Our Nation's nuclear reactors currently depend on Russia for nearly 15 percent of their enriched uranium.

This is troubling because over the last 2 years we have seen how Russia tries to wield its energy resources as a weapon. It is simply unsustainable.

I support ending our dangerous reliance on Russia for enriched uranium, but if we are serious about energy security, we cannot simply switch one foreign dependence for another. That is why we must invest in our own uranium fuel cycle here at home.

Right now, we have limited fuel facilities to provide the nuclear fuel our existing fleet needs, much less the advanced fuels that future reactors will need. Any move we make to end our reliance on Russian uranium must be partnered with a build-out of our domestic uranium supply chain. Otherwise, any action would just increase cost to consumers and impact reliability.

That is why in committee, Democrats attempted to partner this bill with authorizations to the Department of Energy to invest in U.S. domestic enrichment and conversion capacity. Unfortunately, those efforts were initially rejected by our Republican majority, therefore, I opposed this bill at that time.

Fortunately, the committee has now advanced legislation that authorizes those investments in our domestic fuel cycle, and that language will be included in the final defense authorization bill.

With that legislation set to become law, I am now much more comfortable moving this bill. After passage of the defense authorization bill, we must ensure these important programs are funded at the levels authorized so we can finally end our dangerous reliance on Russian uranium.

The combination of banning imports of Russian uranium and investing in domestic capacity will provide private industry with both the certainty and the incentives it needs to invest in the nuclear fuel supply chain. This will help us become a world leader again, not just in fuel production for our current reactors, but in fuel production for the next generation of reactors, as well.

I urge support for this bill, Mr. Speaker. I ask that we support this bill on a bipartisan basis. It is a good bill at this point, and we want to get it to the Senate as quickly as possible.

Mr. Speaker, I yield back the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I, too, urge support for this bill. I am pleased we have been able to come together to move this legislation forward, and I yield back the balance of my time.

□ 1600

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Washington (Mrs. RODGERS) that the House suspend the rules and pass the bill, H.R. 1042, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

## LOWER COSTS, MORE TRANSPARENCY ACT

Mrs. RODGERS of Washington. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5378) to promote price transparency in the health care sector, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5378

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Lower Costs, More Transparency Act''.

**SEC. 2. TABLE OF CONTENTS.**

The table of contents of this Act is as follows:



**TITLE I—IMPROVING HEALTH CARE TRANSPARENCY**

**SEC. 101. HOSPITAL PRICE TRANSPARENCY.**

(a) MEDICARE.—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. HOSPITAL PRICE TRANSPARENCY.**

''(a) TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2026, each specified hospital 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) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

''(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; and

''(iii) an attestation that all information made public pursuant to this subparagraph is complete and accurate.

''(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 plain language 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, as applicable, 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, as applicable, 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 cash price charged by the hospital to self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the hospital's charity care policy that

includes, if applicable, any sliding scale payment structure employed for determining charges for a self-pay individual).

''(iv) The payer-specific negotiated charges, as applicable, 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.

''(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

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

In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

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

''(i) shall, in the case of such method and format for making public standard charges pursuant to subparagraph (A)(i), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary);

''(ii) 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;

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

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

''(3) 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.

''(4) ENFORCEMENT.—

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

''(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan to comply with such requirements); and

''(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

''(I) the Secretary shall, not later than 45 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such hospital a request for a corrective action plan to comply with such requirements; or

''(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—

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

''(I) in the case of a specified hospital with 30 or fewer beds, $300 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

''(II) in the case of a specified hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

''(III) in the case of a specified hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a specified hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

''(V) in the case of a specified hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $35 per bed per day).

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

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

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

''(III) the amounts specified in clause (iii)(II).

''(iii) PERSISTENT NONCOMPLIANCE.—

''(I) IN GENERAL.—In the case of a specified hospital (other than a specified 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 the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

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

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

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

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

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a specified hospital located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

''(II) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under subclause (I) with respect to a specified hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a specified hospital during a 6-year period.

''(v) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to specified hospitals requesting such assistance.

''(vi) 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.

''(vii) NONDUPLICATION OF CERTAIN PENALTIES.—The Secretary may not subject a specified hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this section for a period if the Secretary has imposed a civil monetary penalty on such hospital under section 2718(f) of the Public Health Service Act for failure to comply with the provisions of such section for such period.

''(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 in real time and include—

''(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 identity 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;

''(vi) any waivers or reductions of penalties made pursuant to a certification by the Secretary under subparagraph (B)(iv), including—

''(I) the name of any specified hospital that received such a waiver or reduction;

''(II) the dollar amount of each such penalty so waived or reduced; and

''(III) the rationale for the granting of each such waiver or reduction; and

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

''(b) ENSURING ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing the amendments made by this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.

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

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

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

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

''(4) 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.

''(5) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means the charge that a specified hospital or provider of services or supplier, as applicable, has negotiated with a third party payer for an item or service.

''(6) 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.

''(7) 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)).

''(8) 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) PHSA.—

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

''(f) HOSPITAL TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2026, each hospital 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 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) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital;

''(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; and

''(iii) an attestation that all information made public pursuant to this subparagraph is complete and accurate.

''(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 hospital, the following:

''(i) A plain language 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, current procedure terminology codes, or other identifier used or approved by the Centers for Medicare & Medicaid Services.

''(ii) The gross charge, as applicable, 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, as applicable, 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 cash price charged by the hospital to self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the hospital's charity care policy that includes, if applicable, any sliding scale payment structure employed for determining charges for a self-pay individual).

''(iv) The payer-specific negotiated charges, as applicable, 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.

''(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

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

In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

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

''(i) shall, in the case of such method and format for making public standard charges pursuant to subparagraph (A)(i), ensure that such charges are made available in a machine-readable format (or a successor technology specified by the Secretary);

''(ii) 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;

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

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

''(3) 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 hospital's compliance with this subsection is reviewed not less frequently than once every 3 years.

''(4) ENFORCEMENT.—

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

''(i) not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such hospital a notification of such determination (which may include, as determined appropriate by the Secretary, a request for a corrective action plan to comply with such requirements); and

''(ii) in the case of a hospital that does not receive a request for a corrective action plan as part of a notification submitted by the Secretary under clause (i)—

''(I) the Secretary shall, not later than 45 days after such notification is sent, determine whether such hospital is in compliance with such requirements; and

''(II) if the Secretary determines under subclause (I) that such hospital is not in compliance with such requirements, the Secretary shall either—

''(aa) submit to such hospital a request for a corrective action plan to comply with such requirements; or

''(bb) if the Secretary determines that such hospital has not taken meaningful actions to come into compliance since such notification was sent, impose a civil monetary penalty in accordance with subparagraph (B).

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of law, a hospital that has received a request for a corrective action plan under clause (i) or (ii) of subparagraph (A) and fails to comply with the requirements of this subsection by the

date that is 45 days after such request is made, and a hospital with respect to which the Secretary has made a determination described in clause (ii)(II)(bb) of such subparagraph, shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure was ongoing. Such amount shall not exceed—

''(I) in the case of a hospital with 30 or fewer beds, $300 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per bed per day);

''(II) in the case of a hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

''(III) in the case of a hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

''(V) in the case of a hospital with more than 500 beds, $25 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $35 per bed per day).

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

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

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

''(III) the amounts specified in clause (iii)(II).

''(iii) PERSISTENT NONCOMPLIANCE.—

''(I) IN GENERAL.—In the case of a hospital (other than a 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 the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

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

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

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

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

''(iv) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to a hospital located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such hospital.

''(II) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under subclause (I) with respect to a hospital more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a hospital more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to a hospital during a 6-year period.

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

''(vi) 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.

''(vii) NONDUPLICATION OF PENALTIES.—The Secretary may not subject a hospital to a civil monetary penalty under this subparagraph with respect to noncompliance with the provisions of this subsection for a period if the Secretary has imposed a civil monetary penalty on such hospital under section 1899C of the Social Security Act for failure to comply with the provisions of such section for such period.

''(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 in real time and include—

''(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 identity of each 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;

''(vi) any waivers or reductions of penalties made pursuant to a certification by the Secretary under subparagraph (B)(iv), including—

''(I) the name of any hospital that received such a waiver or reduction;

''(II) the dollar amount of each such penalty so waived or reduced; and

''(III) the rationale for the granting of each such waiver or reduction; and

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

''(5) ENSURING ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing the amendments made by this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.

''(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 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 of the Social Security Act.

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

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

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

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

(2) CONFORMING AMENDMENTS.—Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18) is amended—

(A) in subsection (b)(3), by inserting ''(other than the provisions of subsection (f))'' after ''this section''; and

(B) in subsection (e), by adding at the end the following new sentence: ''The preceding provisions of this subsection shall not apply beginning on January 1, 2026.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply beginning January 1, 2026.

(c) ACCESSIBILITY THROUGH IMPLEMENTATION.—In implementing the amendments made by this section, the Secretary of Health and Human Services shall through rulemaking ensure that a hospital submitting charges and information pursuant to such amendments takes reasonable steps (as specified by the Secretary) to ensure the accessibility of such charges and information to individuals with limited English proficiency. Such steps may include the hospital's provision of interpretation services or the hospital's provision of translations of charges and information.

**SEC. 102. CLINICAL DIAGNOSTIC LABORATORY TEST PRICE TRANSPARENCY.**

Section 1846 of the Social Security Act (42 U.S.C. 1395w–2) is amended—

(1) in the header, by inserting ''**AND ADDITIONAL REQUIREMENTS**'' after ''**SANCTIONS**''; and

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

''(c) PRICE TRANSPARENCY REQUIREMENT.—

''(1) IN GENERAL.—Beginning January 1, 2026, any applicable laboratory that receives payment under this title for furnishing any specified clinical diagnostic laboratory test under this title shall—

''(A) make publicly available on an internet website the information described in

paragraph (2) with respect to each such specified clinical diagnostic laboratory test that such laboratory so furnishes; and

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

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

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

''(B) The deidentified minimum payer-specific negotiated charge between such laboratory and any third party payer for such test.

''(C) The deidentified maximum payer-specific negotiated charge between such laboratory and any third party payer for such test.

''(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2026, the Secretary shall establish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format—

''(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in section 1899C(a)(2)(C)(ii));

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

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

''(4) INCLUSION OF ANCILLARY SERVICES.—Any price or rate for a specified clinical diagnostic laboratory test available to be furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the price or rate (as applicable) for any ancillary item or service (such as specimen collection services) that would normally be furnished by such laboratory as part of such test, as specified by the Secretary.

''(5) ENFORCEMENT.—

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

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

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

''(B) INCREASE AUTHORITY.—In applying this paragraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (A)(ii).

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

''(6) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to applicable laboratories requesting such assistance.

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

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' has the meaning given such term in section 414.502, of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by a hospital pursuant to section 1899C or section 2718(f) of the Public Health Service Act.

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

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

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

''(E) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—the term 'specified clinical diagnostic laboratory test' means a clinical diagnostic laboratory test that is included on the list of shoppable services specified by the Centers for Medicare & Medicaid Services (as described in section 1899C(a)(2)(A)(ii)(I)), other than such a test that is only available to be furnished by a single provider of services or supplier.

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

**SEC. 103. IMAGING PRICE TRANSPARENCY.**

Section 1899C of the Social Security Act, as added by section 101, is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection:

''(b) IMAGING SERVICES PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1, 2028, each provider of services and supplier that receives payment under this title for furnishing a specified imaging service, other than such a provider or supplier with respect to which standard charges and prices for such services furnished by such provider or supplier are made available by a hospital pursuant to section 1899C or section 2718(f) of the Public Health Service Act, shall—

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

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

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

''(A) 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 payer-specific negotiated charge for such service and the deidentified maximum payer-specific negotiated charge for such service.

''(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2028, the Secretary shall establish a standard, uniform method and format for providers of services and suppliers to use in making public information described in paragraph (2). Any such method and format—

''(A) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in section 1899C(a)(2)(C)(ii));

''(B) shall meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such information; 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 a provider of services or supplier is not in compliance with paragraph (1)—

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

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

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

''(B) INCREASE AUTHORITY.—In applying this paragraph with respect to violations occurring in 2029 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 penalty imposed under subsection (a) of such section.

''(D) AUTHORITY TO WAIVE OR REDUCE PENALTY.—

''(i) IN GENERAL.—Subject to clause (ii), 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 certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such provider or supplier.

''(ii) LIMITATION.—The Secretary may not elect to waive or reduce a penalty under clause (i) with respect to a specific provider of services or supplier more than 3 times.

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

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

(3) in subsection (c), as so redesignated by paragraph (1)—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) SPECIFIED IMAGING SERVICE.—the term 'specified imaging service' means an imaging service that is a Centers for Medicare & Medicaid Services-specified shoppable service (as described in subsection (a)(2)(A)(ii)(I)).''.

**SEC. 104. AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.**

Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(aa) AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1, 2026, 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 subparagraph (C), compile and make public (without subscription and free of charge), for each year—

''(i) all 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; and

''(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.

''(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 plain language 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, as applicable, expressed as a dollar amount, for each such item or service.

''(iii) The discounted cash price, as applicable, 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 median cash price charged to self-pay individuals for such item or service for the previous three years, expressed as a dollar amount).

''(iv) The 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.

''(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service.

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

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

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

''(ii) 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;

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

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

''(3) 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.

''(4) 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.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary may waive any penalty, or reduce any penalty by not more than 75 percent, otherwise applicable under this subparagraph with respect to an ambulatory surgical center located in a rural or underserved area if the Secretary certifies that imposition of such penalty would result in an immediate threat to access to care for individuals in the service area of such surgical center.

''(II) LIMITATION ON APPLICATION.—The Secretary may not elect to waive a penalty under subclause (I) with respect to an ambulatory surgical center more than once in a 6-year period and may not elect to reduce such a penalty with respect to such a surgical center more than once in such a period. Nothing in the preceding sentence shall be construed as prohibiting the Secretary from both waiving and reducing a penalty with respect to an ambulatory surgical center during a 6-year period.

''(5) 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 an ambulatory 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 an ambulatory 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.''.

**SEC. 105. HEALTH COVERAGE PRICE TRANSPARENCY.**

(a) PRICE TRANSPARENCY REQUIREMENTS.—

(1) IRC.—

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

**''SEC. 9819. TRANSPARENCY IN COVERAGE.**

''(a) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, a group health plan shall permit a participant or beneficiary to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant or beneficiary's plan that the participant or beneficiary 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 participant or beneficiary. At a minimum, such information

shall include the information specified in paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and provided at no cost to such participant or beneficiary) 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 a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(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 allowed amount or other dollar 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 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 participant 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.

''(G) Any shared savings (such as any credit, payment, or other benefit provided by such plan) available to the participant or beneficiary with respect to such item or service furnished by such provider known at the time such request is made.

''(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 (or successor technology specified by the Secretary);

''(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; or

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

''(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 to ensure the accessibility and usability of information provided through such tool.

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 January 1, 2026, 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, for each month, not later than the tenth day of such month, 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 (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service.

''(B) With respect to each drug (identified by national drug code) for which benefits are available under such plan—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug; and

''(ii) 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.

''(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 separate machine-readable files (and 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 through subregulatory guidance. 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 or 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 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 through subregulatory guidance a template that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2026, each group health plan shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan with respect to such plan during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

''(C) The name of such plan, a description of the type of network of participating providers used by such plan, and a description of whether such plan is self-insured or fully-insured.

''(D) For each item or service which is paid as part of a bundled rate—

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such bundle; and

''(ii) a list of the items and services included in such bundle.

''(E) The percentage of items and services that are paid for on a fee-for-service basis and the percentage of items and services that are paid for as part of a bundled rate, capitated payment rate, or other alternative payment model.

''(6) 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) ACCESSIBILITY.—A group health plan shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (a), and rate and payment information made public under subsection (b), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(d) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a

contractual relationship with the plan, respectively, for furnishing such item or service under the plan, and includes facilities, respectively.

''(2) PROVIDER.—The term 'provider' includes a health care facility.

''(3) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group 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 (reflected as a dollar amount) in effect between such plan and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.''.

(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. Transparency in coverage.''.

(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. TRANSPARENCY IN COVERAGE.**

''(a) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall permit an individual enrolled under such plan or coverage 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 an individual enrolled under such plan or 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 a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such individual may be liable for additional charges.

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

''(D) The amount the individual has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate individuals 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 imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such individual has accrued towards such limitation with respect to such item or service.

''(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.

''(G) Any shared savings (such as any credit, payment, or other benefit provided by such plan or issuer) available to the individual with respect to such item or service furnished by such provider known at the time such request is made.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(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; or

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

''(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 to ensure the accessibility and usability of information provided through such tool.

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 January 1, 2026, each group health plan and health insurance issuer offering group or individual health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall, for each month, not later than the tenth day of such month, 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 (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service.

''(B) With respect to each drug (identified by national drug code) for which benefits are available under such plan or coverage—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug; and

''(ii) 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 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, 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.

''(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 separate machine-readable files (and 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 through subregulatory guidance. 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 or 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 health insurance issuer offering 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 through subregulatory guidance a template that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2026, each group health plan and health insurance issuer offering group or individual health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer

identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

''(C) The name of such plan, a description of the type of network of participating providers used by such plan or coverage, and, in the case of a group health plan, a description of whether such plan is self-insured or fully-insured.

''(D) For each item or service which is paid as part of a bundled rate—

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such bundle; and

''(ii) a list of the items and services included in such bundle.

''(E) The percentage of items and services that are paid for on a fee-for-service basis and the percentage of items and services that are paid for as part of a bundled rate, capitated payment rate, or other alternative payment model.

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

''(c) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (a), and rate and payment information made public under subsection (b), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(d) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, and includes facilities, respectively.

''(2) PROVIDER.—The term 'provider' includes a health care facility.

''(3) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.''.

(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. TRANSPARENCY IN COVERAGE.**

''(a) COST-SHARING TRANSPARENCY.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2026, a group health plan and a health insurance issuer offering group health insurance coverage shall permit a participant or beneficiary to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant or beneficiary's plan or coverage that the participant or beneficiary 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 participant or beneficiary. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available to such participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or, at the option of such participant or beneficiary, through a paper disclosure or phone or other electronic disclosure (as selected by such participant or beneficiary and provided at no cost to such participant or beneficiary) 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 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 a participating provider with respect to such item or service, the maximum allowed amount or other dollar amount that such plan or coverage will recognize as payment for such item or service, along with a notice that such participant or beneficiary may be liable for additional charges.

''(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 allowed amount or other dollar 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 under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries 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 imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant 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 or coverage.

''(G) Any shared savings (such as any credit, payment, or other benefit provided by such plan or issuer) available to the participant or beneficiary with respect to such item or service furnished by such provider known at the time such request is made.

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

''(A) is based on an internet website (or successor technology specified by the Secretary);

''(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; or

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

''(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 to ensure the accessibility and usability of information provided through such tool.

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 January 1, 2026, each group health plan and health insurance issuer offering group health insurance coverage (other than a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall, for each month, not later than the tenth day of such month, 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 (expressed as a dollar amount) in effect as of the date on which such information is made public with each provider that is a participating provider with respect to such item or service.

''(B) With respect to each drug (identified by national drug code) for which benefits are available under such plan or coverage—

''(i) the in-network rate (expressed as a dollar amount) in effect as of the first day of the month in which such information is made public with each provider that is a participating provider with respect to such drug; and

''(ii) 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 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, 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.

''(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 separate machine-readable files (and 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 through subregulatory guidance. 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 or 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 health insurance issuer offering 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 through subregulatory guidance a template that such a plan may use in developing instructions for purposes of the preceding sentence.

''(5) SUMMARY.—For each plan year beginning on or after January 1, 2026, each group health plan and health insurance issuer offering group health insurance coverage shall make public a data file, in a manner that ensures that such file may be easily downloaded and read by standard spreadsheet software and that meets such requirements as established by the Secretary, containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such plan year. Such file shall include the following:

''(A) The mean, median, and interquartile range of the in-network rate, and the amount allowed for an item or service when not furnished by a participating provider, in effect as of the first day of such plan year for each item or service (identified by payer identifier approved or used by the Centers for Medicare & Medicaid Services) for which benefits are available under the plan or coverage, broken down by the type of provider furnishing the item or service and by the geographic area in which such item or service is furnished.

''(B) Trends in payment rates for such items and services over such plan year, including an identification of instances in which such rates have increased, decreased, or remained the same.

''(C) The name of such plan, a description of the type of network of participating providers used by such plan or coverage, and, in the case of a group health plan, a description of whether such plan is self-insured or fully-insured.

''(D) For each item or service which is paid as part of a bundled rate—

''(i) a description of the formulae, pricing methodologies, or other information used to calculate the payment rate for such bundle; and

''(ii) a list of the items and services included in such bundle.

''(E) The percentage of items and services that are paid for on a fee-for-service basis and the percentage of items and services that are paid for as part of a bundled rate, capitated payment rate, or other alternative payment model.

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

''(c) ACCESSIBILITY.—A group health plan and a health insurance issuer offering group health insurance coverage shall take reasonable steps (as specified by the Secretary) to ensure that information provided in response to a request described in subsection (a), and rate and payment information made public under subsection (b), is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to those with limited English proficiency and those with disabilities.

''(d) DEFINITIONS.—In this section:

''(1) PARTICIPATING PROVIDER.—The term 'participating provider' means, with respect to an item or service and a group health plan or health insurance issuer offering group or individual health insurance coverage, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, and includes facilities, respectively.

''(2) PROVIDER.—The term 'provider' includes a health care facility.

''(3) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service, regardless of whether such rate is calculated based on a set amount, a fee schedule, or an amount derived from another amount, or a formula, or other method.''.

(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. Transparency in coverage.''.

(b) APPLICATION PROGRAMMING INTERFACE REPORT.—Not later than January 1, 2025, and annually thereafter, the Secretary of Health and Human Services shall, in consultation with the Office of the National Coordinator for Health Information Technology, Department of Labor, the Department of the Treasury, and stakeholders, submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the use of standards-based application programming interfaces (in this subsection referred to as ''APIs'') to facilitate access to health care price transparency information and the interoperability of other medical information. Such report shall include an evaluation of the capacity of the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury to regulate and implement standards related to APIs and recommendations for improving such capacity. Such report shall include the following:

(1) A description of current use, and proposed use, of APIs under Federal rules to facilitate interoperability, including information related to capacity constraints within the agencies, barriers to adoption, privacy and security, administrative burdens and efficiencies, care coordination, and levels of compliance.

(2) A description of the feasibility of agency participation in the development of APIs to enable application access to price transparency data under the amendments made by subsection (a).

(3) A specification of the timeline for which such data standards can be required to make such data accessible via an API.

(4) An analysis of the benefits and challenges of implementing standards-based APIs for price transparency data, including the ability for consumers to access rate and payment information and the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the consumer's plan through third-party internet-based tools and applications.

(5) An analysis of the impact that APIs which provide real-time access to pricing and cost-sharing information may have in increasing the amount of services shoppable for individuals, such as by standardizing more health care spend via episode bundles.

(6) An analysis of which health care items and services may be useful under API, such as those for which prices change with the greatest frequency.

(7) An analysis of the cost of API standards implementation on issuers, employers, and other private-sector entities.

(8) An analysis of the ability of State regulators to enforce API standards and the costs to the Federal Government and States to regulate and enforce API standards.

(9) An analysis of the interaction with API standards and Federal health information privacy standards.

(c) PROVIDER TOOL REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall, in consultation with stakeholders, conduct a study and submit to the House Committees on Education and the Workforce, Energy and Commerce, and Ways and Means, and the Senate Committees on Finance and Health, Education, Labor, and Pensions a report on the usefulness and feasibility of the establishment of a provider tool by a group health plan, or a health insurance issuer offering group and individual health insurance coverage, in facilitating the provision of information made available pursuant to the amendments made by subsection (a). Such report shall include the following:

(A) A description of the feasibility of establishing a requirement for the various types of plans and coverage to offer such a provider tool, including any challenges to establishing a provider tool using the same technology platform as the self-service tool described in such amendments.

(B) An evaluation on the usefulness of a provider tool to aid patient-decision making and how such tool would coordinate with other information available to a patient and their provider under other Federal requirements in place or under consideration.

(C) An evaluation of whether the information provided by such tool would be duplicative of the advanced explanation of benefits required under Federal law or any other existing requirement.

(D) A description of the usability and expected utilization of such tool among providers, including among different provider types.

(E) An analysis of the impact of a provider tool in value-based care arrangements.

(F) An analysis on the potential impact of the provider tool on—

(i) patients' out-of-pocket spending;

(ii) plan design, including impacts on cost-sharing requirements;

(iii) care coordination and quality;

(iv) plan premiums;

(v) overall health care spending and utilization; and

(vi) health care access in rural areas.

(G) An analysis of the feasibility of a provider tool to include additional functionality to facilitate and improve the administration of the requirements on providers to submit notifications to such plan or coverage under section 2799B–6 of the Public Health Service Act and the requirements on such plan or coverage to provide an advanced explanation of benefits to individuals under section 2799A–1(f) of such Act.

(H) An analysis of which health care items and services, would be most useful for patients utilizing a provider tool.

(I) An analysis of rulemaking required to ensure such a tool complies with federal health information privacy standards.

(J) An analysis of the burden and cost of the creation of a provider tool by plans and coverage on providers, issuers, employers, and other private-sector entities.

(K) An analysis of the ability of state regulators to enforce provider tool standards and the costs to the Department and states to regulate and enforce provider tool standards.

(2) DEFINITION.—The term ''provider tool'' means a tool designed to facilitate the provision of information made available pursuant to the amendments made by subsection (a) and established by a group health plan or a health insurance issuer offering group and individual health insurance coverage that allows providers to access the information such plan or coverage must provide through the self-service tool described in such amendments to an individual with whom the provider is actively treating at the time of such request, upon the request of the provider, and with the consent of such individual.

(d) REPORTS.—

(1) COMPLIANCE.—Not later than January 1, 2027, the Comptroller General of the United States shall submit to Congress a report containing—

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

(B) an analysis of enforcement of such amendments by the Secretaries of Health and Human Services, Labor, and the Treasury;

(C) recommendations relating to improving such enforcement; and

(D) recommendations relating to improving public disclosure, and public awareness, of information required to be made available by group health plans and health insurance issuers pursuant to such amendments.

(2) PRICES.—Not later than January 1, 2028, and biennially thereafter, the Secretaries of Health and Human Services, Labor, and the Treasury shall jointly submit to Congress a report containing an assessment of differences in negotiated prices (and any trends in such prices) in the private market between—

(A) rural and urban areas;

(B) the individual, small group, and large group markets;

(C) consolidated and nonconsolidated health care provider areas (as specified by the Secretary of Health and Human Services);

(D) nonprofit and for-profit hospitals;

(E) nonprofit and for-profit insurers; and

(F) insurers serving local or regional areas and insurers serving multistate or national areas.

(e) QUALITY REPORT.—Not later than 1 year after the date of enactment of this subsection, the Secretaries of Health and Human Services, Labor, and the Treasury shall jointly submit to Congress a report on the feasibility of including data relating to the quality of health care items and services with the price transparency information required to be made available under the amendments made by subsection (a). Such report shall include recommendations for legislative and regulatory actions to identify appropriate metrics for assessing and comparing quality of care.

(f) 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 January 1, 2026.

**SEC. 106. PHARMACY BENEFITS PRICE TRANSPARENCY.**

(a) 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 2 years after the date of enactment of this section, a group health plan or a 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 other third party that limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than every 6 months (or at the request of a group health plan, not less frequently than quarterly, but under the same conditions, terms, and cost of the semiannual report under this subsection), 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 issuer, shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in a machine-readable format and shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan or health insurance issuer offering group health insurance coverage during each reporting period—

''(A) in the case of such a plan offered by a specified large employer (or such coverage offered in connection with such a plan offered by a specified large employer)—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

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

''(II) the type of dispensing channel used to furnish such drug, including retail, mail order, or specialty pharmacy;

''(III) with respect to each drug dispensed under each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants, beneficiaries, and enrollees for whom a claim for such drug was filed;

''(CC) dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(IV) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan or coverage after manufacturer rebates, fees, and other remuneration or adjustments;

''(V) the total amount of out-of-pocket spending by participants, beneficiaries, and enrollees on such drug, including spending through copayments, coinsurance, and deductibles;

''(VI) the total net spending by the plan or coverage during the reporting period;

''(VII) the total amount received, or expected to be received, by the plan or coverage from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor;

''(VIII) the total amount received, or expected to be received by the plan or issuer, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; and

''(bb) that is related to utilization rebates for such drug; and

''(IX) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan or coverage for such drug;

''(ii) for each category or class of drugs for which a claim was filed, a breakdown of the total gross spending on drugs in such category or class before rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, and the net spending after such rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, including—

''(I) the number of participants, beneficiaries, and enrollees who filled a prescription for a drug in such category or class, including the National Drug Code for each such drug;

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

''(III) the total out-of-pocket spending under the plan or coverage by participants, beneficiaries, and enrollees, including spending through copayments, coinsurance, and deductibles;

''(iii) in the case of a drug for which gross spending by such plan, coverage, or entity

exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class; and

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

''(iv) in the case such plan or coverage (or an entity providing pharmacy benefits management services on behalf of such plan or coverage) has an affiliated pharmacy or pharmacy under common ownership—

''(I) the percentage of total prescriptions dispensed by such pharmacies to individuals enrolled in such plan or coverage;

''(II) a list of all drugs dispensed by such pharmacies to individuals enrolled in such plan or coverage, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan or issuer, and to participants, beneficiaries, and enrollees enrolled in such plan or coverage;

''(bb) the median amount charged to such plan or issuer, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants, beneficiaries, and enrollees, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan and participants, beneficiaries, and enrollees, that is available from any pharmacy included in the network of such plan or coverage; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount;

''(B) in the case of a plan or coverage not described in subparagraph (A)—

''(i) the total net spending by the plan or coverage for all drugs covered by such plan or coverage during such reporting period;

''(ii) the total amount received, or expected to be received, by the plan or coverage from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor for all such drugs; and

''(iii) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan or coverage for such drugs;

''(C) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act) 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 an entity providing pharmacy benefits management services, including the identity of the recipient of such amounts;

''(D) an explanation of any benefit design parameters that encourage or require participants, beneficiaries, and enrollees in such plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(E) total gross spending on all drugs during the reporting period.

''(3) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—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 13402(a) of the Health Information Technology for Clinical Health Act and consistent with the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act) and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefits management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

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

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act).

''(4) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA Privacy Rule (45 CFR parts 160 and 164, subparts A and E).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent 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 coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, 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, or the Comptroller General of the United States.

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

''(5) 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 such plan or coverage, shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a group health plan under paragraph (1) and other such reports as requested, in accordance with the privacy requirements under paragraph (3), the disclosure and redisclosure standards under paragraph (4), the standards specified pursuant to paragraph (6), and such other information that the Comptroller General determines necessary to carry out the study under section 106(d) of the Lower Costs, More Transparency Act.

''(6) STANDARD FORMAT.—Not later than 1 year after the date of enactment of this section, the Secretary shall specify through rulemaking standards for group health plans, health insurance issuers offering group health insurance coverage, and entities providing pharmacy benefits management services on behalf of such plans or coverage, required to submit reports under paragraph (1) to submit such reports in a standard format.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—The Secretary shall enforce this section.

''(2) FAILURE TO PROVIDE INFORMATION.—A health insurance issuer or an entity providing pharmacy benefits management services on behalf of such plan or coverage that violates sub-section (a) or fails to provide the 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 an entity providing pharmacy benefits management services on behalf of such a plan or coverage 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 subsections (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 such section.

''(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 the requirements in this section.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a group health plan, health insurance issuer, or entity providing pharmacy benefits management services on behalf of such plan or coverage, to restrict disclosure to, or otherwise limit the access of, the Department of Health and Human Services to a report described in subsection (b)(1) or information related to compliance with subsection (a) or (b) by entities subject to such subsection.

''(e) DEFINITIONS.—In this section:

''(1) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

''(2) WHOLESALE ACQUISITION COST.—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 (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''.

(b) 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 BENEFIT MANAGER SERVICES.**

''(a) IN GENERAL.—For plan years beginning on or after the date that is 2 years after the date of enactment of this section, a group health plan or a 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 other third party that limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than every 6 months (or at the request of a group health plan, not less frequently than quarterly, but under the same conditions, terms, and cost of the semiannual report under this subsection), 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 issuer, shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in a machine-readable format and shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan or health insurance issuer offering group health insurance coverage during each reporting period—

''(A) in the case of such a plan offered by a specified large employer (or such coverage offered in connection with such a plan offered by a specified large employer)—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

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

''(II) the type of dispensing channel used to furnish such drug, including retail, mail order, or specialty pharmacy;

''(III) with respect to each drug dispensed under each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants and beneficiaries for whom a claim for such drug was filed;

''(CC) dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(IV) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan or coverage after manufacturer rebates, fees, and other remuneration or adjustments;

''(V) the total amount of out-of-pocket spending by participants, beneficiaries, and enrollees on such drug, including spending through copayments, coinsurance, and deductibles;

''(VI) the total net spending by the plan or coverage during the reporting period;

''(VII) the total amount received, or expected to be received, by the plan or coverage from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor;

''(VIII) the total amount received, or expected to be received by the plan or issuer, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; and

''(bb) that is related to utilization rebates for such drug; and

''(IX) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan or coverage for such drug;

''(ii) for each category or class of drugs for which a claim was filed, a breakdown of the total gross spending on drugs in such category or class before rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, and the net spending after such rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, including—

''(I) the number of participants, beneficiaries, and enrollees who filled a prescription for a drug in such category or class, including the National Drug Code for each such drug;

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

''(III) the total out-of-pocket spending under the plan or coverage by participants, beneficiaries, and enrollees, including spending through copayments, coinsurance, and deductibles;

''(iii) in the case of a drug for which gross spending by such plan, coverage, or entity exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class; and

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

''(iv) in the case such plan or coverage (or an entity providing pharmacy benefits management services on behalf of such plan or coverage) has an affiliated pharmacy or pharmacy under common ownership—

''(I) the percentage of total prescriptions dispensed by such pharmacies to individuals enrolled in such plan or coverage;

''(II) a list of all drugs dispensed by such pharmacies to individuals enrolled in such plan or coverage, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan or issuer, and to participants, beneficiaries, and enrollees enrolled in such plan or coverage;

''(bb) the median amount charged to such plan or issuer, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants, beneficiaries, and enrollees, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan and participants, beneficiaries, and enrollees, that is available from any pharmacy included in the network of such plan or coverage; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount;

''(B) in the case of a plan or coverage not described in subparagraph (A)—

''(i) the total net spending by the plan or coverage for all drugs covered by such plan or coverage during such reporting period;

''(ii) the total amount received, or expected to be received, by the plan or coverage from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor for all such drugs; and

''(iii) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan or coverage for such drugs;

''(C) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA)) 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 an entity providing pharmacy benefits management services, including the identity of the recipient of such amounts;

''(D) an explanation of any benefit design parameters that encourage or require participants, beneficiaries, and enrollees in such plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(E) total gross spending on all drugs during the reporting period.

''(3) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—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 13402(a) of the Health Information Technology for Clinical Health Act and consistent with the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act) and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefits management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

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

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act).

''(4) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA Privacy Rule (45 CFR parts 160 and 164, subparts A and E).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent 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 coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, 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, or the Comptroller General of the United States.

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

''(5) 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 such plan or coverage, shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a group health plan under paragraph (1) and other such reports as requested, in accordance with the privacy requirements under paragraph (3), the disclosure and redisclosure standards under paragraph (4), the standards specified pursuant to paragraph (6), and such other information that the Comptroller General determines necessary to carry out the study under section 106(d) of the Lower Costs, More Transparency Act.

''(6) STANDARD FORMAT.—Not later than 1 year after the date of enactment of this section, the Secretary shall specify through rulemaking standards for group health plans, health insurance issuers offering group health insurance coverage, and entities providing pharmacy benefits management services on behalf of such plans or coverage, required to submit reports under paragraph (1) 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, health insurance issuer, or entity providing pharmacy benefits management services on behalf of such plan or coverage, 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 entities subject to such subsection.

''(d) DEFINITIONS.—In this section:

''(1) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

''(2) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.''.

(B) in section 502 (29 U.S.C. 1132)—

(i) in subsection (b)(3), by striking ''under subsection (c)(9))'' and inserting ''under paragraphs (9) and (13) of subsection (c))''; and

(ii) 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 INFORMATION.—The Secretary may impose a penalty against any health insurance issuer or entity providing pharmacy benefits management services 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 may impose a penalty against a health insurance issuer or entity providing pharmacy benefits management services 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.''.

(c) 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 BENEFIT MANAGER SERVICES.**

''(a) IN GENERAL.—For plan years beginning on or after the date that is 2 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 other third party that limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan or entity from making the reports described in subsection (b).

''(b) REPORTS.—

''(1) IN GENERAL.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than every 6 months (or at the request of a group health plan, not less frequently than quarterly, but under the same conditions, terms, and cost of the semiannual report under this subsection), a group health plan, or an entity providing pharmacy benefits management services on behalf of such a plan, shall submit to the group health plan a report in accordance with this section. Each such report shall be made available to such group health plan in a machine-readable format and shall include the information described in paragraph (2).

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is, with respect to drugs covered by a group health plan during each reporting period—

''(A) in the case of such a plan offered by a specified large employer—

''(i) a list of drugs for which a claim was filed and, with respect to each such drug on such list—

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

''(II) the type of dispensing channel used to furnish such drug, including retail, mail order, or specialty pharmacy;

''(III) with respect to each drug dispensed under each type of dispensing channel (including retail, mail order, or specialty pharmacy)—

''(aa) whether such drug is a brand name drug or a generic drug, and—

''(AA) in the case of a brand name drug, the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(BB) in the case of a generic drug, the average wholesale price, listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and

''(bb) the total number of—

''(AA) prescription claims (including original prescriptions and refills);

''(BB) participants, beneficiaries, and enrollees for whom a claim for such drug was filed;

''(CC) dosage units per fill of such drug; and

''(DD) days supply of such drug per fill;

''(IV) the net price per course of treatment or single fill, such as a 30-day supply or 90-day supply to the plan after manufacturer rebates, fees, and other remuneration or adjustments;

''(V) the total amount of out-of-pocket spending by participants, beneficiaries, and enrollees on such drug, including spending through copayments, coinsurance, and deductibles;

''(VI) the total net spending by the plan during the reporting period;

''(VII) the total amount received, or expected to be received, by the plan from any

entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor;

''(VIII) the total amount received, or expected to be received by the plan, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration—

''(aa) that has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; and

''(bb) that is related to utilization rebates for such drug; and

''(IX) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan for such drug;

''(ii) for each category or class of drugs for which a claim was filed, a breakdown of the total gross spending on drugs in such category or class before rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, and the net spending after such rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, including—

''(I) the number of participants, beneficiaries, and enrollees who filled a prescription for a drug in such category or class, including the National Drug Code for each such drug;

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

''(III) the total out-of-pocket spending under the plan by participants, beneficiaries, and enrollees, including spending through copayments, coinsurance, and deductibles; and

''(iii) in the case of a drug for which gross spending by such plan or entity exceeded $10,000 during the reporting period—

''(I) a list of all other drugs in the same therapeutic category or class; and

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

''(iv) in the case such plan (or an entity providing pharmacy benefits management services on behalf of such plan) that has an affiliated pharmacy or pharmacy under common ownership—

''(I) the percentage of total prescriptions dispensed by such pharmacies to individuals enrolled in such plan;

''(II) a list of all drugs dispensed by such pharmacies to individuals enrolled in such plan, and, with respect to each drug dispensed—

''(aa) the amount charged, per dosage unit, per 30-day supply, or per 90-day supply (as applicable) to the plan, and to participants, beneficiaries, and enrollees enrolled in such plan;

''(bb) the median amount charged to such plan, and the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants, beneficiaries, and enrollees, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

''(cc) the lowest cost per dosage unit, per 30-day supply and per 90-day supply, for each such drug, including amounts charged to the plan and participants, beneficiaries, and enrollees, that is available from any pharmacy included in the network of such plan; and

''(dd) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if such drug is subject to a maximum price discount;

''(B) in the case of a plan not described in subparagraph (A)—

''(i) the total net spending by the plan for all drugs covered by such plan during such reporting period;

''(ii) the total amount received, or expected to be received, by the plan from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party (including group purchasing organizations) other than the plan sponsor for all such drugs; and

''(iii) to the extent feasible, information on the total amount of remuneration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of such drug manufacturer) to the participants, beneficiaries, and enrollees enrolled in such plan for such drugs;

''(C) amounts paid directly or indirectly in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act) to brokers, consultants, advisors, or any other individual or firm, for the referral of the group health plan's business to an entity providing pharmacy benefits management services, including the identity of the recipient of such amounts;

''(D) an explanation of any benefit design parameters that encourage or require participants, beneficiaries, and enrollees in such plan to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

''(E) total gross spending on all drugs during the reporting period.

''(3) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—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 13402(a) of the Health Information Technology for Clinical Health Act and consistent with the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act) and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) IN GENERAL.—An entity providing pharmacy benefits management services on behalf of a group health plan that submits a report under paragraph (1) shall ensure that such report contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

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

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act).

''(4) DISCLOSURE AND REDISCLOSURE.—

''(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA Privacy Rule (45 CFR parts 160 and 164, subparts A and E).

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent 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 coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, 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, or the Comptroller General of the United States.

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

''(5) REPORT TO GAO.—A group health plan, or an entity providing pharmacy benefits management services on behalf of such plan, shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a group health plan under paragraph (1) and other such reports as requested, in accordance with the privacy requirements under paragraph (3), the disclosure and rediscloure standards under paragraph (4), the standards specified pursuant to paragraph (6), and such other information that the Comptroller General determines necessary to carry out the study under section 106(d) of the Lower Costs, More Transparency Act.

''(6) STANDARD FORMAT.—Not later than 1 year after the date of enactment of this section, the Secretary shall specify through rulemaking standards for group health plans, and entities providing pharmacy benefits management services on behalf of such plans, required to submit reports under paragraph (1) 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 entity providing pharmacy benefits management services on behalf of such plan, 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 subsections (a) or (b) by entities subject to such subsection.

''(d) DEFINITIONS.—In this section:

''(1) SPECIFIED LARGE EMPLOYER.—The term 'specified large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

''(2) WHOLESALE ACQUISITION COST.—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 Internal Revenue Code of 1986 is amended by adding at the end the following new item:

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

(d) GAO REPORTS.—

(1) REPORT ON PHARMACY NETWORK DESIGN.—

(A) 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—

(i) pharmacy networks that have contracted with group health plans, health insurance issuers offering group health insurance coverage, or entities providing pharmacy benefits management services on behalf of such plans or issuers, including networks with pharmacies that are under common ownership (in whole or part) with such plans, issuers, or entities (including entities that provide pharmacy benefits administrative services on behalf of such plans or issuers);

(ii) pharmacy network design parameters that encourage individuals enrolled in such plans or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are wholly or partially owned by a plan, issuer, or entity;

(iii) whether such plans and issuers have options to elect different network pricing arrangements in the marketplace with entities that provide pharmacy benefits management services and the prevalence of electing such different network pricing arrangements;

(iv) with respect to pharmacy networks that include pharmacies under common ownership described in clause (i)—

(I) whether such networks are designed to encourage individuals enrolled in a group health plan or health insurance 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;

(v) the degree to which mail order, specialty, or retail pharmacies that dispense prescription drugs to an enrollee in a plan or coverage that are under common ownership (in whole or part) with plans, issuers, or entities providing pharmacy benefits management services or pharmacy benefits administrative services on behalf of such plan or coverage receive reimbursement that is greater than the median price charged to the plan or 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 plan or issuer, or entity providing pharmacy benefits management services on behalf of such plan or issuer.

(B) REQUIREMENT.—The Comptroller General of the United States shall ensure that the report under subparagraph (A) does not contain information that would identify a specific group health plan or health insurance issuer (or an entity providing pharmacy benefits management services on behalf of such plan or issuer), or otherwise contain commercial or financial information that is privileged or confidential.

(C) DEFINITIONS.—In this paragraph, 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).

(2) REPORT ON COPAY ASSISTANCE PROGRAMS.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on what is known about the role of copay assistance programs and the impact of such programs on commercial health insurance, stop loss, and drug prices. Such report shall include to the extent feasible—

(A) a description of copay assistance programs, including—

(i) the types of programs available and the methods of providing copay assistance through such programs, including cash discounts, copay cards, or drugs provided to an individual at no cost;

(ii) how such programs are funded;

(iii) the types of entities that own, operate, or otherwise conduct such programs, the types of information such entities collect, and the direct and indirect contractual relationships between the entities in the drug supply chain that interact with such programs, such as a drug manufacturer, pharmacy, wholesaler, switch, rebate aggregator, pharmacy benefit manager, and other entities in the drug supply chain;

(iv) the effect of such programs on patient out-of-pocket spending, including for stop-loss insurance, and drug utilization, including drug adherence; and

(v) patient eligibility criteria for such programs; and

(B) an analysis of—

(i) the sources of funding for such programs; and

(ii) the effects of such programs on Federal health care programs and the individuals enrolled in such Federal health care programs.

**SEC. 107. REPORTS ON HEALTH CARE TRANSPARENCY TOOLS AND DATA.**

(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 transparency 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. 108. 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 applicable 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 respect 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) DEFINITIONS.—For purposes of this paragraph:

''(i) APPLICABLE MA ORGANIZATION.—The term 'applicable MA organization' means,

with respect to a plan year, an MA organization with at least 25,000 individuals enrolled under Medicare Advantage plans offered by such organization during such plan year.

''(ii) SPECIFIED HEALTH CARE PROVIDER.—The term 'specified health care provider' means, with respect to an applicable 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);

''(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 Advantage 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).''.

**SEC. 109. ADVISORY COMMITTEE.**

(a) IN GENERAL.—Not later than January 1, 2025, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall jointly convene an advisory committee (in this section referred to as the ''committee'') consisting of 9 members to advise the Secretaries on how to improve the usefulness, accessibility, and usability of information made available in accordance the amendments made by sections 105 and 106, and by section 204 of division BB of the Consolidated Appropriation Act, 2021 (Public Law 116–260), streamline the reporting of such information, and ensure that—

(1) such information is accurate, accessible, and is delivered in a form and manner consistent with the requirements of such section;

(2) the form and manner in which such information is delivered is routinely updated in accordance with widely-used practices in order to ensure accessibility; and

(3) such information is available for audit (including by making recommendations relating to how Federal and State actors may conduct such audits).

(b) MEMBERSHIP.—The Secretaries shall jointly appoint members representing end-users of the information described in subsection (a). Vacancies on the committee shall be filled by appointment consistent with this subsection not later than 3 months after the vacancy arises.

(c) TERMINATION.—The committee shall terminate on January 1, 2028.

(d) NONAPPLICAITON OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the committee.

**SEC. 110. REPORT ON IMPACT OF MEDICARE REGULATIONS ON PROVIDER AND PAYER CONSOLIDATION.**

(a) ANNUAL REPORT ON THE IMPACT OF CERTAIN MEDICARE REGULATIONS ON PROVIDER AND PAYER CONSOLIDATION; PUBLIC COMMENT ON PROVIDER AND PAYER CONSOLIDATION FOR CERTAIN PROPOSED RULES.—

(1) ANNUAL REPORT.—Not later than December 30, 2026, and annually thereafter, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report on the impact in the aggregate on provider and payer consolidation with respect to regulations for parts A, B, C, and D of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) implemented in the calendar year immediately prior to such report. Such report shall include regulations that—

(A) implement a change to an applicable payment system, a rate schedule, or another payment system under part A, B, C, or D of such title; or

(B) result in a significant rule effecting provider or payer consolidation.

(2) PUBLIC COMMENT ON IMPACT TO PROVIDER AND PAYER CONSOLIDATION.—Beginning for 2025, as part of any notice and comment rule-making process that will result in a significant rule effecting provider or payer consolidation with respect to a proposed rule for parts A, B, C, and D of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), the Secretary shall seek public comment on the projected impact of such proposed rule on provider and payer consolidation in the aggregate.

(3) DEFINITIONS.—In this section:

(A) PROVIDER AND PAYER CONSOLIDATION.—The term ''provider and payer consolidation'' includes the vertical or horizontal integration among providers of services (as defined in subsection (u) of section 1861 of the Social Security Act (42 U.S.C. 1395x)), suppliers (as defined in subsection (d) of such section), accountable care organizations under section 1899 of the Social Security Act (42 U.S.C. 1395jjj), Medicare Advantage organizations, PDP sponsors, pharmacy benefit managers, pharmacies, and integrated delivery systems.

(B) APPLICABLE PAYMENT SYSTEM.—The term ''applicable payment system'' includes—

(i) with respect to outpatient hospital services, the prospective payment system for covered OPD services established under section 1833(t) of such Act (42 U.S.C. 1395(l)); and

(ii) with respect to physicians' services, the physician fee schedules established under section 1848 of such Act (42 U.S.C. 1395w–4).

(b) CONSIDERATION OF EFFECTS ON PROVIDER AND PAYER CONSOLIDATION WITH RESPECT TO CMI MODELS.—

(1) IN GENERAL.—Section 1115A(b)(4)(A) of the Social Security Act (42 U.S.C. 1315a(b)(4)(A)) is amended—

(A) in clause (i), by striking at the end ''and'';

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

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

''(iii) the extent to which, and how, the model has effected and could effect provider and payer consolidation, which includes the vertical or horizontal integration among providers of services (as defined in subsection (u) of section 1861), suppliers (as defined in subsection (d) of such section), and accountable care organizations under section 1899.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to models tested on or after January 1, 2025.

**SEC. 111. IMPLEMENTATION FUNDING.**

(a) IN GENERAL.—For the purposes described in subsection (b), there are appropriated, in addition to amounts otherwise available, out of amounts in the Treasury not otherwise appropriated, to the Secretary of Health and Human Services and the Secretary of the Treasury, $65,000,000 for fiscal year 2024, to remain available through fiscal year 2029.

(b) PERMITTED PURPOSES.—The purposes described in this subsection are the following purposes, insofar as such purposes are to carry out the provisions of, including the amendments made by, this title:

(1) Preparing, drafting, and issuing proposed and final regulations or interim regulations.

(2) Preparing, drafting, and issuing guidance and public information.

(3) Preparing, drafting, and publishing reports.

(4) Enforcement of such provisions.

(5) Reporting, collection, and analysis of data.

(6) Other administrative duties necessary for implementation of such provisions.

(c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—Each Secretary described in subsection (a) shall annually submit, no later than September 1st of each year, to the Committees on Energy and Commerce, on Ways and Means, on Education and Workforce, and on Appropriations of the House of Representatives and on the Committees on Health, Education, Labor, and Pensions and on Appropriations of the Senate a report on funds expended pursuant to funds appropriated under this section.

## TITLE II—REDUCING HEALTH CARE COSTS FOR PATIENTS

**SEC. 201. INCREASING TRANSPARENCY IN GENERIC DRUG APPLICATIONS.**

(a) IN GENERAL.—Section 505(j)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(3)) is amended by adding at the end the following:

''(H)(i) Upon request (in controlled correspondence or an analogous process) by a person that has submitted or intends to submit an abbreviated application under this subsection for a drug that is required by regulation to contain one or more of the same inactive ingredients in the same concentrations as the listed drug referred to, or for which the Secretary determines there is a scientific justification for an approach that is in vitro in whole or in part to be used to demonstrate bioequivalence for a drug if such a drug contains one or more of the same inactive ingredients in the same concentrations as the listed drug, the Secretary shall inform the person whether such drug is qualitatively and quantitatively the same as the listed drug. The Secretary may also provide such information to such a person on the Secretary's own initiative during the review of an abbreviated application under this subsection for such drug.

''(ii) Notwithstanding section 301(j), if the Secretary determines that such drug is not qualitatively or quantitatively the same as the listed drug, the Secretary shall identify and disclose to the person—

''(I) the ingredient or ingredients that cause such drug not to be qualitatively or quantitatively the same as the listed drug; and

''(II) for any ingredient for which there is an identified quantitative deviation, the amount of such deviation.

''(iii) If the Secretary determines that such drug is qualitatively and quantitatively the same as the listed drug, the Secretary shall not change or rescind such determination after the submission of an abbreviated application for such drug under this subsection unless—

''(I) the formulation of the listed drug has been changed and the Secretary has determined that the prior listed drug formulation was withdrawn for reasons of safety or effectiveness; or

''(II) the Secretary makes a written determination that the prior determination must be changed because an error has been identified.

''(iv) If the Secretary makes a written determination described in clause (iii)(II), the Secretary shall provide notice and a copy of the written determination to the person making the request under clause (i).

''(v) The disclosures required by this subparagraph are disclosures authorized by law, including for purposes of section 1905 of title 18, United States Code.''.

(b) GUIDANCE.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall issue draft guidance, or update guidance, describing how the Secretary will determine whether a drug is qualitatively and quantitatively the same as the listed drug (as such terms are used in section 505(j)(3)(H) of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a)), including with respect to assessing pH adjusters.

(2) PROCESS.—In issuing guidance under this subsection, the Secretary of Health and Human Services shall—

(A) publish draft guidance;

(B) provide a period of at least 60 days for comment on the draft guidance; and

(C) after considering any comments received and not later than one year after the close of the comment period on the draft guidance, publish final guidance.

(c) APPLICABILITY.—Section 505(j)(3)(H) of the Federal Food, Drug, and Cosmetic Act, as added by subsection (a), applies beginning on the date of enactment of this Act, irrespective of the date on which the guidance required by subsection (b) is finalized.

**SEC. 202. IMPROVING TRANSPARENCY AND PREVENTING THE USE OF ABUSIVE SPREAD PRICING AND RELATED PRACTICES IN MEDICAID.**

(a) SPREAD PRICING.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended by adding at the end the following:

''(6) PHARMACY PRICE REIMBURSEMENT REQUIRED.—

''(A) IN GENERAL.—A contract between the State and a pharmacy benefit manager (in this paragraph referred to as a 'PBM'), or a contract between the State and a designated entity (as defined in subparagraph (C)) that includes provisions making the designated entity responsible for the administration of medical assistance consisting of covered outpatient drugs for individuals enrolled with the designated entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or designated entity, is based on a pharmacy price reimbursement model under which—

''(i) any payment made by the designated entity or the PBM (as applicable) for such a drug—

''(I) is limited to—

''(aa) ingredient cost; and

''(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State plan or waiver would pay if the plan or waiver was making the payment directly;

''(II) is passed through in its entirety by the designated entity or PBM to the pharmacy or provider that dispenses the drug and is not retroactively denied or reduced except as permitted or required under Federal or State law or regulation; and

''(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the designated entity or the PBM, except that any payment by the designated entity or the PBM for the ingredient cost of such a drug purchased by a covered entity (as defined in subsection (a)(5)(B)) may exceed the actual acquisition cost (as defined in section 447.502 of title 42, Code of Federal Regulations (or any successor regulation)) for such drug if—

''(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act;

''(bb) such payment for such cost of such drug does not exceed the maximum payment that would have been made by the designated entity or the PBM for the ingredient cost of such drug had such drug not been purchased by such a covered entity; and

''(cc) such covered entity reports to the Secretary, on an annual basis (in a form and manner specified by the Secretary) and with respect to payments for such costs of such drugs so purchased by such covered entity that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess;

''(ii) payment to the designated entity or the PBM (as applicable) for administrative services performed by the designated entity or PBM is limited to an administrative fee that reflects the fair market value of providing such services;

''(iii) the designated entity or the PBM (as applicable) makes available to the State, and the Secretary upon request, all costs and payments related to covered outpatient drugs and accompanying administrative services incurred, received, or made by the designated entity or the PBM, including ingredient costs, professional dispensing fees, administrative fees, post-sale and post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees, and any and all other remuneration; and

''(iv) any form of spread pricing whereby any amount charged or claimed by the designated entity or the PBM (as applicable) is in excess of the amount paid to the pharmacies by the designated entity or the PBM, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments (after allowing for a fair market administrative fee as described in clause (ii)), is not allowable for purposes of claiming Federal matching payments under this title.

''(B) MAKING CERTAIN INFORMATION AVAILABLE.—The Secretary shall publish, not less frequently than on an annual basis, information received by the Secretary pursuant to subparagraph (A)(i)(III)(cc). Such information shall be so published in an electronic and searchable format, such as through the 340B Office of Pharmacy Affairs Information System (or a successor system).

''(C) DEFINITIONS.—In this paragraph:

''(i) DESIGNATED ENTITY.—The term 'designated entity' means a managed care entity or other specified entity.

''(ii) MANAGED CARE ENTITY; OTHER SPECIFIED ENTITY.—The terms 'managed care entity' and 'other specified entity' have the meaning given such terms in section 1903(m)(9)(D).''.

(2) CONFORMING AMENDMENTS.—Section 1903(m) of such Act (42 U.S.C. 1396b(m)) is amended—

(A) in paragraph (2)(A)(xiii)—

(i) by striking ''and (III)'' and inserting ''(III)'';

(ii) by inserting before the period at the end the following: '', and (IV) with respect to covered outpatient drugs and related administrative services (as applicable) provided by the entity (or by a pharmacy benefit manager on behalf of the entity under a contract or other arrangement with the entity), that payment for such drugs and related administrative services is based on a pharmacy price reimbursement model described in section 1927(e)(6)(A)''; and

(iii) by moving the margin 2 ems to the left; and

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

''(10) No payment shall be made under this title to a State with respect to expenditures incurred by it for payment for services provided by an other specified entity (as defined in paragraph (9)(D)) unless the contract between the State and the entity for the provision of such services provides, with respect to covered outpatient drugs and related administrative services (as applicable) provided by the entity (or by a pharmacy benefit manager on behalf of the entity under a contract or other arrangement with the entity), that payment for such drugs and related administrative services is based on a pharmacy price reimbursement model described in section 1927(e)(6)(A).''.

(3) EFFECTIVE DATE.—The amendments made by this subsection apply to contracts between States and pharmacy benefit managers and designated entities (as defined in section 1927(e)(6) of the Social Security Act, as added by paragraph (1)) that have an effective date beginning on or after the date that is 18 months after the date of enactment of this Act.

(b) ENSURING ACCURATE PAYMENTS TO PHARMACIES UNDER MEDICAID.—

(1) IN GENERAL.—Section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) is amended—

(A) by striking ''and'' after the semicolon at the end of paragraph (1)(A)(i) and all that precedes it through ''(1)'' and inserting the following:

''(1) DETERMINING PHARMACY ACTUAL ACQUISITION COSTS.—The Secretary shall conduct a survey of retail community pharmacy drug prices to determine the national average drug acquisition cost as follows:

''(A) USE OF VENDOR.—The Secretary may contract services for—

''(i) with respect to retail community pharmacies, the determination of retail survey prices of the national average drug acquisition cost for covered outpatient drugs based on a monthly survey of such pharmacies; and'';

(B) by adding at the end of paragraph (1) the following:

''(F) SURVEY REPORTING.—A State shall require that any retail community pharmacy in the State that receives any payment, reimbursement, administrative fee, discount, or rebate related to the dispensing of covered outpatient drugs to individuals receiving benefits under this title, regardless of whether such payment, reimbursement, administrative fee, discount, or rebate is received from the State or a designated entity (as defined in subsection (e)(6)(C)) directly or from a pharmacy benefit manager that has a contract with the State or a designated entity, shall respond to surveys of retail prices conducted under this subsection.

''(G) SURVEY INFORMATION.—Information on national drug acquisition prices obtained under this paragraph shall be made publicly available in a timely manner following the collection of such information and shall include at least the following:

''(i) The monthly response rate to the survey including a list of pharmacies not in compliance with subparagraph (F).

''(ii) The sampling frame and number of pharmacies sampled monthly.

''(iii) Information on price concessions to the pharmacy, including discounts, rebates, and other price concessions, to the extent that such information may be publicly released and is available during the survey period.

''(H) REPORT ON SPECIALTY PHARMACIES.—Not later than 1 year after the date that this subparagraph takes effect, the Secretary shall submit to Congress a report examining specialty drug coverage and reimbursement under this title, including—

''(i) a description of how State Medicaid programs define specialty drugs and specialty pharmacies;

''(ii) the amount State Medicaid programs pay for specialty drugs;

''(iii) how States and designated entities (as defined in subsection (e)(6)(C)) determine payment for specialty drugs;

''(iv) the settings in which specialty drugs are dispensed to individuals receiving benefits under this title (such as retail community pharmacies or specialty pharmacies);

''(v) the extent to which specialty drugs (as defined by the respective States) are captured in the national average drug acquisition cost survey (or through another process);

''(vi) examples of specialty drug dispensing fees to support the services associated with dispensing such specialty drugs; and

''(vii) recommendations as to whether specialty pharmacies should be included in the survey of retail prices to ensure national average drug acquisition costs capture drugs sold at specialty pharmacies, and how such specialty pharmacies should be defined.

''(I) ENFORCEMENT.—At the discretion of the Secretary, the Secretary (acting through the Inspector General and in collaboration with the Administrator of the Centers for Medicare & Medicaid Services) may enforce non-compliance with this paragraph by a pharmacy through the establishment of penalties until compliance with this paragraph has been completed.''; and

(C) in paragraph (2)—

(i) in subparagraph (A), by inserting ''(including payment rates under managed care organization as defined in section 1932(a)(1)(B)(i) and PIHPs and PAHPs as defined in section 1903(m)(9)(D)(iii)(I) and (II), respectively)'' after ''under this title''; and

(ii) in subparagraph (B), by inserting '', and the basis for such dispensing fees'' before the semicolon at the end.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the first day of the first quarter that begins on or after the date that is 18 months after the date of enactment of this Act.

**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.''.

**SEC. 204. 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.

## TITLE III—SUPPORTING PATIENTS, HEALTH CARE WORKERS, COMMUNITY HEALTH CENTERS, AND HOSPITALS

**SEC. 301. EXTENSION FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS THAT OPERATE GME PROGRAMS.**

(a) TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.—

(1) ADDITION TO CAPPED AMOUNTS FOR FISCAL YEARS 2024 AND 2025.—Paragraph (2) of section 340H(b) of the Public Health Service Act (42 U.S.C. 256h(b)) is amended by adding at the end the following:

''(C) ADDITION.—Notwithstanding any provision of this section, for each of fiscal years 2024 and 2025, the Secretary may use any amounts made available in any fiscal year to carry out this section (including amounts recouped under subsection (f)) to make payments described in paragraphs (1)(A) and (1)(B), in addition to the total amount of funds appropriated under subsection (g).''.

(2) RECONCILIATION.—Section 340H(f) of the Public Health Service Act (42 U.S.C. 256h(f)) is amended—

(A) by striking ''The Secretary shall determine'' and inserting the following:

''(1) DETERMINATION.—The Secretary shall determine''; and

(B) by adding at the end the following:

''(2) ANNUAL REPORT TO CONGRESS.—For each fiscal year, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report specifying—

''(A) the total amount of funds recouped under paragraph (1);

''(B) the rationale for the funds being recouped; and

''(C) in the case of the reports for each of fiscal years 2024 and 2025, the total amount of funds recouped under paragraph (1) that were used pursuant to subsection (b)(2)(C) to adjust total payment amounts above the total amounts appropriated under subsection (g).''.

(3) FUNDING.—Section 340H(g) of the Public Health Service Act (42 U.S.C. 256h(g)) is amended—

(A) by amending paragraph (1) to read as follows:

''(1) IN GENERAL.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed—

''(A) $230,000,000, for the period of fiscal years 2011 through 2015;

''(B) $60,000,000 for each of fiscal years 2016 and 2017;

''(C) $126,500,000 for each of fiscal years 2018 through 2023;

''(D) $16,635,616 for the period beginning on October 1, 2023, and ending on November 17, 2023;

''(E) $21,834,247 for the period beginning on November 18, 2023, and ending on January 19, 2024;

''(F) $136,530,137 for the period beginning on January 20, 2024, and ending on September 30, 2024;

''(G) $175,000,000 for fiscal year 2025;

''(H) $225,000,000 for each of fiscal years 2026 and 2027; and

''(I) $300,000,000 for each of fiscal years 2028, 2029, and 2030.''; and

(B) by adding at the end the following:

''(3) AVAILABILITY.—The amounts made available under paragraph (1) shall remain available until expended.''.

(b) EXTENSION FOR COMMUNITY HEALTH CENTERS.—Section 10503(b)(1)(F) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is amended—

(1) by striking ''and'' before ''$690,410,959''; and

(2) by inserting '', $3,183,561,644 for the period beginning on January 20, 2024, and ending on September 30, 2024, $4,400,000,000 for fiscal year 2025, and $1,109,000,000 for the period beginning October 1, 2025, and ending December 31, 2025'' before the semicolon at the end.

(c) EXTENSION FOR THE NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b–2(b)(2)) is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

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

(3) by adding at the end the following:

''(J) $255,726,028 for the period beginning on January 20, 2024, and ending on September 30, 2024, $350,000,000 for fiscal year 2025, and $88,219,178 for the period beginning October 1, 2025, and ending December 31, 2025.''.

(d) GOVERNMENT ACCOUNTABILITY OFFICE REPORT.—

(1) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report assessing the effectiveness of the National Health Service Corps at attracting health care professionals to HPSAs, including by—

(A) assessing the metrics used by the Health Resources and Services Administration in evaluating the program;

(B) comparing the retention rates of NHSC participants in the HPSAs where they completed their period of obligated service to the retention rate of non-NHSC participants in the corresponding HPSAs;

(C) comparing the retention rates of NHSC participants in the HPSAs where they completed their period of obligated service to the retention rates of NHSC participants in HPSAs other than those where they completed their period of obligated service;

(D) identifying factors that influence a NHSC participant's decision to practice in a HPSA other than the HPSA where they completed their period of obligated service;

(E) identifying factors other than participation in the National Health Service Corps Scholarship and Loan Repayment Programs that attract health care professionals to a HPSA;

(F) assessing the impact the National Health Service Corps has on wages for health care professionals in a HPSA; and

(G) comparing the distribution of NHSC participants across HPSAs, including a comparison of rural versus non-rural HPSAs.

(2) DEFINITION.—In this section:

(A) The term ''HPSA'' means a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The term ''NHSC participant'' means a National Health Service Corps member participating in the National Health Service Corps Scholarship or Loan Repayment Program.

(e) APPLICATION OF PROVISIONS.—Amounts appropriated pursuant to the amendments made by this section shall be subject to the requirements contained in Public Law 117–328 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act.

(f) CONFORMING AMENDMENT.—Paragraph (4) of section 3014(h) of title 18, United States Code, is amended by striking ''and section 2321(d) of the Continuing Appropriations Act, 2024 and Other Extensions Act'' and inserting ''section 2321(d) of the Continuing Appropriations Act, 2024 and Other Extensions Act, and section 301(e) of the Lower Costs, More Transparency Act''.

**SEC. 302. EXTENSION OF SPECIAL DIABETES PROGRAMS.**

(a) EXTENSION OF SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)) 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 a semicolon; and

(3) by adding at the end the following:

''(F) $124,383,562 for the period beginning on January 20, 2024, and ending on September 30, 2024, to remain available until expended;

''(G) $170,000,000 for fiscal year 2025, to remain available until expended; and

''(H) $42,849,315 for the period beginning October 1, 2025, and ending December 31, 2025, to remain available until expended.''.

(b) EXTENDING FUNDING FOR SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)) 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 a semicolon; and

(3) by adding at the end the following:

''(F) $124,383,562 for the period beginning on January 20, 2024, and ending on September 30, 2024, to remain available until expended;

''(G) $170,000,000 for fiscal year 2025, to remain available until expended; and

''(H) $42,849,315 for the period beginning October 1, 2025, and ending December 31, 2025, to remain available until expended.''.

**SEC. 303. DELAYING CERTAIN DISPROPORTIONATE SHARE PAYMENT CUTS.**

Section 1923(f)(7)(A) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)) is amended—

(1) in clause (i)—

(A) by striking ''For the period beginning January 20, 2024, and ending September 30, 2024, and for each of fiscal years 2025'' and inserting ''For each of fiscal years 2026''; and

(B) by striking ''or period'' each place such term appears; and

(2) in clause (ii), by striking ''for the period beginning January 20, 2024, and ending September 30, 2024, and for each of fiscal years 2025'' and inserting ''for each of fiscal years 2026''.

**SEC. 304. MEDICAID IMPROVEMENT FUND.**

Section 1941(b)(3)(A) of the Social Security Act (42 U.S.C. 1396w–1(b)(3)(A)) is amended by striking '' $6,357,117,810'' and inserting ''$0''.

## TITLE IV—INCREASING ACCESS TO QUALITY HEALTH DATA AND LOWERING HIDDEN FEES

**SEC. 401. INCREASING PLAN FIDUCIARIES' ACCESS TO HEALTH DATA.**

(a) PLAN FIDUCIARY ACCESS TO INFORMATION.—

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

''(C) No contract or arrangement for services between a group health plan and any other entity, including a health care provider (including a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, or pharmacy benefit manager, is reasonable within the meaning of this paragraph unless such contract or arrangement—

''(i) allows the responsible plan fiduciary (as defined in subparagraph (B)(ii)(I)(ee)) to audit or review all de-identified claims and encounter information or data described in section 724(a)(1)(B) to—

''(I) ensure that such entity complies with the terms of the plan and any applicable law; and

''(II) determine the reasonableness of compensation received by such entity; and

''(ii) does not—

''(I) unreasonably limit the number of audits permitted during a given period of time;

''(II) limit the number of de-identified claims and encounter information or data that the responsible plan fiduciary may access during an audit;

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

''(aa) payment calculations and formulas;

''(bb) quality measures;

''(cc) contract terms;

''(dd) payment amounts;

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

''(ff) other payment methodologies used by an entity, including a health care provider (including a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, or pharmacy benefit manager;

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

''(V) limit the right of the responsible plan fiduciary to select an auditor;

''(VI) otherwise limit or unduly delay by greater than 60 calendar days after the date of request the responsible plan fiduciary from auditing all de-identified claims and encounter information or data; or

''(VII) permit the entity to charge a fee beyond the reasonable direct costs to provide the required information and otherwise comply and assist with an audit request.''.

(2) CIVIL ENFORCEMENT.—

(A) IN GENERAL.—Subsection (c) of section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new paragraph:

''(13) In the case of an agreement between a group health plan and a health care provider (including a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, or pharmacy benefit manager, that violates the provisions of section 724, the Secretary may assess a civil penalty against such provider, network or association, service provider offering access to a network of providers, third-party administrator, pharmacy benefit manager, or other service provider in the

amount of $10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.''.

(B) CONFORMING AMENDMENT.—Paragraph (6) of section 502(a) of such Act is amended by striking ''or (9)'' and inserting ''(9), or (13)''.

(3) EXISTING PROVISIONS VOID.—Section 410 of such Act is amended by adding at the end the following new subsection:

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

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

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

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

''(3) ATTESTATION.—

''(A) IN GENERAL.—Subject to subparagraph (C), the plan fiduciary of a group health plan or health insurance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection. Such attestation shall also include a statement verifying that—

''(i) the information or data described under subparagraphs (A) and (B) of paragraph (1) is available upon request and provided to the plan fiduciary, the plan administrator, or the issuer in a timely manner; and

''(ii) there are no terms in the agreement under such paragraph (1) that directly or indirectly restrict or unduly delay a plan fiduciary, the plan administrator, or the issuer from auditing, reviewing, or otherwise accessing such information, except as permitted under section 408(b)(2)(C).

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

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

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

''(ii) a description of the efforts made by the plan fiduciary to remove any gag clause provisions from the agreement under paragraph (1); and

''(iii) a description of any response by the third-party administrator or other service provider with respect to efforts to comply with the attestation requirement under subparagraph (A).''.

(c) REPORT ON PLAN ASSETS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall submit to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the status of de-identified claims and encounter information or data described in section 724(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m), including information on the following:

(1) Whether changes to regulations or guidance would permit such information or data to be deemed a group health plan asset (as defined under section 3(42) of such Act).

(2) Whether restrictions on the ability of a plan fiduciary to access such information or data violates a requirement of current law.

(3) The existing regulatory authority of the Secretary to clarify whether such information or data is the property of a group health plan, rather than a service provider.

(4) Legislative recommendations to establish that such information or data related to a plan belongs to a group health plan and is handled in the best interests of plan participants and beneficiaries.

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

**SEC. 402. HIDDEN FEES DISCLOSURE REQUIREMENTS.**

(a) CLARIFICATION OF THE APPLICATION OF FEE DISCLOSURE REQUIREMENTS TO COVERED SERVICE PROVIDERS.—

(1) SERVICES.—Clause (ii)(I)(bb) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended—

(A) in subitem (AA) by striking ''Brokerage services,'' and inserting ''Services (including brokerage services),''; and

(B) in subitem (BB)—

(i) by striking ''Consulting,'' and inserting ''Other services,''; and

(ii) by inserting ''any of the following:'' before ''plan design''.

(2) DISCLOSURES.—Clause (iii)(III) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended by striking '', either in the aggregate or by service,'' and inserting ''by service''.

(b) STRENGTHENING DISCLOSURE REQUIREMENTS WITH RESPECT TO PHARMACY BENEFIT MANAGERS AND THIRD PARTY ADMINISTRATORS FOR GROUP HEALTH PLANS.—

(1) CERTAIN ARRANGEMENTS FOR PHARMACY BENEFIT MANAGER SERVICES CONSIDERED AS INDIRECT.—

(A) IN GENERAL.—Clause (i) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended—

(i) by striking ''requirements of this clause'' and inserting ''requirements of this subparagraph''; and

(ii) by adding at the end the following: ''For purposes of applying section 406(a)(1)(C) with respect to a transaction described under this subparagraph, a contract or arrangement for services between a covered plan and a health insurance issuer providing health insurance coverage in connection with the covered plan in which the health insurance issuer contracts, in connection with such plan, with a service provider for pharmacy benefit management services shall be considered to constitute an indirect furnishing of goods, services, or facilities between the plan and the service provider acting as the party in interest.''.

(B) HEALTH INSURANCE ISSUER AND HEALTH INSURANCE COVERAGE DEFINED.—Clause (ii)(I)(aa) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by inserting before the period at the end ''and the terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms in section 733(b)''.

(C) TECHNICAL AMENDMENT.—Clause (ii)(I)(aa) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is further amended by inserting ''in'' after ''defined''.

(2) SPECIFIC DISCLOSURE REQUIREMENTS WITH RESPECT TO PHARMACY BENEFIT MANAGEMENT SERVICES.—

(A) IN GENERAL.—Clause (iii) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(VII) With respect to a contract or arrangement with the covered plan in connection with the provision of pharmacy benefit management services, as part of the description required under subclauses (III) and (IV)—

''(aa) all compensation described in clause (ii)(I)(dd)(AA), including fees, rebates, alternative discounts, co-payment offsets, and other remuneration expected to be received by the covered service provider, an affiliate, or a subcontractor from a pharmaceutical manufacturer, distributor, rebate aggregator, accumulator, and maximizer, group purchasing organization, or any other third party;

''(bb) the amount and form of any rebates, discounts, or price concessions, including the amount expected to be passed through to the plan sponsor or the participants and beneficiaries under the covered plan;

''(cc) all compensation expected to be received by the covered service provider, an affiliate, or a subcontractor as a result of paying a lower amount for the drug than the amount charged as a copayment, coinsurance amount, or deductible;

''(dd) all compensation expected to be received by the covered service provider, an affiliate, or a subcontractor as a result of paying pharmacies less than what is charged the health plan, plan sponsor, or participants and beneficiaries under the covered plan; and

''(ee) all compensation expected to be received by the covered service provider, an affiliate, or a subcontractor from drug manufacturers and any other third party in exchange for—

''(AA) administering, invoicing, allocating, or collecting rebates related to the covered plan;

''(BB) providing business services and activities, including providing access to drug utilization data;

''(CC) keeping a percentage of the list price of a drug; or

''(DD) any other reason related to the role of a covered service provider as a conduit between the drug manufacturers or any other third party and the covered plan.''.

(B) ANNUAL DISCLOSURE.—Clause (v) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(III) A covered service provider, with respect to a contract or arrangement with the covered plan in connection with providing pharmacy benefit management services, shall disclose, on an annual basis not later than 60 days after the beginning of the current plan year, to a responsible plan fiduciary, in writing, the following with respect to the twelve months preceding the current plan year:

''(aa) All direct compensation described in subclause (III) of clause (iii) and indirect compensation described in subclause (IV) of clause (iii) received by the covered service provider (including such compensation described in subclause (VII) of clause (iii)).

''(bb) The total gross spending by the covered plan on drugs (excluding rebates, discounts, or other price concessions).

''(cc) The total net spending by the covered plan on drugs.

''(dd) The total gross spending at all pharmacies wholly or partially owned by the covered service provider or any entity affiliated with the covered service provider, including

mail-order, specialty and retail pharmacies, with a breakdown by individual pharmacy location.

''(ee) The aggregate amount of clawback from such pharmacies, including mail-order, specialty, and retail pharmacies.

''(AA) categorical explanations (grouped by the reason for clawback, such as contractual true-up provisions, overpayments, or non-covered medication dispensed, and including information on the amount in each category that was passed through to the covered plan and to participants and beneficiaries of the covered plan); or

''(BB) individual explanations for such clawbacks.

''(ff) Total aggregate amounts of fees collected by the covered service provider, an affiliate, or a subcontractor in connection with the provision of pharmacy benefit management services to the covered plan.

''(gg) Any other information specified by the Secretary through regulations or guidance that may be necessary for a responsible plan fiduciary to consider the merits of the contract or arrangement with the covered service provider and any conflicts of interest that may exist.''.

(C) PHARMACY BENEFIT MANAGEMENT SERVICES DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(gg) The term 'pharmacy benefit management services' includes any services provided by a covered service provider to a covered plan with respect to the administration of prescription drug benefits under the covered plan, including—

''(AA) processing and payment of claims;

''(BB) design of pharmacy networks;

''(CC) negotiation, aggregation, and distribution of rebates, discounts, and other price concessions;

''(DD) formulary design and maintenance;

''(EE) operation of pharmacies (whether retail, mail order, specialty drug, or otherwise);

''(FF) recordkeeping;

''(GG) utilization review;

''(HH) adjudication of claims; and

''(II) any other services specified by the Secretary through guidance or rulemaking.''.

(D) CLAWBACK DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by subparagraph (C), is amended by adding at the end the following:

''(hh) The term 'clawback' means amounts collected by a provider of pharmacy benefit management services from a pharmacy for copayments collected from a participant or beneficiary in excess of the contracted rate.''.

(3) SPECIFIC DISCLOSURE REQUIREMENTS WITH RESPECT TO THIRD PARTY ADMINISTRATION SERVICES FOR GROUP HEALTH PLANS.—

(A) IN GENERAL.—Clause (iii) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by paragraph (2)(A), is further amended by adding at the end the following:

''(VIII) With respect to a contract or arrangement with the covered plan in connection with the provision of third party administration services for group health plans, as part of the description required under subclauses (III) and (IV)—

''(aa) the amount and form of any rebates, discounts, savings fees, refunds, or amounts received from providers and facilities, including the amounts that will be retained by the covered service provider as a fee;

''(bb) the amount and form of fees expected to be received from other service providers in relation to the covered plan, including the amounts that will be retained by the covered service provider as a fee; and

''(cc) the amount and form of expected recoveries by the covered service provider, including the amounts that will be retained by the covered service provider as a fee (disaggregated by category), as a result of—

''(AA) overpayments;

''(BB) erroneous payments;

''(CC) uncashed checks or incomplete payments;

''(DD) billing errors;

''(EE) subrogation;

''(FF) fraud; or

''(GG) any other reason on behalf of the covered plan.''.

(B) ANNUAL DISCLOSURE.—Clause (v) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by paragraph (2)(B), is amended by adding at the end the following:

''(IV) A covered service provider, with respect to a contract or arrangement with the covered plan in connection with providing third party administration services for group health plans, shall disclose, on an annual basis not later than 60 days after the beginning of the current plan year, to a responsible plan fiduciary, in writing, the following with respect to the twelve months preceding the current plan year:

''(aa) All direct compensation described in subclause (III) of clause (iii).

''(bb) All indirect compensation described in subclause (IV) of clause (iii) received by the covered service provider, an affiliate, or a subcontractor (including such compensation described in subclause (VIII) of clause (iii)).

''(cc) The aggregate amount for which the covered service provider, an affiliate, or a subcontractor received indirect compensation and the estimated amount of cost-sharing incurred by plan participants and beneficiaries as a result.

''(dd) The total gross spending by the covered plan on all costs and fees arising under or paid under the administrative services agreement with the covered service provider (not including any amounts described in items (aa) through (cc) of clause (iii)(VIII)).

''(ee) The total net spending by the covered plan on all costs and fees arising under or paid under the administrative services agreement with the covered service provider.

''(ff) The aggregate fees collected by the covered service provider, an affiliate, or a subcontractor.

''(gg) Any other information specified by the Secretary through regulations or guidance that may be necessary for a responsible plan fiduciary to consider the merits of the contract or arrangement with the covered service provider and any conflicts of interest that may exist.''.

(C) THIRD PARTY ADMINISTRATION SERVICES FOR GROUP HEALTH PLANS DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by paragraph (2)(C), is amended by adding at the end the following:

''(ii) The term 'third party administration services for group health plans' includes any services provided by a covered service provider, an affiliate, or a subcontractor to a covered plan with respect to the administration of health benefits under the covered plan, including—

''(AA) the processing, repricing, and payment of claims;

''(BB) design, creation, and maintenance of provider networks;

''(CC) negotiation of discounts off gross rates;

''(DD) benefit and plan design;

''(EE) negotiation of payment rates;

''(FF) recordkeeping;

''(GG) utilization review;

''(HH) adjudication of claims;

''(II) regulatory compliance; and

''(JJ) any other services set forth in an administrative services agreement or similar agreement or specified by the Secretary through rulemaking.''.

(4) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to imply that a practice in relation to which a covered service provider is required to provide information as a result of such amendments is permissible under Federal law.

(5) EFFECTIVE DATE.—No contract or arrangement entered into prior to January 1, 2025, shall be subject to the requirements of subsection (b).

(c) PRIVACY REQUIREMENTS.—Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)), as amended by section 401, is further amended by adding at the end the following:

''(D) PRIVACY REQUIREMENTS.—Covered service providers shall provide information under subparagraph (B) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 13402(a) of the Health Information Technology for Clinical Health Act (42 U.S.C. 17932(a)), and consistent with the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act) and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations and such HIPAA privacy regulations.

''(E) DISCLOSURE AND REDISCLOSURE.—

''(i) LIMITATION TO BUSINESS ASSOCIATES.—A responsible plan fiduciary receiving information disclosed under subparagraph (B) may disclose such information only to the entity from which the information was received, the group health plan for which the information pertains, or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA Privacy Rule (45 CFR parts 160 and 164, subparts A and E).

''(ii) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent a group health plan or health insurance issuer offering group health insurance coverage, or a covered service provider, from placing reasonable restrictions on the public disclosure of the information described in this subparagraph, except that such plan, issuer, or entity may not restrict disclosure of such information to the Department of Labor.

''(F) ADDITIONAL PRIVACY REQUIREMENTS.—

''(i) IN GENERAL.—Covered service providers shall ensure that information provided under subparagraph (B) contains only summary health information, as defined in section 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

''(ii) RESTRICTIONS.—A group health plan must comply with section 164.504(f) of title 45, Code of Federal Regulations and a responsible plan administrator who is a plan sponsor must act in accordance with the terms of the agreement described in such section.

''(G) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (as defined in section 1180(b)(3) of the Social Security Act).''.

(d) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall issue notice and comment rulemaking as necessary to implement the provisions of this section. The Secretary shall ensure that such rulemaking—

(1) accounts for the varied compensation practices of covered service providers (as defined under section 408(b)(2)(B); and

(2) establishes standards for the disclosure of expected compensation by such covered service providers.

**SEC. 403. PRESCRIPTION DRUG PRICE INFORMATION REQUIREMENT.**

(a) PHSA.—

(1) IN GENERAL.—Part D of title XXVII of the Public Health Service Act, as amended by section 106, is further amended by adding at the end the following new section:

**"SEC. 2799A–12. INFORMATION ON PRESCRIPTION DRUGS.**

''(a) IN GENERAL.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall—

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under such plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the enrollee under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(2) CONFORMING AMENDMENT.—Section 2729 of the Public Health Service Act (42 U.S.C. 300gg–29) is amended by adding at the end the following new subsection:

''(c) SUNSET.—The preceding provisions of this section shall not apply beginning on the date of the enactment of this subsection.''.

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 106, is further amended by adding at the end the following new section:

**"SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.**

''(a) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage shall—

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant or beneficiary in the plan or coverage from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under such plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(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.), as amended by section 106, is further amended by inserting after the item relating to section 726 the following new item:

''Sec. 727. Information on prescription drugs.''.

(c) IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 106, is further amended by adding at the end the following:

**"SEC. 9827. INFORMATION ON PRESCRIPTION DRUGS.**

''(a) IN GENERAL.—A group health plan shall—

''(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant or beneficiary in the plan from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage; and

''(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such plan does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any group health plan or health insurance coverage.

''(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 106, is further amended by adding at the end the following new item:

''Sec. 9827. Information on prescription drugs.''.

**SEC. 404. IMPLEMENTATION FUNDING.**

(a) IN GENERAL.—For the purposes described in subsection (b), and in addition to amounts otherwise available for such purposes there are appropriated, out of amounts in the Treasury not otherwise appropriated, to the Secretary of Labor $35,000,000, for fiscal year 2024, to remain available through fiscal year 2029.

(b) PERMITTED PURPOSES.—The purposes described in this subsection are limited to the following purposes, insofar as such purposes are to carry out the provisions of, including the amendments made by, title I and IV:

(1) Preparing, drafting, and issuing proposed and final regulations or interim regulations.

(2) Preparing, drafting, and issuing guidance and public information.

(3) Preparing, drafting, and publishing reports.

(4) Enforcement of such provisions.

(5) Reporting, collection, and analysis of data.

(6) Other administrative duties necessary for implementation of such provisions.

(c) TRANSPARENCY OF IMPLEMENTATION FUNDS.—The Secretary of Labor shall annually submit, no later than September 1st of each year, to the Committees on Education and Workforce and on Appropriations of the House of Representatives and the Committees on Health, Education, Labor, and Pensions and on Appropriations of the Senate a report on funds expended pursuant to funds appropriated under this section.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Washington (Mrs. RODGERS) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentlewoman from Washington.

GENERAL LEAVE

Mrs. RODGERS of Washington. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Washington?

There was no objection.

Mrs. RODGERS of Washington. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of the Lower Cost, More Transparency Act. We all know that healthcare is too expensive, and the system is far too complicated. In the Committee on Energy and Commerce, we have heard countless stories about real patients who were victims of an opaque system and were on the hook for staggering amounts of money for seeing a doctor, going to a hospital, or getting medicine.

We heard about a patient who tried to shop for her care and was billed thousands of dollars more than what she was quoted. We heard about a patient who was overcharged $11,000 by a hospital for services she didn't receive. We heard moving testimony from cancer patient advocates about policies we can enact right now to lower their drug costs.

The Lower Costs, More Transparency Act includes these and other policies that would directly help all these patients. It lowers costs for Americans through increased healthcare price transparency. It ensures that senior citizens on Medicare never pay more for a drug because of where it is administered, and it makes drug prices transparent to help patients and employers

get the best deals possible on medicines.

Over 90 percent of Americans support increased price transparency in healthcare. By passing this bill, we will be delivering results people are counting on. Further, CBO confirms that the bill would save taxpayers more than $700 million over the next decade.

I thank Chairman JASON SMITH, Chairwoman VIRGINIA FOXX, and Ranking Member FRANK PALLONE for their leadership. I thank Majority Leader STEVE SCALISE for working with us to bring this bill to the floor today.

Also, a special thank you to Ranking Member PALLONE's team, notably Tiffany Guarascio, Waverly Gordon, Una Lee, and Saha Khaterzai for working with us to find this bipartisan agreement.

Finally, I thank my own staff, especially Grace Graham, Corey Ensslin, and Kristin Flukey for their tireless efforts that will make a meaningful difference for patients all across this Nation.

In sum, this bill is a legislative opportunity, bipartisan, regular order, and fully paid for. It advances foundational healthcare reforms for patients, lowers healthcare costs, and reduces the deficit.

Mr. Speaker, I urge all my colleagues to support the Lower Costs, More Transparency Act, and I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of H.R. 5378, the Lower Costs, More Transparency Act. This bipartisan bill does exactly what it says it does: It delivers lower healthcare costs for the American people and brings much-needed transparency to our Nation's healthcare system.

Access to affordable healthcare remains a major challenge for many American families. More than 40 percent of adults say they have either delayed or forgone medical care because of high costs. Prices for healthcare services also vary widely. Consumers often have difficulty obtaining price information to begin with. Another problem is that the information can be misleading or inaccurate, making it difficult for consumers to compare prices across healthcare providers before receiving care. Too many patients are forced to wait until after they receive care and receive their medical bill to see what they actually owe.

H.R. 5378 brings some much-needed transparency to the healthcare system by codifying and strengthening important price transparency protections. It is a victory for everyone who has ever struggled to navigate and understand the cost of a healthcare procedure or a prescription drug at the pharmacy counter. These measures will empower consumers and employers with data on the prices hospitals charge and the rates insurers pay so that they can compare prices and save money.

It also increases transparency of how pharmacy benefit managers, or PBMs, affect drug prices at the pharmacy counter. This will also help increase competition and lower healthcare costs for Americans. We have added new language in the bill to enhance the privacy protections for consumers' health information and to ensure that the full protection of the HIPAA privacy rule is applicable.

I also want to mention, Mr. Speaker, the bill reduces costs for patients by ensuring Medicare beneficiaries are not paying more for the exact same drug because it was administered in a hospital outpatient department instead of a physician's office. It will also build on Democrats' work to rein in the soaring cost of prescription drugs by requiring the FDA to provide more information to generic drug manufacturers during the development process. This will help speed up the path to market and increase competition sooner to lower drug prices faster. All of these provisions in this bill will help make healthcare and prescription drugs more affordable for the American people.

I also want to mention, Mr. Speaker, that H.R. 5378 will also make healthcare more accessible to American families thanks to critical investments in our Nation's public health programs that serve low-income and uninsured patients. The bill includes increased funding for community health centers at $4.4 billion per year, an unprecedented 10 percent increase over current funding levels.

Community health centers are a critical source of primary healthcare for more than 30 million patients, 1 in every 11 Americans. These centers deliver high-quality, affordable healthcare to some of our most vulnerable communities, and this increased funding will allow these centers to continue providing this critical care.

The bill increases funding for the National Health Service Corps, which places doctors in high-need communities. It also includes an unprecedented 7 years of funding, more than double the funding under current law, for the Teaching Health Center Graduate Medical Education program to support the training of primary care physicians in community-based settings. This program helps address doctor shortages in underserved areas as graduates of the program are likely to practice close to their training sites and to care for underserved patients. This long-term funding will help bring more certainty to the program to ensure that teaching health centers can plan and recruit for their residency programs.

Finally, the bill also reauthorizes and increases funding for both the Special Diabetes Program and Special Diabetes Program for Indians. These programs provide critical investments in diabetes research and care.

I will also mention that H.R. 5378 eliminates looming cuts to Medicaid Disproportionate Share Hospitals to support these high-need hospitals that provide care for large numbers of Medicaid and uninsured patients.

The increased funding for each of these public health and workforce programs is essential to ensuring access to care for our constituents across the country. All of this funding is fully offset with policies that will further strengthen our healthcare system and help reduce costs for American families.

Mr. Speaker, when a version of this bill came before the Committee on Energy and Commerce, it passed unanimously with bipartisan support. Chair RODGERS and I have been working on this bill all year, and I commend her for her ongoing commitment to get it across the finish line. It is an important bill that delivers meaningful results.

I will also take an opportunity to thank some of the staff who have worked on this. From my committee staff, I thank Tiffany Guarascio, Waverly Gordon, Una Lee, Saha Khaterzai, Rick Van Buren, Stephen Holland, and Lydia Abma. From the Republican staff, I thank Nate Hodson, Sarah Burke, Grace Graham, and Corey Ensslin.

Floor action today simply would not have been possible without months of long-term commitment by the staff on both sides of the aisle to get this done. I think you can tell that I really think this is probably one of the most important bills that will come out of the Committee on Energy and Commerce this session. It is truly bipartisan, which is another thing I think is very important right now.

I strongly urge my colleagues to join me in supporting the bill to lower healthcare costs for the American people and to make healthcare more accessible.

Mr. Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I would like to engage in a colloquy with Ranking Member PALLONE.

This bill codifies and strengthens healthcare price transparency requirements. Congress asserting itself to declare price transparency the law of the land is critical, but Congress can't account for every specificity and eventuality that is needed to ensure price transparency policies established by the Trump and Biden administrations are set in stone. We have to allow implementing agencies discretion to update regulations that reflect changes in terminology and technology over time.

For example, with respect to health insurance price transparency, it is the intent of this House that this law shall be implemented to ensure that health plans report the prices that they have negotiated with the hospitals, other providers, and drug manufacturers to allow patients and employers purchasing coverage to use these data to drive down healthcare prices through open competition.

Under existing regulations, health plans and insurers must disclose very specific price information for all

healthcare items and services. This bill codifies the authority holding up those regulations to ensure that such robust data continues to be disclosed. These data include all billing codes and modifiers, using industry-standard, government-recognized, commonly used code sets used by all medical providers to define specific healthcare items and services. We ensure the data are accurate by requiring providers' ID codes, place of service codes, and health plan identifiers assigned to the group health plan and insurer, all critical information that makes price disclosures comparable across different health plans.

It is our intent that the requirements for transparency in coverage should be as comprehensive as possible, without limitations. I yield to the gentleman from New Jersey (Mr. PALLONE), the ranking member for the purpose of a colloquy.

Mr. PALLONE. Mr. Speaker, let me say that I concur with my colleagues and partners in crafting this important bipartisan piece of legislation that is intended to codify and improve upon the robust requirements that exist in the regulations that have been implemented by both the Trump and Biden administrations. With this bill, we seek to bring true health price transparency to lower costs for patients, employers, and unions purchasing health coverage.

This bill is a floor, not a ceiling, and I intend that the implementing agencies will use the discretion left to them to ensure that health plans and insurers disclose the detailed price information and necessary data on reimbursement rates for healthcare items and services. We intend to follow this colloquy with a bipartisan letter to the agencies reiterating our expectations in greater detail.

In addition, in further colloquy with Chair RODGERS, I address a technical change that needs to be made to the bill in negotiations with the Senate. In the new version of the bill, we have limited the drug price data flowing to small employers in order to strengthen health privacy protections for their employees. However, I want to make clear that we did not intend to exclude multiemployer, public sector, or retiree-only and union health plans under this new provision, and we are committed to fixing this issue before the bill becomes law. Ranking Member BOBBY SCOTT also agrees with this perspective.

I ask Chair RODGERS if she would concur with me that we make sure this issue is addressed in our negotiation with the Senate and before the bill becomes law.

Mrs. RODGERS of Washington. Mr. Speaker, I thank Ranking Member PALLONE for his ongoing leadership, and I agree it is critical that the legislation meets our intent when it comes to ensuring that the PBMs must be transparent with multiemployer, public sector, and retiree-only health plans along with all other employer health plans. I do concur that we will address this issue in negotiations with the Senate, and I look forward to working to make sure this bill becomes law.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT), a member of the Ways and Means Committee.

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Mr. DOGGETT. Mr. Speaker, this transparency bill lacks transparency on two of the major problems that are impacting soaring healthcare costs. The only reason to reject transparency for, first, private equity and, second, Medicare Advantage is that they have got more to hide and apparently more lobbying power.

A growing private equity takeover of healthcare has already undermined care in nursing homes and now threatens hospitals and medical specialty practices across the United States with higher prices, higher cost to taxpayers, and less quality.

A Senate committee has just launched a major investigation into the impact of private equity on hospital costs and lower quality care.

Having failed to save taxpayers a dime that was promised—of the many millions that was promised—Medicare Advantage costs $1,500 per person each year over the cost of traditional Medicare. That is billions in wasted taxpayer dollars.

The best way to fund much-needed services at community health centers and to expand and improve and strengthen Medicare with services such as dental, hearing, and vision is to take it right out of Medicare Advantage.

This bill, I believe, should be rejected until these issues are addressed by permitting the very amendments that we offered in the House Ways and Means Committee that rejected them, as usual, to address private equity and Medicare Advantage.

Mr. Speaker, with all respect to the bipartisan efforts and hard work in the Energy and Commerce Committee, I believe there is a better way to finance needs, and a very important need, to address the issues of transparency on Medicare Advantage and private equity. Therefore, I oppose the bill.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina (Ms. FOXX), the chairwoman of the Education and the Workforce Committee. I appreciate her partnership on this legislation.

Ms. FOXX. Mr. Speaker, the American healthcare system is a complex, expensive maze fueled by heavyhanded regulation, consolidation, and lack of transparency. Growth in health spending is rising at unsustainable rates, forcing insurance premiums and out-of-pocket costs higher and remaining too expensive for working families.

The bill before us is a bipartisan solution to help lower costs by pulling the curtain back on healthcare and revealing anticompetitive industry practices that are stifling the free market.

Included in this bill is the Hidden Fee Disclosure Act, authored by Representatives JOE COURTNEY and ERIN HOUCHIN, which requires pharmacy benefit managers, PBMs, and third-party administrators to disclose hidden compensation to plan sponsors.

The Health DATA Act, authored by Representative LORI CHAVEZ-DEREMER, is also included in this legislation. It prohibits gag clauses between health plans and third-party entities, which restricts a plan sponsor's access to its own data.

Additionally, the bill includes the Transparency in Coverage Act, authored by Representative BOB GOOD. It builds on the general principles of transparency and accountability enshrined in the No Surprises Act by requiring health plans to disclose their prices publicly.

Patients have been left in the dark. Because of opaque rules and industry practices, patients are often left paying higher costs. This is why we are taking action and shining a light on these issues. Increasing transparency has been proven to root out waste successfully and save healthcare dollars.

Bottom line, we want to provide workers and their families with more options at lower prices. The Lower Costs, More Transparency Act does just that while also reducing the deficit by $800 million.

Mr. Speaker, I encourage my colleagues to support its passage.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank my friend, Representative DOGGETT, for his hard work on the important issues that he raised and that have been raised today. I should mention that he is the ranking member of the Ways and Means Health Subcommittee, so he is very familiar with these issues.

I know he thinks that certain things should have been added to this bill, but I want to stress that I think we have to support this bill based on the important policies that we have in the bill. It is not always easy to get consensus between Democrats and Republicans. This is one of those rare examples, unfortunately, where we have come to a consensus, which our committee often does. That is why I do stress the important policies that are in it.

I think the legislation is a victory for the American people. It addresses a lot of obvious failings in our health system. The bill brings some much-needed price transparency to the healthcare system and will help lower healthcare costs for patients.

Americans have been struggling for years to obtain accurate price information before going in for a healthcare procedure. It is difficult for patients to know how much a hospital or their insurance company will charge them for the care that they receive.

All this information should be readily available to the public. This bill requires hospitals and insurance companies to list prices in an easy to understand format for patients.

The bill also prevents hospital outpatient facilities from unfairly overcharging seniors. This policy will save Medicare beneficiaries $1.4 billion in lower premiums.

The bill helps further rein in the cost of prescription drugs by cracking down on price gouging by pharmacy benefit managers and requires the PBMs to be transparent about their price information.

This is going to help lower healthcare costs for both employers and patients and bring needed oversight to the PBM industry.

In addition to these patient protection provisions, the legislation includes a historic $15 billion in investments in safety net and workforce programs and programs to address physician shortages around the country.

The legislation essentially lowers healthcare costs for the American people and makes healthcare more accessible to American families. I think this delivers meaningful results to the American people on a bipartisan basis.

Mr. Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. GUTHRIE), the chairman of the Health Subcommittee.

Mr. GUTHRIE. Mr. Speaker, I rise today to speak in support of H.R. 5378, the Lower Costs, More Transparency Act.

Over the past several years, I have heard from countless Kentuckians about the challenges they face and the pain they are feeling due to rising healthcare costs. This bipartisan, landmark legislation marks the first step in driving transformational change across our healthcare system.

The Lower Costs, More Transparency Act incorporates transparency requirements in nearly every aspect of the healthcare system. We are building on the Trump-era price transparency rules for hospitals and insurance plans. We are requiring pharmacy benefit managers to disclose prices and fees to lower costs for patients and employers. We are even requiring transparency for clinical labs.

We have countless testimonials and data to show that transparency lowers costs. Recently, a multinational equipment manufacturer fired their PBM and started managing their own prescription drug benefits for its employees because they finally understood what they were being charged.

The most important part about this bill is that, for once, it is not a top-down, Washington-knows-best approach to the cost of healthcare.

The American people have given Congress this mandate, with over 95 percent of surveyed voters supporting healthcare price transparency to reduce healthcare costs, according to a 2022 KFF poll.

The Lower Costs, More Transparency Act directly lowers costs that seniors are paying out of pocket for certain drugs like cancer drugs and other medicines administered in doctors' offices that are owned by hospitals.

Seniors receiving Medicare should not be paying more for a drug based solely off the location of where they receive the drug. We are fixing this.

I should note that we are able to get major policy changes in this legislation while making sure the bill saves the American people money, an estimated $700 million. This is an objective that Congress very rarely prioritizes.

Mr. Speaker, I thank Chair RODGERS for her vision and steadfast leadership on this bill. I will proudly be casting a ''yes'' vote on H.R. 5378, and I urge my House colleagues to do the same.

Mr. PALLONE. Mr. Speaker, I have no additional speakers. If the chair needs time for people who will support the bill, I will yield to them.

Mr. Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Missouri (Mr. SMITH), the chairman of the House Ways and Means Committee.

Mr. SMITH of Missouri. Mr. Speaker, the Lower Costs, More Transparency Act empowers patients and will lower healthcare costs for millions of Americans.

This bipartisan bill has been a collaborative effort, and I thank my colleagues on the Energy and Commerce Committee and the Education and the Workforce Committee for their partnership.

American families have struggled for far too long to afford the cost of their healthcare. What is worse is they have been unable to anticipate those costs because our current system makes it nearly impossible to figure out the actual price for almost any type of treatment, medicine, drug, or procedure.

The legislation before us would ensure timely and accurate details about the cost of care, treatments, and services are available and accessible before a patient goes into the doctor's office or hospital.

Hospitals, insurance companies, labs, imaging providers, and others would be required to publicly disclose their prices, creating incentives to lower prices across the board. This bill would increase access to care by combating healthcare consolidation, which reduces options and drives up costs.

It also would take an important step to address the soaring costs of prescription drugs by requiring health insurers and PBM middlemen to disclose negotiated drug rebates and discounts. It would ease the financial burden on our seniors, widen access to more affordable generic drugs, and arm employers with vital drug price information.

This bill would make important investments in training programs for new doctors to help address the healthcare workforce shortage and further invest in hospitals that serve high Medicaid populations.

Mr. Speaker, I urge my colleagues to support this bill to deliver a healthcare system that is more accessible and affordable for the American people.

Mr. PALLONE. Mr. Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS), a subcommittee chair.

Mr. BILIRAKIS. Mr. Speaker, I rise in strong support of H.R. 5378, the Lower Costs, More Transparency Act.

I hear from my constituents on a regular basis that the cost of healthcare is too high, and it remains a burden for everyday Americans who are struggling to get by.

This bipartisan package led by Chair RODGERS, who I appreciate so much, finally looks to turn the tide of these high costs by injecting much-needed transparency and accountability into our healthcare system. This includes updating CMS' price transparency rules so they actually work effectively for patients. It ensures we better understand and reduce consolidation among hospitals, insurers, and PBMs alike.

This also includes my bill with Representative DEGETTE to reauthorize the Special Diabetes Program for 2 years with increased funding, all while reducing the deficit by $750 million.

Mr. Speaker, I urge my colleagues to support this transformative package.

Mr. PALLONE. Mr. Speaker, I reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. BUCSHON), the vice chair of the Health Subcommittee.

Mr. BUCSHON. Mr. Speaker, I rise today in strong support of H.R. 5378, the Lower Costs, More Transparency Act.

This bill, which was a product of thorough bipartisan work across three committees, is one of the strongest healthcare bills I can remember voting on since coming to Congress in 2011. Honestly, it really is. I want to say that again: It is one of the strongest healthcare bills I can remember voting on since coming to Congress.

I thank Chair RODGERS, Ranking Member PALLONE, and the members of the other two committees for their hard work on getting this bill to the floor.

At nearly $13,000 per person, or about 18 percent of the GDP, U.S. national health expenditures far exceed other high-income countries, and they continue to rise at unsustainable rates.

Congress must enact serious reforms that spur competition and show taxpayers where all of these healthcare dollars are going. They are certainly not always going to them.

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The problem is not limited to one part of our healthcare system, and so

the solution must also reach across the entire system. This legislation seeks to increase transparency and lower costs related to hospital care, outpatient services, and prescription drugs, among other things. It also reauthorizes community health centers and supports disproportionate share hospitals.

Finally, we cannot get control of our national debt and deficit unless we first have transparency in our healthcare system, one of the largest expenditures that the Federal Government has. This bill is a tremendous step in that direction.

Mr. Speaker, I am proud to support this legislation, and I urge all my colleagues to support it.

Mr. PALLONE. Mr. Speaker, I continue to reserve the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentlewoman for yielding.

Mr. Speaker, I rise today in strong support of H.R. 5378, the Lower Costs, More Transparency Act.

As a pharmacist for over four decades, I have seen firsthand how our healthcare system treats patients with unaffordable prices and inaccessible care.

Under the leadership of Chairwoman RODGERS and Health Subcommittee Chairman GUTHRIE, we can do something about it by reining in the PBMs and putting patients before profits.

Included in this bill is my Drug Price Transparency in Medicaid Act which puts an end to the PBM games by prohibiting spread pricing in Medicaid and increasing transparency and fairness to community pharmacies by allowing them to be reimbursed at an appropriate rate for dispensing medications to Medicaid patients.

I am also pleased to see my PBM Accountability Act is also included in this bill.

The Lower Costs, More Transparency Act is such an important first step towards bringing down prescription drug prices by addressing the root cause: the middlemen who prey on patients for profits.

Mr. Speaker, I urge my colleagues to support the Lower Costs, More Transparency Act.

Mrs. RODGERS of Washington. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. JOYCE).

Mr. JOYCE of Pennsylvania. Mr. Speaker, I thank the gentlewoman for yielding.

The Lower Costs, More Transparency Act is part of our commitment to supporting our patients, creating access to affordable medications, and making the healthcare process easier to access for literally all Americans.

Included in this legislation is my bill, the Strengthening Community Care Act, which would reauthorize support for community health centers. These centers are a vital source of care for over 30 million Americans and nearly 240,000 individuals in Pennsylvania's 13th Congressional District.

By reducing barriers like cost, lack of insurance, or distance, community health centers are able to provide high-quality treatment to the patients who need it the most: the patients who are underinsured or not insured at all.

Mr. Speaker, I urge all of my colleagues to support the Lower Costs, More Transparency Act, and I will be voting ''yes'' for this important piece of legislation.

Mr. PALLONE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I cannot emphasize the importance of this bill. I think that in terms of the overall effort to increase affordability, to increase access to healthcare, and to make sure that there is competition, if you will, within the hospital industry and within the insurance industry, this bill does all of those things.

It is really amazing, in my opinion, that we are able to do this on a bipartisan basis. It came out of committee, I believe, unanimously. I think it will go far towards increasing affordability, accessibility, and competition, which also lowers prices.

For all those reasons, Mr. Speaker, I urge support for the legislation, and I yield back the balance of my time.

Mrs. RODGERS of Washington. Mr. Speaker, I, too, want to urge support for this major bipartisan legislation. It is very important healthcare legislation. We are concerned about consolidation within healthcare and the rising costs within healthcare.

The first way we are going to address that is by demanding transparency. We have to know what the prices actually are so that we can empower patients and we can get some more competition within our healthcare system.

I thank everyone who has worked together. This was a priority we laid out at the very beginning of this Congress. It has been months' worth of work.

A big thank you, again, to the ranking member of the Energy and Commerce Committee, as well as the other committees, the chairmanship of VIRGINIA FOXX and the chairman of the Ways and Means Committee, JASON SMITH, for working together. We have all contributed, and we have a better product because of it.

I definitely urge support by my colleagues both Republicans and Democrats. This is one that we need to get on the President's desk with a big vote today.

Mr. Speaker, I yield back the balance of my time.

Mr. SCOTT of Virginia. Mr. Speaker, one of the reasons health care costs are so high is that consumers and employers often do not have enough information about what they are paying for.

This makes it hard for patients to find affordable, high-quality health care providers. And it prevents employers from spending workers' premium dollars carefully. It also hinders competition, which keeps health care costs in check. And finally, it limits our ability as policymakers to improve the health care system.

Americans deserve to know what they are being asked to pay. The Lower Costs, More Transparency Act helps ensure health care costs are driven by those who provide the highest quality services, not those with the most market power.

This bill includes several bipartisan priorities for our Committee Members, and I thank my colleagues on both sides of the aisle for working together on this package.

I am especially pleased that it strengthens oversight of the direct and indirect compensation earned by health plan service providers. This includes not only pharmacy benefit managers but also—critically—insurance companies serving as third-party administrators for self-funded plans.

I was also pleased to work with my colleagues to ensure strong privacy protections for workers.

Finally, I appreciate my colleagues' bipartisan commitment to incorporating technical corrections to ensure that the reporting requirements for pharmacy benefit managers apply fully to multiemployer plans, state and local government plans, and retiree-only plans—consistent with the intent of the legislation.

Moving forward, we must continue to promote transparency and competition and take direct action to lower health care costs for workers and their families.

Ms. FOXX. Mr. Speaker, the goal of the Lower Costs, More Transparency Act is to allow a wide range of employers, workers, and health plans to benefit from increased transparency of pharmacy benefit managers so they can make more informed, cost-conscious health care decisions.

It has come to our attention that the definition of large employer in this bill, as written, may have inadvertently left out certain types of non-employer plans, such as multiemployer, union, governmental, and retiree plans.

I rise today to affirm that my colleagues and I never intended for this bill to exclude these plans from leveraging the transparency tools included in this bill.

We remain committed to addressing this technical issue as we work with our Senate colleagues to expand transparency in health care following passage of the Lower Costs, More Transparency Act today.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Washington (Mrs. RODGERS) that the House suspend the rules and pass the bill, H.R. 5378, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mrs. RODGERS of Washington. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

## SUPPORT FOR PATIENTS AND COMMUNITIES REAUTHORIZATION ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill