

119TH CONGRESS
2D SESSION

H. R. 8324

To amend the Internal Revenue Code of 1986 to increase the limitations on contributions to health savings accounts, to amend the Public Health Service Act to provide for hospital and insurer price transparency, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 16, 2026

Mr. BURLISON (for himself and Mr. BARRETT) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Workforce, the Judiciary, Armed Services, Veterans' Affairs, and Foreign Affairs, 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 Internal Revenue Code of 1986 to increase the limitations on contributions to health savings accounts, to amend the Public Health Service Act to provide for hospital and insurer price transparency, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Great American Healthcare Plan”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH SAVINGS ACCOUNTS

Sec. 101. Short title.

Sec. 102. Increase in contribution limitations.

Sec. 103. Freedom from mandate.

Sec. 104. Amounts paid for health insurance or direct primary care service arrangement.

Sec. 105. Special rule for certain medical expenses incurred before establishment of account.

Sec. 106. Administrative error correction before due date of return.

Sec. 107. Allowing HSA rollover to child or parent of account holder.

Sec. 108. Coverage for amounts paid for healthy food, vitamins, dietary supplements, and sports and fitness expenses.

Sec. 109. Equivalent bankruptcy protections for health savings accounts as retirement funds.

Sec. 110. Satisfaction of employer mandate through health savings account contributions.

Sec. 111. Rollovers from health care FSAs and HRAs permitted.

Sec. 112. Qualified general contributions to health savings accounts.

Sec. 113. Charitable contributions to health savings accounts.

Sec. 114. Amounts paid for health care sharing ministry.

TITLE II—HEALTH MARKETPLACE FOR ALL

Sec. 201. Short title.

Sec. 202. Health marketplace pools deemed an “employer” for purposes of offering group health plans or group health insurance coverage.

Sec. 203. Conforming amendments.

TITLE III—STRENGTHENING HOSPITAL AND INSURER PRICE
 TRANSPARENCY

Sec. 301. Short title.

Sec. 302. Strengthening hospital price transparency requirements.

Sec. 303. Increasing price transparency of clinical diagnostic laboratory tests.

Sec. 304. Imaging transparency.

Sec. 305. Ambulatory surgical center price transparency requirements.

Sec. 306. Strengthening health coverage transparency requirements.

Sec. 307. Increasing group health plan access to health data.

Sec. 308. Oversight of administrative service providers.

Sec. 309. State preemption only in event of conflict.

Sec. 310. Requirement for explanation of benefits.

Sec. 311. Provision of itemized bills.

TITLE IV—PROTECTING PATIENT ACCESS TO CANCER AND
 COMPLEX THERAPIES

Sec. 401. Short title.

Sec. 402. Rebate by manufacturers for selected drugs and biological products subject to maximum fair price negotiation.

TITLE V—EXPANDED-ACCESS PRESCRIPTION DRUGS

Sec. 501. Expanded-access prescription drugs.

Sec. 502. Government sponsored programs.

1 **TITLE I—HEALTH SAVINGS**
2 **ACCOUNTS**

3 **SEC. 101. SHORT TITLE.**

4 This title may be cited as the “Health Savings Ac-
5 counts For All Act of 2026”.

6 **SEC. 102. INCREASE IN CONTRIBUTION LIMITATIONS.**

7 (a) IN GENERAL.—Subsection (b) of section 223 of
8 the Internal Revenue Code of 1986 is amended—

9 (1) in paragraph (1), by striking “the sum of”
10 and all that follows through the period and inserting
11 “an amount equal to the applicable dollar amount
12 under paragraph (1)(B) of section 402(g) (as ad-
13 justed pursuant to paragraph (4) of such section)
14 with respect to such taxable year.”,

15 (2) by striking paragraphs (2), (3), (5), (7),
16 and (8),

17 (3) by inserting after paragraph (1) the fol-
18 lowing:

19 “(2) ADDITIONAL CONTRIBUTIONS FOR INDI-
20 VIDUALS 50 OR OLDER.—In the case of an individual
21 who has attained age 50 before the close of the tax-
22 able year, the amount of the limitation under para-
23 graph (1) shall be increased by an amount equal to

1 the applicable dollar amount under subparagraph
2 (B)(i) of section 414(v)(2) (as adjusted pursuant to
3 subparagraph (C) of such section).”,

4 (4) in paragraph (4), by striking the flush mat-
5 ter following subparagraph (C), and

6 (5) by redesignating paragraphs (4) and (6) as
7 paragraphs (3) and (4), respectively.

8 (b) CONFORMING AMENDMENTS.—

9 (1) Subparagraph (A) of section 223(d)(1) of
10 the Internal Revenue Code of 1986 is amended by
11 striking “the sum of—” and all that follows through
12 the period and inserting “the amount determined
13 under subsection (b)(1).”.

14 (2) Subsection (g)(1) of section 223 of such
15 Code is amended—

16 (A) by striking “(b)(2), (c)(2)(A), and”
17 and inserting “(c)(2)(A) and,”

18 (B) by amending subparagraph (B) to read
19 as follows:

20 “(B) the cost-of-living adjustment deter-
21 mined under section 1(f)(3) for the calendar
22 year in which such taxable year begins deter-
23 mined by substituting ‘calendar year 2003’ for
24 ‘calendar year 2016’ in subparagraph (A)(ii)
25 thereof.”, and

1 (C) by striking “(b)(2), (c)(1)(E)(ii)(II),”
2 and inserting “(c)(1)(E)(ii)(II)”.

3 (3) Section 26(b)(2)(S) of such Code is amend-
4 ed by striking “, 223(b)(8)(B)(i)(II),”.

5 (4) Section 408(d)(9)(C)(i)(I) of such Code is
6 amended by striking “computed on the basis of the
7 type of coverage under the high deductible health
8 plan covering the individual”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to taxable years beginning after
11 the date of the enactment of this Act.

12 **SEC. 103. FREEDOM FROM MANDATE.**

13 (a) IN GENERAL.—Section 223 of the Internal Rev-
14 enue Code of 1986, as amended by section 102, is further
15 amended by striking subsections (c) and (g) and by redес-
16 ignating subsections (d), (e), (f), and (h) as subsections
17 (c), (d), (e), and (f), respectively.

18 (b) CONFORMING AMENDMENTS.—

19 (1) Subsection (a) of section 223 of the Inter-
20 nal Revenue Code of 1986 is amended to read as fol-
21 lows:

22 “(a) DEDUCTION ALLOWED.—In the case of an indi-
23 vidual, there shall be allowed as a deduction for the tax-
24 able year an amount equal to the aggregate amount paid

1 in cash during such taxable year by or on behalf of such
2 individual to a health savings account of such individual.”.

3 (2) Subsection (c)(1)(A) of section 223 of such
4 Code, as amended by section 102 and redesignated
5 by subsection (a), is further amended by striking
6 “subsection (f)(4)” and inserting “subsection
7 (e)(4)”.

8 (3) Subparagraph (U) of section 26(b)(2) of
9 such Code, as amended by section 102, is further
10 amended by striking “section 223(f)(4)” and insert-
11 ing “section 223(e)(4)”.

12 (4) Sections 35(g)(3), 220(f)(5)(A),
13 848(e)(1)(B)(v), 4973(a)(5), and 6051(a)(12) of
14 such Code are each amended by striking “section
15 223(d)” each place it appears and inserting “section
16 223(c)”.

17 (5) Section 106(d)(1) of such Code is amend-
18 ed—

19 (A) by striking “who is an eligible indi-
20 vidual (as defined in section 223(c)(1))”, and

21 (B) by striking “section 223(d)” and in-
22 serting “section 223(c)”.

23 (6) Section 106(e) of such Code is amended—

1 (A) by striking paragraphs (3) and (4) and
2 by redesignating paragraph (5) as paragraph
3 (4),

4 (B) by inserting after paragraph (2) the
5 following new paragraph:

6 “(3) TREATMENT AS ROLLOVER CONTRIBU-
7 TION.—A qualified HSA distribution shall be treated
8 as a rollover contribution described in section
9 223(e)(5).”, and

10 (C) by striking “to any eligible individual
11 covered under a high deductible health plan of
12 the employer” in paragraph (4)(B)(ii) (as so re-
13 designated) and inserting “to any employee
14 with respect to whom a health savings account
15 has been established”.

16 (7) Section 408(d)(9)(A) of such Code is
17 amended by striking “who is an eligible individual
18 (as defined in section 223(e)) and”.

19 (8) Section 877A(g)(6) of such Code is amend-
20 ed by striking “223(f)(4)” and inserting
21 “223(e)(4)”.

22 (9) Section 4973(g) of such Code is amended—

23 (A) by striking “section 223(d)” and in-
24 serting “section 223(c)”,

1 (B) in paragraph (1), by striking “or
2 223(f)(5)” and inserting “or 223(e)(5)”,

3 (C) in paragraph (2)(A), by striking “sec-
4 tion 223(f)(2)” and inserting “section
5 223(e)(2)”, and

6 (D) in the flush matter at the end, by
7 striking “section 223(f)(3)” and inserting “sec-
8 tion 223(e)(3)”.

9 (10) Section 4975 of such Code is amended—

10 (A) in subsection (c)(6)—

11 (i) by striking “section 223(d)” and
12 inserting “section 223(c)”, and

13 (ii) by striking “section 223(e)(2)”
14 and inserting “section 223(d)(2)”, and

15 (B) in subsection (e)(1)(E), by striking
16 “section 223(d)” and inserting “section
17 223(c)”.

18 (11) Subsection (b) of section 4980G of such
19 Code is amended to read as follows:

20 “(b) RULES AND REQUIREMENTS.—

21 “(1) IN GENERAL.—An employer meets the re-
22 quirements of this subsection for any calendar year
23 if the employer makes available comparable con-
24 tributions to the health savings accounts of all com-

1 parable participating employees for each coverage
2 period during such calendar year.

3 “(2) COMPARABLE CONTRIBUTIONS.—

4 “(A) IN GENERAL.—For purposes of para-
5 graph (1), the term ‘comparable contributions’
6 means contributions—

7 “(i) which are the same amount, or

8 “(ii) if the employees are covered by a
9 health plan, which are the same percentage
10 of the annual deductible limit under the
11 plan covering the employees.

12 “(B) PART-YEAR EMPLOYEES.—In the
13 case of an employee who is employed by the em-
14 ployer for only a portion of the calendar year,
15 a contribution to the health savings account of
16 such employee shall be treated as comparable if
17 it is an amount which bears the same ratio to
18 the comparable amount (determined without re-
19 gard to this subparagraph) as such portion
20 bears to the entire calendar year.

21 “(3) COMPARABLE PARTICIPATING EMPLOY-
22 EES.—For purposes of paragraph (1), the term
23 ‘comparable participating employees’ means all em-
24 ployees who are covered (if at all) under the same
25 health plan of the employer and have the same cat-

1 egory of coverage. For purposes of the preceding
2 sentence, the categories of coverage are self-only and
3 family coverage.

4 “(4) PART-TIME EMPLOYEES.—

5 “(A) IN GENERAL.—Paragraph (3) shall
6 be applied separately with respect to part-time
7 employees and other employees.

8 “(B) PART-TIME EMPLOYEE.—For pur-
9 poses of subparagraph (A), the term ‘part-time
10 employee’ means any employee who is custom-
11 arily employed for fewer than 30 hours per
12 week.”.

13 (12) Section 4980G(d) of such Code is amended
14 by striking “section 4980E” and inserting “this sec-
15 tion”.

16 (13) Section 6693(a)(2)(C) of such Code is
17 amended by striking “section 223(h)” and inserting
18 “section 223(f)”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 the date of the enactment of this Act.

1 **SEC. 104. AMOUNTS PAID FOR HEALTH INSURANCE OR DI-**
2 **RECT PRIMARY CARE SERVICE ARRANGE-**
3 **MENT.**

4 (a) IN GENERAL.—Paragraph (2) of section 223(c)
5 of the Internal Revenue Code of 1986, as redesignated by
6 section 103, is amended—

7 (1) in subparagraph (A), by inserting “or pur-
8 suant to an arrangement under which an individual
9 is provided coverage restricted to primary care serv-
10 ices in exchange for a fixed periodic fee or payment
11 for primary care services” after “menstrual care
12 products”,

13 (2) by striking subparagraphs (B) and (C), and

14 (3) by redesignating subparagraph (D) as sub-
15 paragraph (B).

16 (b) CONFORMING AMENDMENT.—Paragraph (2) of
17 section 223(c) of the Internal Revenue Code of 1986, as
18 amended by the preceding sections of this Act, is further
19 amended by striking “and any dependent (as defined in
20 section 152, determined without regard to subsections
21 (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual”
22 and inserting “any dependent (as defined in section 152,
23 determined without regard to subsections (b)(1), (b)(2),
24 and (d)(1)(B) thereof) of such individual, and any child
25 (as defined in section 152(f)(1)) of such individual who

1 has not attained the age of 27 before the end of such indi-
2 vidual's taxable year”.

3 (c) TECHNICAL AMENDMENTS.—

4 (1) Section 220(d)(2)(A) of the Internal Rev-
5 enue Code of 1986 is amended by striking “section
6 223(d)(2)(D)” and inserting “section 223(c)(2)(B)”.

7 (2) Subsection (f) of section 106 of the Internal
8 Revenue Code of 1986 is amended by striking “sec-
9 tion 223(d)(2)(D)” and inserting “section
10 223(c)(2)(B)”.

11 (d) EFFECTIVE DATES.—

12 (1) IN GENERAL.—The amendments made by
13 subsections (a) and (b) shall apply with respect to
14 amounts paid after the date of the enactment of this
15 Act in taxable years beginning after such date.

16 (2) TECHNICAL AMENDMENTS.—The amend-
17 ments made by subsection (c) shall apply with re-
18 spect to taxable years beginning after the date of en-
19 actment of this Act.

20 **SEC. 105. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES**
21 **INCURRED BEFORE ESTABLISHMENT OF AC-**
22 **COUNT.**

23 (a) IN GENERAL.—Paragraph (2) of section 223(c)
24 of the Internal Revenue Code of 1986, as amended and
25 redesignated by the preceding sections of this Act, is fur-

1 ther amended by adding at the end the following new sub-
2 paragraph:

3 “(C) CERTAIN MEDICAL EXPENSES IN-
4 CURRED BEFORE ESTABLISHMENT OF ACCOUNT
5 TREATED AS QUALIFIED.—An expense shall not
6 fail to be treated as a qualified medical expense
7 solely because such expense was incurred before
8 the establishment of the health savings account
9 if such expense was incurred—

10 “(i) during either—

11 “(I) the taxable year in which the
12 health savings account was estab-
13 lished, or

14 “(II) the preceding taxable year,
15 in the case of a health savings ac-
16 count established after the taxable
17 year in which such expense was in-
18 curred but before the time prescribed
19 by law for filing the return for such
20 taxable year (not including extensions
21 thereof), and

22 “(ii) for medical care which (but for
23 the fact that it was incurred before the es-
24 tablishment of the account) otherwise

1 meets the requirements of the preceding
2 subparagraphs.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 this section shall apply to taxable years beginning after
5 the date of the enactment of this Act.

6 **SEC. 106. ADMINISTRATIVE ERROR CORRECTION BEFORE**
7 **DUE DATE OF RETURN.**

8 (a) **IN GENERAL.**—Paragraph (4) of section 223(e)
9 of the Internal Revenue Code of 1986, as amended and
10 redesignated by the preceding sections of this Act, is
11 amended by adding at the end the following new subpara-
12 graph:

13 “(D) **EXCEPTION FOR ADMINISTRATIVE**
14 **ERRORS CORRECTED BEFORE DUE DATE OF RE-**
15 **TURN.**—Subparagraph (A) shall not apply if
16 any payment or distribution is made to correct
17 an administrative, clerical, or payroll contribu-
18 tion error and if—

19 “(i) such distribution is received by
20 the individual on or before the last day
21 prescribed by law (including extensions of
22 time) for filing such individual’s return for
23 such taxable year, and

1 “(ii) such distribution is accompanied
2 by the amount of net income attributable
3 to such contribution.

4 Any net income described in clause (ii) shall be
5 included in the gross income of the individual
6 for the taxable year in which it is received.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 this section shall take effect on the date of the enactment
9 of this Act.

10 **SEC. 107. ALLOWING HSA ROLLOVER TO CHILD OR PARENT**
11 **OF ACCOUNT HOLDER.**

12 (a) IN GENERAL.—Paragraph (8)(A) of section
13 223(e) of the Internal Revenue Code of 1986, as redesignig-
14 nated by the preceding sections of this Act, is amended—

15 (1) by inserting “, child, parent, or grand-
16 parent” after “surviving spouse”,

17 (2) by inserting “, child, parent, or grand-
18 parent, as the case may be,” after “the spouse”,

19 (3) by inserting “, CHILD, PARENT, OR GRAND-
20 PARENT” after “SPOUSE” in the heading thereof,
21 and

22 (4) by adding at the end the following: “In the
23 case of a child who acquires such beneficiary’s inter-
24 est and with respect to whom a deduction under sec-
25 tion 151 is allowable to another taxpayer for a tax-

1 able year beginning in the calendar year in which
2 such individual's taxable year begins, such health
3 savings account shall be treated as a health savings
4 account of such child.”.

5 (b) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to taxable years beginning after
7 the date of the enactment of this Act.

8 **SEC. 108. COVERAGE FOR AMOUNTS PAID FOR HEALTHY**
9 **FOOD, VITAMINS, DIETARY SUPPLEMENTS,**
10 **AND SPORTS AND FITNESS EXPENSES.**

11 (a) IN GENERAL.—Paragraph (2) of section 223(c)
12 of the Internal Revenue Code of 1986, as amended by the
13 preceding provisions of this Act, is amended—

14 (1) in subparagraph (A), by adding at the end
15 the following new sentence: “For purposes of this
16 subparagraph, amounts paid for qualified wellness
17 expenses shall be treated as paid for medical care,
18 but only to the extent that such amounts paid with
19 respect to each individual described in the first sen-
20 tence of this subparagraph do not exceed \$100 per
21 month in the case of a health savings account the
22 balance of which does not exceed \$5,000; \$150 per
23 month in the case of a health savings account the
24 balance of which exceeds \$5,000 but does not exceed
25 \$10,000; and \$200 per month in the case of a

1 health savings account the balance of which exceeds
2 \$10,000.”, and

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

4 “(D) QUALIFIED WELLNESS EXPENSES.—

5 “(i) IN GENERAL.—For purposes of
6 this paragraph, the term ‘qualified wellness
7 expenses’ means amounts paid for healthy
8 food, vitamins, dietary supplements (as de-
9 fined in section 201(ff) of the Federal
10 Food, Drug, and Cosmetic Act (21 U.S.C.
11 321(ff))), or qualified sports and fitness
12 expenses.

13 “(ii) HEALTHY FOOD.—The term
14 ‘healthy food’ means any individual food
15 which meets the criteria of section
16 101.65(d)(3)(i) of title 21, Code of Federal
17 Regulations (or any successor regulations).

18 “(iii) QUALIFIED SPORTS AND FIT-
19 NESS EXPENSES.—

20 “(I) IN GENERAL.—The term
21 ‘qualified sports and fitness expenses’
22 means amounts paid exclusively for
23 the sole purpose of participating in a
24 physical activity, including—

1 “(aa) for membership at a
2 fitness facility,

3 “(bb) for participation or in-
4 struction in physical exercise or
5 physical activity, or

6 “(cc) for equipment used in
7 a program (including a self-di-
8 rected program) of physical exer-
9 cise or physical activity, including
10 a wearable fitness tracker.

11 “(II) FITNESS FACILITY.—For
12 purposes of subclause (I)(aa), the
13 term ‘fitness facility’ means a facil-
14 ity—

15 “(aa) which provides in-
16 struction in a program of phys-
17 ical exercise, offers facilities for
18 the preservation, maintenance,
19 encouragement, or development
20 of physical fitness, or serves as
21 the site of such a program of a
22 State or local government or an
23 organization described in section
24 501(c)(3) and exempt from tax
25 under section 501(a),

1 “(bb) which is not a private
2 club owned and operated by its
3 members,

4 “(cc) which does not offer
5 golf, hunting, sailing, or riding
6 facilities,

7 “(dd) the health or fitness
8 component of which is not inci-
9 dental to its overall function and
10 purpose, and

11 “(ee) which is fully compli-
12 ant with the State of jurisdiction
13 and Federal anti-discrimination
14 laws.

15 “(III) TREATMENT OF EXERCISE
16 VIDEOS, ETC.—Videos, books, and
17 similar materials shall be treated as
18 described in subclause (I)(bb) if the
19 content of such materials constitutes
20 instruction in a program of physical
21 exercise or physical activity.

22 “(IV) LIMITATIONS RELATED TO
23 SPORTS AND FITNESS EQUIPMENT.—
24 Amounts paid for equipment described
25 in subclause (I)(cc) shall be treated as

1 qualified sports and fitness expenses
2 only—

3 “(aa) if such equipment is
4 utilized exclusively for participa-
5 tion in fitness, exercise, sport, or
6 other physical activity, and

7 “(bb) in the case of amounts
8 paid for apparel or footwear, if
9 such apparel or footwear is of a
10 type that is necessary for, and is
11 not used for any purpose other
12 than, a specific physical activ-
13 ity.”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to taxable years beginning after
16 the date of the enactment of this Act.

17 **SEC. 109. EQUIVALENT BANKRUPTCY PROTECTIONS FOR**
18 **HEALTH SAVINGS ACCOUNTS AS RETIRE-**
19 **MENT FUNDS.**

20 (a) IN GENERAL.—Section 522 of title 11, United
21 States Code, is amended by adding at the end the fol-
22 lowing new subsection:

23 “(r) TREATMENT OF HEALTH SAVINGS AC-
24 COUNTS.—For purposes of this section, any health savings
25 account (as described in section 223 of the Internal Rev-

1 enue Code of 1986) shall be treated in the same manner
2 as an individual retirement account described in section
3 408 of such Code.”.

4 (b) EFFECTIVE DATE.—The amendment made by
5 this section shall apply to cases commencing under title
6 11, United States Code, after the date of the enactment
7 of this Act.

8 **SEC. 110. SATISFACTION OF EMPLOYER MANDATE**
9 **THROUGH HEALTH SAVINGS ACCOUNT CON-**
10 **TRIBUTIONS.**

11 (a) IN GENERAL.—Section 4980H of the Internal
12 Revenue Code of 1986 is amended by adding at the end
13 the following new subsection:

14 “(e) CONTRIBUTIONS TO HEALTH SAVINGS AC-
15 COUNTS.—

16 “(1) IN GENERAL.—An offer to make a con-
17 tribution of \$450 per month to an employee’s health
18 savings account shall be treated for purposes of this
19 section as an offer to enroll in minimum essential
20 coverage under an eligible employer-sponsored plan
21 for such month.

22 “(2) TREATMENT AS AFFORDABLE COV-
23 ERAGE.—Any employee offered a contribution de-
24 scribed in paragraph (1) by any employer for any
25 month shall not be treated as described in subsection

1 (b)(1)(B) with respect to such employer for such
2 month.”.

3 (b) APPLICATION OF EXCLUSION FOR EMPLOYER
4 CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—Sec-
5 tion 106(d) of such Code is amended—

6 (1) by redesignating paragraphs (2) and (3) as
7 paragraphs (3) and (4), respectively, and

8 (2) by inserting after paragraph (1) the fol-
9 lowing new paragraph:

10 “(2) LIMITATION.—In the case of an employee
11 whose employer makes a contribution of at least
12 \$450 per month to such employee’s health savings
13 account, paragraph (1) shall apply to such a con-
14 tribution only if such employee is enrolled in health
15 care coverage for such month.”.

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to months beginning in taxable
18 years beginning after the date of the enactment of this
19 Act.

20 **SEC. 111. ROLLOVERS FROM HEALTH CARE FSAS AND HRAS**
21 **PERMITTED.**

22 (a) IN GENERAL.—Section 106 of the Internal Rev-
23 enue Code of 1986 is amended by adding at the end the
24 following new subsection:

1 “(h) FSA AND HRA ROLLOVERS TO HEALTH SAV-
2 INGS ACCOUNTS.—

3 “(1) IN GENERAL.—A plan shall not fail to be
4 treated as a health flexible spending arrangement or
5 health reimbursement arrangement under this sec-
6 tion or section 105 merely because such plan pro-
7 vides for a qualified HSA rollover distribution.

8 “(2) QUALIFIED HSA ROLLOVER DISTRIBU-
9 TION.—For purposes of this subsection, the term
10 ‘qualified HSA rollover distribution’ means any por-
11 tion of a beneficiary’s unused balance of a health
12 flexible spending arrangement or health reimburse-
13 ment arrangement at the end of any plan year (or
14 such other times as the Secretary may provide)
15 which is transferred in a direct trustee-to-trustee
16 transfer to a health savings account of such bene-
17 ficiary.

18 “(3) TREATMENT AS HSA ROLLOVER CON-
19 TRIBUTION.—For purposes of this title, a qualified
20 HSA rollover distribution shall be treated as a con-
21 tribution described in section 223(e)(5).”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 this section shall apply to taxable years beginning after
24 the date of the enactment of this Act.

1 **SEC. 112. QUALIFIED GENERAL CONTRIBUTIONS TO**
2 **HEALTH SAVINGS ACCOUNTS.**

3 (a) IN GENERAL.—Section 223 of the Internal Rev-
4 enue Code of 1986, as amended by the preceding provi-
5 sions of this Act, is amended—

6 (1) in subsection (c)(1)(A), by inserting “or a
7 qualified general contribution,” after “section
8 220(f)(5),”, and

9 (2) in subsection (e)—

10 (A) in paragraph (3)(B), by inserting “, or
11 a qualified general contribution” after “section
12 220(f)(5)”, and

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

15 “(9) QUALIFIED GENERAL CONTRIBUTION.—

16 For purposes of this section—

17 “(A) IN GENERAL.—The term ‘qualified
18 general contribution’ means any contribution
19 which—

20 “(i) is made by the Secretary pursu-
21 ant to a general funding contribution,

22 “(ii) is made to the health savings ac-
23 count of an account beneficiary in the
24 qualified class of account beneficiaries
25 specified in the general funding contribu-
26 tion, and

1 “(iii) is in an amount which is equal
2 to the ratio of—

3 “(I) the amount of such general
4 funding contribution, to

5 “(II) the number of account
6 beneficiaries in such qualified class.

7 “(B) GENERAL FUNDING CONTRIBU-
8 TION.—The term ‘general funding contribution’
9 means a contribution which—

10 “(i) is made by—

11 “(I) an entity described in sec-
12 tion 170(c)(1) (other than a posses-
13 sion of the United States or a political
14 subdivision thereof) or an Indian trib-
15 al government, or

16 “(II) an organization described
17 in section 501(c)(3) and exempt from
18 tax under section 501(a), and

19 “(ii) which specifies a qualified class
20 of account beneficiaries to whom such con-
21 tribution is to be distributed.

22 “(C) QUALIFIED CLASS.—

23 “(i) IN GENERAL.—The term ‘quali-
24 fied class’ means any of the following:

25 “(I) All account beneficiaries.

1 “(II) All account beneficiaries
2 who reside in one or more States or
3 other qualified geographic areas speci-
4 fied by the terms of the general fund-
5 ing contribution.

6 “(ii) QUALIFIED GEOGRAPHIC
7 AREA.—The term ‘qualified geographic
8 area’ means any geographic area in which
9 not less than 5,000 account beneficiaries
10 reside and which is designated by the Sec-
11 retary as a qualified geographic area under
12 this clause.”.

13 (b) EXCLUSION FROM GROSS INCOME.—

14 (1) IN GENERAL.—Part III of subchapter B of
15 chapter 1 of such Code is amended by inserting be-
16 fore section 140 the following new section:

17 **“SEC. 139M. QUALIFIED GENERAL CONTRIBUTIONS TO**
18 **HEALTH SAVINGS ACCOUNTS.**

19 “(a) IN GENERAL.—Gross income of an account ben-
20 eficiary shall not include any qualified general contribution
21 to a health savings account of the account beneficiary.

22 “(b) DEFINITIONS.—Any term used in this section
23 which is used in section 223 shall have the meaning given
24 such term under section 223.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to taxable years beginning after
3 the date of the enactment of this Act.

4 **SEC. 114. AMOUNTS PAID FOR HEALTH CARE SHARING MIN-**
5 **ISTRY.**

6 (a) IN GENERAL.—Section 223(c)(2)(A) of the Inter-
7 nal Revenue Code of 1986, as amended by the preceding
8 provisions of this Act, is amended by adding at the end
9 the following new sentence: “For purposes of this subpara-
10 graph, amounts paid by a member of a health care sharing
11 ministry (as defined in section 5000A(d)(2)(B)(ii) without
12 regard to subclause (IV) thereof) for the sharing of med-
13 ical expenses among members, or administrative fees of
14 such ministry, shall be treated as paid for medical care.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 this section shall apply to taxable years beginning after
17 the date of the enactment of this Act.

18 **TITLE II—HEALTH**
19 **MARKETPLACE FOR ALL**

20 **SEC. 201. SHORT TITLE.**

21 This title may be cited as the “Health Marketplace
22 for All Act of 2026”.

1 **SEC. 202. HEALTH MARKETPLACE POOLS DEEMED AN “EM-**
2 **LOYER” FOR PURPOSES OF OFFERING**
3 **GROUP HEALTH PLANS OR GROUP HEALTH**
4 **INSURANCE COVERAGE.**

5 (a) DEFINITION OF EMPLOYER.—Section 3(5) of the
6 Employee Retirement Income Security Act of 1974 (29
7 U.S.C. 1002(5)) is amended by adding at the end the fol-
8 lowing: “Such term shall be deemed to include, for pur-
9 poses of offering a group health plan (as defined in section
10 733(a)(1)) or group health insurance coverage (as defined
11 in section 733(b)(4)) (which, notwithstanding any other
12 provision of law, may include such a plan or coverage cov-
13 ering prescription or nonprescription drugs as the only
14 benefit offered by the plan or coverage in accordance with
15 section 736(b)(5)(B)), any entity that meets the require-
16 ments under section 736(b).”.

17 (b) GROUP HEALTH PLANS AND GROUP HEALTH IN-
18 SURANCE COVERAGE.—Part 7 of subtitle B of title I of
19 the Employee Retirement Income Security Act of 1974
20 (29 U.S.C. 1181 et seq.) is amended by adding at the end
21 the following:

1 ing an employee of an employer or a dependent
2 of an employee).

3 “(2) OFFERING GROUP HEALTH PLANS AND
4 GROUP HEALTH INSURANCE COVERAGE.—

5 “(A) DIFFERENT GROUPS.—

6 “(i) IN GENERAL.—The health mar-
7 ketplace pool, which may be in conjunction
8 with a health insurance issuer that offers
9 group health insurance coverage through
10 the health marketplace pool, shall make
11 available a group health plan or group
12 health insurance coverage to all members
13 of the health marketplace pool (and, in the
14 case of members that are employers, em-
15 ployees of the employers) at rates that—

16 “(I) are established by the health
17 marketplace pool, or a health insur-
18 ance issuer contracting with such
19 health marketplace pool, on a policy
20 or product specific basis; and

21 “(II) subject to sections 701 and
22 702, may vary for individuals covered
23 through the health marketplace pool.

24 “(ii) PERMISSIBLE COVERAGE FOR
25 DEPENDENTS.—Such group health plan or

1 group health insurance coverage may be
2 made available under clause (i) to any de-
3 pendents of members of the health market-
4 place pool or dependents of employees of
5 employers that are such members.

6 “(B) NONDISCRIMINATION IN COVERAGE
7 OFFERED.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii), the health marketplace pool may not
10 offer coverage under a group health plan
11 or group health insurance coverage to a
12 member of the health marketplace pool un-
13 less the same coverage is offered to all
14 such members of the health marketplace
15 pool.

16 “(ii) CONSTRUCTION.—Nothing in
17 this subsection shall be construed as re-
18 quiring a health insurance issuer or group
19 health plan to provide coverage outside the
20 service area of the issuer or plan, or pre-
21 venting a health insurance issuer or group
22 health plan from underwriting or from ex-
23 cluding or limiting the coverage on any in-
24 dividual, subject to the requirements under
25 sections 701 and 702.

1 “(C) ASSUMPTION OF RISK.—The health
2 marketplace pool may provide—

3 “(i) group health insurance coverage
4 through a contract with a health insurance
5 issuer; or

6 “(ii) a group health plan through self-
7 insurance.

8 “(3) GEOGRAPHIC AREAS.—Nothing in this
9 subsection shall be construed as preventing the es-
10 tablishment and operation of more than 1 health
11 marketplace pool in a geographic area or as limiting
12 the number of health marketplace pools that may
13 operate in any area.

14 “(4) PROVISION OF ADMINISTRATIVE SERVICES
15 TO PURCHASERS.—The health marketplace pool may
16 provide administrative services for members. Such
17 services may include accounting, billing, and enroll-
18 ment information.

19 “(5) DRUG COVERAGE.—The group health plan
20 or group health insurance coverage offered by the
21 health marketplace pool may offer—

22 “(A) drug coverage, including coverage of
23 over-the-counter drugs, in combination with
24 other benefits covered by the group health plan
25 or group health insurance coverage; or

1 “(B) notwithstanding any other provision
2 of law, drug coverage, including coverage of
3 over-the-counter drugs, as the only benefit cov-
4 ered by the group health plan or group health
5 insurance coverage.

6 “(6) MEMBERS.—

7 “(A) IN GENERAL.—With respect to an in-
8 dividual who is a member of the health market-
9 place pool—

10 “(i) the individual may enroll for cov-
11 erage under the group health plan or
12 group health insurance coverage offered by
13 the health marketplace pool (including, if
14 applicable, enrollment for coverage for a
15 dependent of such individual); or

16 “(ii) the employer of the individual
17 may enroll the individual for coverage
18 under the group health plan or group
19 health insurance coverage offered by the
20 health marketplace pool (including, if ap-
21 plicable, enrollment for coverage for a de-
22 pendent of such individual).

23 “(B) ELIGIBILITY.—An individual shall be
24 eligible to be a member of the health market-
25 place pool if such individual is—

1 “(i) a member of an entity that estab-
2 lishes or joins the health marketplace pool
3 (or a dependent of such a member, as ap-
4 plicable);

5 “(ii) an employee of a member of an
6 entity described in clause (i) (or a depend-
7 ent of such an employee, as applicable); or

8 “(iii) an employee of an entity (or a
9 dependent of such an employee, as applica-
10 ble) controlled by a member of an entity
11 described in clause (i).

12 “(C) RULES FOR ENROLLMENT.—Nothing
13 in this paragraph shall preclude the health mar-
14 ketplace pool from establishing rules of enroll-
15 ment and reenrollment of members. Such rules
16 shall be applied consistently to all members
17 within the health marketplace pool and shall
18 not be based in any manner on health status-
19 related factors in accordance with sections 701
20 and 702.

21 “(c) DETERMINATION OF EMPLOYER AND JOINT EM-
22 PLOYER STATUS.—Participating in or facilitating a group
23 health plan or group health insurance coverage under this
24 section shall not be construed as establishing under any
25 Federal or State law—

1 “(1) an employer relationship for any purpose
2 other than offering the group health plan or group
3 health insurance coverage; or

4 “(2) a joint employer relationship for any pur-
5 pose.

6 “(d) DEFINITION.—In this section, the term ‘depend-
7 ent’, as applied to a group health plan or group health
8 insurance coverage offered in a State, shall have the mean-
9 ing applied to such term with respect to such plan or cov-
10 erage under the State law applying to such plan or cov-
11 erage. Such term may include the spouse and children of
12 the individual involved in accordance with such State
13 law.”.

14 **SEC. 203. CONFORMING AMENDMENTS.**

15 Section 3 of the Employee Retirement Income Secu-
16 rity Act of 1974 (29 U.S.C. 1002) is amended—

17 (1) in paragraph (6), by inserting before the pe-
18 riod “, except (with respect to an entity meeting the
19 requirements under section 736(b)) such term in-
20 cludes any member of such entity”;

21 (2) in paragraph (21)—

22 (A) in subparagraph (A), by striking “sub-
23 paragraph (B)” and inserting “subparagraphs
24 (B) and (C)”;

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

1 “(C) With respect to a person that is a member of
2 an entity (referred to in section 736 and this subpara-
3 graph as a ‘health marketplace pool’) that meets the re-
4 quirements of section 736(b) and offers a group health
5 plan (as defined in section 733(a)(1)) or group health in-
6 surance coverage (as defined in section 733(b)(4)) (which,
7 notwithstanding any other provision of law, may include
8 such a plan or coverage covering prescription or non-
9 prescription drugs as the only benefit offered by the plan
10 or coverage), membership in the health marketplace pool
11 shall not by itself cause the person to be a fiduciary with
12 respect to the group health plan or group health insurance
13 coverage.”; and

14 (3) in paragraph (40)(A)—

15 (A) in clause (ii), by striking “, or” and in-
16 serting “,”;

17 (B) in clause (iii), by striking the period
18 and inserting “, or”; and

19 (C) by adding at the end the following:

20 “(iv) as a group health plan (as defined in sec-
21 tion 733(a)(1)), or group health insurance coverage
22 (as defined in section 733(b)(4)), offered by an enti-
23 ty meeting the requirements under section 736(b)
24 (which, notwithstanding any other provision of law,
25 may include such an entity offering such a plan or

1 coverage covering prescription or nonprescription
 2 drugs as the only benefit offered by the plan or cov-
 3 erage).”.

4 **TITLE III—STRENGTHENING**
 5 **HOSPITAL AND INSURER**
 6 **PRICE TRANSPARENCY**

7 **SEC. 301. SHORT TITLE.**

8 This title may be cited as the “Patients Deserve Price
 9 Tags Act”.

10 **SEC. 302. STRENGTHENING HOSPITAL PRICE TRANS-**
 11 **PARENCY REQUIREMENTS.**

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

15 “(e) STANDARD HOSPITAL CHARGES.—

16 “(1) IN GENERAL.—

17 “(A) DISCLOSURE OF STANDARD
 18 CHARGES.—Each hospital shall, in accordance
 19 with a method and format established by the
 20 Secretary under subparagraph (C), on a month-
 21 ly basis compile and make public (without sub-
 22 scription and free of charge)—

23 “(i) all of the hospital’s standard
 24 charges (including the information de-

1 scribed in subparagraph (B)) for each item
2 and service furnished by such hospital; and

3 “(ii) hospital standard charge infor-
4 mation, including the information de-
5 scribed in subparagraph (B), in a con-
6 sumer-friendly format (as specified by the
7 Secretary), that includes—

8 “(I) as many of the Centers for
9 Medicare & Medicaid Services-speci-
10 fied shoppable services that are fur-
11 nished by the hospital, and as many
12 additional hospital-selected shoppable
13 services (or all such additional serv-
14 ices, if such hospital furnishes fewer
15 than 300 shoppable services) as may
16 be necessary for a combined total of
17 at least 300 shoppable services
18 through December 31, 2027, after
19 which the hospital’s prices shall in-
20 clude all shoppable services; and

21 “(II) with respect to each Cen-
22 ters for Medicare & Medicaid Serv-
23 ices-specified shoppable service that is
24 not furnished by the hospital, an indi-

1 cation that such service is not so fur-
2 nished.

3 “(B) STANDARD CHARGES DESCRIBED.—

4 For purposes of subparagraph (A), standard
5 charges means:

6 “(i) A plain language description of
7 each item or service, accompanied by any
8 applicable billing codes, including modi-
9 fiers, using commonly recognized billing
10 code sets, including the Current Proce-
11 dural Terminology code, the Healthcare
12 Common Procedure Coding System code,
13 the diagnosis-related group, the National
14 Drug Code, and other nationally recog-
15 nized identifier.

16 “(ii) The gross charge, expressed as a
17 dollar amount, for each such item or serv-
18 ice, when provided in, as applicable, the in-
19 patient setting and outpatient department
20 setting.

21 “(iii) The discounted cash price ex-
22 pressed as a dollar amount, for each such
23 item or service when provided in, as appli-
24 cable, the inpatient setting and outpatient
25 department setting (or, in the case no dis-

1 counted cash price is available for an item
2 or service, the minimum cash price accept-
3 ed by the hospital from self-pay individuals
4 for such item or service, expressed as a
5 dollar amount, as well as, with respect to
6 prices made public pursuant to subpara-
7 graph (A)(ii), a link to a consumer-friendly
8 document that clearly explains the hos-
9 pital’s charity care policy). The hospital
10 shall accept the discounted cash price as
11 payment in full from any patient that
12 chooses to pay in cash without regard to
13 the patient’s coverage.

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

1 in its contract and any other terms, sched-
2 ules, exhibits, data, or other information
3 referenced in any such contract as shall be
4 required to determine and disclose the ne-
5 gotiated charge.

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

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

24 “(C) UNIFORM METHOD AND FORMAT.—

25 Not later than January 1, 2027, the Secretary

1 shall establish a standard, uniform method and
2 format for hospitals to use in compiling and
3 making public standard charges pursuant to
4 subparagraph (A)(i) and a standard, uniform
5 method and format for such hospitals to use in
6 compiling and making public prices pursuant to
7 subparagraph (A)(ii). Such methods and for-
8 mats shall—

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

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

18 “(iii) be updated as determined appro-
19 priate by the Secretary, in consultation
20 with stakeholders.

21 “(2) NO DEEMED COMPLIANCE.—The avail-
22 ability of a price estimator tool shall not be consid-
23 ered to deem compliance with or otherwise vitiate
24 the requirements of paragraph (1)(A)(ii) or any
25 other requirements of this section. Furthermore, the

1 use of an estimator tool shall not be used for pur-
2 poses of compliance with any provisions in this sec-
3 tion.

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

11 “(4) ATTESTATION.—A senior official from
12 each hospital (the Chief Executive Officer, Chief Fi-
13 nancial Officer, or an official of equivalent seniority)
14 shall attest to the accuracy and completeness of the
15 disclosures made in accordance with the hospital
16 price transparency requirements set forth in this
17 regulation. Such attestation shall be deemed to be
18 material to payment from the Federal Government
19 to the hospital.

20 “(5) ENFORCEMENT.—

21 “(A) IN GENERAL.—In the case of a hos-
22 pital that fails to comply with the requirements
23 of this subsection, not later than 30 days after
24 the date on which the Secretary determines
25 such failure exists, the Secretary shall submit

1 to such hospital a notification of such deter-
2 mination, which shall include a request for a
3 corrective action plan to comply with such re-
4 quirements.

5 “(B) CIVIL MONETARY PENALTY.—

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

21 “(I) in the case of a hospital with
22 30 or fewer beds, \$300 per day;

23 “(II) in the case of a hospital
24 with more than 30 beds but fewer
25 than 101 beds, \$12.50 per bed per

1 day (or, in the case of such a hospital
2 that has been noncompliant with such
3 requirements for a 1-year period or
4 longer, beginning with the first day
5 following such 1-year period, \$15 per
6 bed per day);

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

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

1 “(V) in the case of a hospital
2 with more than 500 beds, \$25 per bed
3 per day (or, in the case of such a hos-
4 pital that has been noncompliant with
5 such requirements for a 1-year period
6 or longer, beginning with the first day
7 following such 1-year period, \$35 per
8 bed per day).

9 “(ii) INCREASE AUTHORITY.—In ap-
10 plying this subparagraph with respect to
11 violations occurring in 2028 or a subse-
12 quent year, the Secretary may through no-
13 tice and comment rulemaking increase—

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

17 “(II) the limitations on the per
18 bed per day amount of any penalty
19 applicable under any of subclauses
20 (II) through (V) of clause (i); and

21 “(III) the limitation on the in-
22 crease of any penalty applied under
23 clause (iii) pursuant to the amounts
24 specified in subclause (II) of such
25 clause.

1 “(iii) PERSISTENT NONCOMPLI-
2 ANCE.—

3 “(I) IN GENERAL.—In the case
4 of a hospital that the Secretary has
5 determined to be knowingly and will-
6 fully noncompliant with the provisions
7 of this subsection two or more times
8 during a 1-year period, the Secretary
9 may increase any penalty otherwise
10 applicable under this subparagraph by
11 the amount specified in subclause (II)
12 with respect to such hospital and may
13 require such hospital to complete such
14 additional corrective actions plans as
15 the Secretary may specify.

16 “(II) SPECIFIED AMOUNT.—For
17 purposes of subclause (I), the amount
18 specified in this subclause is, with re-
19 spect to a hospital—

20 “(aa) with more than 30
21 beds but fewer than 101 beds, an
22 amount that is not less than
23 \$500,000 and not more than
24 \$1,000,000;

1 “(bb) with more than 100
2 beds but fewer than 301 beds, an
3 amount that is greater than
4 \$1,000,000 and not more than
5 \$2,000,000;

6 “(cc) with more than 300
7 beds but fewer than 501 beds, an
8 amount that is greater than
9 \$2,000,000 and not more than
10 \$4,000,000; and

11 “(dd) with more than 500
12 beds, an amount that is not less
13 than \$5,000,000 and not more
14 than \$10,000,000.

15 “(iv) PROVISION OF TECHNICAL AS-
16 SISTANCE.—The Secretary may, to the ex-
17 tent practicable, provide technical assist-
18 ance relating to compliance with the provi-
19 sions of this section to hospitals requesting
20 such assistance.

21 “(v) APPLICATION OF CERTAIN PROVI-
22 SIONS.—The provisions of section 1128A
23 (other than subsections (a) and (b) of such
24 section) shall apply to a civil monetary
25 penalty imposed under this subparagraph

1 in the same manner as such provisions
2 apply to a civil monetary penalty imposed
3 under subsection (a) of such section.

4 “(C) NO WAIVER.—The Secretary shall not
5 grant or extend any waiver, delay, tolling, or
6 other mitigation of a civil monetary penalty for
7 violation of this subsection.

8 “(6) DEFINITIONS.—For purposes of this sub-
9 section:

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

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

22 “(C) HOSPITAL.—The term ‘hospital’
23 means a hospital (as defined in section 1861(e)
24 of the Social Security Act), a critical access
25 hospital (as defined in section 1861(mmm)(1)

1 of the Social Security Act), or a rural emer-
2 gency hospital (as defined in section 1861(kkk)
3 of the Social Security Act), together with any
4 parent, subsidiary, or other affiliated provider
5 or supplier of health care items and services
6 without regard to whether such parent, sub-
7 sidiary, or other affiliated provider or supplier
8 operates under separate licensure, certification,
9 or designation.

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

15 “(E) SHOPPABLE SERVICE.—The term
16 ‘shoppable service’ means a service that can be
17 scheduled by a health care consumer in advance
18 and includes all ancillary items and services
19 customarily furnished as part of such service.

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 “(7) 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 (b) EFFECTIVE DATE.—

6 (1) IN GENERAL.—The amendment made by
7 subsection (a) shall apply beginning January 1,
8 2027.

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

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

1 **SEC. 303. INCREASING PRICE TRANSPARENCY OF CLINICAL**
2 **DIAGNOSTIC LABORATORY TESTS.**

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

6 “(f) **CLINICAL DIAGNOSTIC LABORATORY PRICE**
7 **TRANSPARENCY.**—

8 “(1) **IN GENERAL.**—Beginning July 1, 2028, an
9 applicable laboratory shall—

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

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

18 “(2) **INFORMATION DESCRIBED.**—For purposes
19 of paragraph (1), the information described in this
20 paragraph is, with respect to an applicable labora-
21 tory and a specified clinical diagnostic laboratory
22 test, the following:

23 “(A) A plain language description of each
24 item or service, accompanied by any applicable
25 billing codes, including modifiers, using com-
26 monly recognized billing code sets, including the

1 Current Procedural Terminology code, the
2 Healthcare Common Procedure Coding System
3 code, the diagnosis-related group, the National
4 Drug Code, and other nationally recognized
5 identifier.

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

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

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

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

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

18 “(F) Any other additional information the
19 Secretary may require for the purpose of im-
20 proving the accuracy of, or enabling consumers
21 to easily understand and compare, standard
22 charges and prices for an item or service, ex-
23 cept information that is duplicative of any other
24 reporting requirement under this subsection. In
25 the case of standard charges and prices for an

1 item or service included as part of a bundled,
2 per diem, episodic, or other similar arrange-
3 ment, the information described in this sub-
4 paragraph shall be made available as deter-
5 mined appropriate by the Secretary.

6 “(3) UNIFORM METHOD AND FORMAT.—Not
7 later than January 1, 2028, the Secretary shall es-
8 tablish a standard, uniform method and format for
9 applicable laboratories to use in compiling and mak-
10 ing public information pursuant to paragraph (1).
11 Such method and format shall—

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

16 “(B) meet such standards as determined
17 appropriate by the Secretary in order to ensure
18 the accessibility and usability of such informa-
19 tion; and

20 “(C) be updated as determined appropriate
21 by the Secretary, in consultation with stake-
22 holders.

23 “(4) INCLUSION OF ANCILLARY SERVICES.—
24 Any price or rate for a specified clinical diagnostic
25 laboratory test available to be furnished by an appli-

1 cable laboratory made publicly available in accord-
2 ance with paragraph (1) shall include the price or
3 rate for any ancillary item or service (including spec-
4 imen collection services, specimen transport, cen-
5 trifugation, aliquoting, labeling, requisition proc-
6 essing, and standard result reporting services) that
7 would customarily and routinely be furnished by
8 such laboratory as part of such test, as specified by
9 the Secretary.

10 “(5) ENFORCEMENT.—

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

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

17 “(ii) if such laboratory continues to
18 fail to comply with such paragraph after
19 the date that is 90 days after such notifi-
20 cation is sent, the Secretary may impose a
21 civil monetary penalty in an amount not to
22 exceed \$300 for each day (beginning with
23 the day on which the Secretary first deter-
24 mined that such laboratory was failing to

1 comply with such paragraph) during which
2 such failure is ongoing.

3 “(B) INCREASE AUTHORITY.—In applying
4 this paragraph with respect to violations occur-
5 ring in 2029 or a subsequent year, the Sec-
6 retary may through notice and comment rule-
7 making increase the per day limitation on civil
8 monetary penalties under subparagraph (A)(ii).

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

17 “(6) PROVISION OF TECHNICAL ASSISTANCE.—
18 The Secretary shall, to the extent practicable, pro-
19 vide technical assistance relating to compliance with
20 the provisions of this subsection to applicable labora-
21 tories requesting such assistance.

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

23 “(A) APPLICABLE LABORATORY.—The
24 term ‘applicable laboratory’ means a ‘labora-
25 tory’ as such term is defined in section 493.2,

1 of title 42, Code of Federal Regulations (or a
2 successor regulation), except that such term
3 does not include a laboratory with respect to
4 which standard charges and prices for specified
5 clinical diagnostic laboratory tests furnished by
6 such laboratory are made available by a hos-
7 pital pursuant to subsection (e) of this section.

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

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

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

21 “(E) SPECIFIED CLINICAL DIAGNOSTIC
22 LABORATORY TEST.—The term ‘specified clin-
23 ical diagnostic laboratory test’ means a clinical
24 diagnostic laboratory test that is included on
25 the list of shoppable services specified by the

1 Centers for Medicare & Medicaid Services (as
2 described in subsection (e) of this section),
3 other than such a test that is only available to
4 be furnished by a single provider of services or
5 supplier.

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

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

15 **SEC. 304. IMAGING TRANSPARENCY.**

16 Section 2718 of the Public Health Service Act (42
17 U.S.C. 300gg–18), as amended by section 303, is further
18 amended by adding at the end the following:

19 “(g) IMAGING SERVICES PRICE TRANSPARENCY.—

20 “(1) IN GENERAL.—Beginning July 1, 2028,
21 each provider of services or supplier that furnishes
22 a specified imaging service, other than such a pro-
23 vider or supplier with respect to which standard
24 charges and prices for such services furnished by

1 such provider or supplier are made available by a
2 hospital pursuant to subsection (e), shall—

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

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

10 “(2) INFORMATION DESCRIBED.—For purposes
11 of paragraph (1), the information described in this
12 paragraph is, with respect to a provider of services
13 or supplier and a specified imaging service, the fol-
14 lowing:

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

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

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

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

1 of another amount, or other formula or criteria,
2 the provider or supplier also shall disclose such
3 algorithm, percentage, formula, or criteria as
4 set forth in its contract and any other terms,
5 schedules, exhibits, data, or other information
6 referenced in any such contract as shall be re-
7 quired to determine and disclose the negotiated
8 charge.

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

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

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

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

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

16 “(C) be updated as determined appropriate
17 by the Secretary, in consultation with stake-
18 holders.

19 “(4) MONITORING COMPLIANCE.—The Sec-
20 retary shall, through notice and comment rule-
21 making and in consultation with the Inspector Gen-
22 eral of the Department of Health and Human Serv-
23 ices, establish a process to monitor compliance with
24 this subsection.

25 “(5) ENFORCEMENT.—

1 “(A) IN GENERAL.—In the case that the
2 Secretary determines that a provider of services
3 or supplier is not in compliance with paragraph
4 (1)—

5 “(i) not later than 30 days after such
6 determination, the Secretary shall notify
7 such provider or supplier of such deter-
8 mination;

9 “(ii) upon request of the Secretary,
10 such provider or supplier shall submit to
11 the Secretary, not later than 45 days after
12 the date of such request, a corrective ac-
13 tion plan to comply with such paragraph;
14 and

15 “(iii) if such provider or supplier con-
16 tinues to fail to comply with such para-
17 graph after the date that is 90 days after
18 such notification is sent (or, in the case of
19 such a provider or supplier that has sub-
20 mitted a corrective action plan described in
21 clause (ii) in response to a request so de-
22 scribed, after the date that is 90 days after
23 such submission), the Secretary may im-
24 pose a civil monetary penalty in an amount
25 not to exceed \$300 for each day (beginning

1 with the day on which the Secretary first
2 determined that such provider or supplier
3 was failing to comply with such paragraph)
4 during which such failure to comply or fail-
5 ure to submit is ongoing.

6 “(B) INCREASE AUTHORITY.—In applying
7 this paragraph with respect to violations occur-
8 ring in 2028 or a subsequent year, the Sec-
9 retary may through notice and comment rule-
10 making increase the amount of the civil mone-
11 tary penalty under subparagraph (A)(iii).

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

20 “(D) NO AUTHORITY TO WAIVE OR RE-
21 DUCE PENALTY.—The Secretary shall not grant
22 or extend any waiver, delay, tolling, or other
23 mitigation of a civil monetary penalty for viola-
24 tion of this subsection.

1 “(E) PROVISION OF TECHNICAL ASSIST-
2 ANCE.—The Secretary shall, to the extent prac-
3 ticable, provide technical assistance relating to
4 compliance with the provisions of this sub-
5 section to providers of services and suppliers re-
6 questing such assistance.

7 “(F) CLARIFICATION OF NONAPPLICA-
8 BILITY OF OTHER ENFORCEMENT PROVI-
9 SIONS.—Notwithstanding any other provision of
10 this title, this paragraph shall be the sole
11 means of enforcing the provisions of this sub-
12 section.

13 “(6) SPECIFIED IMAGING SERVICE DEFINED.—
14 The term ‘specified imaging service’ means an imag-
15 ing service that is a Centers for Medicare & Med-
16 icaid Services-specified shoppable service (as de-
17 scribed in subsection (e)).

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

1 **SEC. 305. AMBULATORY SURGICAL CENTER PRICE TRANS-**
2 **PARENCY REQUIREMENTS.**

3 Section 2718 of the Public Health Service Act (42
4 U.S.C. 300gg-18), as amended by section 304, is further
5 amended by adding at the end the following:

6 “(h) AMBULATORY SURGERY CENTER TRANS-
7 PARENCY.—

8 “(1) IN GENERAL.—Beginning July 1, 2028,
9 each specified ambulatory surgical center shall com-
10 ply with the price transparency requirement de-
11 scribed in paragraph (2).

12 “(2) REQUIREMENT DESCRIBED.—

13 “(A) IN GENERAL.—A specified ambula-
14 tory surgical center, in accordance with a meth-
15 od and format established by the Secretary
16 under subparagraph (C), shall compile and
17 make public (without subscription and free of
18 charge), for each year—

19 “(i) one or more lists, in a machine-
20 readable format specified by the Secretary,
21 of the ambulatory surgical center’s stand-
22 ard charges (including the information de-
23 scribed in subparagraph (B)) for each item
24 and service furnished by such surgical cen-
25 ter;

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

17 “(iii) with respect to each Centers for
18 Medicare & Medicaid Services-specified
19 shoppable service (as described in clause
20 (ii)) that is not furnished by the ambula-
21 tory surgical center, an indication that
22 such service is not so furnished.

23 “(B) INFORMATION DESCRIBED.—For pur-
24 poses of subparagraph (A), the information de-
25 scribed in this subparagraph is, with respect to

1 standard charges and prices made public by a
2 specified ambulatory surgical center, the fol-
3 lowing:

4 “(i) A description of each item or
5 service, accompanied by the Healthcare
6 Common Procedure Coding System code,
7 the national drug code, or other identifier
8 used or approved by the Centers for Medi-
9 care & Medicaid Services.

10 “(ii) The gross charge, expressed as a
11 dollar amount, for each such item or serv-
12 ice.

13 “(iii) The discounted cash price, ex-
14 pressed as a dollar amount, for each such
15 item or service (or, in the case no dis-
16 counted cash price is available for an item
17 or service, the minimum cash price accept-
18 ed by the specified ambulatory surgical
19 center from self-pay individuals for such
20 item or service when provided in such set-
21 tings for the previous three years, ex-
22 pressed as a dollar amount, as well as,
23 with respect to prices made public pursu-
24 ant to subparagraph (A)(ii), a link to a
25 consumer-friendly document that clearly

1 explains the provider of services or sup-
2 plier’s charity care policy). The specified
3 ambulatory surgical center shall accept the
4 discounted cash price as payment in full
5 from any patient that chooses to pay in
6 cash without regard to the patient’s cov-
7 erage.

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

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

5 “(vi) Any other additional information
6 the Secretary may require for the purpose
7 of improving the accuracy of, or enabling
8 consumers to easily understand and com-
9 pare, standard charges and prices for an
10 item or service, except information that is
11 duplicative of any other reporting require-
12 ment under this subsection.

13 “(C) UNIFORM METHOD AND FORMAT.—
14 Not later than January 1, 2028, the Secretary
15 shall establish a standard, uniform method and
16 format for specified ambulatory surgical centers
17 to use in making public standard charges pur-
18 suant to subparagraph (A)(i) and a standard,
19 uniform method and format for such centers to
20 use in making public prices pursuant to sub-
21 paragraph (A)(ii). Any such method and format
22 shall—

23 “(i) in the case of such charges made
24 public by an ambulatory surgical center,

1 ensure that such charges are made avail-
2 able in a machine-readable 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 “(3) 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 this subsection (aa). Further-
14 more, the use of an estimator tool shall not be used
15 for purposes of compliance with any provisions in
16 this subsection.

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

25 “(5) ENFORCEMENT.—

1 “(A) IN GENERAL.—In the case of a speci-
2 fied ambulatory surgical center that fails to
3 comply with the requirements of this sub-
4 section—

5 “(i) the Secretary shall notify such
6 ambulatory surgical center of such failure
7 not later than 30 days after the date on
8 which the Secretary determines such fail-
9 ure exists; and

10 “(ii) upon request of the Secretary,
11 the ambulatory surgical center shall submit
12 to the Secretary, not later than 45 days
13 after the date of such request, a corrective
14 action plan to comply with such require-
15 ments.

16 “(B) CIVIL MONETARY PENALTY.—

17 “(i) IN GENERAL.—A specified ambu-
18 latory surgical center that has received a
19 notification under subparagraph (A)(i) and
20 fails to comply with the requirements of
21 this subsection by the date that is 90 days
22 after such notification (or, in the case of
23 an ambulatory surgical center that has
24 submitted a corrective action plan de-
25 scribed in subparagraph (A)(ii) in response

1 to a request so described, by the date that
2 is 90 days after such submission) shall be
3 subject to a civil monetary penalty of an
4 amount specified by the Secretary for each
5 day (beginning with the day on which the
6 Secretary first determined that such hos-
7 pital was not complying with such require-
8 ments) during which such failure is ongo-
9 ing (not to exceed \$300 per day).

10 “(ii) INCREASE AUTHORITY.—In ap-
11 plying this subparagraph with respect to
12 violations occurring in 2028 or a subse-
13 quent year, the Secretary may through no-
14 tice and comment rulemaking increase the
15 limitation on the per day amount of any
16 penalty applicable to a specified ambula-
17 tory surgical center under clause (i).

18 “(iii) APPLICATION OF CERTAIN PRO-
19 VISIONS.—The provisions of section 1128A
20 of the Social Security Act (other than sub-
21 sections (a) and (b) of such section) shall
22 apply to a civil monetary penalty imposed
23 under this subparagraph in the same man-
24 ner as such provisions apply to a civil mon-

1 etary penalty imposed under subsection (a)
2 of such section.

3 “(iv) NO AUTHORITY TO WAIVE OR
4 REDUCE PENALTY.—The Secretary shall
5 not grant or extend any waiver, delay, toll-
6 ing, or other mitigation of a civil monetary
7 penalty for violation of this subsection.

8 “(6) PROVISION OF TECHNICAL ASSISTANCE.—
9 The Secretary shall, to the extent practicable, pro-
10 vide technical assistance relating to compliance with
11 the provisions of this subsection to specified ambula-
12 tory surgical centers requesting such assistance.

13 “(7) DEFINITIONS.—For purposes of this sec-
14 tion:

15 “(A) DISCOUNTED CASH PRICE.—The
16 term ‘discounted cash price’ means the charge
17 that applies to an individual who pays cash, or
18 cash equivalent, for a item or service furnished
19 by an ambulatory surgical center.

20 “(B) GROSS CHARGE.—The term ‘gross
21 charge’ means the charge for an individual item
22 or service that is reflected on a specified sur-
23 gical center’s chargemaster, absent any dis-
24 counts.

1 “(C) GROUP HEALTH PLAN; GROUP
2 HEALTH INSURANCE COVERAGE; INDIVIDUAL
3 HEALTH INSURANCE COVERAGE.—The terms
4 ‘group health plan’, ‘group health insurance
5 coverage’, and ‘individual health insurance cov-
6 erage’ have the meaning given such terms in
7 section 2791 of the Public Health Service Act.

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

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

18 “(F) SPECIFIED AMBULATORY SURGICAL
19 CENTER.—The term ‘specified ambulatory sur-
20 gical center’ means an ambulatory surgical cen-
21 ter with respect to which a hospital (or any per-
22 son with an ownership or control interest (as
23 defined in section 1124(a)(3) of the Social Se-
24 curity Act) in a hospital) is a person with an
25 ownership or control interest (as so defined).

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

6 “(8) 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. 306. STRENGTHENING HEALTH COVERAGE TRANS-**
11 **PARENCY REQUIREMENTS.**

12 (a) TRANSPARENCY IN COVERAGE.—Section
13 1311(e)(3)(C) of the Patient Protection and Affordable
14 Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

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

17 “(i) IN GENERAL.—The Exchange”;

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

19 (A) by striking “participating provider”
20 and inserting “provider”;

21 (B) by inserting “shall include the infor-
22 mation specified in clause (ii) and” after “such
23 information”;

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

4 (D) by striking “and such other” and all
5 that follows through the period and inserting
6 “or, at the option such individual, through a
7 paper or phone disclosure (as selected by such
8 individual and provided at no cost to such indi-
9 vidual) that meets such requirements as the
10 Secretary may specify.”; and

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

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

19 “(I) If such provider is a partici-
20 pating provider with respect to such
21 item or service, the in-network rate
22 (as defined in subparagraph (F)) for
23 such item or service.

24 “(II) If such provider is not de-
25 scribed in subclause (I), the maximum

1 allowed dollar amount for such item
2 or service.

3 “(III) The amount of cost shar-
4 ing (including deductibles, copay-
5 ments, and coinsurance) that the indi-
6 vidual will incur for such item or serv-
7 ice (which, in the case such item or
8 service is to be furnished by a pro-
9 vider described in subclause (II), shall
10 be calculated using the maximum
11 amount described in such subclause).

12 “(IV) The amount the individual
13 has already accumulated with respect
14 to any deductible or out-of-pocket
15 maximum under the plan (broken
16 down, in the case separate deductibles
17 or maximums apply to separate indi-
18 viduals enrolled in the plan, by such
19 separate deductibles or maximums, in
20 addition to any cumulative deductible
21 or maximum).

22 “(V) In the case such plan im-
23 poses any frequency or volume limita-
24 tions with respect to such item or
25 service (excluding medical necessity

1 determinations), the amount that such
2 individual has accrued towards such
3 limitation with respect to such item or
4 service.

5 “(VI) Any prior authorization,
6 concurrent review, step therapy, fail
7 first, or similar requirements applica-
8 ble to coverage of such item or service
9 under such plan.

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

14 “(I) is based on an internet
15 website;

16 “(II) provides for real-time re-
17 sponses to requests described in such
18 clause;

19 “(III) is updated in a manner
20 such that information provided
21 through such tool is timely and accu-
22 rate;

23 “(IV) allows such a request to be
24 made with respect to an item or serv-
25 ice furnished by—

1 “(aa) a specific provider
2 that is a participating provider
3 with respect to such item or serv-
4 ice;

5 “(bb) all providers that are
6 participating providers with re-
7 spect to such plan and such item
8 or service; or

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

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

14 “(aa) the billing code for
15 such item or service; or

16 “(bb) through use of a de-
17 scriptive term for such item or
18 service to produce a list of billing
19 code options from which the indi-
20 vidual selects to indicate the sub-
21 ject matter items or services; and

22 “(VI) holds a member harmless
23 for the amount of any difference in
24 excess of the amount of the individ-
25 ual’s responsibility generated by the

1 self-service tool and the amount ulti-
2 mately billed or charged to the indi-
3 vidual.”.

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

8 “(E) RATE AND PAYMENT INFORMA-
9 TION.—

10 “(i) IN GENERAL.—Not later than
11 January 1, 2028, and every month there-
12 after, each health plan shall submit to the
13 Exchange, the Secretary, the State insur-
14 ance commissioner, and make available to
15 the public, the rate and payment informa-
16 tion described in clause (ii) in accordance
17 with clause (iii).

18 “(ii) RATE AND PAYMENT INFORMA-
19 TION DESCRIBED.—For purposes of clause
20 (i), the rate and payment information de-
21 scribed in this clause is, with respect to a
22 health plan, the following:

23 “(I) With respect to each item or
24 service for which benefits are available
25 under such plan (expressed as a dollar

1 amount), including prescription drugs,
2 identified by CPT, HCPCS, DRG,
3 NDC, or other applicable nationally
4 recognized identifier, including any
5 applicable code modifiers, and accom-
6 panied by a brief description of the
7 item or service, the in-network rate in
8 effect as of the date of the submission
9 of such information with each pro-
10 vider (identified by national provider
11 identifier) that is a participating pro-
12 vider with respect to such item or
13 service, other than such a rate in ef-
14 fect with a provider—

15 “(aa) that has submitted no
16 claims; and

17 “(bb) expects to receive no
18 claims in the then applicable cal-
19 endar year for such item or serv-
20 ices to such plan.

21 “(II) With respect to each drug
22 (identified by National Drug Code, J-
23 code, or other commonly recognized
24 billing code used for drugs) for which
25 benefits are available under such plan:

1 “(aa) The in-network rate
2 (expressed as a dollar amount),
3 including the individual and total
4 amounts for any bundled rates,
5 in effect as of the first day of the
6 month in which such information
7 is made public with each provider
8 that is a participating provider
9 with respect to such drug.

10 “(bb) The historical net
11 price paid by such plan (net of
12 rebates, discounts, and price con-
13 cessions) (expressed as a dollar
14 amount) for such drug dispensed
15 or administered during the 90-
16 day period beginning 180 days
17 before such date of submission to
18 each provider that was a partici-
19 pating provider with respect to
20 such drug, broken down by each
21 such provider (identified by na-
22 tional provider identifier), other
23 than such an amount paid to a
24 provider that has submitted no

1 claims for such drug to such
2 plan.

3 “(III) With respect to each item
4 or service for which benefits are avail-
5 able under such plan (expressed as a
6 dollar amount), identified by CPT,
7 DRG, HCPCS, NDC, or other appli-
8 cable nationally recognized identifier,
9 including any applicable code modi-
10 fiers, and accompanied by a brief de-
11 scription of the item or service, the
12 amount billed or charged by the pro-
13 vider, and the amount allowed by the
14 plan, for each such item or service
15 furnished during the 90-day period
16 beginning 180 days before such date
17 of submission by each provider that
18 was not a participating provider with
19 respect to such item or service, broken
20 down by each such provider (identified
21 by national provider identifier), other
22 than items and services with respect
23 to which no claims for such item or
24 service were submitted to such plan
25 during such period.

1 “(iii) MANNER OF SUBMISSION.—Rate
2 and payment information required to be
3 submitted and made available under this
4 subparagraph shall be so submitted and so
5 made available as follows:

6 “(I) Information shall be con-
7 tained in 3 separate machine-readable
8 files corresponding to the information
9 described in each of subclauses (I)
10 through (III) of clause (ii) that meet
11 such requirements as specified by the
12 Secretary through rulemaking, in con-
13 sultation with the Secretaries of
14 Labor and the Treasury to apply com-
15 parable requirements to group health
16 plans and to entities providing benefit
17 management or other third-party ad-
18 ministration services on a contractual
19 basis with a group health plan.

20 “(II) Requirements specified by
21 the Secretary through rulemaking
22 shall ensure that:

23 “(aa) Such files are limited
24 to an appropriate size, are made
25 available in a widely available

1 format that allows for informa-
2 tion contained in such files to be
3 compared across health plans,
4 and are accessible to individuals
5 at no cost and without the need
6 to establish a user account or
7 provider other credentials.

8 “(bb) The rates, amounts,
9 and prices to be disclosed include
10 contractual terms containing cal-
11 culation formulae, pricing meth-
12 odologies, and other information
13 necessary to determine the dollar
14 value of reimbursement.

15 “(cc) Each such file includes
16 each of the following data ele-
17 ments:

18 “(AA) A numerical
19 identifier for the group
20 health plan and/or health in-
21 surance issuer (such as a
22 Health Insurance Oversight
23 System identifier).

24 “(BB) A plain-language
25 description of the item or

1 service (including, for drugs,
2 the proprietary and non-
3 proprietary name assigned).

4 “(CC) The billing code,
5 including any applicable
6 modifiers, associated with
7 such item or service, includ-
8 ing the Healthcare Common
9 Procedure Coding System
10 code, diagnosis-related
11 group, national drug code,
12 or other commonly recog-
13 nized code set.

14 “(DD) The place of
15 service code.

16 “(EE) The National
17 Provider Identifier or pro-
18 vider Tax Identification
19 Number.

20 “(III) The rate and payment in-
21 formation disclosed under subclauses
22 (I) through (III) of clause (ii) shall be
23 separately delineated for each item or
24 service, regardless of whether such
25 item or service is reimbursed as a part

1 of a bundle, episode, or other group-
2 ing of items and services.

3 “(IV) An officer or executive of
4 competent authority shall attest to the
5 accuracy and completeness of infor-
6 mation submitted and made available
7 under this subparagraph. Such attes-
8 tation shall be subject to enforcement
9 under subparagraph (H) and, where
10 applicable, shall be deemed material
11 to payments from the Federal Govern-
12 ment received by the group health
13 plan or health insurance issuer.

14 “(V) Regulations promulgated
15 pursuant to this section shall provide
16 that:

17 “(aa) The Secretary shall
18 audit the three machine-readable
19 files required by subparagraph
20 (E)(ii) posted by no fewer than
21 20 group health plans or health
22 insurance issuers.

23 “(bb) The Secretary of
24 Labor shall audit the three ma-
25 chine-readable files required by

1 subparagraph (E)(ii) posted by
2 no fewer than 200 group health
3 plans or service providers fur-
4 nishing third-party administrator
5 services to a group health plan.

6 “(cc) Findings, conclusions,
7 and enforcement actions taken
8 based on audits of the machine-
9 readable files shall be reported
10 annually to Congress no later
11 than July 1 of the calendar year
12 during which the files were au-
13 dited. Such report to Congress
14 shall be accessible to the public.

15 “(iv) USER GUIDE.—Each health plan
16 shall make available to the public instruc-
17 tions written in plain language explaining
18 how individuals may search for information
19 described in clause (ii) in files submitted in
20 accordance with clause (iii).

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

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

1 “(ii) IN-NETWORK RATE.—The term
2 ‘in-network rate’ means, with respect to a
3 health plan and an item or service fur-
4 nished by a provider that is a participating
5 provider with respect to such plan and
6 item or service, the contracted rate in ef-
7 fect between such plan and such provider
8 for such item or service. If the rate is
9 based on an algorithm, percentage of an-
10 other amount, or other formula or criteria,
11 the health plan also shall disclose such al-
12 gorithm, percentage, formula, or criteria as
13 set forth in its contract and any other
14 terms, schedules, exhibits, data, or other
15 information referenced in any such con-
16 tract as shall be required to determine and
17 disclose the negotiated rate.

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

1 “(H) ENFORCEMENT.—

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

7 “(ii) NOTIFICATION AND REQUEST
8 FOR CORRECTIVE ACTION.—In the case of
9 a health plan that fails to comply with the
10 requirements of this subsection, not later
11 than 30 days after the date on which the
12 Secretary determines such failure exists,
13 the Secretary shall submit to such health
14 plan a notification of such determination,
15 which shall include a request for a correc-
16 tive action plan to comply with such re-
17 quirements.

18 “(iii) CIVIL MONETARY PENALTY.—A
19 health plan that has received a request for
20 a corrective action plan under clause (ii)
21 and fails to comply with the requirements
22 of this subsection by the date that is 90
23 days after such request is made shall be
24 subject to a civil monetary penalty of an
25 amount specified by the Secretary for each

1 day (beginning with the day on which the
2 Secretary first determined that such lab-
3 oratory was failing to comply with such
4 paragraph) during which such failure was
5 ongoing. Such amount shall not exceed
6 \$300 per member per day or \$10,000,000,
7 whichever is lesser.

8 “(I) RULEMAKING.—The Secretary shall
9 implement subparagraphs (E) through (H)
10 through notice and comment rulemaking in ac-
11 cordance with section 553 of title 5, United
12 States Code.”.

13 (c) EFFECTIVE DATE.—

14 (1) IN GENERAL.—The amendments made by
15 subsections (a) and (b) shall apply beginning Janu-
16 ary 1, 2027.

17 (2) CONTINUED APPLICABILITY OF RULES FOR
18 PREVIOUS YEARS.—Nothing in the amendments
19 made by this section may be construed as affecting
20 the applicability of the rule entitled “Transparency
21 in Coverage” published by the Department of the
22 Treasury, the Department of Labor, and the De-
23 partment of Health and Human Services on Novem-
24 ber 12, 2020 (85 Fed. Reg. 72158) before January
25 1, 2027.

1 **SEC. 307. INCREASING GROUP HEALTH PLAN ACCESS TO**
2 **HEALTH DATA.**

3 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
4 TION.—

5 (1) IN GENERAL.—Paragraph (2) of section
6 408(b) of the Employee Retirement Income Security
7 Act of 1974 (29 U.S.C. 1108(b)) is amended by
8 adding at the end the following new subparagraphs:

9 “(C) No contract or arrangement for serv-
10 ices, and no extension or renewal of such con-
11 tract or arrangement, between a group health
12 plan (as that term is defined in section 733(a)
13 of this title) and party in interest, including a
14 health care provider (which for purposes of this
15 subparagraph, includes a health care facility),
16 network or association of providers, service pro-
17 vider offering access to a network of providers,
18 or third-party administrator (collectively re-
19 ferred to as ‘Covered Service Providers’), is rea-
20 sonable within the meaning of this paragraph
21 unless such contract or arrangement—

22 “(i) allows the responsible plan fidu-
23 ciary (as that term is defined in subpara-
24 graph (B)(ii)(I)(ee)) access to all claims
25 and encounter information or data, and
26 any documentation supporting claim pay-

1 ments, including, but not limited to, med-
2 ical records and policy documents, or infor-
3 mation or data described in section
4 724(a)(1)(B) to—

5 “(I) enable such entity to comply
6 with the terms of the plan and any
7 applicable law; and

8 “(II) determine the accuracy or
9 reasonableness of payment; and

10 “(ii) does not—

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

15 “(II) limit the volume of claims
16 and encounter information or data
17 that the group health plan, the plan
18 sponsor, the plan administrator, or a
19 business associate of such plan may
20 access during an audit or pursuant to
21 any request for such information or
22 data;

23 “(III) limit the disclosure of prie-
24 ing terms for value-based payment ar-

1 rangements or capitated payment ar-
2 rangements, including—

3 “(aa) payment calculations
4 and formulas;

5 “(bb) quality measures;

6 “(cc) contract terms;

7 “(dd) payment amounts;

8 “(ee) measurement periods
9 for all incentives; and

10 “(ff) other payment meth-
11 odologies used by an entity, in-
12 cluding a health care provider
13 (including a health care facility),
14 network or association of pro-
15 viders, service provider offering
16 access to a network of providers,
17 or third-party administrator;

18 “(IV) limit the disclosure of over-
19 payments and overpayment recovery
20 terms;

21 “(V) limit the right of the group
22 health plan, the plan sponsor, or the
23 plan administrator of such plan to se-
24 lect an auditor or define audit scope
25 or frequency;

1 “(VI) otherwise limit or unduly
2 delay the group health plan, the plan
3 sponsor, the plan administrator, or a
4 business associate of such plan from
5 accessing claims and encounter infor-
6 mation or data in a daily batch;

7 “(VII) limit the disclosure of fees
8 charged to the group health plan re-
9 lated to plan administration and
10 claims processing, including renegoti-
11 ation fees, access fees, repricing fees,
12 or enhanced review fees;

13 “(VIII) limit the right of the
14 group health plan, the plan sponsor,
15 or the plan administrator to request
16 action on any suspect claim payments;
17 or

18 “(IX) limit public disclosure of
19 de-identified or aggregate information.

20 “(D)(i) Covered Service Providers shall
21 provide information or data under this para-
22 graph in a manner consistent with the privacy
23 and security regulations promulgated under the
24 Health Insurance Portability and Accountability

1 Act (referred to in this subparagraph as
2 ‘HIPAA’).

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

8 “(iii) Nothing in this subparagraph shall
9 be construed to modify the requirements for the
10 creation, receipt, maintenance, or transmission
11 of protected health information under the
12 HIPAA privacy regulation (as defined in section
13 1180(b)(3) of the Social Security Act) as they
14 apply directly or indirectly to an entity pursu-
15 ant to this paragraph.

16 “(iv) This subparagraph shall not be read
17 to abridge or limit the disclosure requirements
18 under this paragraph or to impose additional
19 privacy or security requirements on Covered
20 Service Providers or plan sponsors.

21 “(E) A group health plan receiving infor-
22 mation or data under this paragraph may dis-
23 close such information only in a manner that is
24 consistent with the Health Insurance Port-
25 ability and Accountability Act (HIPAA) and the

1 privacy and security regulations promulgated
2 thereunder, regardless of their direct or indirect
3 applicability to the plan or any entities that
4 could be or are business associates.

5 “(F) Information made available under
6 this section shall conform to the following
7 standards:

8 “(i) All claims from a healthcare pro-
9 vider shall be made to the group health
10 plan in accordance with transaction stand-
11 ards adopted by regulation under HIPAA,
12 as follows:

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

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

21 “(III) The files shall be unmodi-
22 fied copies of the files sent from the
23 provider. In the event that paper
24 claims are sent by the provider, they
25 shall be converted to the appropriate

1 standard electronic format. Files shall
2 be accessible to the plan at no cost to
3 the group health plan.

4 “(ii) All claim payment (or EFT, elec-
5 tronic funds transfer) and electronic remit-
6 tance advice (ERA) notices sent by a Cov-
7 ered Service Provider shall be made avail-
8 able to the group health plan as ASC
9 X12N 835 files in accordance with stand-
10 ards adopted by regulation under HIPAA.
11 The files shall be unmodified copies of the
12 files sent by the Covered Service Provider
13 to the healthcare provider. Files shall be
14 accessible at no cost to the group health
15 plan.

16 “(iii) The contractual terms con-
17 taining calculation formulae, pricing meth-
18 odologies, and other information used to
19 determine the dollar value of reimburse-
20 ment.

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

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

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

9 “(13) In the case of an agreement between a
10 group health plan (as defined in section 733(a)), the
11 plan sponsor of such plan (as defined in section
12 3(16)(B)), or the plan administrator of such plan
13 (as defined in section 3(16)(A)) and a health care
14 provider (which, for purposes of this paragraph, in-
15 cludes a health care facility), network or association
16 of providers, service provider offering access to a
17 network or association of providers, or third-party
18 administrator, that violates the provisions of section
19 724, the Secretary may assess a civil penalty against
20 such provider, network or association, service pro-
21 vider offering access to a network or association of
22 providers, third-party administrator, or other service
23 provider in the amount of \$10,000 for each day dur-
24 ing which such violation continues. Such penalty

1 shall be in addition to other penalties as may be pre-
2 scribed by law.”.

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

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

8 (1) unduly delays or limits a group health plan
9 (as defined in section 733(a)), the plan sponsor of
10 such plan (as defined in section 3(16)(B)), or the
11 plan administrator of such plan (as defined in sec-
12 tion 3(16)(A)) from accessing the claims and en-
13 counter information or data described in section
14 724(a)(1)(B); or

15 (2) violates the requirements of section
16 408(b)(2)(C).”.

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

21 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
22 ITY INFORMATION.—Section 724(a)(3) of the Employee
23 Retirement Income Security Act of 1974 (29 U.S.C.
24 1185m(a)(3)) is amended to read as follows:

25 “(3) ATTESTATION.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (C), a group health plan or health insur-
3 ance issuer offering group health insurance cov-
4 erage shall annually submit to the Secretary an
5 attestation that such plan or issuer of such cov-
6 erage is in compliance with the requirements of
7 this subsection. Such attestation shall also in-
8 clude a statement verifying that—

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

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

24 “(B) LIMITATION ON SUBMISSION.—Sub-
25 ject to clause (ii), a group health plan or issuer

1 offering group health insurance coverage may
2 not enter into an agreement with a third-party
3 administrator or other service provider to sub-
4 mit the attestation required under subpara-
5 graph (A).

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

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

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

1 plan (as defined in section 3(16)(B)), the plan adminis-
2 trator of such plan (as defined in section 3(16)(A)), or
3 a business associate of such plan (as defined in section
4 160.103 of title 45, Code of Federal Regulations), (or
5 health insurance issuer offering group health insurance
6 coverage in connection with such a plan), and a health
7 care provider, network or association of providers, third-
8 party administrator, service provider offering access to a
9 network of providers, or any other third party (each re-
10 ferred to as a ‘health plan service provider’) is permissible
11 if such agreement limits (or delays beyond the applicable
12 reporting period described in subsection (b)(1)) the dislo-
13 sure of information to group health plans in such a man-
14 ner that prevents such plan, issuer, or entity from pro-
15 viding the information described in subsection (b).

16 “(b) REQUIRED DISCLOSURES.—

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

1 “(A) The information described in section
2 724(a)(1)(B).

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

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

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

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

19 “(2) PRIVACY REQUIREMENTS.—

20 “(A) IN GENERAL.—Health plan service
21 providers shall provide the information or data
22 under paragraph (1) consistent with the pri-
23 vacy, security, and breach notification regula-
24 tions at parts 160 and 164 of title 45, Code of
25 Federal Regulations, promulgated under sub-

1 title F of the Health Insurance Portability and
2 Accountability Act of 1996, subtitle D of the
3 Health Information Technology for Clinical
4 Health Act of 2009, and section 1180 of the
5 Social Security Act, and shall restrict the use
6 and disclosure of such information according to
7 such privacy, security, and breach notification
8 regulations. An entity that receives a disclosure
9 from a party in interest pursuant to subpara-
10 graph (B) or (C) shall comply with the privacy
11 and security regulations promulgated under
12 HIPAA.

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

19 “(C) RULE OF CONSTRUCTION.—Nothing
20 in this section shall be construed to modify the
21 requirements for the creation, receipt, mainte-
22 nance, or transmission of protected health in-
23 formation under the HIPAA privacy regulations
24 (45 CFR parts 160 and 164, subparts A and
25 E).

1 “(3) DISCLOSURE AND REDISCLOSURE.—

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

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

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

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

23 “(C) FAILURE TO PROVIDE.—The obliga-
24 tion to provide information pursuant to this
25 subsection shall exist notwithstanding the pres-

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

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

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

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

23 “(ii) Prescription drug claims shall be
24 in the National Council for Prescription
25 Drug Programs (NCPDP) format, as

1 transmitted by the provider, or in the case
2 of paper claims, converted to the NCPDP
3 electronic format.

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

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

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

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

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

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

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

20 (2) PENALTY.—

21 (A) IN GENERAL.—Section 502(a) of the
22 Employee Retirement Income Security Act of
23 1974 (29 U.S.C. 1132(a)) is amended by add-
24 ing at the end the following new paragraph:

1 beyond the applicable reporting period described in sub-
2 section (b)(1)) the disclosure of information to group
3 health plans in such a manner that prevents such plan,
4 issuer, or entity from providing the information described
5 in subsection (b).

6 “(b) REQUIRED DISCLOSURES.—

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

15 “(A) The information described in section
16 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
17 119(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 to accurately assess, verify, and en-
2 sure compliance with the terms of any contrac-
3 tual and subcontractual agreement governing
4 the reimbursement amounts.

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

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

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

1 payments, and any other reimbursement or pay-
2 ment models, where the group health plan paid
3 fees, incurred obligations, or made payments in
4 connection with the group health plan related to
5 such arrangements.

6 “(2) PRIVACY REQUIREMENTS.—

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

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

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

15 “(3) DISCLOSURE AND REDISCLOSURE.—

16 “(A) IN GENERAL.—A group health plan
17 that is a self-funded, non-Federal governmental
18 plan receiving information under paragraph (1)
19 may 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 as defined in section
23 160.103 of title 45, Code of Federal Regu-
24 lations (or successor regulations); or

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

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

17 “(C) FAILURE TO PROVIDE.—The obliga-
18 tion to provide information pursuant to this
19 subsection shall exist notwithstanding the pres-
20 ence of any formal data-sharing agreement be-
21 tween the parties. Failure to provide the re-
22 quired information as specified shall constitute
23 a violation of this Act and the Secretary shall
24 initiate enforcement action under section
25 2723(b) (42 U.S.C. 300gg-22(b)) within 90

1 days of becoming aware of a violation of this
2 section, except that nothing in this section shall
3 be construed to limit the Secretary's existing
4 authority under this Act.

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

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

13 “(i) Institutional, professional, and
14 dental claims and adjustments to these
15 claims shall be provided to the group
16 health plan that is a self-funded, non-Fed-
17 eral governmental plan in the ASC X12N
18 837 format.

19 “(ii) Prescription drug claims shall be
20 in the National Council for Prescription
21 Drug Programs (NCPDP) format.

22 “(iii) The files shall be unmodified
23 copies of the files sent from the provider.
24 In the event that paper claims are sent by
25 the provider, they shall be converted to the

1 appropriate standard electronic format.
2 Such data shall be provided at no cost to
3 the group health plan.

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

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

22 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
23 provision in an agreement that unduly delays or limits a
24 group health plan that is a self-funded, non-Federal gov-
25 ernmental plan’s access to information described in this

1 section or that restricts the format or timing of the provi-
2 sion of such information in a manner that is inconsistent
3 with the requirements of this section shall be prohibited
4 and, if a self-funded, non-Federal governmental plan en-
5 ters into such agreement, shall be deemed void as against
6 public policy.

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

14 “(4) ENFORCEMENT AUTHORITY RELATING TO
15 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
16 standing any provisions to the contrary, the Sec-
17 retary may assess a penalty against a health plan
18 service provider, as defined in section 2799A–12(a)
19 (42 U.S.C. 300gg–121(a)), of \$100,000 per day for
20 each violation of such section, pursuant to substan-
21 tially similar processes and procedures as those set
22 forth in section 2723(b)(2)(D) through (G) (42
23 U.S.C. 300gg–121(b)(2)(D) through (G)).”

1 **SEC. 309. STATE PREEMPTION ONLY IN EVENT OF CON-**
2 **FLECT.**

3 The provisions of sections 302 through 305 (includ-
4 ing the amendments made by such sections) shall not su-
5 percede any provision of State law which establishes, im-
6 plements, or continues in effect any requirement or prohi-
7 bition related to health care price transparency, including
8 hospital, clinical diagnostic laboratory tests, imaging serv-
9 ices, and ambulatory surgical center, except to the extent
10 that such requirement or prohibition prevents the applica-
11 tion of a requirement or prohibition of such sections (or
12 amendment). Nothing in this section shall be construed
13 to affect group health plans established under the Em-
14 ployee Retirement Income Security Act of 1974, or alter
15 the application of section 514 of such Act (29 U.S.C.
16 1144).

17 **SEC. 310. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

18 (a) PHSA AMENDMENTS.—

19 (1) EMERGENCY SERVICES.—Section 2799A–
20 1(f)(1)(C) of the Public Health Service Act (42
21 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
22 follows:

23 “(C) A good faith estimate of the amount
24 the plan or coverage is responsible for paying
25 for items and services included in the estimate
26 described in subparagraph (B), including a

1 plain language description of each item or serv-
2 ice and all applicable billing codes for each item
3 or service, including modifiers, using standard
4 and commonly recognized billing code sets that
5 are clearly identified.”.

6 (2) EXPLANATION OF BENEFITS.—Section
7 2799A–1 of the Public Health Service Act (42
8 U.S.C. 300gg–111) is amended by adding at the end
9 the following:

10 “(g) EXPLANATION OF BENEFITS.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after January 1, 2027, each group health
13 plan, or a health insurance issuer offering group or
14 individual health insurance coverage shall, within 45
15 days of receiving any request for payment for an
16 item or service under the plan, provide to the partic-
17 ipant, beneficiary, or enrollee (through mail or elec-
18 tronic means, as requested by the participant, bene-
19 ficiary, or enrollee) a notification (in clear and un-
20 derstandable language and utilizing substantially the
21 same format as the advanced explanation of benefits
22 required by subsection (f) to enable comparison) in-
23 cluding the following:

24 “(A) Whether or not the provider or facil-
25 ity is a participating provider or a participating

1 facility with respect to the plan or coverage
2 with respect to the furnishing of such item or
3 service.

4 “(B) An itemized explanation of benefits
5 that includes the following:

6 “(i) A plain language description of
7 each item or service.

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

12 “(iii) The amount the plan or cov-
13 erage is responsible for paying for each
14 item or service.

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

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

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

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

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

12 (b) IRC AMENDMENTS.—

13 (1) EMERGENCY SERVICES.—Section
14 9816(f)(1)(C) of the Internal Revenue Code of 1986
15 is amended to read as follows:

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

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

4 “(g) EXPLANATION OF BENEFITS.—

5 “(1) IN GENERAL.—For plan years beginning
6 on or after January 1, 2027, each group health plan
7 shall, within 45 days of receiving any request for
8 payment for an item or service under the plan, pro-
9 vide to the participant or beneficiary (through mail
10 or electronic means, as requested by the participant
11 or beneficiary) a notification (in clear and under-
12 standable language and utilizing substantially the
13 same format as the advanced explanation of benefits
14 required by subsection (f) to enable comparison) in-
15 cluding the following:

16 “(A) Whether or not the provider or facil-
17 ity is a participating provider or a participating
18 facility with respect to the plan with respect to
19 the furnishing of such item or service.

20 “(B) An itemized explanation of benefits
21 that includes the following:

22 “(i) A plain language description of
23 each item or service.

24 “(ii) All applicable billing codes for
25 each item or service, including modifiers,

1 using standard and commonly recognized
2 billing code sets that are clearly identified.

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

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

9 “(v) The amount that the participant
10 or beneficiary has incurred toward meeting
11 the limit of the financial responsibility (in-
12 cluding with respect to deductibles and
13 out-of-pocket maximums) under the plan
14 (as of the date of such 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 503 of the Employee Retirement Income Secu-
21 rity Act of 1974 or regulations 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 (c) ERISA AMENDMENTS.—

2 (1) EMERGENCY SERVICES.—Section
3 716(f)(1)(C) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is
5 amended to read as follows:

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

15 (2) EXPLANATION OF BENEFITS.—Section 716
16 of the Employee Retirement Income Security Act of
17 1974 (29 U.S.C. 1185e) is amended by adding at
18 the end the following:

19 “(g) EXPLANATION OF BENEFITS.—

20 “(1) IN GENERAL.—For plan years beginning
21 on or after January 1, 2027, each group health plan
22 or health insurance issuer offering group health in-
23 surance coverage shall, within 45 days of receiving
24 any request for payment for an item or service
25 under the plan, provide to the participant or bene-

1 beneficiary (through mail or electronic means, as re-
2 requested by the participant or beneficiary) a notifica-
3 tion (in clear and understandable language and uti-
4 lizing substantially the same format as the advanced
5 explanation of benefits required by subsection (f) to
6 enable comparison) including the following:

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

12 “(B) An itemized explanation of benefits
13 that includes the following:

14 “(i) A plain language description of
15 each item or service.

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

20 “(iii) The amount the plan or cov-
21 erage is responsible for paying for each
22 item or service.

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

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

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

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

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

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

20 **SEC. 311. PROVISION OF ITEMIZED BILLS.**

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

1 **“SEC. 2799B-10. PROVIDER REQUIREMENTS FOR ITEMIZED**
2 **BILLS.**

3 “(a) REQUIREMENTS.—

4 “(1) ITEMIZED BILL AND OTHER INFORMATION
5 REQUIRED.—

6 “(A) IN GENERAL.—A health care provider
7 or health care facility that requests payment
8 from an individual after providing a health care
9 item or service to the patient shall include with
10 such request a written, itemized bill of the cost
11 of each reasonably expected item or service the
12 health care provider or health care facility pro-
13 vided to the individual, including telehealth vis-
14 its or visits by other electronic means. The
15 health care provider or health care facility shall
16 provide the itemized bill not later than 30 days
17 after the health care provider or health care fa-
18 cility received a final payment on the provided
19 service or supply from a third party.

20 “(B) REQUIRED INFORMATION.—For each
21 item or service provided by the health care pro-
22 vider or facility or for which the health care
23 provider or facility is billing the individual, the
24 itemized bill must include—

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

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

6 “(iii) the price and billed amount, if
7 different, of each distinct health care item
8 or service or if the provider or facility is
9 offering binding, all-in prices for bundled
10 items and services, the total binding price
11 for bundled items and services and billed
12 amount;

13 “(iv) any payments made to the
14 health care provider or health care facility
15 by or on behalf of the individual (including
16 payments by any health plan or insurance)
17 for any health care item or service covered
18 in the itemized bill;

19 “(v) information about the availability
20 of language-assistance services for individ-
21 uals with limited English proficiency
22 (LEP);

23 “(vi) the identification of an office or
24 individual at the health care provider or
25 health care facility, including phone num-

1 ber and email address, that shall be able to
2 discuss the specific details of the itemized
3 statement and be authorized to make ap-
4 propriate changes thereto; and

5 “(vii) information about the health
6 care provider’s or health care facility’s
7 charity care policies and instructions on
8 how to apply for charity care.

9 “(2) COLLECTIONS ACTIONS.—

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

13 “(i) for any provided health care item
14 or service unless the health care provider
15 or health care facility has complied with
16 paragraph (1); or

17 “(ii) with respect to any items or serv-
18 ices for which the amount appearing on an
19 itemized bill described above in paragraph
20 (1) exceeds the amount disclosed pursuant
21 to Federal health care price transparency
22 regulations, including part 180 of title 45,
23 Code of Federal Regulations, or provided
24 in a good faith estimate that complies with
25 section 2799B–6 of this Act and section

1 149.610 of title 45, Code of Federal Regu-
2 lations, or another good faith estimate pro-
3 vided by a health care entity covered under
4 this section but not otherwise covered
5 under such section 2799B-6 unless the
6 provider or facility documents that the ad-
7 ditional items or services were medically
8 necessary due to unforeseen complications
9 or a patient-initiated change, and could not
10 reasonably have been anticipated.

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

16 “(b) FAILURE TO COMPLY.—

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

22 “(2) PRESUMPTION IN FAVOR OF INDI-
23 VIDUAL.—If a health care provider or health care fa-
24 cility fails to comply with the requirements of this
25 section, the presumption shall be that charges were

1 substantially in excess of the good faith estimate (as
2 set forth in section 2799B–6) for the purpose of any
3 patient-provider dispute, including in accordance
4 with section 2799B–7 and regulations promulgated
5 thereunder.

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

10 **TITLE IV—PROTECTING PA-**
11 **TIENT ACCESS TO CANCER**
12 **AND COMPLEX THERAPIES**

13 **SEC. 401. SHORT TITLE.**

14 This title may be cited as the “Protecting Patient Ac-
15 cess to Cancer and Complex Therapies Act”.

16 **SEC. 402. REBATE BY MANUFACTURERS FOR SELECTED**
17 **DRUGS AND BIOLOGICAL PRODUCTS SUB-**
18 **JECT TO MAXIMUM FAIR PRICE NEGOTIA-**
19 **TION.**

20 (a) MAINTAINING PAYMENTS UNDER PART B BASED
21 ON ASP+6.—Section 1847A(b)(1)(B) of the Social Secu-
22 rity Act (42 U.S.C. 1395w–3a(b)(1)(B)) is amended by
23 striking “or in the case of such a drug or biological prod-
24 uct that is a selected drug” and all that follows through
25 the semicolon and inserting a semicolon.

1 (b) REBATE BY MANUFACTURERS FOR SELECTED
2 DRUGS AND BIOLOGICAL PRODUCTS SUBJECT TO MAX-
3 IMUM FAIR PRICE NEGOTIATION.—

4 (1) IN GENERAL.—Section 1847A of the Social
5 Security Act (42 U.S.C. 1395w–3a) is amended—

6 (A) by redesignating subsection (j) as sub-
7 section (k); and

8 (B) by inserting after subsection (i) the
9 following new subsection:

10 “(j) REBATE BY MANUFACTURERS FOR SELECTED
11 DRUGS AND BIOLOGICAL PRODUCTS SUBJECT TO MAX-
12 IMUM FAIR PRICE NEGOTIATION.—

13 “(1) REQUIREMENTS.—

14 “(A) SECRETARIAL PROVISION OF INFOR-
15 MATION.—Not later than 6 months after the
16 end of each calendar quarter beginning on or
17 after the first day of the initial price applica-
18 bility period (as defined in section 1191(b)(2)),
19 the Secretary shall, for each selected drug (as
20 defined in section 1192(e)) of each manufac-
21 turer with an agreement under section 1193 for
22 which a maximum fair price is in effect and for
23 which payment may be made under this part,
24 report to each manufacturer of such selected

1 drug the following for such calendar quarter
2 during such price applicability period:

3 “(i) Information on the total number
4 of units of the billing and payment code
5 for such selected drug furnished under this
6 part during such calendar quarter.

7 “(ii) Information on the sum of—

8 “(I) the amount (if any) by
9 which—

10 “(aa) the ASP+6 payment
11 amount (as defined in paragraph
12 (5)) for such drug and calendar
13 quarter, less the ASP+6 coinsur-
14 ance amount for such drug and
15 calendar quarter; exceeds

16 “(bb) the MFP+6 payment
17 amount (as so defined) for such
18 drug and calendar quarter, less
19 the MFP+6 coinsurance amount
20 for such drug and calendar quar-
21 ter; and

22 “(II) the amount (if any) by
23 which—

24 “(aa) the ASP+6 coinsur-
25 ance amount (as defined in para-

1 graph (5)) for such drug and cal-
2 endar quarter; exceeds

3 “(bb) the MFP+6 coinsur-
4 ance amount (as so defined) for
5 such drug and calendar quarter.

6 “(iii) The rebate amount specified
7 under subparagraph (B) for such drug and
8 calendar quarter.

9 “(B) MANUFACTURER REQUIREMENT.—

10 For each calendar quarter beginning on or after
11 the first day of the initial price applicability pe-
12 riod (as defined in section 1191(b)(2)), the
13 manufacturer of a selected drug shall, for such
14 drug, not later than 30 days after the date of
15 receipt from the Secretary of the information
16 described in subparagraph (A) for such cal-
17 endar quarter, provide to the Secretary a rebate
18 that is equal to the amount specified in sub-
19 paragraph (A)(ii) multiplied by the number of
20 units specified in subparagraph (A)(i) for such
21 drug for such calendar quarter. The rebate re-
22 quired under this subparagraph shall be in ad-
23 dition to any other rebates required under this
24 title or title XIX, including the payments re-
25 quired under subsections (h) and (i).

1 “(2) CALCULATION OF BENEFICIARY COINSUR-
2 ANCE BASED ON MFP+6.—

3 “(A) IN GENERAL.—Subject to subpara-
4 graph (B), in the case of a selected drug with
5 respect to which a rebate is paid under this
6 subsection—

7 “(i) the amount of any coinsurance
8 applicable under this part to an individual
9 to whom such drug is furnished during a
10 calendar quarter shall be equal to the
11 MFP+6 coinsurance amount; and

12 “(ii) the amount of such coinsurance
13 for such calendar quarter shall be applied
14 as a percent, as determined by the Sec-
15 retary, to the payment amount that would
16 otherwise apply under subsection
17 (b)(1)(B).

18 “(B) CLARIFICATION REGARDING APPLICA-
19 TION OF INFLATION REBATE.—If a rebate is re-
20 quired under subsection (i) with respect to a se-
21 lected drug for a calendar quarter, the lesser of
22 the amount of coinsurance computed under sub-
23 paragraph (A) or the coinsurance computed
24 under subsection (i)(5) shall apply for such
25 drug and calendar quarter.

1 “(3) REBATE DEPOSITS.—Amounts paid as re-
2 bates under paragraph (1)(B) shall be deposited into
3 the Federal Supplementary Medical Insurance Trust
4 Fund established under section 1841.

5 “(4) CIVIL MONEY PENALTY.—The civil money
6 penalty established under paragraph (7) of sub-
7 section (i) shall apply to the failure to comply with
8 this subsection in the same manner as such penalty
9 applies to failures to comply with the requirements
10 under paragraph (1)(B) of subsection (i).

11 “(5) DEFINITIONS.—In this subsection, with re-
12 spect to a selected drug for a calendar quarter dur-
13 ing a price applicability period:

14 “(A) ASP+6 COINSURANCE AMOUNT.—
15 The ‘ASP+6 coinsurance amount’ is equal to
16 20 percent of the ASP+6 payment amount.

17 “(B) ASP+6 PAYMENT AMOUNT.—The
18 ‘ASP+6 payment amount’ is equal to 106 per-
19 cent of the amount determined under para-
20 graph (4) of subsection (b) for such drug dur-
21 ing such calendar quarter.

22 “(C) MFP+6 COINSURANCE AMOUNT.—
23 The ‘MFP+6 coinsurance amount’ is equal to
24 20 percent of the MFP+6 payment amount.

1 “(D) MFP+6 PAYMENT AMOUNT.—The
2 ‘MFP+6 payment amount’ is equal to 106 per-
3 cent of the maximum fair price (as defined in
4 section 1191(c)(2)) applicable for such drug
5 during such calendar quarter.

6 “(6) CLARIFICATION.—Nothing in part E of
7 title XI or this subsection shall be construed to re-
8 quire a manufacturer to provide selected drugs at
9 maximum fair prices other than through the rebate
10 required under this subsection.”.

11 (2) AMOUNTS PAYABLE; COST-SHARING.—Sec-
12 tion 1833(a)(1) of the Social Security Act (42
13 U.S.C. 1395l(a)(1)) is amended—

14 (A) in subparagraph (G), by striking “sub-
15 section (i)(9)” and inserting “paragraphs (9)
16 and (10) of subsection (i)”;

17 (B) in subparagraph (S), by striking “sub-
18 paragraph (EE)” and inserting “subparagraphs
19 (EE) and (II)”;

20 (C) by striking “and (HH)” and inserting
21 “(HH)”;

22 (D) by inserting before the semicolon at
23 the end the following: “, and (II) with respect
24 to a selected drug (as defined in section
25 1192(c)) that is subject to a rebate under sec-

1 tion 1847A(j), the amounts paid shall be equal
2 to the percent of the payment amount otherwise
3 determined under section 1847A(b)(1)(B) that
4 equals the difference between (i) 100 percent,
5 and (ii) the percent applied under section
6 1847A(j)(2)(A)(ii)”.

7 (3) ASC CONFORMING AMENDMENTS.—Section
8 1833(i) of the Social Security Act (42 U.S.C.
9 1395l(i)) is amended by adding at the end the fol-
10 lowing new paragraph:

11 “(11) In the case of a selected drug (as defined
12 in section 1192(c)), subject to a rebate under section
13 1847A(j) for which payment under this subsection is
14 not packaged into a payment for a service furnished
15 on or after the initial price applicability year for the
16 selected drug under the revised payment system
17 under this subsection, in lieu of calculation of coin-
18 surance and the amount of payment otherwise appli-
19 cable under this subsection, the provisions of section
20 1847(j)(2) and paragraph (1)(II) of subsection (a),
21 shall, as determined appropriate by the Secretary,
22 apply under this subsection in the same manner as
23 such provisions of section 1847A(j)(2) and sub-
24 section (a) apply under such section and sub-
25 section.”.

1 (4) OPPS CONFORMING AMENDMENT.—Section
2 1833(t)(8) of the Social Security Act (42 U.S.C.
3 1395l(t)(8)) is amended by adding at the end the
4 following new subparagraph:

5 “(G) SELECTED DRUGS SUBJECT TO RE-
6 BATE.—In the case of a selected drug (as de-
7 fined in section 1192(c)), subject to a rebate
8 under section 1847A(j) for which payment
9 under this subsection is not packaged into a
10 payment for a covered OPD service (or group
11 of services) furnished on or after the initial
12 price applicability year for the selected drug,
13 and the payment for such drug is the same as
14 the amount for a calendar quarter under sec-
15 tion 1847A(b)(1)(B), under the system under
16 this subsection, in lieu of the calculation of the
17 copayment amount and the amount otherwise
18 applicable under this subsection (other than the
19 application of the limitation described in sub-
20 paragraph (C)), the provisions of section
21 1847A(j)(2) and paragraph (1)(II) of sub-
22 section (a), shall, as determined by the Sec-
23 retary apply under this section in the same
24 manner as such provisions of section

1 1847A(j)(2) and subsection (a) apply under
2 such section and subsection.”.

3 (5) EXCLUSION OF SELECTED DRUG MFP RE-
4 BATES FROM ASP CALCULATION.—Section
5 1847A(c)(3) of the Social Security Act (42 U.S.C.
6 1395w–3a(c)(3)) is amended by striking “subsection
7 (i)” and inserting “subsection (i), subsection (j)”.

8 (6) COORDINATION WITH MEDICAID REBATE IN-
9 FORMATION DISCLOSURES.—Section
10 1927(b)(3)(D)(i) of the Social Security Act (42
11 U.S.C. 1396r–8(b)(3)(D)(i)) is amended by striking
12 “and the rebate” and inserting “and the rebates”.

13 (7) PROVISION OF REBATES.—Section 1193(a)
14 of the Social Security Act (42 U.S.C. 1320f–2(a)) is
15 amended—

16 (A) in paragraph (1), by striking subpara-
17 graph (B) and inserting the following:

18 “(B) by paying rebates in accordance with
19 section 1847A(j);”;

20 (B) in paragraph (2), by striking subpara-
21 graph (B) and inserting the following:

22 “(B) by paying rebates in accordance with
23 section 1847A(j);”;

24 (C) in paragraph (3), by striking subpara-
25 graph (B) and inserting the following:

1 “(B) by paying rebates in accordance with
2 section 1847A(j);”.

3 (c) CONFORMING AMENDMENTS.—

4 (1) Section 1847A(i)(5) of the Social Security
5 Act (42 U.S.C. 1395w-3a(i)(5)) is amended, in the
6 matter preceding subparagraph (A)—

7 (A) by striking “In the case” and inserting
8 “Subsection to subsection (j)(2)(B), in the
9 case”; and

10 (B) by striking “(or, in the case of a part
11 B rebatable drug that is a selected drug (as de-
12 fined in section 1192(c)), the payment amount
13 described in subsection (b)(1)(B) for such
14 drug)”; and

15 (2) Section 1833(a)(1)(EE) of the Social Secu-
16 rity Act (42 U.S.C. 1395l(a)(1)(EE)) is amended—

17 (A) by striking “(or, in the case of a part
18 B rebatable drug that is a selected drug (as de-
19 fined in section 1192(c) for which, the payment
20 amount described in section 1847A(b)(1)(B))
21 for such drug for such quarter”; and

22 (B) by striking “or section
23 1847A(b)(1)(B), as applicable,”.

1 **TITLE V—EXPANDED-ACCESS**
2 **PRESCRIPTION DRUGS**

3 **SEC. 501. EXPANDED-ACCESS PRESCRIPTION DRUGS.**

4 (a) IN GENERAL.—Section 503(b) of the Federal
5 Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) is
6 amended by adding at the end the following:

7 “(6) EXPANDED-ACCESS PRESCRIPTION DRUGS.—

8 “(A) ESTABLISHMENT OF LIST.—The Secretary
9 shall establish and maintain a list of expanded-ac-
10 cess prescription drugs.

11 “(B) DESIGNATION.—The Secretary shall des-
12 ignate such expanded-access prescription drugs
13 based on safety data, evidence of low risk, and suit-
14 ability for assessment in a pharmacy or similar set-
15 ting (such as certain antibiotics for minor infections,
16 antivirals, hormonal therapies, and maintenance
17 drugs for chronic conditions).

18 “(C) DISPENSING AND ADMINISTERING.—Not-
19 withstanding paragraph (1), an expanded-access pre-
20 scription drug may be dispensed and administered
21 by a covered individual after conducting an appro-
22 priate patient assessment consistent with protocols
23 to be issued by the Secretary.

24 “(D) RULEMAKING.—Not later than 120 days
25 after the date of enactment of this paragraph, the

1 Secretary shall issue such regulations through no-
2 tice-and-comment rulemaking as may be necessary
3 to carry out this paragraph, including—

4 “(i) to establish and maintain the list
5 under subparagraph (A); and

6 “(ii) to issue protocols under subparagraph
7 (C).

8 “(E) PREEMPTION.—

9 “(i) IN GENERAL.—Except as provided in
10 clause (ii), no State or political subdivision of a
11 State may establish, enforce, or continue in ef-
12 fect with respect to an expanded-access pre-
13 scription drug any provision of law or legal re-
14 quirement, including with respect to licensure of
15 a covered individual, that is different from, or
16 is in conflict with, any requirement applicable
17 under this paragraph.

18 “(ii) STATE OPT-OUT AUTHORITY.—The
19 prohibition in clause (i) shall not apply in the
20 case of a State (excluding a political subdivision
21 thereof) that has in effect a law explicitly pro-
22 hibiting or limiting the prescribing or dis-
23 pensing of an expanded-access prescription drug
24 by a covered individual.

1 “(F) COVERED INDIVIDUAL DEFINED.—In this
2 paragraph, the term ‘covered individual’ means an
3 individual who is licensed under applicable State law
4 as—

5 “(i) a pharmacist;

6 “(ii) an advanced practice registered nurse;

7 “(iii) an advanced practice provider;

8 “(iv) a physician assistant; or

9 “(v) such other health care professional, as
10 may be specified by the Secretary.”.

11 (b) CONGRESSIONAL REPORT.—Not later than 2
12 years after the date of enactment of this Act, the Sec-
13 retary of Health and Human Services shall submit to Con-
14 gress a report on the implementation of, and State opt-
15 outs under, paragraph (6) of section 503(b) of the Federal
16 Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) (as
17 added by subsection (a)).

18 **SEC. 502. GOVERNMENT SPONSORED PROGRAMS.**

19 (a) REQUIREMENT.—The President shall take such
20 steps as are necessary to ensure that each Government
21 sponsored program includes coverage for expanded-access
22 prescription drugs administered by covered individuals to
23 beneficiaries of the program.

24 (b) PREEMPTION.—A covered individual may admin-
25 ister expanded-access prescription drugs pursuant to sub-

1 section (a) regardless of a provision of law or legal require-
2 ment in the State of the covered individual regarding the
3 licensure or scope-of-practice of the individual.

4 (c) DEFINITIONS.—In this section:

5 (1) The term “covered individual” has the
6 meaning given that term in section 503(b)(6) of the
7 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
8 353(b)(6)), as added by section 501 of this Act.

9 (2) The term “expanded-access prescription
10 drugs” means drugs covered under such section
11 503(b)(6).

12 (3) The term “Government sponsored program”
13 means any coverage described in section
14 5000A(f)(1)(A) of the Internal Revenue Code of
15 1986.

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