

119TH CONGRESS
1ST SESSION

H. R. 5582

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

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 2025

Mr. JAMES (for himself, Ms. GOODLANDER, Mrs. KIGGANS of Virginia, and Mr. DAVIS of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

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

1 **SEC. 2. STRENGTHENING HOSPITAL PRICE TRANSPARENCY**
2 **REQUIREMENTS.**

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

6 “(e) STANDARD HOSPITAL CHARGES.—

7 “(1) IN GENERAL.—

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

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

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

23 “(I) as many of the Centers for
24 Medicare & Medicaid Services-speci-
25 fied shoppable services that are fur-
26 nished by the hospital, and as many

1 additional hospital-selected shoppable
2 services (or all such additional serv-
3 ices, if such hospital furnishes fewer
4 than 300 shoppable services) as may
5 be necessary for a combined total of
6 at least 300 shoppable services
7 through December 31, 2026, after
8 which the hospital's prices shall in-
9 clude all shoppable services; and

10 “(II) with respect to each Cen-
11 ters for Medicare & Medicaid Serv-
12 ices-specified shoppable service that is
13 not furnished by the hospital, an indi-
14 cation that such service is not so fur-
15 nished.

16 “(B) STANDARD CHARGES DESCRIBED.—

17 For purposes of subparagraph (A), standard
18 charges means:

19 “(i) A plain language description of
20 each item or service, accompanied by any
21 applicable billing codes, including modi-
22 fiers, using commonly recognized billing
23 code sets, including the Current Proce-
24 dural Terminology code, the Healthcare
25 Common Procedure Coding System code,

1 the diagnosis-related group, the National
2 Drug Code, and other nationally recog-
3 nized identifier.

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

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

1 chooses to pay in cash without regard to
2 the patient's coverage.

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

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

24 “(vi) Any other additional information
25 the Secretary may require for the purpose

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

13 “(C) UNIFORM METHOD AND FORMAT.—

14 Not later than January 1, 2026, the Secretary
15 shall establish a standard, uniform method and
16 format for hospitals to use in compiling and
17 making public standard charges pursuant to
18 subparagraph (A)(i) and a standard, uniform
19 method and format for such hospitals to use in
20 compiling and making public prices pursuant to
21 subparagraph (A)(ii). Such methods and for-
22 mats shall—

23 “(i) in the case of such method and
24 format for making public standard charges
25 pursuant to subparagraph (A)(i), ensure

1 that such charges are made available in a
2 machine-readable spreadsheet format;

3 “(ii) meet such standards as deter-
4 mined appropriate by the Secretary in
5 order to ensure the accessibility and
6 usability of such charges and prices; and

7 “(iii) be updated as determined appro-
8 priate by the Secretary, in consultation
9 with stakeholders.

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

18 “(3) MONITORING COMPLIANCE.—The Sec-
19 retary shall, in consultation with the Inspector Gen-
20 eral of the Department of Health and Human Serv-
21 ices, establish a process to monitor compliance with
22 this subsection. Such process shall ensure that each
23 hospital’s compliance with this subsection is re-
24 viewed not less frequently than once every year.

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

10 “(5) ENFORCEMENT.—

11 “(A) IN GENERAL.—In the case of a hos-
12 pital that fails to comply with the requirements
13 of this subsection, not later than 30 days after
14 the date on which the Secretary determines
15 such failure exists, the Secretary shall submit
16 to such hospital a notification of such deter-
17 mination, which shall include a request for a
18 corrective action plan to comply with such re-
19 quirements.

20 “(B) CIVIL MONETARY PENALTY.—

21 “(i) IN GENERAL.—In addition to any
22 other enforcement actions or penalties that
23 may apply under another provision of law,
24 a hospital that has received a request for
25 a corrective action plan under subpara-

1 graph (A) and fails to comply with the re-
2 quirements of this subsection by the date
3 that is 45 days after such request is made
4 shall be subject to a civil monetary penalty
5 of an amount specified by the Secretary for
6 each day (beginning with the day on which
7 the Secretary first determined that such
8 hospital was not complying with such re-
9 quirements) during which such failure was
10 ongoing. Such amount shall not exceed—

11 “(I) in the case of a hospital with
12 30 or fewer beds, \$300 per day;

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

22 “(III) in the case of a hospital
23 with more than 100 beds but fewer
24 than 301 beds, \$17.50 per bed per
25 day (or, in the case of such a hospital

1 that has been noncompliant with such
2 requirements for a 1-year period or
3 longer, beginning with the first day
4 following such 1-year period, \$20 per
5 bed per day);

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

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

23 “(ii) INCREASE AUTHORITY.—In ap-
24 plying this subparagraph with respect to
25 violations occurring in 2027 or a subse-

1 quent year, the Secretary may through no-
2 tice and comment rulemaking increase—

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

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

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

15 “(iii) PERSISTENT NONCOMPLI-
16 ANCE.—

17 “(I) IN GENERAL.—In the case
18 of a hospital that the Secretary has
19 determined to be knowingly and will-
20 fully noncompliant with the provisions
21 of this subsection two or more times
22 during a 1-year period, the Secretary
23 may increase any penalty otherwise
24 applicable under this subparagraph by
25 the amount specified in subclause (II)

1 with respect to such hospital and may
2 require such hospital to complete such
3 additional corrective actions plans as
4 the Secretary may specify.

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

9 “(aa) with more than 30
10 beds but fewer than 101 beds, an
11 amount that is not less than
12 \$500,000 and not more than
13 \$1,000,000;

14 “(bb) with more than 100
15 beds but fewer than 301 beds, an
16 amount that is greater than
17 \$1,000,000 and not more than
18 \$2,000,000;

19 “(cc) with more than 300
20 beds but fewer than 501 beds, an
21 amount that is greater than
22 \$2,000,000 and not more than
23 \$4,000,000; and

24 “(dd) with more than 500
25 beds, an amount that is not less

1 than \$5,000,000 and not more
2 than \$10,000,000.

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

9 “(v) APPLICATION OF CERTAIN PROVI-
10 SIONS.—The provisions of section 1128A
11 (other than subsections (a) and (b) of such
12 section) shall apply to a civil monetary
13 penalty imposed under this subparagraph
14 in the same manner as such provisions
15 apply to a civil monetary penalty imposed
16 under subsection (a) of such section.

17 “(C) NO WAIVER.—The Secretary shall not
18 grant or extend any waiver, delay, tolling, or
19 other mitigation of a civil monetary penalty for
20 violation of this subsection.

21 “(6) DEFINITIONS.—For purposes of this sub-
22 section:

23 “(A) DISCOUNTED CASH PRICE.—The
24 term ‘discounted cash price’ means the min-
25 imum charge, exclusive of any hospital or third-

1 party payer assistance, that the hospital accepts
2 from an individual who pays cash, or cash
3 equivalent, for a hospital-furnished item or
4 service, without regard to patient coverage, as
5 payment in full.

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

10 “(C) HOSPITAL.—The term ‘hospital’
11 means a hospital (as defined in section 1861(e)
12 of the Social Security Act), a critical access
13 hospital (as defined in section 1861(mmm)(1)
14 of the Social Security Act), or a rural emer-
15 gency hospital (as defined in section 1861(kkk)
16 of the Social Security Act), together with any
17 parent, subsidiary, or other affiliated provider
18 or supplier of health care items and services
19 without regard to whether such parent, sub-
20 sidiary, or other affiliated provider or supplier
21 operates under separate licensure, certification,
22 or designation.

23 “(D) PAYER-SPECIFIC NEGOTIATED
24 CHARGE.—The term ‘payer-specific negotiated
25 charge’ means the charge that a hospital has

1 negotiated with a third-party payer for an item
2 or service.

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

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

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

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—The amendment made by
19 subsection (a) shall apply beginning January 1,
20 2026.

21 (2) CONTINUED APPLICABILITY OF RULES FOR
22 PREVIOUS YEARS.—Nothing in the amendment made
23 by this section may be construed as affecting the ap-
24 plicability of the regulations codified at part 180 of

1 title 45, Code of Federal Regulations, before Janu-
2 ary 1, 2025.

3 (c) CONTINUED APPLICABILITY OF STATE LAW.—

4 The provisions of this Act shall not supersede any provi-
5 sion of State law that establishes, implements, or con-
6 tinues in effect any requirement or prohibition related to
7 health care price transparency, except to the extent that
8 such requirement or prohibition prevents the application
9 of a requirement or prohibition of this Act.

10 **SEC. 3. INCREASING PRICE TRANSPARENCY OF CLINICAL**
11 **DIAGNOSTIC LABORATORY TESTS.**

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

15 “(f) CLINICAL DIAGNOSTIC LABORATORY PRICE
16 TRANSPARENCY.—

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

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

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

4 “(2) INFORMATION DESCRIBED.—For purposes
5 of paragraph (1), the information described in this
6 paragraph is, with respect to an applicable labora-
7 tory and a specified clinical diagnostic laboratory
8 test, the following:

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

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

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

1 provided in such settings for the previous three
2 years, expressed as a dollar amount, as well as,
3 with respect to prices made public pursuant to
4 subparagraph (A)(ii), a link to a consumer-
5 friendly document that clearly explains the lab-
6 oratory's charity care policy). The laboratory
7 shall accept the discounted or minimum cash
8 price as payment in full from any patient that
9 chooses to pay in cash without regard to the pa-
10 tient's coverage.

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

1 shall be required to determine and disclose the
2 negotiated charge.

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

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

19 “(3) UNIFORM METHOD AND FORMAT.—Not
20 later than January 1, 2027, the Secretary shall es-
21 tablish a standard, uniform method and format for
22 applicable laboratories to use in compiling and mak-
23 ing public information pursuant to paragraph (1).
24 Such method and format shall—

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

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

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

12 “(4) INCLUSION OF ANCILLARY SERVICES.—
13 Any price or rate for a specified clinical diagnostic
14 laboratory test available to be furnished by an appli-
15 cable laboratory made publicly available in accord-
16 ance with paragraph (1) shall include the price or
17 rate for any ancillary item or service (including spec-
18 imen collection services, specimen transport, cen-
19 trifugation, aliquoting, labeling, requisition proc-
20 essing, and standard result reporting services) that
21 would customarily and routinely be furnished by
22 such laboratory as part of such test, as specified by
23 the Secretary.

24 “(5) ENFORCEMENT.—

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

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

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

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

23 “(C) APPLICATION OF CERTAIN PROVI-
24 SIONS.—The provisions of section 1128A of the
25 Social Security Act (other than subsections (a)

1 and (b) of such section) shall apply to a civil
2 monetary penalty imposed under this paragraph
3 in the same manner as such provisions apply to
4 a civil monetary penalty imposed under sub-
5 section (a) of such section.

6 “(6) PROVISION OF TECHNICAL ASSISTANCE.—

7 The Secretary shall, to the extent practicable, pro-
8 vide technical assistance relating to compliance with
9 the provisions of this subsection to applicable labora-
10 tories requesting such assistance.

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

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

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

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

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

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

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

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

5 **SEC. 4. IMAGING TRANSPARENCY.**

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

9 “(g) IMAGING SERVICES PRICE TRANSPARENCY.—

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

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

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

24 “(2) INFORMATION DESCRIBED.—For purposes
 25 of paragraph (1), the information described in this

1 paragraph is, with respect to a provider of services
2 or supplier and a specified imaging service, the fol-
3 lowing:

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

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

15 “(C) The discounted cash price expressed
16 as a dollar amount, for each such item or serv-
17 ice (or, in the case no discounted cash price is
18 available for an item or service, the minimum
19 cash price accepted by the provider of services
20 or supplier from self-pay individuals for such
21 item or service when provided in such settings
22 for the previous three years, expressed as a dol-
23 lar amount, as well as, with respect to prices
24 made public pursuant to subparagraph (A)(ii),
25 a link to a consumer-friendly document that

1 clearly explains the provider of services or sup-
2 plier's charity care policy). The provider of
3 services or supplier shall accept the discounted
4 or minimum cash price as payment in full from
5 any patient that chooses to pay in cash without
6 regard to the patient's coverage.

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

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

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

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

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

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

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

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

14 “(5) ENFORCEMENT.—

15 “(A) IN GENERAL.—In the case that the
16 Secretary determines that a provider of services
17 or supplier is not in compliance with paragraph
18 (1)—

19 “(i) not later than 30 days after such
20 determination, the Secretary shall notify
21 such provider or supplier of such deter-
22 mination;

23 “(ii) upon request of the Secretary,
24 such provider or supplier shall submit to
25 the Secretary, not later than 45 days after

1 the date of such request, a corrective ac-
2 tion plan to comply with such paragraph;
3 and

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

20 “(B) INCREASE AUTHORITY.—In applying
21 this paragraph with respect to violations occur-
22 ring in 2027 or a subsequent year, the Sec-
23 retary may through notice and comment rule-
24 making increase the amount of the civil mone-
25 tary penalty under subparagraph (A)(iii).

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

9 “(D) NO AUTHORITY TO WAIVE OR RE-
10 DUCE PENALTY.—The Secretary shall not grant
11 or extend any waiver, delay, tolling, or other
12 mitigation of a civil monetary penalty for viola-
13 tion of this subsection.

14 “(E) PROVISION OF TECHNICAL ASSIST-
15 ANCE.—The Secretary shall, to the extent prac-
16 ticable, provide technical assistance relating to
17 compliance with the provisions of this sub-
18 section to providers of services and suppliers re-
19 questing such assistance.

20 “(F) CLARIFICATION OF NONAPPLICA-
21 BILITY OF OTHER ENFORCEMENT PROVI-
22 SIONS.—Notwithstanding any other provision of
23 this title, this paragraph shall be the sole
24 means of enforcing the provisions of this sub-
25 section.

1 “(6) SPECIFIED IMAGING SERVICE DEFINED.—
 2 the term ‘specified imaging service’ means an imag-
 3 ing service that is a Centers for Medicare & Med-
 4 icaid Services-specified shoppable service (as de-
 5 scribed in subsection (e)).

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

10 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
 11 **PARENCY REQUIREMENTS.**

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

15 “(h) AMBULATORY SURGERY CENTER TRANS-
 16 PARENCY.—

17 “(1) IN GENERAL.—Beginning July 1, 2027,
 18 each specified ambulatory surgical center shall com-
 19 ply with the price transparency requirement de-
 20 scribed in paragraph (2).

21 “(2) REQUIREMENT DESCRIBED.—

22 “(A) IN GENERAL.—A specified ambula-
 23 tory surgical center, in accordance with a meth-
 24 od and format established by the Secretary
 25 under subparagraph (C), shall compile and

1 make public (without subscription and free of
2 charge), for each year—

3 “(i) one or more lists, in a machine-
4 readable format specified by the Secretary,
5 of the ambulatory surgical center’s stand-
6 ard charges (including the information de-
7 scribed in subparagraph (B)) for each item
8 and service furnished by such surgical cen-
9 ter;

10 “(ii) information in a consumer-
11 friendly format (as specified by the Sec-
12 retary) on the ambulatory surgical center’s
13 prices (including the information described
14 in subparagraph (B)) for as many of the
15 Centers for Medicare & Medicaid Services-
16 specified shoppable services included on the
17 list described in subsection (e) that are
18 furnished by such surgical center, and as
19 many additional ambulatory surgical cen-
20 ter-selected shoppable services (or all such
21 additional services, if such surgical center
22 furnishes fewer than 300 shoppable serv-
23 ices) as may be necessary for a combined
24 total of at least 300 shoppable services;
25 and

1 “(iii) with respect to each Centers for
2 Medicare & Medicaid Services-specified
3 shoppable service (as described in clause
4 (ii)) that is not furnished by the ambula-
5 tory surgical center, an indication that
6 such service is not so furnished.

7 “(B) INFORMATION DESCRIBED.—For pur-
8 poses of subparagraph (A), the information de-
9 scribed in this subparagraph is, with respect to
10 standard charges and prices made public by a
11 specified ambulatory surgical center, the fol-
12 lowing:

13 “(i) A description of each item or
14 service, accompanied by the Healthcare
15 Common Procedure Coding System code,
16 the national drug code, or other identifier
17 used or approved by the Centers for Medi-
18 care & Medicaid Services.

19 “(ii) The gross charge, expressed as a
20 dollar amount, for each such item or serv-
21 ice.

22 “(iii) The discounted cash price, ex-
23 pressed as a dollar amount, for each such
24 item or service (or, in the case no dis-
25 counted cash price is available for an item

1 or service, the minimum cash price accept-
2 ed by the specified ambulatory surgical
3 center from self-pay individuals for such
4 item or service when provided in such set-
5 tings for the previous three years, ex-
6 pressed as a dollar amount, as well as,
7 with respect to prices made public pursu-
8 ant to subparagraph (A)(ii), a link to a
9 consumer-friendly document that clearly
10 explains the provider of services or sup-
11 plier's charity care policy). The specified
12 ambulatory surgical center shall accept the
13 discounted cash price as payment in full
14 from any patient that chooses to pay in
15 cash without regard to the patient's cov-
16 erage.

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

1 amount, or other formula or criteria, the
2 ambulatory surgical center also shall dis-
3 close such algorithm, percentage, formula,
4 or criteria as set forth in its contract and
5 any other terms, schedules, exhibits, data,
6 or other information referenced in any
7 such contract as shall be required to deter-
8 mine and disclose the negotiated charge.

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

13 “(vi) Any other additional information
14 the Secretary may require for the purpose
15 of improving the accuracy of, or enabling
16 consumers to easily understand and com-
17 pare, standard charges and prices for an
18 item or service, except information that is
19 duplicative of any other reporting require-
20 ment under this subsection.

21 “(C) UNIFORM METHOD AND FORMAT.—

22 Not later than January 1, 2027, the Secretary
23 shall establish a standard, uniform method and
24 format for specified ambulatory surgical centers
25 to use in making public standard charges pur-

1 suant to subparagraph (A)(i) and a standard,
2 uniform method and format for such centers to
3 use in making public prices pursuant to sub-
4 paragraph (A)(ii). Any such method and format
5 shall—

6 “(i) in the case of such charges made
7 public by an ambulatory surgical center,
8 ensure that such charges are made avail-
9 able in a machine-readable format;

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

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

17 “(3) NO DEEMED COMPLIANCE.—The avail-
18 ability of a price estimator tool shall not be consid-
19 ered to deem compliance with or otherwise vitiate
20 the requirements of this subsection (aa). Further-
21 more, the use of an estimator tool shall not be used
22 for purposes of compliance with any provisions in
23 this subsection.

24 “(4) MONITORING COMPLIANCE.—The Sec-
25 retary shall, in consultation with the Inspector Gen-

1 eral of the Department of Health and Human Serv-
2 ices, establish a process to monitor compliance with
3 this subsection. Such process shall ensure that each
4 specified ambulatory surgical center’s compliance
5 with this subsection is reviewed not less frequently
6 than once every year.

7 “(5) ENFORCEMENT.—

8 “(A) IN GENERAL.—In the case of a speci-
9 fied ambulatory surgical center that fails to
10 comply with the requirements of this sub-
11 section—

12 “(i) the Secretary shall notify such
13 ambulatory surgical center of such failure
14 not later than 30 days after the date on
15 which the Secretary determines such fail-
16 ure exists; and

17 “(ii) upon request of the Secretary,
18 the ambulatory surgical center shall submit
19 to the Secretary, not later than 45 days
20 after the date of such request, a corrective
21 action plan to comply with such require-
22 ments.

23 “(B) CIVIL MONETARY PENALTY.—

24 “(i) IN GENERAL.—A specified ambu-
25 latory surgical center that has received a

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

17 “(ii) INCREASE AUTHORITY.—In ap-
18 plying this subparagraph with respect to
19 violations occurring in 2027 or a subse-
20 quent year, the Secretary may through no-
21 tice and comment rulemaking increase the
22 limitation on the per day amount of any
23 penalty applicable to a specified ambula-
24 tory surgical center under clause (i).

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

10 “(iv) NO AUTHORITY TO WAIVE OR
11 REDUCE PENALTY.—The Secretary shall
12 not grant or extend any waiver, delay, toll-
13 ing, or other mitigation of a civil monetary
14 penalty for violation of this subsection.

15 “(6) PROVISION OF TECHNICAL ASSISTANCE.—
16 The Secretary shall, to the extent practicable, pro-
17 vide technical assistance relating to compliance with
18 the provisions of this subsection to specified ambula-
19 tory surgical centers requesting such assistance.

20 “(7) DEFINITIONS.—For purposes of this sec-
21 tion:

22 “(A) DISCOUNTED CASH PRICE.—The
23 term ‘discounted cash price’ means the charge
24 that applies to an individual who pays cash, or

1 cash equivalent, for a item or service furnished
2 by an ambulatory surgical center.

3 “(B) GROSS CHARGE.—The term ‘gross
4 charge’ means the charge for an individual item
5 or service that is reflected on a specified sur-
6 gical center’s chargemaster, absent any dis-
7 counts.

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

15 “(D) PAYER-SPECIFIC NEGOTIATED
16 CHARGE.—The term ‘payer-specific negotiated
17 charge’ means the charge that a specified sur-
18 gical center has negotiated with a third-party
19 payer for an item or service.

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

“(F) SPECIFIED AMBULATORY SURGICAL CENTER.—The term ‘specified ambulatory surgical center’ means an ambulatory surgical center with respect to which a hospital (or any person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in a hospital) is a person with an ownership or control interest (as so defined).

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

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

SEC. 6. STRENGTHENING HEALTH COVERAGE TRANSPARENCY REQUIREMENTS.

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

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

“(i) IN GENERAL.—The Exchange”;

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

2 (A) by striking “participating provider”
3 and inserting “provider”;

4 (B) by inserting “shall include the infor-
5 mation specified in clause (ii) and” after “such
6 information”;

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

10 (D) by striking “and such other” and all
11 that follows through the period and inserting
12 “or, at the option such individual, through a
13 paper or phone disclosure (as selected by such
14 individual and provided at no cost to such indi-
15 vidual) that meets such requirements as the
16 Secretary may specify.”; and

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

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

1 “(I) If such provider is a partici-
2 pating provider with respect to such
3 item or service, the in-network rate
4 (as defined in subparagraph (F)) for
5 such item or service.

6 “(II) If such provider is not de-
7 scribed in subclause (I), the maximum
8 allowed dollar amount for such item
9 or service.

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

19 “(IV) The amount the individual
20 has already accumulated with respect
21 to any deductible or out of pocket
22 maximum under the plan (broken
23 down, in the case separate deductibles
24 or maximums apply to separate indi-
25 viduals enrolled in the plan, by such

1 separate deductibles or maximums, in
2 addition to any cumulative deductible
3 or maximum).

4 “(V) In the case such plan im-
5 poses any frequency or volume limita-
6 tions with respect to such item or
7 service (excluding medical necessity
8 determinations), the amount that such
9 individual has accrued towards such
10 limitation with respect to such item or
11 service.

12 “(VI) Any prior authorization,
13 concurrent review, step therapy, fail
14 first, or similar requirements applica-
15 ble to coverage of such item or service
16 under such plan.

17 “(iii) SELF-SERVICE TOOL.—For pur-
18 poses of clause (i), a self-service tool estab-
19 lished by a health plan meets the require-
20 ments of this clause if such tool—

21 “(I) is based on an internet
22 website;

23 “(II) provides for real-time re-
24 sponses to requests described in such
25 clause;

1 “(III) is updated in a manner
2 such that information provided
3 through such tool is timely and accu-
4 rate;

5 “(IV) allows such a request to be
6 made with respect to an item or serv-
7 ice furnished by—

8 “(aa) a specific provider
9 that is a participating provider
10 with respect to such item or serv-
11 ice;

12 “(bb) all providers that are
13 participating providers with re-
14 spect to such plan and such item
15 or service; or

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

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

21 “(aa) the billing code for
22 such item or service; or

23 “(bb) through use of a de-
24 scriptive term for such item or
25 service to produce a list of billing

1 code options from which the indi-
2 vidual selects to indicate the sub-
3 ject matter items or services; and
4 “(VI) holds a member harmless
5 for the amount of any difference in
6 excess of the amount of the individ-
7 ual’s responsibility generated by the
8 self-service tool and the amount ulti-
9 mately billed or charged to the indi-
10 vidual.”.

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

15 “(E) RATE AND PAYMENT INFORMA-
16 TION.—

17 “(i) IN GENERAL.—Not later than
18 January 1, 2027, and every month there-
19 after, each health plan shall submit to the
20 Exchange, the Secretary, the State insur-
21 ance commissioner, and make available to
22 the public, the rate and payment informa-
23 tion described in clause (ii) in accordance
24 with clause (iii).

1 “(ii) RATE AND PAYMENT INFORMA-
2 TION DESCRIBED.—For purposes of clause
3 (i), the rate and payment information de-
4 scribed in this clause is, with respect to a
5 health plan, the following:

6 “(I) With respect to each item or
7 service for which benefits are available
8 under such plan (expressed as a dollar
9 amount), including prescription drugs,
10 identified by CPT, HCPCS, DRG,
11 NDC, or other applicable nationally
12 recognized identifier, including any
13 applicable code modifiers, and accom-
14 panied by a brief description of the
15 item or service, the in-network rate in
16 effect as of the date of the submission
17 of such information with each pro-
18 vider (identified by national provider
19 identifier) that is a participating pro-
20 vider with respect to such item or
21 service, other than such a rate in ef-
22 fect with a provider—

23 “(aa) that has submitted no
24 claims; and

1 “(bb) expects to receive no
2 claims in the then applicable cal-
3 endar year for such item or serv-
4 ice to such plan.

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

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

19 “(bb) The historical net
20 price paid by such plan (net of
21 rebates, discounts, and price con-
22 cessions) (expressed as a dollar
23 amount) for such drug dispensed
24 or administered during the 90-
25 day period beginning 180 days

1 before such date of submission to
2 each provider that was a partici-
3 pating provider with respect to
4 such drug, broken down by each
5 such provider (identified by na-
6 tional provider identifier), other
7 than such an amount paid to a
8 provider that has submitted no
9 claims for such drug to such
10 plan.

11 “(III) With respect to each item
12 or service for which benefits are avail-
13 able under such plan (expressed as a
14 dollar amount), identified by CPT,
15 DRG, HCPCS, NDC, or other appli-
16 cable nationally recognized identifier,
17 including any applicable code modi-
18 fiers, and accompanied by a brief de-
19 scription of the item or service, the
20 amount billed or charged by the pro-
21 vider, and the amount allowed by the
22 plan, for each such item or service
23 furnished during the 90-day period
24 beginning 180 days before such date
25 of submission by each provider that

1 was not a participating provider with
2 respect to such item or service, broken
3 down by each such provider (identified
4 by national provider identifier), other
5 than items and services with respect
6 to which no claims for such item or
7 service were submitted to such plan
8 during such period.

9 “(iii) MANNER OF SUBMISSION.—Rate
10 and payment information required to be
11 submitted and made available under this
12 subparagraph shall be so submitted and so
13 made available as follows:

14 “(I) Information shall be con-
15 tained in 3 separate machine-readable
16 files corresponding to the information
17 described in each of subclauses (I)
18 through (III) of clause (ii) that meet
19 such requirements as specified by the
20 Secretary through rulemaking, in con-
21 sultation with the Secretaries of
22 Labor and the Treasury to apply com-
23 parable requirements to group health
24 plans and to entities providing benefit
25 management or other third-party ad-

1 ministration services on a contractual
2 basis with a group health plan.

3 “(II) Requirements specified by
4 the Secretary through rulemaking
5 shall ensure that:

6 “(aa) Such files are limited
7 to an appropriate size, are made
8 available in a widely available
9 format that allows for informa-
10 tion contained in such files to be
11 compared across health plans,
12 and are accessible to individuals
13 at no cost and without the need
14 to establish a user account or
15 provider other credentials.

16 “(bb) The rates, amounts,
17 and prices to be disclosed include
18 contractual terms containing cal-
19 culation formulae, pricing meth-
20 odologies, and other information
21 necessary to determine the dollar
22 value of reimbursement.

23 “(cc) Each such file includes
24 each of the following data ele-
25 ments:

1 “(AA) A numerical
2 identifier for the group
3 health plan and/or health in-
4 surance issuer (such as a
5 Health Insurance Oversight
6 System identifier).

7 “(BB) A plain-language
8 description of the item or
9 service (including, for drugs,
10 the proprietary and non-
11 proprietary name assigned).

12 “(CC) The billing code,
13 including any applicable
14 modifiers, associated with
15 such item or service, includ-
16 ing the Healthcare Common
17 Procedure Coding System
18 code, diagnosis-related
19 group, national drug code,
20 or other commonly recog-
21 nized code set.

22 “(DD) The place of
23 service code.

24 “(EE) The National
25 Provider Identifier or pro-

1 vider Tax Identification
2 Number.

3 “(III) The rate and payment in-
4 formation disclosed under subclauses
5 (I) through (III) of clause (ii) shall be
6 separately delineated for each item or
7 service, regardless of whether such
8 item or service is reimbursed as a part
9 of a bundle, episode, or other group-
10 ing of items and services.

11 “(IV) An officer or executive of
12 competent authority shall attest to the
13 accuracy and completeness of infor-
14 mation submitted and made available
15 under this subparagraph. Such attes-
16 tation shall be subject to enforcement
17 under subparagraph (H) and, where
18 applicable, shall be deemed material
19 to payments from the Federal Govern-
20 ment received by the group health
21 plan or health insurance issuer.

22 “(V) Regulations promulgated
23 pursuant to this section shall provide
24 that:

1 “(aa) The Secretary shall
2 audit the three machine-readable
3 files required by subparagraph
4 (E)(ii) posted by no fewer than
5 20 group health plans or health
6 insurance issuers.

7 “(bb) The Secretary of
8 Labor shall audit the three ma-
9 chine-readable files required by
10 subparagraph (E)(ii) posted by
11 no fewer than 200 group health
12 plans or service providers fur-
13 nishing third-party administrator
14 services to a group health plan.

15 “(cc) Findings, conclusions,
16 and enforcement actions taken
17 based on audits of the machine-
18 readable files shall be reported
19 annually to Congress no later
20 than July 1 of the calendar year
21 during which the files were au-
22 dited. Such report to Congress
23 shall be accessible to the public.

24 “(iv) USER GUIDE.—Each health plan
25 shall make available to the public instruc-

tions written in plain language explaining how individuals may search for information described in clause (ii) in files submitted in accordance with clause (iii).

“(F) DEFINITIONS.—In this paragraph:

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

“(ii) IN-NETWORK RATE.—The term ‘in-network rate’ means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service. If the rate is based on an algorithm, percentage of another amount, or other formula or criteria, the health plan also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such con-

tract as shall be required to determine and disclose the negotiated rate.

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

“(H) ENFORCEMENT.—

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

“(ii) NOTIFICATION AND REQUEST FOR CORRECTIVE ACTION.—In the case of a health plan that fails to comply with the requirements of this subsection, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such health plan a notification of such determination, which shall include a request for a correc-

1 tive action plan to comply with such re-
2 quirements.

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

18 “(I) RULEMAKING.—The Secretary shall
19 implement subparagraphs (E) through (H)
20 through notice and comment rulemaking in ac-
21 cordance with section 553 of title 5, United
22 States Code.”.

23 (c) EFFECTIVE DATE.—

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

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

13 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**
 14 **HEALTH DATA.**

15 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
 16 TION.—

17 (1) IN GENERAL.—Paragraph (2) of section
 18 408(b) of the Employee Retirement Income Security
 19 Act of 1974 (29 U.S.C. 1108(b)) is amended by
 20 adding at the end the following new subparagraphs:

21 “(C) No contract or arrangement for serv-
 22 ices, and no extension or renewal of such con-
 23 tract or arrangement, between a group health
 24 plan (as that term is defined in section 733(a)
 25 of this title) and party in interest, including a

1 health care provider (which for purposes of this
2 subparagraph, includes a health care facility),
3 network or association of providers, service pro-
4 vider offering access to a network of providers,
5 third-party administrator, or pharmacy benefit
6 manager (collectively referred to as ‘Covered
7 Service Providers’), is reasonable within the
8 meaning of this paragraph unless such contract
9 or arrangement—

10 “(i) allows the responsible plan fidu-
11 ciary (as that term is defined in subpara-
12 graph (B)(ii)(I)(ee)) access to all claims
13 and encounter information or data, and
14 any documentation supporting claim pay-
15 ments, including, but not limited to, med-
16 ical records and policy documents, or infor-
17 mation or data described in section
18 724(a)(1)(B) to—

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

22 “(II) determine the accuracy or
23 reasonableness of payment; and

24 “(ii) does not—

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

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

13 “(III) limit the disclosure of pric-
14 ing terms for value-based payment ar-
15 rangements or capitated payment ar-
16 rangements, including—

17 “(aa) payment calculations
18 and formulas;

19 “(bb) quality measures;

20 “(cc) contract terms;

21 “(dd) payment amounts;

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

24 “(ff) other payment meth-
25 odologies used by an entity, in-

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

8 “(IV) limit the disclosure of over-
9 payments and overpayment recovery
10 terms;

11 “(V) limit the right of the group
12 health plan, the plan sponsor, or the
13 plan administrator of such plan to se-
14 lect an auditor or define audit scope
15 or frequency;

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

22 “(VII) limit the disclosure of fees
23 charged to the group health plan re-
24 lated to plan administration and
25 claims processing, including renegoti-

1 ation fees, access fees, repricing fees,
2 or enhanced review fees;

3 “(VIII) limit the right of the
4 group health plan, the plan sponsor,
5 or the plan administrator to request
6 action on any suspect claim payments;
7 or

8 “(IX) limit public disclosure of
9 de-identified or aggregate information.

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

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

22 “(iii) Nothing in this subparagraph shall
23 be construed to modify the requirements for the
24 creation, receipt, maintenance, or transmission
25 of protected health information under the

1 HIPAA privacy regulation (as defined in section
2 1180(b)(3) of the Social Security Act) as they
3 apply directly or indirectly to an entity pursu-
4 ant to this paragraph.

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

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

19 “(F) Information made available under
20 this section shall conform to the following
21 standards:

22 “(i) All claims from a healthcare pro-
23 vider shall be made to the group health
24 plan in accordance with transaction stand-

ards adopted by regulation under HIPAA,
as follows:

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

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

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

“(ii) All claim payment (or EFT, elec-
tronic funds transfer) and electronic remit-
tance advice (ERA) notices sent by a Cov-
ered Service Provider shall be made avail-
able to the group health plan as ASC
X12N 835 files in accordance with stand-
ards adopted by regulation under HIPAA.

1 The files shall be unmodified copies of the
2 files sent by the Covered Service Provider
3 to the healthcare provider. Files shall be
4 accessible at no cost to the group health
5 plan.

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

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

16 “(G) The Secretary shall implement sub-
17 paragraphs (C) through (F) through notice and
18 comment rulemaking in accordance with section
19 553 of title 5, United States Code.”.

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

24 “(13) In the case of an agreement between a
25 group health plan (as defined in section 733(a)), the

1 plan sponsor of such plan (as defined in section
 2 3(16)(B)), or the plan administrator of such plan
 3 (as defined in section 3(16)(A)) and a health care
 4 provider (which, for purposes of this paragraph, in-
 5 cludes a health care facility), network or association
 6 of providers, service provider offering access to a
 7 network or association of providers, third-party ad-
 8 ministrator, or pharmacy benefit manager, that vio-
 9 lates the provisions of section 724, the Secretary
 10 may assess a civil penalty against such provider, net-
 11 work or association, service provider offering access
 12 to a network or association of providers, third-party
 13 administrator, pharmacy benefit manager, or other
 14 service provider in the amount of \$10,000 for each
 15 day during which such violation continues. Such
 16 penalty shall be in addition to other penalties as
 17 may be prescribed by law.”.

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

21 “(c) Any provision in an agreement or instrument
 22 shall be void as against public policy if such provision—
 23 “(1) unduly delays or limits a group health plan
 24 (as defined in section 733(a)), the plan sponsor of
 25 such plan (as defined in section 3(16)(B)), or the

1 plan administrator of such plan (as defined in sec-
2 tion 3(16)(A)) from accessing the claims and en-
3 counter information or data described in section
4 724(a)(1)(B); or

5 “(2) violates the requirements of section
6 408(b)(2)(C).”.

7 (4) TECHNICAL AMENDMENT.—Clause (i) of
8 section 408(b)(2)(B) of such Act is amended by
9 striking “this clause” and inserting “this para-
10 graph”.

11 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
12 ITY INFORMATION.—Section 724(a)(3) of the Employee
13 Retirement Income Security Act of 1974 (29 U.S.C.
14 1185m(a)(3)) is amended to read as follows:

15 “(3) ATTESTATION.—

16 “(A) IN GENERAL.—Subject to subpara-
17 graph (C), a group health plan or health insur-
18 ance issuer offering group health insurance cov-
19 erage shall annually submit to the Secretary an
20 attestation that such plan or issuer of such cov-
21 erage is in compliance with the requirements of
22 this subsection. Such attestation shall also in-
23 clude a statement verifying that—

24 “(i) the information or data described
25 under subparagraphs (A) and (B) of para-

graph (1) is available upon request and provided to the group health plan, the plan sponsor, the plan administrator, or the business associate of such plan, or the issuer in a timely manner; and

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

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

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

1 plan or issuer may submit a written statement
2 in lieu of such attestation that includes—

3 “(i) an explanation of why such plan
4 or issuer was unsuccessful in obtaining
5 such information or data, including wheth-
6 er such plan, the plan sponsor, or the plan
7 administrator or issuer was limited or pre-
8 vented from auditing, reviewing, or other-
9 wise accessing such information or data;

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

15 “(iii) a description of any response by
16 the third-party administrator or other serv-
17 ice provider with respect to efforts to com-
18 ply with the attestation requirement under
19 subparagraph (A), including the name of
20 the third-party administrator or other serv-
21 ice provider.”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 subsections (a) and (b) shall apply with respect to a plan
24 beginning with the first plan year that begins on or after

1 the date that is 1 year after the date of enactment of this
2 Act.

3 **SEC. 8. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
4 **VIDERS.**

5 (a) ERISA AMENDMENTS.—

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

10 **“SEC. 726. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
11 **VIDERS.**

12 “(a) IN GENERAL.—For plan years beginning on or
13 after the date that is 2 years after the date of enactment
14 of this section, no agreement between a group health plan
15 (as defined in section 733(a)), the plan sponsor of such
16 plan (as defined in section 3(16)(B)), the plan adminis-
17 trator of such plan (as defined in section 3(16)(A)), or
18 a business associate of such plan (as defined in section
19 160.103 of title 45, Code of Federal Regulations), (or
20 health insurance issuer offering group health insurance
21 coverage in connection with such a plan), and a health
22 care provider, network or association of providers, third-
23 party administrator, service provider offering access to a
24 network of providers, pharmacy benefit managers, or any
25 other third party (each referred to as a ‘health plan service

1 provider’) is permissible if such agreement limits (or
2 delays beyond the applicable reporting period described in
3 subsection (b)(1)) the disclosure of information to group
4 health plans in such a manner that prevents such plan,
5 issuer, or entity from providing the information described
6 in subsection (b).

7 “(b) REQUIRED DISCLOSURES.—

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

16 “(A) The information described in section
17 724(a)(1)(B).

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

1 health plan or health insurance issuer to accu-
2 rately assess, verify, and ensure compliance
3 with the terms of any contractual and sub-
4 contractual agreement governing the reimburse-
5 ment amounts.

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

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

21 “(E) All payment data and reconciliation
22 information related to alternative compensation
23 arrangements including accountable care orga-
24 nizations, value-based programs, shared savings
25 programs, incentive compensation, bundled pay-

1 ments, capitation arrangements, performance
2 payments, and any other reimbursement or pay-
3 ment models, where the group health plan or
4 health insurance issuer paid fees, incurred obli-
5 gations, or made payments in connection with
6 the group health plan related to such arrange-
7 ments.

8 “(2) PRIVACY REQUIREMENTS.—

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

1 and security regulations promulgated under
2 HIPAA.

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

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

16 “(3) DISCLOSURE AND REDISCLOSURE.—

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

20 “(i) to the entity from which the in-
21 formation was received or to that entity’s
22 business associates or to the group health
23 plan’s business associates as defined in
24 section 160.103 of title 45, Code of Fed-

1 eral Regulations (or successor regulations);

2 or

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

6 “(B) AVAILABILITY OF INFORMATION.—To
7 the extent the information required by this sub-
8 section is made available to the health insur-
9 ance issuer offering group health insurance in
10 connection with a group health plan, the health
11 insurance issuer shall make such information
12 available, at the same time, in the same format,
13 and at no cost, to the group health plan.

14 “(C) FAILURE TO PROVIDE.—The obliga-
15 tion to provide information pursuant to this
16 subsection shall exist notwithstanding the pres-
17 ence of any formal data-sharing agreement be-
18 tween the parties. Failure to provide the re-
19 quired information as specified shall constitute
20 a violation of this Act and the Secretary shall
21 initiate enforcement action under section 502
22 within 90 days of becoming aware of a violation
23 of this section, except that nothing in this sec-
24 tion shall be construed to limit the Secretary’s
25 existing authority under the Act.

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

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

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

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

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

22 “(B) All claim payment (or EFT, elec-
23 tronic funds transfer) and electronic remittance
24 advice (ERA) information sent by a health plan
25 service provider shall be provided to the group

1 health plan or health insurance issuer in the
2 ASC X12N 835 format in accordance with
3 transaction standards adopted under HIPAA,
4 unmodified from the form in which it was
5 transmitted to the healthcare provider. Such in-
6 formation shall be provided at no cost to the
7 group health plan or health insurance issuer.

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

14 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
15 provision in an agreement between a group health plan,
16 the plan sponsor, the plan administrator, or a business
17 associate of such plan or a health insurance issuer and
18 a health plan service provider that unduly delays or limits
19 a group health plan’s or health insurance issuer’s access
20 to information described in this section or that restricts
21 the format or timing of the provision of such information
22 in a manner that is inconsistent with the requirements of
23 this section shall be prohibited and, if a group health plan
24 or health insurance issuer enters into such agreement,
25 shall be deemed void as against public policy.

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

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

11 (2) PENALTY.—

12 (A) IN GENERAL.—Section 502(a) of the
 13 Employee Retirement Income Security Act of
 14 1974 (29 U.S.C. 1132(a)) is amended by add-
 15 ing at the end the following new paragraph:

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

19 (B) TECHNICAL AMENDMENT.—Paragraph
 20 (6) of section 502(a) of the Employee Retire-
 21 ment Income Security Act of 1974 (29 U.S.C.
 22 1132(a)) is amended by striking “or (9)” and
 23 inserting it with the phrase “(9), (13), or
 24 (14)”.

25 (b) PHSA AMENDMENTS.—

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

4 **“SEC. 2799A–11. OVERSIGHT OF ADMINISTRATIVE SERVICE**
5 **PROVIDERS.**

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

21 “(b) REQUIRED DISCLOSURES.—

22 “(1) CONTENTS AND FREQUENCY.—With re-
23 spect to plan years beginning on or after the date
24 that is 1 year after the date of enactment of this
25 section, not less frequently than quarterly, a health

1 plan service provider shall provide to the group
2 health plan that is a self-funded, non-Federal gov-
3 ernmental plan the following information at no cost
4 to the plan:

5 “(A) The information described in section
6 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
7 119(a)(1)(B)).

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

20 “(C) The total amount received or ex-
21 pected to be received by the health plan service
22 provider or its subcontractors in provider or
23 supplier rebates, fees, alternative discounts, and
24 all other remuneration including amounts held
25 in escrow or variance accounts that has been

1 paid or is to be paid for claims incurred and
2 administrative services including data sales or
3 network payments.

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

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

21 “(2) PRIVACY REQUIREMENTS.—

22 “(A) IN GENERAL.—Health plan service
23 providers shall provide the information or data
24 under paragraph (1) consistent with the pri-
25 vacy, security, and breach notification regula-

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

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

“(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health in-

1 formation under the HIPAA privacy regulations
2 (45 C.F.R. parts 160 and 164, subparts A and
3 E).

4 “(3) DISCLOSURE AND REDISCLOSURE.—

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

9 “(i) to the entity from which the in-
10 formation was received or to that entity’s
11 business associates as defined in section
12 160.103 of title 45, Code of Federal Regu-
13 lations (or successor regulations); or

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

17 “(B) RULE OF CONSTRUCTION.—Nothing
18 in this section shall be construed to prevent a
19 group health plan that is a self-funded, non-
20 Federal Governmental plan, or a health plan
21 service provider providing services with respect
22 to such a plan, from placing reasonable restric-
23 tions on the public disclosure of the information
24 described in paragraph (1), except that such
25 plan or entity may not restrict disclosure of

1 such information to the Department of Health
2 and Human Services, the Department of Labor,
3 the Department of the Treasury, or the Comp-
4 troller General of the United States.

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

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

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

1 “(i) Institutional, professional, and
2 dental claims and adjustments to these
3 claims shall be provided to the group
4 health plan that is a self-funded, non-Fed-
5 eral Governmental plan in the ASC X12N
6 837 format.

7 “(ii) Prescription drug claims shall be
8 in the National Council for Prescription
9 Drug Programs (NCPDP) format.

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

17 “(B) All claim payment (or EFT, elec-
18 tronic funds transfer) and electronic remittance
19 advice (ERA) information sent by a health plan
20 service provider shall be provided to the group
21 health plan or health insurance issuer in the
22 ASC X12N 835 format, in accordance with
23 standards adopted under HIPAA at section
24 162.1602 of title 45, Code of Federal Regula-
25 tions, unmodified from the form in which it was

1 transmitted to the healthcare provider. Such in-
2 formation shall be provided at no cost to the
3 group health plan.

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

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

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

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

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

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

15 The provisions of sections 2 through 5 (including the
 16 amendments made by such sections) shall not supersede
 17 any provision of State law which establishes, implements,
 18 or continues in effect any requirement or prohibition re-
 19 lated to health care price transparency, including hospital,
 20 clinical diagnostic laboratory tests, imaging services, and
 21 ambulatory surgical center, except to the extent that such
 22 requirement or prohibition prevents the application of a
 23 requirement or prohibition of such sections (or amend-
 24 ment). Nothing in this section shall be construed to affect
 25 group health plans established under the Employee Retire-

1 ment Income Security Act of 1974, or alter the application
2 of section 514 of such Act (29 U.S.C. 1144).

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

4 (a) PHSA AMENDMENTS.—

5 (1) EMERGENCY SERVICES.—Section 2799A–
6 1(f)(1)(C) of the Public Health Service Act (42
7 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
8 follows:

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

18 (2) EXPLANATION OF BENEFITS.—Section
19 2799A–1 of the Public Health Service Act (42
20 U.S.C. 300gg–111) is amended by adding at the end
21 the following:

22 “(g) EXPLANATION OF BENEFITS.—

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

1 individual health insurance coverage shall, within 45
2 days of receiving any request for payment for an
3 item or service under the plan, provide to the partic-
4 ipant, beneficiary, or enrollee (through mail or elec-
5 tronic means, as requested by the participant, bene-
6 ficiary, or enrollee) a notification (in clear and un-
7 derstandable language and utilizing substantially the
8 same format as the advanced explanation of benefits
9 required by subsection (f) to enable comparison) in-
10 cluding the following:

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

16 “(B) An itemized explanation of benefits
17 that includes the following:

18 “(i) A plain language description of
19 each item or service.

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

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

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

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

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

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

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

1 (b) IRC AMENDMENTS.—

2 (1) EMERGENCY SERVICES.—Section
3 9816(f)(1)(C) of the Internal Revenue Code of 1986
4 is amended to read as follows:

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

14 (2) EXPLANATION OF BENEFITS.—Section
15 9816 of the Internal Revenue Code of 1986 is
16 amended by adding at the end the following:

17 “(g) EXPLANATION OF BENEFITS.—

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

1 same format as the advanced explanation of benefits
2 required by subsection (f) to enable comparison) in-
3 cluding the following:

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

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

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

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

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

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

22 “(v) The amount that the participant
23 or beneficiary has incurred toward meeting
24 the limit of the financial responsibility (in-
25 cluding with respect to deductibles and

1 out-of-pocket maximums) under the plan
2 (as of the date of such notification).

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

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

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

14 (c) ERISA AMENDMENTS.—

15 (1) EMERGENCY SERVICES.—Section
16 716(f)(1)(C) of the Employee Retirement Income
17 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is
18 amended to read as follows:

19 “(C) A good faith estimate of the amount
20 the health plan is responsible for paying for
21 items and services included in the estimate de-
22 scribed in subparagraph (B), including a plain
23 language description of each item or service and
24 all applicable billing codes for each item or serv-
25 ice, including modifiers, using standard and

1 commonly recognized billing code sets that are
2 clearly identified.”.

3 (2) EXPLANATION OF BENEFITS.—Section 716
4 of the Employee Retirement Income Security Act of
5 1974 (29 U.S.C. 1185e) is amended by adding at
6 the end the following:

7 “(g) EXPLANATION OF BENEFITS.—

8 “(1) IN GENERAL.—For plan years beginning
9 on or after January 1, 2026, each group health plan
10 or health insurance issuer offering group health in-
11 surance coverage shall, within 45 days of receiving
12 any request for payment for an item or service
13 under the plan, provide to the participant or bene-
14 ficiary (through mail or electronic means, as re-
15 quested by the participant or beneficiary) a notifica-
16 tion (in clear and understandable language and uti-
17 lizing substantially the same format as the advanced
18 explanation of benefits required by subsection (f) to
19 enable comparison) including the following:

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

1 “(B) An itemized explanation of benefits
2 that includes the following:

3 “(i) A plain language description of
4 each item or service.

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

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

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

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

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

24 “(2) FORMAT.—If applicable, the notification
25 described in paragraph (1) may be provided in con-

1 junction with, or as part of, a notice of a claim de-
 2 termination or other communication required by sec-
 3 tion 503 or regulations thereunder.

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

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

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

12 **“SEC. 2799B–10. PROVIDER REQUIREMENTS FOR ITEMIZED**
 13 **BILLS.**

14 “(a) REQUIREMENTS.—

15 “(1) ITEMIZED BILL AND OTHER INFORMATION
 16 REQUIRED.—

17 “(A) IN GENERAL.—A health care provider
 18 or health care facility that requests payment
 19 from an individual after providing a health care
 20 item or service to the patient shall include with
 21 such request a written, itemized bill of the cost
 22 of each reasonably expected item or service the
 23 health care provider or health care facility pro-
 24 vided to the individual, including telehealth vis-
 25 its or visits by other electronic means. The

1 health care provider or health care facility shall
2 provide the itemized bill not later than 30 days
3 after the health care provider or health care fa-
4 cility received a final payment on the provided
5 service or supply from a third party.

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

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

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

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

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

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

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

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

22 “(2) COLLECTIONS ACTIONS.—

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

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

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

24 “(B) BURDEN OF PROOF.—The burden of
25 proof under subparagraph (A)(ii) shall rest with

1 the provider, and absent the documentation de-
2 scribed in such subparagraph, the good faith es-
3 timate shall be binding.

4 “(b) FAILURE TO COMPLY.—

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

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

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

○