(III) In the case such individual is covered under a group health plan, group or individual health insurance coverage, a Federal health care program, or the program established under chapter 89 of title 5, United States Code, an identifying number assigned by such plan, coverage, or program to such individual.

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

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

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

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

''(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each ambulatory surgical center's compliance with this subsection is reviewed not less frequently than once every 3 years.

''(5) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of an ambulatory surgical center that fails to comply with the requirements of this subsection—

''(i) the Secretary shall notify such ambulatory surgical center of such failure not later than 30 days after the date on

which the Secretary determines such failure exists; and

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

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of law, an ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of an ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each subsequent day during which such

failure is ongoing (not to exceed $300 per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to an ambulatory surgical center under clause (i).

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

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary may waive or reduce any penalty otherwise applicable with respect to an ambulatory surgical center under this subparagraph if the Secretary determines that imposition of such penalty would result in a significant

hardship for such ambulatory surgical center (such as in the case of an ambulatory surgical center located in a rural or underserved area where imposition of such penalty may result in, or contribute to, a lack of access to care for individuals in such area).

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

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

''(B) FEDERAL HEALTH CARE PROGRAM.—The term 'Federal health care program' has the meaning given such term in section 1128B.

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

''(D) GROUP HEALTH PLAN; GROUP HEALTH INSURANCE COVERAGE; INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms

'group health plan', 'group health insurance coverage', and 'individual health insurance coverage' have the meaning given such terms in section 2791 of the Public Health Service Act.

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

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

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

"(c) IMAGING SERVICES PRICE TRANSPARENCY.—

"(1) IN GENERAL.—Beginning January 1, 2025, each provider of services and supplier that receives payment under this title for furnishing a specified imaging service shall—

"(A) make publicly available (in a form and manner specified by the Secretary) on an Internet website the information described in paragraph (2) with respect to each such service that such provider of services or supplier furnishes; and

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

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

"(A) The discounted cash price for such service (or, if no such price exists, the gross charge for such service).

"(B) If required by the Secretary, the deidentified minimum negotiated rate in effect between such provider or supplier and any group health plan or group or individual health insurance coverage for such service and the deidentified maximum negotiated rate in effect between such provider or supplier and any such plan or coverage for such service.

''(3) METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish one or more methods and formats for each provider of services and supplier to use in compiling and making public standard charges and prices (as applicable) pursuant to paragraph (1). Any such method and format—

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

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

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

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

''(5) SPECIFICATION OF SERVICES.—Not later than January 1, 2025, the Secretary shall publish a list of at least 50 imaging services that the Secretary determines are shoppable (or all such services, if the Secretary determines that fewer than 50 such services are shoppable) between providers of services and suppliers of such services. The Secretary shall update such list as determined appropriate by the Secretary.

''(6) ENFORCEMENT.—

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

''(i) not later than 30 days after such determination, the Secretary shall notify such provider or supplier of such determination;

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

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

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

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

alty imposed under subsection (a) of such section.

''(D) AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary may waive or reduce any penalty otherwise applicable with respect to a provider of services or supplier under this subparagraph if the Secretary determines that imposition of such penalty would result in a significant hardship for such provider or supplier (such as in the case of a provider or supplier located in a rural or underserved area where imposition of such penalty may result in, or contribute to, a lack of access to care for individuals in such area).

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

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

''(A) GROUP HEALTH PLAN; GROUP HEALTH INSURANCE COVERAGE; INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms 'group health plan', 'group health insurance

coverage', and 'individual health insurance coverage' have the meaning given such terms in section 2791 of the Public Health Service Act.

"(B) SPECIFIED IMAGING SERVICE.—the term 'specified imaging service' means an imaging service that is included on the list published by the Secretary under subsection (e).

"(d) CLINICAL LABORATORY PRICE TRANSPARENCY.—

"(1) IN GENERAL.—Beginning January 1, 2025, each applicable laboratory that receives payment under this title for furnishing a specified clinical diagnostic laboratory test shall—

"(A) make publicly available (in a manner and form specified by the Secretary) on an Internet website the information described in paragraph (2) with respect to each such specified clinical diagnostic laboratory test that such laboratory is so available to furnish; and

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

"(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this subsection is, with respect to an applicable labora-

tory and a specified clinical diagnostic laboratory test, the following:

"(A) The discounted cash price for such test (or, if no such price exists, the gross charge for such test).

"(B) If required by the Secretary, the deidentified minimum negotiated rate in effect between such laboratory and any group health plan or group or individual health insurance coverage for such test and the deidentified maximum negotiated rate in effect between such laboratory and any such plan or coverage for such test.

"(3) METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish one or more methods and formats for each provider of services and supplier to use in compiling and making public standard charges and prices (as applicable) pursuant to paragraph (1). Any such method and format—

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

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

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

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

''(5) ENFORCEMENT.—

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

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

''(ii) upon request of the Secretary, such laboratory shall submit to the Secretary, not later than 45 days after such request is sent, a corrective action plan to comply with such subsection; and

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

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

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

alty imposed under subsection (a) of such section.

''(D) AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary may waive or reduce any penalty otherwise applicable with respect to an applicable laboratory under this paragraph if the Secretary determines that imposition of such penalty would result in a significant hardship for such laboratory (such as in the case of an applicable laboratory located in a rural or underserved area where imposition of such penalty may result in, or contribute to, a lack of access to care for individuals in such area).

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

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

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' has the meaning given such term in section 414.502, of title 42, Code of Federal Regulations (or any successor regulation).

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

"(C) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—The term 'specified clinical diagnostic laboratory test' means a clinical diagnostic laboratory test that is included on the list of shoppable services specified by the Centers for Medicare & Medicaid Services pursuant to section 180.60 of title 45, Code of Federal Regulations (or a successor regulation), other than such a test that is an advanced diagnostic laboratory test (as defined in section 1834A(d)(5)).".

(b) PUBLICATION OF HOSPITAL COMPLIANCE WITH PRICE TRANSPARENCY REQUIREMENTS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(u) PUBLICATION OF HOSPITAL COMPLIANCE WITH PRICE TRANSPARENCY REQUIREMENTS.—

"(1) IN GENERAL.—Beginning January 1, 2026, the Secretary shall, for each hospital with respect to which the Secretary has conducted a review of such hospital's compliance with the provisions of section 1899C(a) and found such hospital noncompliant with such provisions—

"(A) indicate such noncompliance on such hospital's entry on the Hospital Compare internet website (or a successor website); and

"(B) specify whether such hospital—

"(i) submitted a corrective action plan described in subsection (a)(5)(A)(ii) of such section (and, if so, the date such plan was received by the Secretary); or

"(ii) was subject to a civil monetary penalty imposed under subsection (a)(5)(B) of such section (and, if so, the date of the imposition of such penalty and the amount of such penalty).

"(2) ADDITIONS AND UPDATES.—The Secretary shall update any specification described in subparagraph (A) or (B) of paragraph (1) with respect to such hospital—

"(A) in the case of the specification described in such paragraph (1)(A), as soon as

practicable after sending the notification described in section 1899C(a)(5)(A)(i); and

''(B) in the case of the specification described in such paragraph (1)(B)(ii), as soon as practicable after the imposition of a civil monetary penalty described in such paragraph.''.

(c) CONFORMING AMENDMENT.—Section 2718(e) of the Public Health Service Act (42 U.S.C. 300gg–18(e)) is amended by adding at the end the following new sentence: ''The preceding sentence shall not apply beginning January 1, 2026.''.

(d) FUNDING.—

(1) IN GENERAL.—In addition to funds otherwise available, out of any moneys in the Treasury not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2024, to remain available until expended, for purposes of—

(A) implementing the amendment made by this subsection (a); and

(B) monitoring the compliance of entities with such amendment.

(2) REPORT ON EXPENDITURES.—Not later than 5 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means

and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that—

(A) describes activities undertaken funded through funds made available under paragraph (1), including a specification of the amount of such funds expended for each such activity; and

(B) identifies all entities with which the Secretary has entered into contracts for purposes of implementing the amendment made by this subsection (a), monitoring compliance of entities with such amendment, or providing technical assistance to entities to promote compliance with such amendment.

(e) IMPLEMENTATION.—

(1) ACCESSIBILITY.—In implementing section 1899C(a)(2)(A)(ii) of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall through rulemaking ensure that information made available pursuant to such amendment by an entity is so made available in plain, easily understandable language and that such entity provides access to such interpretation services, translations, and other assistive services to make such information accessible to individuals with

limited English proficiency and individuals with disabilities.

(2) TECHNICAL ASSISTANCE.—The Secretary of Health and Human Services shall, to the extent practicable, provide technical assistance to entities making public standard charges and prices (as applicable) pursuant to the amendment made by subsection (a).

SEC. 102. PROMOTING GROUP HEALTH PLAN PRICE TRANSPARENCY.

(a) PRICE TRANSPARENCY REQUIREMENTS.—

(1) IRC.—

(A) IN GENERAL.—Section 9819 of the Internal Revenue Code of 1986 (26. U.S.C. 9816) is amended to read as follows:

"SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.

''(a) COST SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, a group health plan shall permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect

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

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

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

''(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

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

"(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items and services furnished by a provider that is not a participating provider, under the plan (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

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

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall be treated as information specified in this paragraph, if determined appropriate by the Secretary.

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

''(A) is based on an Internet website;

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

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

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

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

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

"(iii) a provider that is not described in clause (ii);

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

"(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

"(b) RATE AND PAYMENT INFORMATION.—

"(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, each group health plan (other

than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

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

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan, the in-network rate in effect with each provider that is a participating provider with respect to such item or service, other than such a rate in effect with a provider that, during the 1-year period ending 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan.

''(B) With respect to each drug (identified by national drug code) for which benefits are

available under such plan, the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan.

''(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan during such period.

''(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available

under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other files made available under this subsection, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across group health plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

''(4) USER INSTRUCTIONS.—Each group health plan shall make available to the public instructions written in plain language explaining how individuals may search for information described in paragraph (2) in files submitted in accordance with paragraph (3). The Secretary shall develop and publish a tem-

plate that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) ATTESTATION.—Each group health plan shall post, along with rate and payment information made public by such plan, an attestation that such information is complete and accurate.

''(c) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 9816.

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service.''.

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

''Sec. 9819. Price transparency requirements.''.

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

"SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.

''(a) COST SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, a group health plan or a health insurance issuer offering group or individual health insurance coverage shall permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such individual through a self-service tool that meets the requirements of paragraph (3) or, at the option of such individual, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for

which benefits are available under a group health plan or group or individual health insurance coverage furnished by a health care provider to a participant or beneficiary of such plan, or enrollee in such coverage, the following:

"(A) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subsection (c)) for such item or service.

"(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

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

"(D) The amount the participant, beneficiary, or enrollee has already accumulated with respect to any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items

and services furnished by a provider that is not a participating provider, under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants, beneficiaries or enrollees enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall be treated as information specified in this paragraph, if determined appropriate by the Secretary.

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

''(A) is based on an Internet website;

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

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

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

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

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

''(iii) a provider that is not described in clause (ii);

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

or through use of a descriptive term for such item or service; and

''(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

''(b) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) or group or individual health insurance coverage, shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

''(2) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of paragraph (1), the rate

and payment information described in this paragraph is, with respect to a group health plan or group or individual health insurance coverage, the following:

''(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate in effect with each provider that is a participating provider with respect to such item or service, other than such a rate in effect with a provider that, during the 1-year period ending 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan or coverage.

''(B) With respect to each drug (identified by national drug code) for which benefits are available under such plan, the average amount paid by such plan or coverage (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than

such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

''(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

''(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such re-

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

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

''(5) ATTESTATION.—Each group health plan and group or individual health insurance coverage shall post, along with rate and payment information

made public by such plan or coverage, an attestation that such information is complete and accurate.

''(c) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 2791A–1(a)(3)(G)(ii).

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan or coverage and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan or coverage and such provider for such item or service.''.

(3) ERISA.—

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

''SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.

''(a) COST SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, a group health plan or a health insurance issuer offering group health insur-

ance coverage shall permit individuals to learn the amount of cost-sharing (including deductibles, co-payments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such individual through a self-service tool that meets the requirements of paragraph (3) or, at the option of such individual, through a paper disclosure or phone or other electronic disclosure (as selected by such individual and provided at no cost to such individual) that meets such requirements as the Secretary may specify.

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

"(A) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subsection (c)) for such item or service.

"(B) If such provider is not described in subparagraph (A), the maximum allowed amount for such item or service.

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

"(D) The amount the participant, beneficiary, or enrollee has already accumulated with respect to any deductible or out of pocket maximum, whether for items and services furnished by a participating provider or for items and services furnished by a provider that is not a participating provider, under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants, beneficiaries or enrollees enrolled in

the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

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

The Secretary may provide that information described in any of subparagraphs (A) through (F) not be treated as information specified in this paragraph, and specify additional information that shall be treated as information specified in this paragraph, if determined appropriate by the Secretary.

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

"(A) is based on an Internet website;

"(B) provides for real-time responses to requests described in paragraph (1);

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

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

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

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

"(iii) a provider that is not described in clause (ii);

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

"(F) meets any other requirement determined appropriate by the Secretary.

The Secretary may require such tool, as a condition of complying with subparagraph (E), to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

''(b) RATE AND PAYMENT INFORMATION.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Health Care Price Transparency Act of 2023, each group health plan (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act) or group health insurance coverage, shall, not less frequently than once every 3 months (or, in the case of information described in paragraph (2)(B), not less frequently than monthly), make available to the public the rate and payment information described in paragraph (2) in accordance with paragraph (3).

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

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate in effect with each provider that is a participating provider with respect to such item or service, other than such a rate in effect with a provider that, during the 1-year period ending 10 business days before the date of the publication of such information, did not submit any claim for such item or service to such plan or coverage.

"(B) With respect to each drug (identified by national drug code) for which benefits are available under such plan, the average amount paid by such plan or coverage (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of publication to each provider that was a participating provider with respect to such drug, broken down by each such provider, other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider, other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

"(3) MANNER OF PUBLICATION.—Rate and payment information required to be made available under this subsection shall be so made available in dollar amounts through 3 separate machine-readable files (or any successor technology, such as application program interface technology, determined appropriate by the Secretary) corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (2) that meet such requirements as specified by the Secretary. Such requirements shall ensure that such files are limited to an appropriate size, do not include disclosure of unnecessary duplicative information contained in other

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

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

''(5) ATTESTATION.—Each group health plan and group health insurance coverage shall post, along with rate and payment information made public by such plan or coverage, an attestation that such information is complete and accurate.

''(c) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 716(a)(3)(G)(ii).

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan or coverage and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan or coverage and such provider for such item or service.''.

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

''Sec. 719. Price transparency requirements.''.

(b) ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing the amendments made by subsection (a), the Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall take reasonable steps to ensure the accessibility of information made available pursuant to such amendments, including reasonable steps to ensure that such information is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided by group health plans and health insurance issuers

offering group or individual health insurance coverage to make such information accessible to those with limited English proficiency and those with disabilities.

(c) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by subsection (a) may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158) for any plan year beginning before the date that is 2 years after the date of the enactment of this Act.

SEC. 103. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

(a) IRC.—

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

''SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 3 years after the date of enactment of this section, a group health plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan, shall not enter into a contract

with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan, from making the report described in subsection (b).

''(b) ANNUAL REPORT.—

''(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 3 years after the date of enactment of this section, for each such plan year, a group health plan, or an entity providing pharmacy benefits management services on behalf of such a plan, shall submit to the plan sponsor (as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974) of such plan a report in a machine-readable format. Each such report shall include, with respect to such plan provided for such plan year—

''(A) to the extent feasible, information collected from drug manufacturers (or an entity administering copay assistance on behalf of such manufacturers) by such plan (or entity or subsidiary providing pharmacy benefits management services on behalf of such plan) on the

total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan;

''(B) a list of each drug covered by such plan that was dispensed during the plan year, including, with respect to each such drug during such plan year—

''(i) the brand name, chemical entity, and National Drug Code;

''(ii) the number of participants and beneficiaries for whom the drug was dispensed during the plan year, the total number of prescription claims for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, disaggregated by dispensing channel (such as retail, mail order, or specialty pharmacy);

''(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dosage unit;

"(iv) the total out-of-pocket spending by participants and beneficiaries on such drug, including participant and beneficiary spending through copayments, coinsurance, and deductibles;

"(v) for any drug for which gross spending of the group health plan exceeded $10,000 during the plan year—

"(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

"(II) the rationale for the formulary placement of such drug in that therapeutic category or class, if applicable;

"(vi) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration for claims incurred for such drug during the plan year;

''(vii) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan on such drug; and

''(viii) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan and its participants and beneficiaries after manufacturer rebates, fees, and other remuneration for such drug dispensed during the plan year;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan during the plan year, and, with respect to each such therapeutic category or class of drugs, during the plan year—

''(i) total gross spending by the plan, before manufacturer rebates, fees, or other manufacturer remuneration;

''(ii) the number of participants and beneficiaries who were dispensed a drug covered by such plan in that category or class, broken down by each such drug (identified by National Drug Code);

"(iii) if applicable to that category or class, a description of the formulary tiers and utilization management (such as prior authorization or step therapy) employed for drugs in that category or class; and

"(iv) the total out-of-pocket spending by participants and beneficiaries, including participant and beneficiary spending through copayments, coinsurance, and deductibles;

"(D) total gross spending on prescription drugs by the plan during the plan year, before rebates and other manufacturer fees or remuneration;

"(E) total amount received, or expected to be received, by the health plan in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan during the plan year;

"(F) the total net spending on prescription drugs by the health plan during the plan year; and

"(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's business to the pharmacy benefits manager.

"(2) PRIVACY REQUIREMENTS.—Entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

"(3) DISCLOSURE AND REDISCLOSURE.—

"(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

"(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in

this section prevents an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

''(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior.

''(4) REPORT TO GAO.—A group health plan, or an entity providing pharmacy benefits management services on behalf of a group health plan, shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such plan, and other such reports as requested, in accordance

with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other information that the Comptroller General determines necessary to carry out the study under section 103(d) of the Health Care Price Transparency Act of 2023.

''(5) STANDARD FORMAT.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking standards for entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a group health plan or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary of the Treasury to a report described in subsection (b)(1) or information related to compliance with subsection (a) or (b) by such plan or other entity subject to such subsections.

''(d) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Inter-

nal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 9826. Oversight of pharmacy benefits manager services.".

(b) PHSA.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) in part D (42 U.S.C. 300gg–111 et seq.), by adding at the end the following new section:

"SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

"(a) IN GENERAL.—For plan years beginning on or after the date that is 3 years after the date of enactment of this section, a group health plan or health insurance issuer offering group health insurance coverage, or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer, shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making the report described in subsection (b).

"(b) ANNUAL REPORT.—

"(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 3 years after

the date of enactment of this section, for each such plan year, a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of such a plan or an issuer, shall submit to the plan sponsor (as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974) of such plan or coverage a report in a machine-readable format. Each such report shall include, with respect to such plan or coverage provided for such plan year—

''(A) to the extent feasible, information collected from drug manufacturers (or an entity administering copay assistance on behalf of such manufacturers) by such plan or issuer (or entity or subsidiary providing pharmacy benefits management services on behalf of such plan or issuer) on the total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants, beneficiaries, and enrollees in such plan or coverage;

''(B) a list of each drug covered by such plan or coverage that was dispensed during the

plan year, including, with respect to each such drug during such plan year—

"(i) the brand name, chemical entity, and National Drug Code;

"(ii) the number of participants, beneficiaries, and enrollees for whom the drug was dispensed during the plan year, the total number of prescription claims for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, disaggregated by dispensing channel (such as retail, mail order, or specialty pharmacy);

"(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dosage unit;

"(iv) the total out-of-pocket spending by participants, beneficiaries, and enrollees on such drug, including participant, beneficiary, and enrollee spending through co-payments, coinsurance, and deductibles;

"(v) for any drug for which gross spending of the group health plan or

health insurance coverage exceeded $10,000 during the plan year—

''(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

''(II) the rationale for the formulary placement of such drug in that therapeutic category or class, if applicable;

''(vi) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration for claims incurred for such drug during the plan year;

''(vii) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on such drug; and

''(viii) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan or health insurance coverage and its participants, beneficiaries, and enrollees, after manufacturer rebates, fees, and other remuneration for such drug dispensed during the plan year;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan or health insurance coverage during the plan year, and, with respect to each such therapeutic category or class of drugs, during the plan year—

''(i) total gross spending by the plan or coverage, before manufacturer rebates, fees, or other manufacturer remuneration;

''(ii) the number of participants, beneficiaries, and enrollees who were dispensed a drug covered by such plan or coverage in that category or class, broken down by each such drug (identified by National Drug Code);

''(iii) if applicable to that category or class, a description of the formulary tiers

and utilization management (such as prior authorization or step therapy) employed for drugs in that category or class; and

''(iv) the total out-of-pocket spending by participants, beneficiaries, and enrollees, including participant, beneficiary, and enrollee spending through copayments, coinsurance, and deductibles;

''(D) total gross spending on prescription drugs by the plan or coverage during the plan year, before rebates and other manufacturer fees or remuneration;

''(E) total amount received, or expected to be received, by the health plan or health insurance coverage in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan or health insurance coverage during the plan year;

''(F) the total net spending on prescription drugs by the health plan or health insurance coverage during the plan year; and

"(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's or health insurance issuer's business to the pharmacy benefits manager.

"(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

"(3) DISCLOSURE AND REDISCLOSURE.—

"(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

"(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

"(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior.

"(4) REPORT TO GAO.—A group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy ben-

efits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other information that the Comptroller General determines necessary to carry out the study under section 103(d) of the Health Care Price Transparency Act of 2023.

''(5) STANDARD FORMAT.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking standards for health insurance issuers and entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—Notwithstanding section 2723, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall enforce this section.

''(2) FAILURE TO PROVIDE TIMELY INFORMATION.—A health insurance issuer or an entity providing pharmacy benefits management services that violates subsection (a) or fails to provide information required under subsection (b) shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—A health insurance issuer or entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary of Health and Human Services to a report described in subsection (b)(1) or information related to compliance with subsection (a) or (b) by such issuer, plan, or other entity subject to such subsections.

''(e) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''; and

(2) in section 2723 of such Act (42 U.S.C. 300gg–22)—

(A) in subsection (a)—

(i) in paragraph (1), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(ii) in paragraph (2), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(B) in subsection (b)—

(i) in paragraph (1), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D'';

(ii) in paragraph (2)(A), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''; and

(iii) in paragraph (2)(C)(ii), by inserting ''(other than subsections (a) and (b) of section 2799A–11)'' after ''part D''.

(c) ERISA.—

(1) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021 et seq.) is amended—

(A) in subpart B of part 7 (29 U.S.C. 1185 et seq.), by adding at the end the following:

''SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 3 years after the date of enactment of this section, a group health plan or health insurance

issuer offering group health insurance coverage, or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer, shall not enter into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making the report described in subsection (b).

''(b) ANNUAL REPORT.—

''(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 3 years after the date of enactment of this section, for each such plan year, a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of such a plan or an issuer, shall submit to the plan sponsor (as defined in section 3(16)(B)) of such plan or coverage a report in a machine-readable format. Each such report shall include, with respect to such plan or coverage provided for such plan year—

''(A) to the extent feasible, information collected from drug manufacturers (or an entity administering copay assistance on behalf of such manufacturers) by such plan or issuer (or entity or subsidiary providing pharmacy benefits management services on behalf of such plan or issuer) on the total amount of copayment assistance dollars paid, or copayment cards applied, that were funded by the drug manufacturer with respect to the participants, beneficiaries, and enrollees in such plan or coverage;

''(B) a list of each drug covered by such plan or coverage that was dispensed during the plan year, including, with respect to each such drug during such plan year—

''(i) the brand name, chemical entity, and National Drug Code;

''(ii) the number of participants, beneficiaries, and enrollees for whom the drug was dispensed during the plan year, the total number of prescription claims for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, disaggregated by dispensing channel

(such as retail, mail order, or specialty pharmacy);

''(iii) the wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dosage unit;

''(iv) the total out-of-pocket spending by participants, beneficiaries, and enrollees on such drug, including participant, beneficiary, and enrollee spending through co-payments, coinsurance, and deductibles;

''(v) for any drug for which gross spending of the group health plan or health insurance coverage exceeded $10,000 during the plan year—

''(I) a list of all other drugs in the same therapeutic category or class, including brand name drugs and biological products and generic drugs or biosimilar biological products that are in the same therapeutic category or class as such drug; and

''(II) the rationale for the formulary placement of such drug in that

therapeutic category or class, if applicable;

''(vi) the amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration for claims incurred for such drug during the plan year;

''(vii) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on such drug; and

''(viii) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the health plan or health insurance coverage and its participants, beneficiaries, and enrollees, after manufacturer rebates, fees, and other remuneration for such drug dispensed during the plan year;

''(C) a list of each therapeutic category or class of drugs that were dispensed under the health plan or health insurance coverage during the plan year, and, with respect to each such

therapeutic category or class of drugs, during the plan year—

"(i) total gross spending by the plan or coverage, before manufacturer rebates, fees, or other manufacturer remuneration;

"(ii) the number of participants, beneficiaries, and enrollees who were dispensed a drug covered by such plan or coverage in that category or class, broken down by each such drug (identified by National Drug Code);

"(iii) if applicable to that category or class, a description of the formulary tiers and utilization management (such as prior authorization or step therapy) employed for drugs in that category or class; and

"(iv) the total out-of-pocket spending by participants, beneficiaries, and enrollees, including participant, beneficiary, and enrollee spending through copayments, coinsurance, and deductibles;

"(D) total gross spending on prescription drugs by the plan or coverage during the plan year, before rebates and other manufacturer fees or remuneration;

"(E) total amount received, or expected to be received, by the health plan or health insurance coverage in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under that health plan or health insurance coverage during the plan year;

"(F) the total net spending on prescription drugs by the health plan or health insurance coverage during the plan year; and

"(G) amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's or health insurance issuer's business to the pharmacy benefits manager.

"(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under

section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller

General of the United States, or applicable State agencies.

"(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior.

"(4) REPORT TO GAO.—A group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan sponsor under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5), and such other information that the Comptroller General determines necessary to carry out the study under section 103(d) of the Health Care Price Transparency Act of 2023.

''(5) STANDARD FORMAT.—Not later than 18 months after the date of enactment of this section, the Secretary shall specify through rulemaking standards for health insurance issuers and entities required to submit reports under paragraph (4) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—Notwithstanding section 502, the Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, shall enforce this section.

''(2) FAILURE TO PROVIDE TIMELY INFORMATION.—A health insurance issuer or an entity providing pharmacy benefits management services that violates subsection (a) or fails to provide information required under subsection (b) shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

''(3) FALSE INFORMATION.—A health insurance issuer or entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money

penalty shall be in addition to other penalties as may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

''(5) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Secretary of Labor to a report described in subsection (b)(1) or information related to compliance with subsection (a) or (b) by such issuer, plan, or other entity subject to such subsections.

''(e) DEFINITION.—In this section, the term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''; and

(B) in section 502 (29 U.S.C. 1132)—

(i) in subsection (a)—

(I) in paragraph (6), by striking ''or (9)'' and inserting ''(9), or (13)'';

(II) in paragraph (10), by striking at the end ''or'';

(III) in paragraph (11), at the end by striking the period and inserting ''; or''; and

(IV) by adding at the end the following new paragraph:

''(12) by the Secretary, in consultation with the Secretary of Health and Human Services, and the Secretary of the Treasury, to enforce section 726.'';

(ii) in subsection (b)(3), by inserting ''and subsections (a)(12) and (c)(13)'' before '', the Secretary is not''; and

(iii) in subsection (c), by adding at the end the following new paragraph:

''(13) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.—

"(A) FAILURE TO PROVIDE TIMELY INFORMATION.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, may impose a penalty against any group health plan or health insurance issuer offering group health insurance coverage, or entity providing pharmacy benefits management services on behalf of such plan or coverage, that violates section 726(a) or fails to provide information required under section 726(b), in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

"(B) FALSE INFORMATION.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of the Treasury, may impose a penalty against a group health plan or health insurance issuer offering group health coverage, or an entity providing pharmacy benefits management services on behalf of such plan or coverage, that knowingly provides false information under section 726 in an amount not to exceed $100,000 for each item of false information. Such penalty

shall be in addition to other penalties as may be prescribed by law.

''(C) WAIVERS.—The Secretary may waive penalties under subparagraph (A), or extend the period of time for compliance with a requirement of section 726, for an entity in violation of such section that has made a good-faith effort to comply with such section.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 725 the following new item:

''Sec. 726. Oversight of pharmacy benefits manager services.''.

(d) GAO STUDY.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on—

(A) pharmacy networks of group health plans, health insurance issuers, and entities providing pharmacy benefits management services under such group health plan or group or individual health insurance coverage, including networks that have pharmacies that are under common ownership (in whole or part) with

group health plans, health insurance issuers, or entities providing pharmacy benefits management services or pharmacy benefits administrative services under group health plan or group or individual health insurance coverage;

(B) as it relates to pharmacy networks that include pharmacies under common ownership described in subparagraph (A)—

(i) whether such networks are designed to encourage enrollees of a plan or coverage to use such pharmacies over other network pharmacies for specific services or drugs, and if so, the reasons the networks give for encouraging use of such pharmacies; and

(ii) whether such pharmacies are used by enrollees disproportionately more in the aggregate or for specific services or drugs compared to other network pharmacies;

(C) whether group health plans and health insurance issuers offering group or individual health insurance coverage have options to elect different network pricing arrangements in the marketplace with entities that provide pharmacy benefits management services, the preva-

lence of electing such different network pricing arrangements;

(D) pharmacy network design parameters that encourage enrollees in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are wholly or partially-owned by that issuer or entity; and

(E) the degree to which mail order, specialty, or retail pharmacies that dispense prescription drugs to an enrollee in a group health plan or health insurance coverage that are under common ownership (in whole or part) with group health plans, health insurance issuers, or entities providing pharmacy benefits management services or pharmacy benefits administrative services under group health plan or group or individual health insurance coverage receive reimbursement that is greater than the median price charged to the group health plan or health insurance issuer when the same drug is dispensed to enrollees in the plan or coverage by other pharmacies included in the pharmacy network of that plan, issuer, or entity that are not wholly or partially owned by the health in-

surance issuer or entity providing pharmacy benefits management services.

(2) REQUIREMENT.—The Comptroller General of the United States shall ensure that the report under paragraph (1) does not contain information that would allow a reader to identify a specific plan or entity providing pharmacy benefits management services or otherwise contain commercial or financial information that is privileged or confidential.

(3) DEFINITIONS.—In this subsection, the terms ''group health plan'', ''health insurance coverage'', and ''health insurance issuer'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 104. REPORTS ON HEALTH CARE TRANSPARENCY TOOLS AND DATA REQUIREMENTS.

(a) INITIAL REPORT.—Not later than December 31, 2024, the Comptroller General of the United States shall submit to the Committees (as defined in subsection (d)) an initial report that—

(1) identifies and describes health care transparency tools and Federal health care reporting requirements (as described in subsection (d)) that are in effect as of the date of the submission of such initial report, including the frequency of reports with

respect to each such requirement and whether any such requirements are duplicative;

(2) reviews how such reporting requirements are enforced;

(3) analyzes whether the public availability of health care transparency tools, and the publication of data pursuant to such reporting requirements, has—

(A) been utilized and valued by consumers, including reasons for such utilization (or lack thereof); and

(B) assisted health insurance plan sponsors and fiduciaries improve benefits, lower health care costs for plan participants, and meet fiduciary requirements;

(4) includes recommendations to the Committees, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury to—

(A) improve the efficiency, accuracy, and usability of health care transparency tools;

(B) streamline Federal health care reporting requirements to eliminate duplicative requirements and reduce the burden on entities

required to submit reports pursuant to such provisions;

(C) improve the accuracy and efficiency of such reports while maintaining the integrity and usability of the data provided by such reports;

(D) address any gaps in data provided by such reports; and

(E) ensure that the data and information reported is comparable and usable to consumers, including patients, plan sponsors, and policy makers.

(b) FINAL REPORT.—Not later than December 31, 2028, the Comptroller General of the United States shall submit to the Committees a report that includes—

(1) the information provided in the initial report, along with any updates to such information; and

(2) any new information with respect to health care transparency tools that have been released following the submission of such initial report, or new reporting requirements in effect as of the date of the submission of the final report.

(c) REPORT ON EXPANDING PRICE TRANSPARENCY REQUIREMENTS.—Not later than December 31, 2025, the

Comptroller General of the United States, in consultation with the Secretary of Health and Human Services, health care provider groups, and patient advocacy groups, shall submit to the Committees a report that includes recommendations to expand price transparency reporting requirements to additional care settings, with an emphasis on settings where shoppable services (as defined in subsection (d)) are furnished.

(d) DEFINITIONS.—In this section:

(1) COMMITTEES.—The term ''Committees'' means the Committee on Ways and Means, the Committee on Energy and Commerce, and the Committee on Education and the Workforce of the House of Representatives, and the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate.

(2) FEDERAL HEALTH CARE REPORTING REQUIREMENTS.—The term ''Federal health care reporting requirements'' includes regulatory and statutory requirements with respect to the reporting and publication of health care price, cost access, and quality data, including requirements established by the Consolidated Appropriations Act of 2021 (Public Law 116–260), this Act, and other reporting and publication requirements with respect to trans-

parency in health care as identified by the Comptroller General of the United States.

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

SEC. 105. REPORT ON INTEGRATION IN MEDICARE.

(a) REQUIRED MA AND PDP REPORTING.—

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

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

''(A) IN GENERAL.—For plan year 2025 and for every third plan year thereafter, each MA organization offering an MA plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary—

''(i) the taxpayer identification number for each health care provider that was a specified health care provider with re-

spect to such organization during such year;

"(ii) the total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from, such specified health care providers during such plan year; and

"(iii) the total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from, providers of services and suppliers not described in clause (ii) during such plan year.

"(B) DEFINITION.—For purposes of this paragraph, the term 'specified health care provider' means, with respect to an MA organization and a plan year, a provider of services or supplier with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such organization) is a person with an ownership or control interest (as so defined).".

(2) PRESCRIPTION DRUG PLANS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C.

1395w–112(b)) is amended by adding at the end the following new paragraph:

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

"(A) IN GENERAL.—For plan year 2025 and for every third plan year thereafter, each PDP sponsor offering a prescription drug plan under this part during such plan year shall submit to the Secretary, at a time and in a manner specified by the Secretary, the taxpayer identification number and National Provider Identifier for each pharmacy that was a specified pharmacy with respect to such sponsor during such year.

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

"(i) such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such sponsor) is a person with an ownership or control interest (as so defined); or

''(ii) a pharmacy benefit manager offering services under such plan (or any person with an ownership or control interest (as so defined) in such sponsor) is a person with an ownership or control interest (as so defined).''.

(b) MEDPAC REPORTS.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.), as amended by section 101, is further amended by adding at the end the following new section:

''SEC. 1899D. REPORTS ON VERTICAL INTEGRATION UNDER MEDICARE.

''(a) IN GENERAL.—Not later than June 15, 2029, and every 3 years thereafter, the Medicare Payment Advisory Commission shall submit to Congress a report on the state of vertical integration in the health care sector during the applicable year with respect to entities participating in the Medicare program, including health care providers, pharmacies, prescription drug plan sponsors, Medicare Advantage organizations, and pharmacy benefit managers. Such report shall include—

''(1) with respect to Medicare Advantage organizations, the evaluation described in subsection (b);

''(2) with respect to prescription drug plans, pharmacy benefit managers, and pharmacies, the

comparisons and evaluations described in subsection (c);

''(3) with respect to Medicare Advantage plans under which benefits are available for physician-administered drugs, the information described in subsection (d); and

''(4) the identifications described in subsection (e); and

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

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

''(1) the average number of qualifying diagnoses made during such year with respect to enrollees of a Medicare Advantage plan offered by such organization who, during such year, received a health risk assessment from a specified health care provider;

''(2) the average risk score for such enrollees who received such an assessment during such year;

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

''(4) the average risk score for enrollees of such plan who received any item or service from a specified health care provider during such year;

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

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

''(c) PRESCRIPTION DRUG PLANS.—For purposes of subsection (a)(2), the comparisons and evaluations described in this subsection are, with respect to prescription drug plans and an applicable year, the following:

''(1) For each covered part D drug for which benefits are available under such a plan, a comparison of the average negotiated rate in effect with specified pharmacies with such rates in effect for in-

network pharmacies that are not specified pharmacies.

''(2) Comparisons of the following:

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

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

''(C) Fees paid under by plan to specified pharmacy benefit managers compared to such fees paid to pharmacy benefit managers that are not specified pharmacy benefit managers.

''(3) An evaluation of the total amount of direct and indirect remuneration for covered part D drugs passed through to prescription drug plan sponsors and the total amount retained by pharmacy benefit managers (including entities under contract with such a manager).

''(4) To the extent that the available data permits, an evaluation of fees charged by rebate aggregators that are affiliated with plan sponsors.

''(d) PHYSICIAN-ADMINISTERED DRUGS.—For purposes of subsection (a)(3), the information described in this subsection is, with respect to physician-administered drugs for which benefits are available under a Medicare Advantage plan during an applicable year, the following:

''(1) With respect to each such plan, an identification of each drug for which benefits were available under such plan only when administered by a health care provider that acquired such drug from an affiliated pharmacy.

''(2) An evaluation of the difference between the total number of drugs administered by a health care provider that were acquired from affiliated pharmacies compared to the number of such drugs so administered that were acquired from pharmacies other than affiliated pharmacies, and an evaluation of the difference in payments for such drugs so administered when acquired from a specified pharmacy and when acquired from a pharmacy that is not a specified pharmacy.

''(3) An evaluation of the dollar value of all such drugs that were not so administered because of

a delay attributable to an affiliated pharmacy compared to the dollar value of all such drugs that were not so administered because of a delay attributable to pharmacy that is not an affiliated pharmacy.

''(4) The number of enrollees administered such a drug that was acquired from an affiliated pharmacy.

''(5) The number of enrollees furnished such a drug that was acquired from a pharmacy that is not an affiliated pharmacy.

''(e) IDENTIFICATIONS.—For purposes of subsection (a)(4), the identifications described in this subsection are, with respect to an applicable year, identifications of each health care entity participating under the Medicare program with respect to which another health care entity so participating is a person with an ownership or control interest (as defined in section 1124(a)(3)).

''(f) DEFINITIONS.—In this section:

''(1) AFFILIATED PHARMACY.—The term 'affiliated pharmacy' means, with respect to a Medicare Advantage plan offered by a Medicare Advantage organization, a pharmacy with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in

such organization) is a person with an ownership or control interest (as so defined).

''(2) APPLICABLE YEAR.—The term 'applicable year' means, with respect to a report submitted under subsection (a), the first calendar year beginning at least 4 years prior to the date of the submission of such report.

''(3) COVERED PART D DRUG.—The term 'covered part D drug' has the meaning given such term in section 1860D–2(e).

''(4) DIRECT AND INDIRECT REMUNERATION.—The term 'direct and indirect remuneration' has the meaning given such term in section 423.308 of title 42, Code of Federal Regulations (or any successor regulation).

''(5) QUALIFYING DIAGNOSIS.—The term 'qualifying diagnosis' means, with respect to an enrollee of a Medicare Advantage plan, a diagnosis that is taken into account in calculating a risk score for such enrollee under the risk adjustment methodology established by the Secretary pursuant to section 1853(a)(3).

''(6) RISK SCORE.—The term 'risk score' means, with respect to an enrollee of a Medicare Ad-

vantage plan, the score calculated for such individual using the methodology described in paragraph (5).

''(7) PHYSICIAN-ADMINISTERED DRUG.—The term 'physician-administered drug' means a drug furnished to an individual that, had such individual been enrolled under part B and not enrolled under part C, would have been payable under section 1842(o).

''(8) SPECIFIED HEALTH CARE PROVIDER.—The term 'specified health care provider' means, with respect to a Medicare Advantage plan offered by a Medicare Advantage organization, a health care provider with respect to which such organization (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such organization) is a person with an ownership or control interest (as so defined).

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

''(A) such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such sponsor) is a person

with an ownership or control interest (as so defined); or

''(B) a pharmacy benefit manager offering services under such plan (or any person with an ownership or control interest (as so defined) in such sponsor) is a person with an ownership or control interest (as so defined).

''(10) SPECIFIED PHARMACY BENEFIT MANAGER.—The term 'specified pharmacy benefit manager' means, with respect to a prescription drug plan offered by a prescription drug plan sponsor, a pharmacy benefit manager with respect to which such sponsor (or any person with an ownership or control interest (as defined in section 1124(a)(3)) in such sponsor) is a person with an ownership or control interest (as so defined).''.

TITLE II—FAIR PRICES FOR PATIENTS

SEC. 201. LIMITATION ON COST SHARING TO NET PRICE AMOUNT UNDER MEDICARE PART D.

(a) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(1) in subsection (b)—

(A) in paragraph (2)(A), by striking ''(8) and (9)'' and inserting ''(8), (9), and (10)'';

(B) in paragraph (9)(B)(ii), by striking ''For a plan year'' and inserting ''Subject to paragraph (10), for a plan year''; and

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

''(10) LIMITATION ON COST SHARING TO NET PRICE AMOUNT.—

''(A) IN GENERAL.—For a plan year beginning on or after January 1, 2027, the coverage provides benefits for a supply of a covered part D drug dispensed by a pharmacy, for costs in excess of the deductible specified in paragraph (1) and prior to an individual reaching the out-of-pocket threshold under paragraph (4), with cost-sharing for a month's supply that does not exceed the average net price for such a supply of such drug during such plan year (or, if lower, the applicable cash price for such a supply of such drug so dispensed by such pharmacy).

''(B) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE CASH PRICE.—The term 'applicable cash price' means, with respect to a supply of a covered part D drug dispensed by a pharmacy, the price

that such pharmacy would charge for such supply of such drug dispensed to an individual without benefits for such drug under any Federal health care program (as defined in section 1128B), a group health plan or group or individual health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), or the program established under chapter 89 of title 5, United States Code.

''(ii) AVERAGE NET PRICE.—The term 'average net price' means, with respect to a supply of a covered part D drug, a prescription drug plan, and a plan year, the average amount paid under such plan (including any amounts paid by an individual enrolled under such plan as cost sharing for such drug) as payment for such a supply of such drug dispensed during such year, less any rebates or other forms of remuneration received under such plan with respect to such drug.''; and

(2) in subsection (c), by adding at the end the following new paragraph:

''(7) COST SHARING LIMITED TO NET PRICE.—The coverage is provided in accordance with subsection (b)(10).''.

(b) CONFORMING AMENDMENT TO COST-SHARING FOR LOW-INCOME INDIVIDUALS.—Section 1860D–14(a)(1)(D)(iii) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(iii)) is amended by adding at the end the following new sentence: ''For plan year 2027 and subsequent plan years, the copayment amount applicable under this clause to a supply of a covered part D drug dispensed to the individual may not exceed the amount provided under section 1860D–2(b)(10).''.

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

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

(2) an analysis of enforcement of such amendments;

(3) recommendations with respect to improving such enforcement; and

(4) recommendations relating to improving public disclosure, and public awareness of, the requirements of such amendments.

SEC. 202. REQUIRING A SEPARATE IDENTIFICATION NUMBER AND AN ATTESTATION FOR EACH OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.

(a) IN GENERAL.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

"(23) USE OF UNIQUE HEALTH IDENTIFIERS; ATTESTATION.—

"(A) IN GENERAL.—No payment may be made under this subsection (or under an applicable payment system pursuant to paragraph (21)) for items and services furnished on or after January 1, 2026, by an off-campus outpatient department of a provider (as defined in subparagraph (C)) unless—

"(i) such department has obtained, and such items and services are billed under, a standard unique health identifier for health care providers (as described in section 1173(b)) that is separate from such identifier for such provider; and

"(ii) such provider has submitted to the Secretary, during the 2-year period ending on the date such items and services are so furnished, an attestation that such

department is compliant with the requirements described in section 413.65 of title 42, Code of Federal Regulations (or a successor regulation).

"(B) PROCESS FOR SUBMISSION AND REVIEW.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall, through notice and comment rulemaking, establish a process for each provider with an off-campus outpatient department of a provider to submit an attestation pursuant to subparagraph (A)(ii), and for the Secretary to review each such attestation and determine, through site visits, remote audits, or other means (as determined appropriate by the Secretary), whether such department is compliant with the requirements described in such subparagraph.

"(C) OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER DEFINED.—For purposes of this paragraph, the term 'off-campus outpatient department of a provider' means a department of a provider (as defined in section 413.65 of title 42, Code of Federal Regulations, or any successor regulation) that is not located—

"(i) on the campus (as defined in such section) of such provider; or

"(ii) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).".

(b) HHS OIG ANALYSIS.—Not later than January 1, 2030, the Inspector General of the Department of Health and Human Services shall submit to Congress—

(1) an analysis of the process established by the Secretary of Health and Human Services to conduct the reviews and determinations described in section 1833(t)(23)(B) of the Social Security Act, as added by subsection (a) of this section; and

(2) recommendations based on such analysis, as the Inspector General determines appropriate.

SEC. 203. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES FURNISHED OFF-CAMPUS.

(a) IN GENERAL.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

"(H) PARITY IN FEE SCHEDULE AMOUNT FOR CERTAIN SERVICES FURNISHED BY AN

OFF-CAMPUS OUTPATIENT DEPARTMENT OF A PROVIDER.—

"(i) IN GENERAL.—Subject to clause (iii), in the case of specified OPD services (as defined in clause (v)) that are furnished during 2025 or a subsequent year by an off-campus outpatient department of a provider (as defined in clause (iv)) (or, in the case of an off-campus outpatient department of a provider that is a hospital described in section 1886(d)(1)(B)(v), or is located in a rural area or a health professional shortage area, such services that are furnished during 2026 or a subsequent year), there shall be substituted for the amount otherwise determined under this subsection for such service and year an amount equal to the payment amount that would have been payable under the applicable payment system under this part (other than under this subsection) had such services been furnished by such a department subject to such payment system pursuant to paragraph (21)(C).

"(ii) NOT BUDGET NEUTRAL IMPLEMENTATION.—In making any budget neutrality adjustments under this subsection for 2025 or a subsequent year, the Secretary shall not take into account the reduced expenditures that result from the application of this subparagraph.

"(iii) TRANSITION.—The Secretary shall provide for a 4-year phase-in of the application of clause (i), with clause (i) being fully applicable for specified OPD services beginning with 2028 (or in the case of an off-campus outpatient department of a provider that is a hospital described in section 1886(d)(1)(B)(v), or is located in a rural area or a health professional shortage area, beginning with 2029).

"(iv) OFF-CAMPUS DEPARTMENT OF A PROVIDER.—For purposes of this subparagraph, the term 'off-campus outpatient department of a provider' means a department of a provider (as defined in section 413.65(a)(2) of title 42, Code of Federal Regulations) that is not located—

"(I) on the campus (as such term is defined in such section) of such provider; or

"(II) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section).

"(v) OTHER DEFINITIONS.—For purposes of this subparagraph:

"(I) DESIGNATED AMBULATORY PAYMENT CLASSIFICATION GROUP.—The term 'designated ambulatory payment classification group' means an ambulatory payment classification group for drug administration services.

"(II) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term in section 332(a)(1)(A) of the Public Health Service Act.

"(III) RURAL AREA.—The term 'rural area' has the meaning given such term in section 1886(d)(2)(D).

"(IV) SPECIFIED OPD SERVICES.—The term 'specified OPD services' means covered OPD services assigned to a designated ambulatory payment classification group.".

(b) IMPLEMENTATION.—Section 1833(t)(12) of the Social Security Act (42 U.S.C. 1395l(t)(12)) is amended—

(1) in subparagraph (D), by striking "and" at the end;

(2) in subparagraph (E), by striking the period at the end and inserting "; and"; and

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

"(F) the determination of any payment amount under paragraph (16)(H), including the transition under clause (iii) of such paragraph.".

TITLE III—PATIENT-FOCUSED INVESTMENTS

SEC. 301. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of a Medicare Advantage plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (5)) during a plan year, such plan shall—

''(A) beginning with the third plan year beginning after the date of the enactment of this subsection—

''(i) establish the electronic prior authorization program described in paragraph (2); and

''(ii) meet the enrollee protection standards specified pursuant to paragraph (4); and

''(B) beginning with the fourth plan year beginning after the date of the enactment of

this subsection, meet the transparency requirements specified in paragraph (3).

''(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—

''(i) a prior authorization request from a provider of services or supplier to a Medicare Advantage plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider or supplier; and

''(ii) any attachment relating to such request or response.

''(B) ELECTRONIC TRANSMISSION.—

''(i) EXCLUSIONS.—For purposes of this paragraph, a facsimile, a proprietary payer portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic

transmission described in subparagraph (A).

''(ii) STANDARDS.—An electronic transmission described in subparagraph (A) shall comply with—

''(I) applicable technical standards adopted by the Secretary pursuant to section 1173; and

''(II) other requirements to promote the standardization and streamlining of electronic transactions under this part specified by the Secretary.

''(iii) DEADLINE FOR SPECIFICATION OF ADDITIONAL REQUIREMENTS.—Not later than July 1, 2024, the Secretary shall finalize requirements described in clause (ii)(II).

''(C) REAL-TIME DECISIONS.—

''(i) IN GENERAL.—Subject to clause (iv), the program described in subparagraph (A) shall provide for real-time decisions (as defined by the Secretary in accordance with clause (v)) by a Medicare Advantage plan with respect to prior authorization requests for applicable items

and services identified by the Secretary pursuant to clause (ii) if such requests are submitted with all medical or other documentation required by such plan.

"(ii) IDENTIFICATION OF ITEMS AND SERVICES.—

"(I) IN GENERAL.—For purposes of clause (i), the Secretary shall identify, not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for the third plan year beginning after the date of the enactment of this subsection is required to be announced, applicable items and services for which prior authorization requests are routinely approved.

"(II) UPDATES.—The Secretary shall consider updating the applicable items and services identified under subclause (I) based on the information described in paragraph (3)(A)(i) (if available and determined practicable to utilize by the Secretary) and any other information determined appro-

priate by the Secretary not less frequently than biennially. The Secretary shall announce any such update that is to apply with respect to a plan year not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for such plan year is required to be announced.

''(iii) REQUEST FOR INFORMATION.—The Secretary shall issue a request for information for purposes of initially identifying applicable items and services under clause (ii)(I).

''(iv) EXCEPTION FOR EXTENUATING CIRCUMSTANCES.—In the case of a prior authorization request submitted to a Medicare Advantage plan for an individual enrolled in such plan during a plan year with respect to an item or service identified by the Secretary pursuant to clause (ii) for such plan year, such plan may, in lieu of providing a real-time decision with respect to such request in accordance with clause (i), delay such decision under extenuating circumstances (as specified by the Sec-

retary), provided that such decision is provided no later than 72 hours after receipt of such request (or, in the case that the provider of services or supplier submitting such request has indicated that such delay may seriously jeopardize such individual's life, health, or ability to regain maximum function, no later than 24 hours after receipt of such request).

''(v) DEFINITION OF REAL-TIME DECISION.—In establishing the definition of a real-time decision for purposes of clause (i), the Secretary shall take into account current medical practice, technology, health care industry standards, and other relevant information relating to how quickly a Medicare Advantage plan may provide responses with respect to prior authorization requests.

''(vi) IMPLEMENTATION.—The Secretary shall use notice and comment rulemaking for each of the following:

''(I) Establishing the definition of a 'real-time decision' for purposes of clause (i).

''(II) Updating such definition.

''(III) Initially identifying applicable items or services pursuant to clause (ii)(I).

''(IV) Updating applicable items and services so identified as described in clause (ii)(II).

''(3) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the transparency requirements specified in this paragraph are, with respect to a Medicare Advantage plan, the following:

''(i) The plan, annually and in a manner specified by the Secretary, shall submit to the Secretary the following information:

''(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan during the previous plan year.

''(II) The percentage and number of specified requests (as defined in subparagraph (F)) approved during the previous plan year by the plan in an initial determination and the per-

centage and number of specified requests denied during such plan year by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(III) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year, and the percentage and number of such requests that were subject to an exception under paragraph (2)(C)(iv) (categorized by each item and service).

''(IV) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year that were approved (categorized by each item and service).

''(V) The percentage and number of specified requests that were denied during the previous plan year by the plan in an initial determination and that were subsequently appealed.

''(VI) The number of appeals of specified requests resolved during the preceding plan year, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

''(VII) The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-

making technology, or any other technology specified by the Secretary.

''(VIII) The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan.

''(IX) The percentage and number of specified requests that were excluded from the calculation described in subclause (VIII) based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(X) Information on each occurrence during the previous plan year in which, during a surgical or medical procedure involving the furnishing of

an applicable item or service with respect to which such plan had approved a prior authorization request, the provider of services or supplier furnishing such item or service determined that a different or additional item or service was medically necessary, including a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

''(XI) A disclosure and description of any technology described in subclause (VII) that the plan utilized during the previous plan year in making determinations with respect to specified requests.

''(XII) The number of grievances (as described in subsection (f)) received by such plan during the previous plan year that were related to a prior authorization requirement.

''(XIII) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider or supplier who seeks to enter into a contract with such plan to furnish applicable items and services under such plan, the list described in clause (i)(I) and any policies or procedures used by the plan for making determinations with respect to prior authorization requests;

''(II) to each such provider and supplier that enters into such a contract, access to the criteria used by the plan for making such determinations and an itemization of the medical or other documentation required to be submitted by a provider or supplier with respect to such a request; and

''(III) to an enrollee of the plan, upon request, access to the criteria used by the plan for making determinations with respect to prior authorization requests for an item or service.

''(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of the information described in subparagraph (A)(i) provided to the Secretary during a plan year, a Medicare Advantage plan may elect to include information regarding the percentage and number of specified requests made with respect to an individual and an item or service that were denied by the plan during the preceding plan year in an initial determination based on such requests failing to demonstrate that such individuals met the clinical criteria established by such plan to receive such items or services.

''(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, establish requirements for Medicare Advantage plans regarding the provision of—

''(i) access to criteria described in subparagraph (A)(ii)(II) to providers of services and suppliers in accordance with such subparagraph; and

''(ii) access to such criteria to enrollees in accordance with subparagraph (A)(ii)(III).

"(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information described in subparagraph (A)(i) and subparagraph (B) on a public website of the Centers for Medicare & Medicaid Services. Such information shall be so published on an individual plan level and may in addition be aggregated in such manner as determined appropriate by the Secretary.

"(E) MEDPAC REPORT.—Not later than 3 years after the date information is first submitted under subparagraph (A)(i), the Medicare Payment Advisory Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency of appeals and overturned decisions. The Commission shall provide recommendations, as appropriate, on any improvement that should be made to the electronic prior authorization programs of Medicare Advantage plans.

"(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term 'specified request' means a prior authorization request

made with respect to an applicable item or service.

''(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(A)(ii), with respect to the use of prior authorization by Medicare Advantage plans for applicable items and services, the enrollee protection standards specified in this paragraph are—

''(A) the adoption of transparent prior authorization programs developed in consultation with enrollees and with providers and suppliers with contracts in effect with such plans for furnishing such items and services under such plans;

''(B) allowing for the waiver or modification of prior authorization requirements based on the performance of such providers and suppliers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

''(C) conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input

from enrollees and from providers and suppliers with such contracts in effect and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

''(5) APPLICABLE ITEM OR SERVICE DEFINED.—For purposes of this subsection, the term 'applicable item or service' means, with respect to a Medicare Advantage plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) REPORTS TO CONGRESS.—

''(A) GAO.—Not later than the end of the fourth plan year beginning on or after the date of the enactment of this subsection, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by Medicare Advantage plans.

''(B) HHS.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and biennially thereafter through the date that is 10 years

after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

''(i) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

''(ii) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.''.

(b) ENSURING TIMELY RESPONSES FOR ALL PRIOR AUTHORIZATION REQUESTS SUBMITTED UNDER PART C.—Section 1852(g) of the Social Security Act (42 U.S.C. 1395w–22(g)) is amended—

(1) in paragraph (1)(A), by inserting ''and in accordance with paragraph (6)'' after ''paragraph (3)'';

(2) in paragraph (3)(B)(iii), by inserting ''(or, subject to subsection (o), with respect to prior authorization requests submitted on or after the first day of the third plan year beginning after the date of the enactment of the [Improving Seniors' Timely Access to Care Act of 2023], not later than 24 hours)'' after ''72 hours''.

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

''(6) TIMEFRAME FOR RESPONSE TO PRIOR AUTHORIZATION REQUESTS.—Subject to paragraph (3) and subsection (o), in the case of an organization determination made with respect to a prior authorization request for an item or service to be furnished to an individual submitted on or after the first day of the third plan year beginning after the date of the enactment of this paragraph, the organization shall notify the enrollee (and the physician involved, as appropriate) of such determination no later than 7 days (or such shorter timeframe as the Secretary may specify through notice and comment rulemaking, taking into account enrollee and stakeholder feedback) after receipt of such request.''.

(c) RULE OF CONSTRUCTION.—None of the amendments made by this section may be construed to affect the finalization of the proposed rule entitled ''Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities,

Issuers of Qualified Health Plans on the Federally Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program'' published on December 13, 2022 (87 Fed. Reg. 76238), or application of such rule so finalized, for plan years before the third plan year beginning on or after the date of the enactment of this Act.

SEC. 302. EXTENSION OF CERTAIN DIRECT SPENDING REDUCTIONS.

Section 251A(6)(D) of the Balanced Budget and Emergency Deficit Control Act of 1985 (901a(6)(D)) is amended—

(1) in clause (i), by striking ''; and'' and inserting a semicolon;

(2) in clause (ii), by striking ''second 6 months in which such order is effective for such fiscal year, the payment reduction shall be 0 percent.'' and inserting ''2 month period beginning on the day after the last day of the period described in clause (i) in which such order is effective for such fiscal year, the payment reduction shall be 1.5 percent; and''; and

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

"(iii) with respect to the last 4 months in which such order is effective for such fiscal year, the payment reduction shall be 0 percent.".

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