

  
(Original Signature of Member)

118TH CONGRESS  
1ST SESSION

**H. R.**

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

IN THE HOUSE OF REPRESENTATIVES

Mr. SMITH of Missouri introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

**A BILL**

To improve price transparency with respect to certain health  
care services, 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 “Health Care Price Transparency Act of 2023”.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE PRICE TRANSPARENCY FOR PATIENTS

- Sec. 101. Requiring certain facilities under the Medicare program to disclose certain information relating to charges and prices.
- Sec. 102. Promoting group health plan price transparency.
- Sec. 103. Oversight of pharmacy benefits manager services.
- Sec. 104. Reports on health care transparency tools and data requirements.
- Sec. 105. Report on integration in Medicare.

TITLE II—FAIR PRICES FOR PATIENTS

- Sec. 201. Limitation on cost sharing to net price amount under Medicare part D.
- Sec. 202. Requiring a separate identification number and an attestation for each off-campus outpatient department of a provider.
- Sec. 203. Parity in Medicare payments for hospital outpatient department services furnished off-campus.

TITLE III—PATIENT-FOCUSED INVESTMENTS

- Sec. 301. Establishing requirements with respect to the use of prior authorization under Medicare Advantage plans.
- Sec. 302. Extension of certain direct spending reductions.

1     **TITLE I—HEALTH CARE PRICE**  
 2     **TRANSPARENCY FOR PATIENTS**

3     **SEC. 101. REQUIRING CERTAIN FACILITIES UNDER THE**  
 4                     **MEDICARE PROGRAM TO DISCLOSE CERTAIN**  
 5                     **INFORMATION RELATING TO CHARGES AND**  
 6                     **PRICES.**

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

10    **“SEC. 1899C. HEALTH CARE PROVIDER PRICE TRANS-**  
 11                     **PARENCY.**

12             “(a) HOSPITAL PRICE TRANSPARENCY.—

13                     “(1) IN GENERAL.—Beginning January 1,  
 14 2026, each specified hospital (as defined in para-  
 15 graph (6)) that receives payment under this title for  
 16 furnishing items and services shall comply with the

1 price transparency requirement described in para-  
2 graph (2).

3 “(2) REQUIREMENT DESCRIBED.—

4 “(A) IN GENERAL.—For purposes of para-  
5 graph (1), the price transparency requirement  
6 described in this paragraph is, with respect to  
7 a specified hospital, that such hospital, in ac-  
8 cordance with a method and format established  
9 by the Secretary under subparagraph (C), com-  
10 pile and make public (without subscription and  
11 free of charge) for each year—

12 “(i) one or more lists, in a format  
13 specified by the Secretary (which may be a  
14 machine-readable format), of the hospital’s  
15 standard charges (including the informa-  
16 tion described in subparagraph (B)) for  
17 each item and service furnished by such  
18 hospital; and

19 “(ii) information in a consumer-  
20 friendly format (as specified by the Sec-  
21 retary)—

22 “(I) on the hospital’s prices (in-  
23 cluding the information described in  
24 subparagraph (B)) for as many of the  
25 Centers for Medicare & Medicaid

1 Services-specified shoppable services  
2 that are furnished by the hospital,  
3 and as many additional hospital-se-  
4 lected shoppable services (or all such  
5 additional services, if such hospital  
6 furnishes fewer than 300 shoppable  
7 services) as may be necessary for a  
8 combined total of at least 300  
9 shoppable services; and

10 “(II) that includes, with respect  
11 to each Centers for Medicare & Med-  
12 icaid Services-specified shoppable  
13 service that is not furnished by the  
14 hospital, an indication that such serv-  
15 ice is not so furnished.

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

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

1 the national drug code, or other identifier  
2 used or approved by the Centers for Medi-  
3 care & Medicaid Services.

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

9 “(iii) The discounted cash price, ex-  
10 pressed as a dollar amount, for each such  
11 item or service when provided in, as appli-  
12 cable, the inpatient setting and outpatient  
13 department setting (or, in the case no dis-  
14 counted cash price is available for an item  
15 or service, the median price charged by the  
16 hospital for such item or service when pro-  
17 vided in such settings for the previous  
18 three years, expressed as a dollar amount).

19 “(iv) Any other information the Sec-  
20 retary may require for purposes of pro-  
21 moting public awareness of specified hos-  
22 pital standard charges or prices in advance  
23 of receiving an item or service from such  
24 a hospital, except information that is dupli-  
25 cative of any other reporting requirement

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

9 “(C) METHOD AND FORMAT.—Not later  
10 than January 1, 2026, the Secretary shall es-  
11 tablish one or more methods and formats for  
12 specified facilities to use in compiling and mak-  
13 ing public standard charges and prices (as ap-  
14 plicable) pursuant to subparagraph (A). Any  
15 such method and format—

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

20 “(ii) shall meet such standards as de-  
21 termined appropriate by the Secretary in  
22 order to ensure the accessibility and  
23 usability of such charges and prices; and

1                   “(iii) shall be updated as determined  
2                   appropriate by the Secretary, in consulta-  
3                   tion with stakeholders.

4                   “(3) DEEMED COMPLIANCE WITH SHOPPABLE  
5                   SERVICES REQUIREMENT FOR HOSPITALS WITH A  
6                   PRICE ESTIMATOR TOOL.—

7                   “(A) IN GENERAL.—With respect to each  
8                   year until the effective date of regulations im-  
9                   plementing the provisions of sections 2799A-  
10                  1(f) and 2799B-6 of the Public Health Service  
11                  Act (relating to advanced explanations of bene-  
12                  fits), including regulations on establishing data  
13                  transfer standards to effectuate such provisions,  
14                  a specified hospital shall be deemed to have  
15                  complied with the requirement described in  
16                  paragraph (2)(A)(ii)(I) (relating to shoppable  
17                  services) if such hospital maintains a price esti-  
18                  mator tool described in subparagraph (B).

19                  “(B) PRICE ESTIMATOR TOOL DE-  
20                  SCRIBED.—For purposes of subparagraph (A),  
21                  the price estimator tool described in this sub-  
22                  paragraph is, with respect to a specified hos-  
23                  pital, a tool that meets the following require-  
24                  ments:

1           “(i) Such tool allows an individual to  
2           immediately obtain a price estimate (tak-  
3           ing into account whether such individual is  
4           covered under any plan, coverage, or pro-  
5           gram described in clause (iv)(III)) and the  
6           discounted cash price charged by a speci-  
7           fied hospital, for each Centers for Medicare  
8           & Medicaid Services-specified shoppable  
9           service that is furnished by such hospital,  
10          and for each additional shoppable service  
11          as such hospital may select, such that price  
12          estimates are available through such tool  
13          for at least 300 shoppable services (or for  
14          all such services, if such hospital furnishes  
15          fewer than 300 shoppable services).

16          “(ii) Such tool allows an individual to  
17          obtain such an estimate by billing code and  
18          by service description.

19          “(iii) Such tool is prominently dis-  
20          played on the public internet website of  
21          such hospital.

22          “(iv) Such tool does not require an in-  
23          dividual seeking such an estimate to create  
24          an account or otherwise input personal in-  
25          formation, except that such tool may re-



1                   quire that such individual provide informa-  
2                   tion specified by the Secretary, which may  
3                   include the following:

4                               “(I) The name of such individual.

5                               “(II) The date of birth of such  
6                   individual.

7                               “(III) In the case such individual  
8                   is covered under a group health plan,  
9                   group or individual health insurance  
10                  coverage, a Federal health care pro-  
11                  gram, or the program established  
12                  under chapter 89 of title 5, United  
13                  States Code, an identifying number  
14                  assigned by such plan, coverage, or  
15                  program to such individual.

16                              “(IV) In the case of an individual  
17                   described in subclause (III), an indi-  
18                   cation as to whether such individual is  
19                   the primary insured individual under  
20                   such plan, coverage, or program (and,  
21                   if such individual is not the primary  
22                   insured individual, a description of the  
23                   individual’s relationship to such pri-  
24                   mary insured individual).

1                   “(V) Any other information spec-  
2                   ified by the Secretary.

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

7                   “(vi) Such tool meets any other re-  
8                   quirement specified by the Secretary.

9                   “(4) MONITORING COMPLIANCE.—The Sec-  
10                  retary shall, through notice and comment rule-  
11                  making and in consultation with the Inspector Gen-  
12                  eral of the Department of Health and Human Serv-  
13                  ices, establish a process to monitor compliance with  
14                  this subsection. Such process shall ensure that each  
15                  specified hospital’s compliance with this subsection  
16                  is reviewed not less frequently than once every 3  
17                  years.

18                  “(5) ENFORCEMENT.—

19                  “(A) IN GENERAL.—In the case of a speci-  
20                  fied hospital that fails to comply with the re-  
21                  quirements of this subsection—

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

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

6           “(B) CIVIL MONETARY PENALTY.—

7           “(i) IN GENERAL.—In addition to any  
8           other enforcement actions or penalties that  
9           may apply under another provision of law,  
10          a specified hospital that has received a no-  
11          tification under subparagraph (A)(i) and  
12          fails to comply with the requirements of  
13          this subsection by the date that is 90 days  
14          after such notification (or, in the case of  
15          such a hospital that has submitted a cor-  
16          rective action plan described in subpara-  
17          graph (A)(ii) in response to a request so  
18          described, by the date that is 90 days after  
19          the Secretary identifies the failure of such  
20          hospital to satisfactorily complete such cor-  
21          rective action plan) shall be subject to a  
22          civil monetary penalty of an amount speci-  
23          fied by the Secretary for each subsequent  
24          day during which such failure is ongoing.  
25          Such amount shall not exceed—

1                   “(I) in the case of a specified  
2                   hospital that is a hospital or critical  
3                   access hospital with 30 or fewer beds,  
4                   \$300 per day; and

5                   “(II) in the case of any specified  
6                   hospital and except as provided in  
7                   clause (iii), \$2,000,000 for a 1-year  
8                   period.

9                   “(ii) INCREASE AUTHORITY.—In ap-  
10                  plying this subparagraph with respect to  
11                  violations occurring in 2027 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                   specified hospital that is a hospital or  
17                   critical access hospital with 30 or  
18                   fewer beds under clause (i)(I);

19                   “(II) the limitation on the  
20                   amount of any penalty applicable for  
21                   a 1-year period under clause (i)(II);  
22                   and

23                   “(III) the limitation on the in-  
24                   crease of any penalty applied under  
25                   clause (iii).

1           “(iii) PERSISTENT NONCOMPLI-  
2 ANCE.—In the case of a specified hospital  
3 (other than a specified hospital that is a  
4 hospital or critical access hospital with 30  
5 or fewer beds) that the Secretary has de-  
6 termined to be knowingly and willfully non-  
7 compliant with the provisions of this sub-  
8 section two or more times during a 1-year  
9 period, the Secretary may increase any  
10 penalty otherwise applicable under this  
11 subparagraph by not more than  
12 \$1,000,000 and may require such hospital  
13 to complete such additional corrective ac-  
14 tions plans as the Secretary may specify.

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

23           “(v) AUTHORITY TO WAIVE OR RE-  
24 DUCE PENALTY.—The Secretary may  
25 waive or reduce any penalty otherwise ap-

1 plicable with respect to a specified hospital  
2 under this subparagraph if the Secretary  
3 determines that imposition of such penalty  
4 would result in a significant hardship for  
5 such hospital (such as in the case of a hos-  
6 pital located in a rural or underserved area  
7 where imposition of such penalty may re-  
8 sult in, or contribute to, a lack of access  
9 to care for individuals in such area).

10 “(C) PUBLICATION OF HOSPITAL PRICE  
11 TRANSPARENCY INFORMATION.—Beginning on  
12 January 1, 2026, the Secretary shall make pub-  
13 licly available on the public website of the Cen-  
14 ters for Medicare & Medicaid Services informa-  
15 tion with respect to compliance with the re-  
16 quirements of this subsection and enforcement  
17 activities undertaken by the Secretary under  
18 this subsection. Such information shall be up-  
19 dated not less than annually and include, with  
20 respect to each year—

21 “(i) the number of reviews of compli-  
22 ance with this subsection undertaken by  
23 the Secretary;

1           “(ii) the number of notifications de-  
2           scribed in subparagraph (A)(i) sent by the  
3           Secretary;

4           “(iii) the identify of each specified  
5           hospital that was sent such a notification  
6           and a description of the nature of such  
7           hospital’s noncompliance with this sub-  
8           section;

9           “(iv) the amount of any civil monetary  
10          penalty imposed on such hospital under  
11          subparagraph (B);

12          “(v) whether such hospital subse-  
13          quently came into compliance with this  
14          subsection; and

15          “(vi) any other information as deter-  
16          mined by the Secretary.

17          “(6) DEFINITIONS.—For purposes of this sub-  
18          section:

19                 “(A) DISCOUNTED CASH PRICE.—The  
20                 term ‘discounted cash price’ means the charge  
21                 that applies to an individual who pays cash, or  
22                 cash equivalent, for a specified hospital-fur-  
23                 nished item or service.

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

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

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

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

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



1           “(G) SPECIFIED HOSPITAL.—The term  
2           ‘specified hospital’ means a hospital (as defined  
3           in section 1861(e)), a critical access hospital (as  
4           defined in section 1861(mmm)(1)), or a rural  
5           emergency hospital (as defined in section  
6           1861(kkk)).

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

12          “(b) AMBULATORY SURGICAL CENTER PRICE  
13          TRANSPARENCY.—

14               “(1) IN GENERAL.—Beginning January 1,  
15               2028, each ambulatory surgical center that receives  
16               payment under this title for furnishing items and  
17               services shall comply with the price transparency re-  
18               quirement described in paragraph (2).

19               “(2) REQUIREMENT DESCRIBED.—

20                       “(A) IN GENERAL.—For purposes of para-  
21                       graph (1), the price transparency requirement  
22                       described in this subsection is, with respect to  
23                       an ambulatory surgical center, that such sur-  
24                       gical center in accordance with a method and  
25                       format established by the Secretary under sub-

1 paragraph (C)), compile and make public (with-  
2 out subscription and free of charge), for each  
3 year—

4 “(i) one or more lists, in a format  
5 specified by the Secretary, of the ambula-  
6 tory surgical center’s standard charges (in-  
7 cluding the information described in sub-  
8 paragraph (B)) for each item and service  
9 furnished by such surgical center;

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

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

1 the ambulatory surgical center, an indica-  
2 tion that such service is not so furnished;  
3 and

4 “(iv) any additional information speci-  
5 fied by the Secretary.

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

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

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

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

1 or service, the gross charge for such item  
2 or service for the previous three years, ex-  
3 pressed as a dollar amount).

4 “(iv) Any other information the Sec-  
5 retary may require that is not duplicative  
6 of any other reporting requirement under  
7 this subsection for purposes of promoting  
8 public awareness of ambulatory surgical  
9 center prices in advance of receiving an  
10 item or service from such an ambulatory  
11 surgical center, which may include any  
12 current payer-specific negotiated charges,  
13 clearly associated with the name of the  
14 third party payer and plan and expressed  
15 as a dollar amount, that applies to each  
16 such item or service.

17 “(C) METHOD AND FORMAT.—Not later  
18 than January 1, 2028, the Secretary shall es-  
19 tablish one or more methods and formats for  
20 ambulatory surgical centers to use in making  
21 public standard charges and prices (as applica-  
22 ble) pursuant to subparagraph (A). Any such  
23 method and format—

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

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

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

7                   “(iii) shall be updated as determined  
8                   appropriate by the Secretary, in consulta-  
9                   tion with stakeholders.

10                  “(3) DEEMED COMPLIANCE WITH SHOPPABLE  
11                  SERVICES REQUIREMENT FOR AMBULATORY SUR-  
12                  GICAL CENTERS WITH A PRICE ESTIMATOR TOOL.—

13                  “(A) IN GENERAL.—An ambulatory sur-  
14                  gical center shall be deemed to have complied  
15                  with the requirement described in subsection  
16                  (b)(2)(A) (relating to shoppable services) if  
17                  such surgical center maintains a price estimator  
18                  tool described in subparagraph (B).

19                  “(B) PRICE ESTIMATOR TOOL DE-  
20                  SCRIBED.—For purposes of subparagraph (A),  
21                  the price estimator tool described in this sub-  
22                  paragraph is, with respect to an ambulatory  
23                  surgical center, a tool that meets the following  
24                  requirements:

1                   “(i) Such tool allows an individual to  
2                   immediately obtain a price estimate (tak-  
3                   ing into account whether such individual is  
4                   covered under any plan, coverage, or pro-  
5                   gram described in clause (iv)(III)) for each  
6                   Centers for Medicare & Medicaid Services-  
7                   specified shoppable service that is fur-  
8                   nished by such surgical center, and for  
9                   each additional shoppable service as such  
10                  surgical center may select, such that price  
11                  estimates are available through such tool  
12                  for at least 300 shoppable services (or for  
13                  all such services, if such surgical center  
14                  furnishes fewer than 300 shoppable serv-  
15                  ices).

16                  “(ii) Such tool allows an individual to  
17                  obtain such an estimate by billing code and  
18                  by service description.

19                  “(iii) Such tool is prominently dis-  
20                  played on the public internet website of  
21                  such ambulatory surgical center.

22                  “(iv) Such tool does not require an in-  
23                  dividual seeking such an estimate to create  
24                  an account or otherwise input personal in-  
25                  formation, except that such tool may re-

1                   quire that such individual provide informa-  
2                   tion specified by the Secretary, which may  
3                   include the following:

4                               “(I) The name of such individual.

5                               “(II) The date of birth of such  
6                   individual.

7                               “(III) In the case such individual  
8                   is covered under a group health plan,  
9                   group or individual health insurance  
10                  coverage, a Federal health care pro-  
11                  gram, or the program established  
12                  under chapter 89 of title 5, United  
13                  States Code, an identifying number  
14                  assigned by such plan, coverage, or  
15                  program to such individual.

16                              “(IV) In the case of an individual  
17                   described in subclause (III), an indi-  
18                   cation as to whether such individual is  
19                   the primary insured individual under  
20                   such plan, coverage, or program (and,  
21                   if such individual is not the primary  
22                   insured individual, a description of the  
23                   individual’s relationship to such pri-  
24                   mary insured individual).

1                   “(V) Any other information spec-  
2                   ified by the Secretary.

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

7                   “(vi) Such tool meets any other re-  
8                   quirement specified by the Secretary.

9                   “(4) MONITORING COMPLIANCE.—The Sec-  
10                  retary shall, through notice and comment rule-  
11                  making and in consultation with the Inspector Gen-  
12                  eral of the Department of Health and Human Serv-  
13                  ices, establish a process to monitor compliance with  
14                  this subsection. Such process shall ensure that each  
15                  ambulatory surgical center’s compliance with this  
16                  subsection is reviewed not less frequently than once  
17                  every 3 years.

18                  “(5) ENFORCEMENT.—

19                  “(A) IN GENERAL.—In the case of an am-  
20                  bulatory surgical center that fails to comply  
21                  with the requirements of this subsection—

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



1 which the Secretary determines such fail-  
2 ure exists; and

3 “(ii) upon request of the Secretary,  
4 the ambulatory surgical center shall submit  
5 to the Secretary, not later than 45 days  
6 after the date of such request, a corrective  
7 action plan to comply with such require-  
8 ments.

9 “(B) CIVIL MONETARY PENALTY.—

10 “(i) IN GENERAL.—In addition to any  
11 other enforcement actions or penalties that  
12 may apply under another provision of law,  
13 an ambulatory surgical center that has re-  
14 ceived a notification under subparagraph  
15 (A)(i) and fails to comply with the require-  
16 ments of this subsection by the date that  
17 is 90 days after such notification (or, in  
18 the case of an ambulatory surgical center  
19 that has submitted a corrective action plan  
20 described in subparagraph (A)(ii) in re-  
21 sponse to a request so described, by the  
22 date that is 90 days after such submission)  
23 shall be subject to a civil monetary penalty  
24 of an amount specified by the Secretary for  
25 each subsequent day during which such

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

3 “(ii) INCREASE AUTHORITY.—In ap-  
4 plying this subparagraph with respect to  
5 violations occurring in 2027 or a subse-  
6 quent year, the Secretary may through no-  
7 tice and comment rulemaking increase the  
8 limitation on the per day amount of any  
9 penalty applicable to an ambulatory sur-  
10 gical center under clause (i).

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

19 “(iv) AUTHORITY TO WAIVE OR RE-  
20 DUCE PENALTY.—The Secretary may  
21 waive or reduce any penalty otherwise ap-  
22 plicable with respect to an ambulatory sur-  
23 gical center under this subparagraph if the  
24 Secretary determines that imposition of  
25 such penalty would result in a significant

1 hardship for such ambulatory surgical cen-  
2 ter (such as in the case of an ambulatory  
3 surgical center located in a rural or under-  
4 served area where imposition of such pen-  
5 alty may result in, or contribute to, a lack  
6 of access to care for individuals in such  
7 area).

8 “(6) DEFINITIONS.—For purposes of this sec-  
9 tion:

10 “(A) DISCOUNTED CASH PRICE.—The  
11 term ‘discounted cash price’ means the charge  
12 that applies to an individual who pays cash, or  
13 cash equivalent, for a item or service furnished  
14 by an ambulatory surgical center.

15 “(B) FEDERAL HEALTH CARE PROGRAM.—  
16 The term ‘Federal health care program’ has the  
17 meaning given such term in section 1128B.

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

23 “(D) GROUP HEALTH PLAN; GROUP  
24 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
25 HEALTH INSURANCE COVERAGE.—The terms

1           ‘group health plan’, ‘group health insurance  
2           coverage’, and ‘individual health insurance cov-  
3           erage’ have the meaning given such terms in  
4           section 2791 of the Public Health Service Act.

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

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

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

20          “(c) IMAGING SERVICES PRICE TRANSPARENCY.—

21                 “(1) IN GENERAL.—Beginning January 1,  
22                 2025, each provider of services and supplier that re-  
23                 ceives payment under this title for furnishing a spec-  
24                 ified imaging service shall—

1           “(A) make publicly available (in a form  
2           and manner specified by the Secretary) on an  
3           Internet website the information described in  
4           paragraph (2) with respect to each such service  
5           that such provider of services or supplier fur-  
6           nishes; and

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

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

14                 “(A) The discounted cash price for such  
15                 service (or, if no such price exists, the gross  
16                 charge for such service).

17                 “(B) If required by the Secretary, the  
18                 deidentified minimum negotiated rate in effect  
19                 between such provider or supplier and any  
20                 group health plan or group or individual health  
21                 insurance coverage for such service and the  
22                 deidentified maximum negotiated rate in effect  
23                 between such provider or supplier and any such  
24                 plan or coverage for such service.

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

8                   “(A) may be similar to any template made  
9                   available by the Centers for Medicare & Med-  
10                  icaid Services as of the date of the enactment  
11                  of this subsection;

12                   “(B) shall meet such standards as deter-  
13                  mined appropriate by the Secretary in order to  
14                  ensure the accessibility and usability of such  
15                  charges and prices; and

16                   “(C) shall be updated as determined ap-  
17                  propriate by the Secretary, in consultation with  
18                  stakeholders.

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.

1           “(5) SPECIFICATION OF SERVICES.—Not later  
2           than January 1, 2025, the Secretary shall publish a  
3           list of at least 50 imaging services that the Sec-  
4           retary determines are shoppable (or all such services,  
5           if the Secretary determines that fewer than 50 such  
6           services are shoppable) between providers of services  
7           and suppliers of such services. The Secretary shall  
8           update such list as determined appropriate by the  
9           Secretary.

10           “(6) ENFORCEMENT.—

11           “(A) IN GENERAL.—In the case that the  
12           Secretary determines that a provider of services  
13           or supplier is not in compliance with paragraph  
14           (1)—

15                   “(i) not later than 30 days after such  
16                   determination, the Secretary shall notify  
17                   such provider or supplier of such deter-  
18                   mination;

19                   “(ii) upon request of the Secretary,  
20                   such provider or supplier shall submit to  
21                   the Secretary, not later than 45 days after  
22                   the date of such request, a corrective ac-  
23                   tion plan to comply with such paragraph;  
24                   and

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

14          “(B) INCREASE AUTHORITY.—In applying  
15          this paragraph with respect to violations occur-  
16          ring in 2027 or a subsequent year, the Sec-  
17          retary may through notice and comment rule-  
18          making increase the amount of the civil mone-  
19          etary penalty under subparagraph (A)(iii).

20          “(C) APPLICATION OF CERTAIN PROVI-  
21          SIONS.—The provisions of section 1128A (other  
22          than subsections (a) and (b) of such section)  
23          shall apply to a civil monetary penalty imposed  
24          under this paragraph in the same manner as  
25          such provisions apply to a civil monetary pen-



1           alty imposed under subsection (a) of such sec-  
2           tion.

3           “(D) AUTHORITY TO WAIVE OR REDUCE  
4           PENALTY.—The Secretary may waive or reduce  
5           any penalty otherwise applicable with respect to  
6           a provider of services or supplier under this  
7           subparagraph if the Secretary determines that  
8           imposition of such penalty would result in a sig-  
9           nificant hardship for such provider or supplier  
10          (such as in the case of a provider or supplier  
11          located in a rural or underserved area where  
12          imposition of such penalty may result in, or  
13          contribute to, a lack of access to care for indi-  
14          viduals in such area).

15          “(E) CLARIFICATION OF NONAPPLICA-  
16          BILITY OF OTHER ENFORCEMENT PROVI-  
17          SIONS.—Notwithstanding any other provision of  
18          this title, this paragraph shall be the sole  
19          means of enforcing the provisions of this sub-  
20          section.

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

22                 “(A) GROUP HEALTH PLAN; GROUP  
23                 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
24                 HEALTH INSURANCE COVERAGE.—The terms  
25                 ‘group health plan’, ‘group health insurance

1 coverage’, and ‘individual health insurance cov-  
2 erage’ have the meaning given such terms in  
3 section 2791 of the Public Health Service Act.

4 “(B) SPECIFIED IMAGING SERVICE.—the  
5 term ‘specified imaging service’ means an imag-  
6 ing service that is included on the list published  
7 by the Secretary under subsection (e).

8 “(d) CLINICAL LABORATORY PRICE TRANS-  
9 PARENCY.—

10 “(1) IN GENERAL.—Beginning January 1,  
11 2025, each applicable laboratory that receives pay-  
12 ment under this title for furnishing a specified clin-  
13 ical diagnostic laboratory test shall—

14 “(A) make publicly available (in a manner  
15 and form specified by the Secretary) on an  
16 Internet website the information described in  
17 paragraph (2) with respect to each such speci-  
18 fied clinical diagnostic laboratory test that such  
19 laboratory is so available to furnish; and

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

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

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

3 “(A) The discounted cash price for such  
4 test (or, if no such price exists, the gross  
5 charge for such test).

6 “(B) If required by the Secretary, the  
7 deidentified minimum negotiated rate in effect  
8 between such laboratory and any group health  
9 plan or group or individual health insurance  
10 coverage for such test and the deidentified max-  
11 imum negotiated rate in effect between such  
12 laboratory and any such plan or coverage for  
13 such test.

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

21 “(A) may be similar to any template made  
22 available by the Centers for Medicare & Med-  
23 icaid Services as of the date of the enactment  
24 of this subsection;

1           “(B) shall meet such standards as deter-  
2           mined appropriate by the Secretary in order to  
3           ensure the accessibility and usability of such  
4           charges and prices; and

5           “(C) shall be updated as determined ap-  
6           propriate by the Secretary, in consultation with  
7           stakeholders.

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

14          “(5) ENFORCEMENT.—

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

18                         “(i) not later than 30 days after such  
19                         determination, the Secretary shall notify  
20                         such laboratory of such determination;

21                         “(ii) upon request of the Secretary,  
22                         such laboratory shall submit to the Sec-  
23                         retary, not later than 45 days after such  
24                         request is sent, a corrective action plan to  
25                         comply with such subsection; and

1           “(iii) if such laboratory continues to  
2           fail to comply with such paragraph after  
3           the date that is 90 days after such notifi-  
4           cation is sent (or, in the case of such a  
5           laboratory that has submitted a corrective  
6           action plan described in clause(ii) in re-  
7           sponse to a request so described, after the  
8           date that is 90 days after such submis-  
9           sion), the Secretary may impose a civil  
10          monetary penalty in an amount not to ex-  
11          ceed \$300 for each subsequent day during  
12          which such failure to comply is ongoing.

13           “(B) INCREASE AUTHORITY.—In applying  
14          this paragraph with respect to violations occur-  
15          ring in 2027 or a subsequent year, the Sec-  
16          retary may through notice and comment rule-  
17          making increase the amount of the civil mone-  
18          tary penalty under subparagraph (A)(iii).

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

1 alty imposed under subsection (a) of such sec-  
2 tion.

3 “(D) AUTHORITY TO WAIVE OR REDUCE  
4 PENALTY.—The Secretary may waive or reduce  
5 any penalty otherwise applicable with respect to  
6 an applicable laboratory under this paragraph if  
7 the Secretary determines that imposition of  
8 such penalty would result in a significant hard-  
9 ship for such laboratory (such as in the case of  
10 an applicable laboratory located in a rural or  
11 underserved area where imposition of such pen-  
12 alty may result in, or contribute to, a lack of  
13 access to care for individuals in such area).

14 “(E) CLARIFICATION OF NONAPPLICA-  
15 BILITY OF OTHER ENFORCEMENT PROVI-  
16 SIONS.—Notwithstanding any other provision of  
17 this title, this subsection shall be the sole means  
18 of enforcing the provisions of this section.

19 “(6) DEFINITIONS.—In this subsection:

20 “(A) APPLICABLE LABORATORY.—The  
21 term ‘applicable laboratory’ has the meaning  
22 given such term in section 414.502, of title 42,  
23 Code of Federal Regulations (or any successor  
24 regulation).

1           “(B) 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           “(C) SPECIFIED CLINICAL DIAGNOSTIC  
9 LABORATORY TEST.—The term ‘specified clin-  
10 ical diagnostic laboratory test’ means a clinical  
11 diagnostic laboratory test that is included on  
12 the list of shoppable services specified by the  
13 Centers for Medicare & Medicaid Services pur-  
14 suant to section 180.60 of title 45, Code of  
15 Federal Regulations (or a successor regulation),  
16 other than such a test that is an advanced diag-  
17 nostic laboratory test (as defined in section  
18 1834A(d)(5)).”.

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

23           “(u) PUBLICATION OF HOSPITAL COMPLIANCE WITH  
24 PRICE TRANSPARENCY REQUIREMENTS.—

1           “(1) IN GENERAL.—Beginning January 1,  
2           2026, the Secretary shall, for each hospital with re-  
3           spect to which the Secretary has conducted a review  
4           of such hospital’s compliance with the provisions of  
5           section 1899C(a) and found such hospital non-  
6           compliant with such provisions—

7                   “(A) indicate such noncompliance on such  
8                   hospital’s entry on the Hospital Compare inter-  
9                   net website (or a successor website); and

10                   “(B) specify whether such hospital—

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

15                           “(ii) was subject to a civil monetary  
16                           penalty imposed under subsection  
17                           (a)(5)(B) of such section (and, if so, the  
18                           date of the imposition of such penalty and  
19                           the amount of such penalty).

20           “(2) ADDITIONS AND UPDATES.—The Secretary  
21           shall update any specification described in subpara-  
22           graph (A) or (B) of paragraph (1) with respect to  
23           such hospital—

24                   “(A) in the case of the specification de-  
25                   scribed in such paragraph (1)(A), as soon as



1 practicable after sending the notification de-  
2 scribed in section 1899C(a)(5)(A)(i); and

3 “(B) in the case of the specification de-  
4 scribed in such paragraph (1)(B)(ii), as soon as  
5 practicable after the imposition of a civil mone-  
6 tary penalty described in such paragraph.”.

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

12 (d) FUNDING.—

13 (1) IN GENERAL.—In addition to funds other-  
14 wise available, out of any moneys in the Treasury  
15 not otherwise appropriated, there are appropriated  
16 \$10,000,000 for fiscal year 2024, to remain avail-  
17 able until expended, for purposes of—

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

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

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

1 and the Committee on Energy and Commerce of the  
2 House of Representatives and the Committee on Fi-  
3 nance of the Senate a report that—

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

8 (B) identifies all entities with which the  
9 Secretary has entered into contracts for pur-  
10 poses of implementing the amendment made by  
11 this subsection (a), monitoring compliance of  
12 entities with such amendment, or providing  
13 technical assistance to entities to promote com-  
14 pliance with such amendment.

15 (e) IMPLEMENTATION.—

16 (1) ACCESSIBILITY.—In implementing section  
17 1899C(a)(2)(A)(ii) of the Social Security Act (as  
18 added by subsection (a)), the Secretary of Health  
19 and Human Services shall through rulemaking en-  
20 sure that information made available pursuant to  
21 such amendment by an entity is so made available  
22 in plain, easily understandable language and that  
23 such entity provides access to such interpretation  
24 services, translations, and other assistive services to  
25 make such information accessible to individuals with

1 limited English proficiency and individuals with dis-  
2 abilities.

3 (2) TECHNICAL ASSISTANCE.—The Secretary of  
4 Health and Human Services shall, to the extent  
5 practicable, provide technical assistance to entities  
6 making public standard charges and prices (as appli-  
7 cable) pursuant to the amendment made by sub-  
8 section (a).

9 **SEC. 102. PROMOTING GROUP HEALTH PLAN PRICE TRANS-**  
10 **PARENCY.**

11 (a) PRICE TRANSPARENCY REQUIREMENTS.—

12 (1) IRC.—

13 (A) IN GENERAL.—Section 9819 of the In-  
14 ternal Revenue Code of 1986 (26. U.S.C. 9816)  
15 is amended to read as follows:

16 **“SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.**

17 **“(a) COST SHARING TRANSPARENCY.—**

18 **“(1) IN GENERAL.—**For plan years beginning  
19 on or after the date that is 2 years after the date  
20 of the enactment of the Health Care Price Trans-  
21 parency Act of 2023, a group health plan shall per-  
22 mit individuals to learn the amount of cost-sharing  
23 (including deductibles, copayments, and coinsurance)  
24 under the individual’s plan or coverage that the indi-  
25 vidual would be responsible for paying with respect

1 to the furnishing of a specific item or service by a  
2 provider in a timely manner upon the request of the  
3 individual. At a minimum, such information shall in-  
4 clude the information specified in paragraph (2) and  
5 shall be made available to such individual through a  
6 self-service tool that meets the requirements of para-  
7 graph (3) or, at the option of such individual,  
8 through a paper disclosure or phone or other elec-  
9 tronic disclosure (as selected by such individual and  
10 provided at no cost to such individual) that meets  
11 such requirements as the Secretary may specify.

12 “(2) SPECIFIED INFORMATION.—For purposes  
13 of paragraph (1), the information specified in this  
14 paragraph is, with respect to an item or service for  
15 which benefits are available under a group health  
16 plan furnished by a health care provider to a partici-  
17 pant or beneficiary of such plan, the following:

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

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

1           “(C) The estimated amount of cost sharing  
2           (including deductibles, copayments, and coin-  
3           surance) that the participant or beneficiary will  
4           incur for such item or service (which, in the  
5           case such item or service is to be furnished by  
6           a provider described in subparagraph (B), shall  
7           be calculated using the maximum amount de-  
8           scribed in such subparagraph).

9           “(D) The amount the participant or bene-  
10          ficiary has already accumulated with respect to  
11          any deductible or out of pocket maximum,  
12          whether for items and services furnished by a  
13          participating provider or for items and services  
14          furnished by a provider that is not a partici-  
15          pating provider, under the plan (broken down,  
16          in the case separate deductibles or maximums  
17          apply to separate participants and beneficiaries  
18          enrolled in the plan, by such separate  
19          deductibles or maximums, in addition to any  
20          cumulative deductible or maximum).

21          “(E) In the case such plan imposes any  
22          frequency or volume limitations with respect to  
23          such item or service (excluding medical neces-  
24          sity determinations), the amount that such par-

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

3           “(F) Any prior authorization, concurrent  
4           review, step therapy, fail first, or similar re-  
5           quirements applicable to coverage of such item  
6           or service under such plan.

7           The Secretary may provide that information de-  
8           scribed in any of subparagraphs (A) through (F) not  
9           be treated as information specified in this para-  
10          graph, and specify additional information that shall  
11          be treated as information specified in this para-  
12          graph, if determined appropriate by the Secretary.

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

17                 “(A) is based on an Internet website;

18                 “(B) provides for real-time responses to re-  
19                 quests described in paragraph (1);

20                 “(C) is updated in a manner such that in-  
21                 formation provided through such tool is timely  
22                 and accurate at the time such request is made;

23                 “(D) allows such a request to be made  
24                 with respect to an item or service furnished  
25                 by—

1 “(i) a specific provider that is a par-  
2 ticipating provider with respect to such  
3 item or service;

4 “(ii) all providers that are partici-  
5 pating providers with respect to such item  
6 or service; or

7 “(iii) a provider that is not described  
8 in clause (ii);

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

14 “(F) meets any other requirement deter-  
15 mined appropriate by the Secretary.

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

21 “(b) RATE AND PAYMENT INFORMATION.—

22 “(1) IN GENERAL.—For plan years beginning  
23 on or after the date that is 2 years after the date  
24 of the enactment of the Health Care Price Trans-  
25 parency Act of 2023, each group health plan (other

1 than a grandfathered health plan (as defined in sec-  
2 tion 1251(e) of the Patient Protection and Afford-  
3 able Care Act) shall, not less frequently than once  
4 every 3 months (or, in the case of information de-  
5 scribed in paragraph (2)(B), not less frequently than  
6 monthly), make available to the public the rate and  
7 payment information described in paragraph (2) in  
8 accordance with paragraph (3).

9 “(2) RATE AND PAYMENT INFORMATION DE-  
10 SCRIBED.—For purposes of paragraph (1), the rate  
11 and payment information described in this para-  
12 graph is, with respect to a group health plan, the  
13 following:

14 “(A) With respect to each item or service  
15 (other than a drug) for which benefits are avail-  
16 able under such plan, the in-network rate in ef-  
17 fect with each provider that is a participating  
18 provider with respect to such item or service,  
19 other than such a rate in effect with a provider  
20 that, during the 1-year period ending 10 busi-  
21 ness days before the date of the publication of  
22 such information, did not submit any claim for  
23 such item or service to such plan.

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



1 available under such plan, the average amount  
2 paid by such plan (net of rebates, discounts,  
3 and price concessions) for such drug dispensed  
4 or administered during the 90-day period begin-  
5 ning 180 days before such date of publication  
6 to each provider that was a participating pro-  
7 vider with respect to such drug, broken down by  
8 each such provider, other than such an amount  
9 paid to a provider that, during such period,  
10 submitted fewer than 20 claims for such drug  
11 to such plan.

12 “(C) With respect to each item or service  
13 for which benefits are available under such  
14 plan, the amount billed, and the amount al-  
15 lowed by the plan, for each such item or service  
16 furnished during the 90-day period specified in  
17 subparagraph (B) by a provider that was not a  
18 participating provider with respect to such item  
19 or service, broken down by each such provider,  
20 other than items and services with respect to  
21 which fewer than 20 claims for such item or  
22 service were submitted to such plan during such  
23 period.

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

1 under this subsection shall be so made available in  
2 dollar amounts through 3 separate machine-readable  
3 files (or any successor technology, such as applica-  
4 tion program interface technology, determined ap-  
5 propriate by the Secretary) corresponding to the in-  
6 formation described in each of subparagraphs (A)  
7 through (C) of paragraph (2) that meet such re-  
8 quirements as specified by the Secretary. Such re-  
9 quirements shall ensure that such files are limited to  
10 an appropriate size, do not include disclosure of un-  
11 necessary duplicative information contained in other  
12 files made available under this subsection, are made  
13 available in a widely-available format through a pub-  
14 licly-available website that allows for information  
15 contained in such files to be compared across group  
16 health plans, and are accessible to individuals at no  
17 cost and without the need to establish a user ac-  
18 count or provide other credentials.

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

1       plate that such a plan may use in developing in-  
2       structions for purposes of the preceding sentence.

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

7       “(c) DEFINITIONS.—In this section:

8           “(1) PARTICIPATING PROVIDER.—The term  
9       ‘participating provider’ has the meaning given such  
10      term in section 9816.

11          “(2) IN-NETWORK RATE.—The term ‘in-net-  
12      work rate’ means, with respect to a health plan and  
13      an item or service furnished by a provider that is a  
14      participating provider with respect to such plan and  
15      item or service, the contracted rate in effect between  
16      such plan and such provider for such item or serv-  
17      ice.”.

18           (B) CLERICAL AMENDMENT.—The item re-  
19      lating to section 9819 of the table of sections  
20      for subchapter B of chapter 100 of the Internal  
21      Revenue Code of 1986 is amended to read as  
22      follows:

“Sec. 9819. Price transparency requirements.”.

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

1 **“SEC. 2799A-4. PRICE TRANSPARENCY REQUIREMENTS.**

2 “(a) COST SHARING TRANSPARENCY.—

3 “(1) IN GENERAL.—For plan years beginning  
4 on or after the date that is 2 years after the date  
5 of the enactment of the Health Care Price Trans-  
6 parency Act of 2023, a group health plan or a  
7 health insurance issuer offering group or individual  
8 health insurance coverage shall permit individuals to  
9 learn the amount of cost-sharing (including  
10 deductibles, copayments, and coinsurance) under the  
11 individual’s plan or coverage that the individual  
12 would be responsible for paying with respect to the  
13 furnishing of a specific item or service by a provider  
14 in a timely manner upon the request of the indi-  
15 vidual. At a minimum, such information shall in-  
16 clude the information specified in paragraph (2) and  
17 shall be made available to such individual through a  
18 self-service tool that meets the requirements of para-  
19 graph (3) or, at the option of such individual,  
20 through a paper disclosure or phone or other elec-  
21 tronic disclosure (as selected by such individual and  
22 provided at no cost to such individual) that meets  
23 such requirements as the Secretary may specify.

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

1       which benefits are available under a group health  
2       plan or group or individual health insurance cov-  
3       erage furnished by a health care provider to a par-  
4       ticipant or beneficiary of such plan, or enrollee in  
5       such coverage, the following:

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

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

13              “(C) The estimated amount of cost sharing  
14              (including deductibles, copayments, and coin-  
15              surance) that the participant or beneficiary will  
16              incur for such item or service (which, in the  
17              case such item or service is to be furnished by  
18              a provider described in subparagraph (B), shall  
19              be calculated using the maximum amount de-  
20              scribed in such subparagraph).

21              “(D) The amount the participant, bene-  
22              ficiary, or enrollee has already accumulated  
23              with respect to any deductible or out of pocket  
24              maximum, whether for items and services fur-  
25              nished by a participating provider or for items

1 and services furnished by a provider that is not  
2 a participating provider, under the plan or cov-  
3 erage (broken down, in the case separate  
4 deductibles or maximums apply to separate par-  
5 ticipants, beneficiaries or enrollees enrolled in  
6 the plan or coverage, by such separate  
7 deductibles or maximums, in addition to any  
8 cumulative deductible or maximum).

9 “(E) In the case such plan or coverage im-  
10 poses any frequency or volume limitations with  
11 respect to such item or service (excluding med-  
12 ical necessity determinations), the amount that  
13 such participant, beneficiary, or enrollee has ac-  
14 crued towards such limitation with respect to  
15 such item or service.

16 “(F) Any prior authorization, concurrent  
17 review, step therapy, fail first, or similar re-  
18 quirements applicable to coverage of such item  
19 or service under such plan or coverage.

20 The Secretary may provide that information de-  
21 scribed in any of subparagraphs (A) through (F) not  
22 be treated as information specified in this para-  
23 graph, and specify additional information that shall  
24 be treated as information specified in this para-  
25 graph, if determined appropriate by the Secretary.

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

6           “(A) is based on an Internet website;

7           “(B) provides for real-time responses to re-  
8 quests described in paragraph (1);

9           “(C) is updated in a manner such that in-  
10 formation provided through such tool is timely  
11 and accurate at the time such request is made;

12           “(D) allows such a request to be made  
13 with respect to an item or service furnished  
14 by—

15           “(i) a specific provider that is a par-  
16 ticipating provider with respect to such  
17 item or service;

18           “(ii) all providers that are partici-  
19 pating providers with respect to such item  
20 or service; or

21           “(iii) a provider that is not described  
22 in clause (ii);

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

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

3                   “(F) meets any other requirement deter-  
4                   mined appropriate by the Secretary.

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

10          “(b) RATE AND PAYMENT INFORMATION.—

11                   “(1) IN GENERAL.—For plan years beginning  
12                   on or after the date that is 2 years after the date  
13                   of the enactment of the Health Care Price Trans-  
14                   parency Act of 2023, each group health plan (other  
15                   than a grandfathered health plan (as defined in sec-  
16                   tion 1251(e) of the Patient Protection and Afford-  
17                   able Care Act) or group or individual health insur-  
18                   ance coverage, shall, not less frequently than once  
19                   every 3 months (or, in the case of information de-  
20                   scribed in paragraph (2)(B), not less frequently than  
21                   monthly), make available to the public the rate and  
22                   payment information described in paragraph (2) in  
23                   accordance with paragraph (3).

24                   “(2) RATE AND PAYMENT INFORMATION DE-  
25                   SCRIBED.—For purposes of paragraph (1), the rate



1 and payment information described in this para-  
2 graph is, with respect to a group health plan or  
3 group or individual health insurance coverage, the  
4 following:

5 “(A) With respect to each item or service  
6 (other than a drug) for which benefits are avail-  
7 able under such plan or coverage, the in-net-  
8 work rate in effect with each provider that is a  
9 participating provider with respect to such item  
10 or service, other than such a rate in effect with  
11 a provider that, during the 1-year period ending  
12 10 business days before the date of the publica-  
13 tion of such information, did not submit any  
14 claim for such item or service to such plan or  
15 coverage.

16 “(B) With respect to each drug (identified  
17 by national drug code) for which benefits are  
18 available under such plan, the average amount  
19 paid by such plan or coverage (net of rebates,  
20 discounts, and price concessions) for such drug  
21 dispensed or administered during the 90-day  
22 period beginning 180 days before such date of  
23 publication to each provider that was a partici-  
24 pating provider with respect to such drug, bro-  
25 ken down by each such provider, other than

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

4           “(C) With respect to each item or service  
5           for which benefits are available under such plan  
6           or coverage, the amount billed, and the amount  
7           allowed by the plan or coverage, for each such  
8           item or service furnished during the 90-day pe-  
9           riod specified in subparagraph (B) by a pro-  
10          vider that was not a participating provider with  
11          respect to such item or service, broken down by  
12          each such provider, other than items and serv-  
13          ices with respect to which fewer than 20 claims  
14          for such item or service were submitted to such  
15          plan or coverage during such period.

16          “(3) MANNER OF PUBLICATION.—Rate and  
17          payment information required to be made available  
18          under this subsection shall be so made available in  
19          dollar amounts through 3 separate machine-readable  
20          files (or any successor technology, such as applica-  
21          tion program interface technology, determined ap-  
22          propriate by the Secretary) corresponding to the in-  
23          formation described in each of subparagraphs (A)  
24          through (C) of paragraph (2) that meet such re-  
25          quirements as specified by the Secretary. Such re-

1        requirements shall ensure that such files are limited to  
2        an appropriate size, do not include disclosure of un-  
3        necessary duplicative information contained in other  
4        files made available under this subsection, are made  
5        available in a widely-available format through a pub-  
6        licly-available website that allows for information  
7        contained in such files to be compared across group  
8        health plans and group and individual health insur-  
9        ance coverage, and are accessible to individuals at no  
10       cost and without the need to establish a user ac-  
11       count or provide other credentials.

12            “(4) USER INSTRUCTIONS.—Each group health  
13        plan and group or individual health insurance cov-  
14        erage shall make available to the public instructions  
15        written in plain language explaining how individuals  
16        may search for information described in paragraph  
17        (2) in files submitted in accordance with paragraph  
18        (3). The Secretary shall develop and publish a tem-  
19        plate that such a plan or coverage may use in devel-  
20        oping instructions for purposes of the preceding sen-  
21        tence.

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

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

3 “(c) DEFINITIONS.—In this section:

4 “(1) PARTICIPATING PROVIDER.—The term  
5 ‘participating provider’ has the meaning given such  
6 term in section 2791A–1(a)(3)(G)(ii).

7 “(2) IN-NETWORK RATE.—The term ‘in-net-  
8 work rate’ means, with respect to a health plan or  
9 coverage and an item or service furnished by a pro-  
10 vider that is a participating provider with respect to  
11 such plan and item or service, the contracted rate in  
12 effect between such plan or coverage and such pro-  
13 vider for such item or service.”.

14 (3) ERISA.—

15 (A) IN GENERAL.—Section 719 of the Em-  
16 ployee Retirement Income Security Act of 1974  
17 (29 U.S.C. 1185h) is amended to read as fol-  
18 lows:

19 **“SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.**

20 “(a) COST SHARING TRANSPARENCY.—

21 “(1) IN GENERAL.—For plan years beginning  
22 on or after the date that is 2 years after the date  
23 of the enactment of the Health Care Price Trans-  
24 parency Act of 2023, a group health plan or a  
25 health insurance issuer offering group health insur-

1       ance coverage shall permit individuals to learn the  
2       amount of cost-sharing (including deductibles, co-  
3       payments, and coinsurance) under the individual’s  
4       plan or coverage that the individual would be re-  
5       sponsible for paying with respect to the furnishing  
6       of a specific item or service by a provider in a timely  
7       manner upon the request of the individual. At a  
8       minimum, such information shall include the infor-  
9       mation specified in paragraph (2) and shall be made  
10      available to such individual through a self-service  
11      tool that meets the requirements of paragraph (3)  
12      or, at the option of such individual, through a paper  
13      disclosure or phone or other electronic disclosure (as  
14      selected by such individual and provided at no cost  
15      to such individual) that meets such requirements as  
16      the Secretary may specify.

17           “(2) SPECIFIED INFORMATION.—For purposes  
18      of paragraph (1), the information specified in this  
19      paragraph is, with respect to an item or service for  
20      which benefits are available under a group health  
21      plan or group health insurance coverage furnished  
22      by a health care provider to a participant or bene-  
23      ficiary of such plan, or enrollee in such coverage, the  
24      following:

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

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

8           “(C) The estimated amount of cost sharing  
9 (including deductibles, copayments, and coin-  
10 surance) that the participant or beneficiary will  
11 incur for such item or service (which, in the  
12 case such item or service is to be furnished by  
13 a provider described in subparagraph (B), shall  
14 be calculated using the maximum amount de-  
15 scribed in such subparagraph).

16           “(D) The amount the participant, bene-  
17 ficiary, or enrollee has already accumulated  
18 with respect to any deductible or out of pocket  
19 maximum, whether for items and services fur-  
20 nished by a participating provider or for items  
21 and services furnished by a provider that is not  
22 a participating provider, under the plan or cov-  
23 erage (broken down, in the case separate  
24 deductibles or maximums apply to separate par-  
25 ticipants, beneficiaries or enrollees enrolled in

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

4 “(E) In the case such plan or coverage im-  
5 poses any frequency or volume limitations with  
6 respect to such item or service (excluding med-  
7 ical necessity determinations), the amount that  
8 such participant, beneficiary, or enrollee has ac-  
9 crued towards such limitation with respect to  
10 such item or service.

11 “(F) Any prior authorization, concurrent  
12 review, step therapy, fail first, or similar re-  
13 quirements applicable to coverage of such item  
14 or service under such plan or coverage.

15 The Secretary may provide that information de-  
16 scribed in any of subparagraphs (A) through (F) not  
17 be treated as information specified in this para-  
18 graph, and specify additional information that shall  
19 be treated as information specified in this para-  
20 graph, if determined appropriate by the Secretary.

21 “(3) SELF-SERVICE TOOL.—For purposes of  
22 paragraph (1), a self-service tool established by a  
23 group health plan or group health insurance cov-  
24 erage meets the requirements of this paragraph if  
25 such tool—

1           “(A) is based on an Internet website;

2           “(B) provides for real-time responses to re-  
3           quests described in paragraph (1);

4           “(C) is updated in a manner such that in-  
5           formation provided through such tool is timely  
6           and accurate at the time such request is made;

7           “(D) allows such a request to be made  
8           with respect to an item or service furnished  
9           by—

10           “(i) a specific provider that is a par-  
11           ticipating provider with respect to such  
12           item or service;

13           “(ii) all providers that are partici-  
14           pating providers with respect to such item  
15           or service; or

16           “(iii) a provider that is not described  
17           in clause (ii);

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

23           “(F) meets any other requirement deter-  
24           mined appropriate by the Secretary.



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

6       “(b) RATE AND PAYMENT INFORMATION.—

7             “(1) IN GENERAL.—For plan years beginning  
8       on or after the date that is 2 years after the date  
9       of the enactment of the Health Care Price Trans-  
10      parency Act of 2023, each group health plan (other  
11      than a grandfathered health plan (as defined in sec-  
12      tion 1251(e) of the Patient Protection and Afford-  
13      able Care Act) or group health insurance coverage,  
14      shall, not less frequently than once every 3 months  
15      (or, in the case of information described in para-  
16      graph (2)(B), not less frequently than monthly),  
17      make available to the public the rate and payment  
18      information described in paragraph (2) in accord-  
19      ance with paragraph (3).

20            “(2) RATE AND PAYMENT INFORMATION DE-  
21      SCRIBED.—For purposes of paragraph (1), the rate  
22      and payment information described in this para-  
23      graph is, with respect to a group health plan or  
24      group health insurance coverage, the following:

1           “(A) With respect to each item or service  
2           (other than a drug) for which benefits are avail-  
3           able under such plan or coverage, the in-net-  
4           work rate in effect with each provider that is a  
5           participating provider with respect to such item  
6           or service, other than such a rate in effect with  
7           a provider that, during the 1-year period ending  
8           10 business days before the date of the publica-  
9           tion of such information, did not submit any  
10          claim for such item or service to such plan or  
11          coverage.

12          “(B) With respect to each drug (identified  
13          by national drug code) for which benefits are  
14          available under such plan, the average amount  
15          paid by such plan or coverage (net of rebates,  
16          discounts, and price concessions) for such drug  
17          dispensed or administered during the 90-day  
18          period beginning 180 days before such date of  
19          publication to each provider that was a partici-  
20          pating provider with respect to such drug, bro-  
21          ken down by each such provider, other than  
22          such an amount paid to a provider that, during  
23          such period, submitted fewer than 20 claims for  
24          such drug to such plan or coverage.

1           “(C) With respect to each item or service  
2           for which benefits are available under such plan  
3           or coverage, the amount billed, and the amount  
4           allowed by the plan or coverage, for each such  
5           item or service furnished during the 90-day pe-  
6           riod specified in subparagraph (B) by a pro-  
7           vider that was not a participating provider with  
8           respect to such item or service, broken down by  
9           each such provider, other than items and serv-  
10          ices with respect to which fewer than 20 claims  
11          for such item or service were submitted to such  
12          plan or coverage during such period.

13           “(3) MANNER OF PUBLICATION.—Rate and  
14          payment information required to be made available  
15          under this subsection shall be so made available in  
16          dollar amounts through 3 separate machine-readable  
17          files (or any successor technology, such as applica-  
18          tion program interface technology, determined ap-  
19          propriate by the Secretary) corresponding to the in-  
20          formation described in each of subparagraphs (A)  
21          through (C) of paragraph (2) that meet such re-  
22          quirements as specified by the Secretary. Such re-  
23          quirements shall ensure that such files are limited to  
24          an appropriate size, do not include disclosure of un-  
25          necessary duplicative information contained in other

1 files made available under this subsection, are made  
2 available in a widely-available format through a pub-  
3 licly-available website that allows for information  
4 contained in such files to be compared across group  
5 health plans and group and individual health insur-  
6 ance coverage, and are accessible to individuals at no  
7 cost and without the need to establish a user ac-  
8 count or provide other credentials.

9 “(4) USER INSTRUCTIONS.—Each group health  
10 plan and group health insurance coverage shall make  
11 available to the public instructions written in plain  
12 language explaining how individuals may search for  
13 information described in paragraph (2) in files sub-  
14 mitted in accordance with paragraph (3). The Sec-  
15 retary shall develop and publish a template that  
16 such a plan or coverage may use in developing in-  
17 structions for purposes of the preceding sentence.

18 “(5) ATTESTATION.—Each group health plan  
19 and group health insurance coverage shall post,  
20 along with rate and payment information made pub-  
21 lic by such plan or coverage, an attestation that such  
22 information is complete and accurate.

23 “(c) DEFINITIONS.—In this section:

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

4           “(2) IN-NETWORK RATE.—The term ‘in-net-  
5           work rate’ means, with respect to a health plan or  
6           coverage and an item or service furnished by a pro-  
7           vider that is a participating provider with respect to  
8           such plan and item or service, the contracted rate in  
9           effect between such plan or coverage and such pro-  
10          vider for such item or service.”.

11           (B) CLERICAL AMENDMENT.—The table of  
12          contents in section 1 of the Employee Retire-  
13          ment Income Security Act of 1974 is amended  
14          by striking the item relating to section 719 and  
15          inserting the following new item:

“Sec. 719. Price transparency requirements.”.

16          (b) ACCESSIBILITY THROUGH IMPLEMENTATION.—  
17          In implementing the amendments made by subsection (a),  
18          the Secretary of the Treasury, the Secretary of Health and  
19          Human Services, and the Secretary of Labor shall take  
20          reasonable steps to ensure the accessibility of information  
21          made available pursuant to such amendments, including  
22          reasonable steps to ensure that such information is pro-  
23          vided in plain, easily understandable language and that  
24          interpretation, translations, and assistive services are pro-  
25          vided by group health plans and health insurance issuers

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

4 (c) CONTINUED APPLICABILITY OF RULES FOR PRE-  
5 VIOUS YEARS.—Nothing in the amendments made by sub-  
6 section (a) may be construed as affecting the applicability  
7 of the rule entitled “Transparency in Coverage” published  
8 by the Department of the Treasury, the Department of  
9 Labor, and the Department of Health and Human Serv-  
10 ices on November 12, 2020 (85 Fed. Reg. 72158) for any  
11 plan year beginning before the date that is 2 years after  
12 the date of the enactment of this Act.

13 **SEC. 103. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
14 **SERVICES.**

15 (a) IRC.—

16 (1) IN GENERAL.—Subchapter B of chapter  
17 100 of the Internal Revenue Code of 1986 is amend-  
18 ed by adding at the end the following:

19 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-**  
20 **AGER SERVICES.**

21 “(a) IN GENERAL.—For plan years beginning on or  
22 after the date that is 3 years after the date of enactment  
23 of this section, a group health plan, or an entity or sub-  
24 sidiary providing pharmacy benefits management services  
25 on behalf of such a plan, shall not enter into a contract

1 with a drug manufacturer, distributor, wholesaler, subcon-  
2 tractor, rebate aggregator, or any associated third party  
3 that limits the disclosure of information to plan sponsors  
4 in such a manner that prevents the plan, or an entity or  
5 subsidiary providing pharmacy benefits management serv-  
6 ices on behalf of a plan, from making the report described  
7 in subsection (b).

8 “(b) ANNUAL REPORT.—

9 “(1) IN GENERAL.—With respect to plan years  
10 beginning on or after the date that is 3 years after  
11 the date of enactment of this section, for each such  
12 plan year, a group health plan, or an entity pro-  
13 viding pharmacy benefits management services on  
14 behalf of such a plan, shall submit to the plan spon-  
15 sor (as defined in section 3(16)(B) of the Employee  
16 Retirement Income Security Act of 1974) of such  
17 plan a report in a machine-readable format. Each  
18 such report shall include, with respect to such plan  
19 provided for such plan year—

20 “(A) to the extent feasible, information col-  
21 lected from drug manufacturers (or an entity  
22 administering copay assistance on behalf of  
23 such manufacturers) by such plan (or entity or  
24 subsidiary providing pharmacy benefits manage-  
25 ment services on behalf of such plan) on the

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

6 “(B) a list of each drug covered by such  
7 plan that was dispensed during the plan year,  
8 including, with respect to each such drug dur-  
9 ing such plan year—

10 “(i) the brand name, chemical entity,  
11 and National Drug Code;

12 “(ii) the number of participants and  
13 beneficiaries for whom the drug was dis-  
14 pensed during the plan year, the total  
15 number of prescription claims for the drug  
16 (including original prescriptions and re-  
17 fills), and the total number of dosage units  
18 of the drug dispensed across the plan year,  
19 disaggregated by dispensing channel (such  
20 as retail, mail order, or specialty phar-  
21 macy);

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



1           “(iv) the total out-of-pocket spending  
2           by participants and beneficiaries on such  
3           drug, including participant and beneficiary  
4           spending through copayments, coinsurance,  
5           and deductibles;

6           “(v) for any drug for which gross  
7           spending of the group health plan exceeded  
8           \$10,000 during the plan year—

9                   “(I) a list of all other drugs in  
10                  the same therapeutic category or  
11                  class, including brand name drugs  
12                  and biological products and generic  
13                  drugs or biosimilar biological products  
14                  that are in the same therapeutic cat-  
15                  egory or class as such drug; and

16                   “(II) the rationale for the for-  
17                  mulary placement of such drug in that  
18                  therapeutic category or class, if appli-  
19                  cable;

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

1           “(vii) the total net spending, after de-  
2           ducting rebates, price concessions, alter-  
3           native discounts or other remuneration  
4           from drug manufacturers, by the health  
5           plan on such drug; and

6           “(viii) the net price per course of  
7           treatment or single fill, such as a 30-day  
8           supply or 90-day supply, incurred by the  
9           health plan and its participants and bene-  
10          ficiaries after manufacturer rebates, fees,  
11          and other remuneration for such drug dis-  
12          pensed during the plan year;

13          “(C) a list of each therapeutic category or  
14          class of drugs that were dispensed under the  
15          health plan during the plan year, and, with re-  
16          spect to each such therapeutic category or class  
17          of drugs, during the plan year—

18                 “(i) total gross spending by the plan,  
19                 before manufacturer rebates, fees, or other  
20                 manufacturer remuneration;

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

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

6                   “(iv) the total out-of-pocket spending  
7                   by participants and beneficiaries, including  
8                   participant and beneficiary spending  
9                   through copayments, coinsurance, and  
10                  deductibles;

11                  “(D) total gross spending on prescription  
12                  drugs by the plan during the plan year, before  
13                  rebates and other manufacturer fees or remun-  
14                  eration;

15                  “(E) total amount received, or expected to  
16                  be received, by the health plan in drug manu-  
17                  facturer rebates, fees, alternative discounts, and  
18                  all other remuneration received from the manu-  
19                  facturer or any third party, other than the plan  
20                  sponsor, related to utilization of drug or drug  
21                  spending under that health plan during the  
22                  plan year;

23                  “(F) the total net spending on prescription  
24                  drugs by the health plan during the plan year;  
25                  and

1           “(G) amounts paid directly or indirectly in  
2 rebates, fees, or any other type of remuneration  
3 to brokers, consultants, advisors, or any other  
4 individual or firm for the referral of the group  
5 health plan’s business to the pharmacy benefits  
6 manager.

7           “(2) PRIVACY REQUIREMENTS.—Entities pro-  
8 viding pharmacy benefits management services on  
9 behalf of a group health plan shall provide informa-  
10 tion under paragraph (1) in a manner consistent  
11 with the privacy, security, and breach notification  
12 regulations promulgated under section 264(c) of the  
13 Health Insurance Portability and Accountability Act  
14 of 1996, and shall restrict the use and disclosure of  
15 such information according to such privacy regula-  
16 tions.

17           “(3) DISCLOSURE AND REDISCLOSURE.—

18           “(A) LIMITATION TO BUSINESS ASSOCI-  
19 ATES.—A group health plan receiving a report  
20 under paragraph (1) may disclose such informa-  
21 tion only to business associates of such plan as  
22 defined in section 160.103 of title 45, Code of  
23 Federal Regulations (or successor regulations).

24           “(B) CLARIFICATION REGARDING PUBLIC  
25 DISCLOSURE OF INFORMATION.—Nothing in

1           this section prevents an entity providing phar-  
2           macy benefits management services on behalf of  
3           a group health plan from placing reasonable re-  
4           strictions on the public disclosure of the infor-  
5           mation contained in a report described in para-  
6           graph (1), except that such entity may not re-  
7           strict disclosure of such report to the Depart-  
8           ment of Health and Human Services, the De-  
9           partment of Labor, the Department of the  
10          Treasury, the Comptroller General of the  
11          United States, or applicable State agencies.

12                   “(C) LIMITED FORM OF REPORT.—The  
13          Secretary shall define through rulemaking a  
14          limited form of the report under paragraph (1)  
15          required of plan sponsors who are drug manu-  
16          facturers, drug wholesalers, or other direct par-  
17          ticipants in the drug supply chain, in order to  
18          prevent anti-competitive behavior.

19                   “(4) REPORT TO GAO.—A group health plan, or  
20          an entity providing pharmacy benefits management  
21          services on behalf of a group health plan, shall sub-  
22          mit to the Comptroller General of the United States  
23          each of the first 4 reports submitted to a plan spon-  
24          sor under paragraph (1) with respect to such plan,  
25          and other such reports as requested, in accordance

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

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

14 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-  
15 tion shall be construed to permit a group health plan or  
16 other entity to restrict disclosure to, or otherwise limit the  
17 access of, the Secretary of the Treasury to a report de-  
18 scribed in subsection (b)(1) or information related to com-  
19 pliance with subsection (a) or (b) by such plan or other  
20 entity subject to such subsections.

21 “(d) DEFINITION.—In this section, the term ‘whole-  
22 sale acquisition cost’ has the meaning given such term in  
23 section 1847A(e)(6)(B) of the Social Security Act.”.

24 (2) CLERICAL AMENDMENT.—The table of sec-  
25 tions for subchapter B of chapter 100 of the Inter-

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

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

3       (b) PHSA.—Title XXVII of the Public Health Serv-  
4       ice Act (42 U.S.C. 300gg et seq.) is amended—

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

7       **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-  
8                             AGER SERVICES.**

9       “(a) IN GENERAL.—For plan years beginning on or  
10       after the date that is 3 years after the date of enactment  
11       of this section, a group health plan or health insurance  
12       issuer offering group health insurance coverage, or an en-  
13       tity or subsidiary providing pharmacy benefits manage-  
14       ment services on behalf of such a plan or issuer, shall not  
15       enter into a contract with a drug manufacturer, dis-  
16       tributor, wholesaler, subcontractor, rebate aggregator, or  
17       any associated third party that limits the disclosure of in-  
18       formation to plan sponsors in such a manner that prevents  
19       the plan or issuer, or an entity or subsidiary providing  
20       pharmacy benefits management services on behalf of a  
21       plan or issuer, from making the report described in sub-  
22       section (b).

23       “(b) ANNUAL REPORT.—

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

1 the date of enactment of this section, for each such  
2 plan year, a group health plan or health insurance  
3 issuer offering group health insurance coverage, or  
4 an entity providing pharmacy benefits management  
5 services on behalf of such a plan or an issuer, shall  
6 submit to the plan sponsor (as defined in section  
7 3(16)(B) of the Employee Retirement Income Secu-  
8 rity Act of 1974) of such plan or coverage a report  
9 in a machine-readable format. Each such report  
10 shall include, with respect to such plan or coverage  
11 provided for such plan year—

12 “(A) to the extent feasible, information col-  
13 lected from drug manufacturers (or an entity  
14 administering copay assistance on behalf of  
15 such manufacturers) by such plan or issuer (or  
16 entity or subsidiary providing pharmacy bene-  
17 fits management services on behalf of such plan  
18 or issuer) on the total amount of copayment as-  
19 sistance dollars paid, or copayment cards ap-  
20 plied, that were funded by the drug manufac-  
21 turer with respect to the participants, bene-  
22 ficiaries, and enrollees in such plan or coverage;

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



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

3 “(i) the brand name, chemical entity,  
4 and National Drug Code;

5 “(ii) the number of participants, bene-  
6 ficiaries, and enrollees for whom the drug  
7 was dispensed during the plan year, the  
8 total number of prescription claims for the  
9 drug (including original prescriptions and  
10 refills), and the total number of dosage  
11 units of the drug dispensed across the plan  
12 year, disaggregated by dispensing channel  
13 (such as retail, mail order, or specialty  
14 pharmacy);

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

19 “(iv) the total out-of-pocket spending  
20 by participants, beneficiaries, and enrollees  
21 on such drug, including participant, bene-  
22 ficiary, and enrollee spending through co-  
23 payments, coinsurance, and deductibles;

24 “(v) for any drug for which gross  
25 spending of the group health plan or

1 health insurance coverage exceeded  
2 \$10,000 during the plan year—

3 “(I) a list of all other drugs in  
4 the same therapeutic category or  
5 class, including brand name drugs  
6 and biological products and generic  
7 drugs or biosimilar biological products  
8 that are in the same therapeutic cat-  
9 egory or class as such drug; and

10 “(II) the rationale for the for-  
11 mulary placement of such drug in that  
12 therapeutic category or class, if appli-  
13 cable;

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

19 “(vii) the total net spending, after de-  
20 ducting rebates, price concessions, alter-  
21 native discounts or other remuneration  
22 from drug manufacturers, by the health  
23 plan or health insurance coverage on such  
24 drug; and

1           “(viii) the net price per course of  
2           treatment or single fill, such as a 30-day  
3           supply or 90-day supply, incurred by the  
4           health plan or health insurance coverage  
5           and its participants, beneficiaries, and en-  
6           rollees, after manufacturer rebates, fees,  
7           and other remuneration for such drug dis-  
8           pensed during the plan year;

9           “(C) a list of each therapeutic category or  
10          class of drugs that were dispensed under the  
11          health plan or health insurance coverage during  
12          the plan year, and, with respect to each such  
13          therapeutic category or class of drugs, during  
14          the plan year—

15               “(i) total gross spending by the plan  
16               or coverage, before manufacturer rebates,  
17               fees, or other manufacturer remuneration;

18               “(ii) the number of participants, bene-  
19               ficiaries, and enrollees who were dispensed  
20               a drug covered by such plan or coverage in  
21               that category or class, broken down by  
22               each such drug (identified by National  
23               Drug Code);

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

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

4 “(iv) the total out-of-pocket spending  
5 by participants, beneficiaries, and enroll-  
6 ees, including participant, beneficiary, and  
7 enrollee spending through copayments, co-  
8 insurance, and deductibles;

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

13 “(E) total amount received, or expected to  
14 be received, by the health plan or health insur-  
15 ance coverage in drug manufacturer rebates,  
16 fees, alternative discounts, and all other remu-  
17 nation received from the manufacturer or any  
18 third party, other than the plan sponsor, re-  
19 lated to utilization of drug or drug spending  
20 under that health plan or health insurance cov-  
21 erage during the plan year;

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

1           “(G) amounts paid directly or indirectly in  
2 rebates, fees, or any other type of remuneration  
3 to brokers, consultants, advisors, or any other  
4 individual or firm for the referral of the group  
5 health plan’s or health insurance issuer’s busi-  
6 ness to the pharmacy benefits manager.

7           “(2) PRIVACY REQUIREMENTS.—Health insur-  
8 ance issuers offering group health insurance cov-  
9 erage and entities providing pharmacy benefits man-  
10 agement services on behalf of a group health plan  
11 shall provide information under paragraph (1) in a  
12 manner consistent with the privacy, security, and  
13 breach notification regulations promulgated under  
14 section 264(c) of the Health Insurance Portability  
15 and Accountability Act of 1996, and shall restrict  
16 the use and disclosure of such information according  
17 to such privacy regulations.

18           “(3) DISCLOSURE AND REDISCLOSURE.—

19           “(A) LIMITATION TO BUSINESS ASSOCI-  
20 ATES.—A group health plan receiving a report  
21 under paragraph (1) may disclose such informa-  
22 tion only to business associates of such plan as  
23 defined in section 160.103 of title 45, Code of  
24 Federal Regulations (or successor regulations).

1           “(B) CLARIFICATION REGARDING PUBLIC  
2 DISCLOSURE OF INFORMATION.—Nothing in  
3 this section prevents a health insurance issuer  
4 offering group health insurance coverage or an  
5 entity providing pharmacy benefits management  
6 services on behalf of a group health plan from  
7 placing reasonable restrictions on the public dis-  
8 closure of the information contained in a report  
9 described in paragraph (1), except that such  
10 issuer or entity may not restrict disclosure of  
11 such report to the Department of Health and  
12 Human Services, the Department of Labor, the  
13 Department of the Treasury, the Comptroller  
14 General of the United States, or applicable  
15 State agencies.

16           “(C) LIMITED FORM OF REPORT.—The  
17 Secretary shall define through rulemaking a  
18 limited form of the report under paragraph (1)  
19 required of plan sponsors who are drug manu-  
20 facturers, drug wholesalers, or other direct par-  
21 ticipants in the drug supply chain, in order to  
22 prevent anti-competitive behavior.

23           “(4) REPORT TO GAO.—A group health plan or  
24 health insurance issuer offering group health insur-  
25 ance coverage, or an entity providing pharmacy ben-

1       efits management services on behalf of a group  
2       health plan shall submit to the Comptroller General  
3       of the United States each of the first 4 reports sub-  
4       mitted to a plan sponsor under paragraph (1) with  
5       respect to such coverage or plan, and other such re-  
6       ports as requested, in accordance with the privacy  
7       requirements under paragraph (2), the disclosure  
8       and redisclosure standards under paragraph (3), the  
9       standards specified pursuant to paragraph (5), and  
10      such other information that the Comptroller General  
11      determines necessary to carry out the study under  
12      section 103(d) of the Health Care Price Trans-  
13      parency Act of 2023.

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

20           “(c) ENFORCEMENT.—

21           “(1) IN GENERAL.—Notwithstanding section  
22      2723, the Secretary, in consultation with the Sec-  
23      retary of Labor and the Secretary of the Treasury,  
24      shall enforce this section.

1           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
2           TION.—A health insurance issuer or an entity pro-  
3           viding pharmacy benefits management services that  
4           violates subsection (a) or fails to provide information  
5           required under subsection (b) shall be subject to a  
6           civil monetary penalty in the amount of \$10,000 for  
7           each day during which such violation continues or  
8           such information is not disclosed or reported.

9           “(3) FALSE INFORMATION.—A health insurance  
10          issuer or entity providing pharmacy benefits man-  
11          agement services that knowingly provides false infor-  
12          mation under this section shall be subject to a civil  
13          money penalty in an amount not to exceed \$100,000  
14          for each item of false information. Such civil money  
15          penalty shall be in addition to other penalties as  
16          may be prescribed by law.

17          “(4) PROCEDURE.—The provisions of section  
18          1128A of the Social Security Act, other than sub-  
19          section (a) and (b) and the first sentence of sub-  
20          section (c)(1) of such section shall apply to civil  
21          monetary penalties under this subsection in the  
22          same manner as such provisions apply to a penalty  
23          or proceeding under section 1128A of the Social Se-  
24          curity Act.



1           “(5) WAIVERS.—The Secretary may waive pen-  
2           alties under paragraph (2), or extend the period of  
3           time for compliance with a requirement of this sec-  
4           tion, for an entity in violation of this section that  
5           has made a good-faith effort to comply with this sec-  
6           tion.

7           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
8           tion shall be construed to permit a health insurance issuer,  
9           group health plan, or other entity to restrict disclosure to,  
10          or otherwise limit the access of, the Secretary of Health  
11          and Human Services to a report described in subsection  
12          (b)(1) or information related to compliance with sub-  
13          section (a) or (b) by such issuer, plan, or other entity sub-  
14          ject to such subsections.

15          “(e) DEFINITION.—In this section, the term ‘whole-  
16          sale acquisition cost’ has the meaning given such term in  
17          section 1847A(c)(6)(B) of the Social Security Act.”; and

18                 (2) in section 2723 of such Act (42 U.S.C.  
19                 300gg-22)—

20                         (A) in subsection (a)—

21                                 (i) in paragraph (1), by inserting  
22                                 “(other than subsections (a) and (b) of  
23                                 section 2799A-11)” after “part D”; and

1 (ii) in paragraph (2), by inserting  
2 “(other than subsections (a) and (b) of  
3 section 2799A–11)” after “part D”; and  
4 (B) in subsection (b)—

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

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

11 (iii) in paragraph (2)(C)(ii), by insert-  
12 ing “(other than subsections (a) and (b) of  
13 section 2799A–11)” after “part D”.

14 (c) ERISA.—

15 (1) IN GENERAL.—Subtitle B of title I of the  
16 Employee Retirement Income Security Act of 1974  
17 (29 U.S.C. 1021 et seq.) is amended—

18 (A) in subpart B of part 7 (29 U.S.C.  
19 1185 et seq.), by adding at the end the fol-  
20 lowing:

21 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
22 **SERVICES.**

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

1 issuer offering group health insurance coverage, or an en-  
2 tity or subsidiary providing pharmacy benefits manage-  
3 ment services on behalf of such a plan or issuer, shall not  
4 enter into a contract with a drug manufacturer, dis-  
5 tributor, wholesaler, subcontractor, rebate aggregator, or  
6 any associated third party that limits the disclosure of in-  
7 formation to plan sponsors in such a manner that prevents  
8 the plan or issuer, or an entity or subsidiary providing  
9 pharmacy benefits management services on behalf of a  
10 plan or issuer, from making the report described in sub-  
11 section (b).

12 “(b) ANNUAL REPORT.—

13 “(1) IN GENERAL.—With respect to plan years  
14 beginning on or after the date that is 3 years after  
15 the date of enactment of this section, for each such  
16 plan year, a group health plan or health insurance  
17 issuer offering group health insurance coverage, or  
18 an entity providing pharmacy benefits management  
19 services on behalf of such a plan or an issuer, shall  
20 submit to the plan sponsor (as defined in section  
21 3(16)(B)) of such plan or coverage a report in a ma-  
22 chine-readable format. Each such report shall in-  
23 clude, with respect to such plan or coverage provided  
24 for such plan year—

1           “(A) to the extent feasible, information col-  
2           lected from drug manufacturers (or an entity  
3           administering copay assistance on behalf of  
4           such manufacturers) by such plan or issuer (or  
5           entity or subsidiary providing pharmacy bene-  
6           fits management services on behalf of such plan  
7           or issuer) on the total amount of copayment as-  
8           sistance dollars paid, or copayment cards ap-  
9           plied, that were funded by the drug manufac-  
10          turer with respect to the participants, bene-  
11          ficiaries, and enrollees in such plan or coverage;

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

16                 “(i) the brand name, chemical entity,  
17                 and National Drug Code;

18                 “(ii) the number of participants, bene-  
19                 ficiaries, and enrollees for whom the drug  
20                 was dispensed during the plan year, the  
21                 total number of prescription claims for the  
22                 drug (including original prescriptions and  
23                 refills), and the total number of dosage  
24                 units of the drug dispensed across the plan  
25                 year, disaggregated by dispensing channel

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

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

7 “(iv) the total out-of-pocket spending  
8 by participants, beneficiaries, and enrollees  
9 on such drug, including participant, bene-  
10 ficiary, and enrollee spending through co-  
11 payments, coinsurance, and deductibles;

12 “(v) for any drug for which gross  
13 spending of the group health plan or  
14 health insurance coverage exceeded  
15 \$10,000 during the plan year—

16 “(I) a list of all other drugs in  
17 the same therapeutic category or  
18 class, including brand name drugs  
19 and biological products and generic  
20 drugs or biosimilar biological products  
21 that are in the same therapeutic cat-  
22 egory or class as such drug; and

23 “(II) the rationale for the for-  
24 mulary placement of such drug in that

1 therapeutic category or class, if appli-  
2 cable;

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

8 “(vii) the total net spending, after de-  
9 ducting rebates, price concessions, alter-  
10 native discounts or other remuneration  
11 from drug manufacturers, by the health  
12 plan or health insurance coverage on such  
13 drug; and

14 “(viii) the net price per course of  
15 treatment or single fill, such as a 30-day  
16 supply or 90-day supply, incurred by the  
17 health plan or health insurance coverage  
18 and its participants, beneficiaries, and en-  
19 rollees, after manufacturer rebates, fees,  
20 and other remuneration for such drug dis-  
21 pensed during the plan year;

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

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

3 “(i) total gross spending by the plan  
4 or coverage, before manufacturer rebates,  
5 fees, or other manufacturer remuneration;

6 “(ii) the number of participants, bene-  
7 ficiaries, and enrollees who were dispensed  
8 a drug covered by such plan or coverage in  
9 that category or class, broken down by  
10 each such drug (identified by National  
11 Drug Code);

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

17 “(iv) the total out-of-pocket spending  
18 by participants, beneficiaries, and enroll-  
19 ees, including participant, beneficiary, and  
20 enrollee spending through copayments, co-  
21 insurance, and deductibles;

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

1           “(E) total amount received, or expected to  
2           be received, by the health plan or health insur-  
3           ance coverage in drug manufacturer rebates,  
4           fees, alternative discounts, and all other remu-  
5           neration received from the manufacturer or any  
6           third party, other than the plan sponsor, re-  
7           lated to utilization of drug or drug spending  
8           under that health plan or health insurance cov-  
9           erage during the plan year;

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

13           “(G) amounts paid directly or indirectly in  
14           rebates, fees, or any other type of remuneration  
15           to brokers, consultants, advisors, or any other  
16           individual or firm for the referral of the group  
17           health plan’s or health insurance issuer’s busi-  
18           ness to the pharmacy benefits manager.

19           “(2) PRIVACY REQUIREMENTS.—Health insur-  
20           ance issuers offering group health insurance cov-  
21           erage and entities providing pharmacy benefits man-  
22           agement services on behalf of a group health plan  
23           shall provide information under paragraph (1) in a  
24           manner consistent with the privacy, security, and  
25           breach notification regulations promulgated under



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

5 “(3) DISCLOSURE AND REDISCLOSURE.—

6 “(A) LIMITATION TO BUSINESS ASSOCI-  
7 ATES.—A group health plan receiving a report  
8 under paragraph (1) may disclose such informa-  
9 tion only to business associates of such plan as  
10 defined in section 160.103 of title 45, Code of  
11 Federal Regulations (or successor regulations).

12 “(B) CLARIFICATION REGARDING PUBLIC  
13 DISCLOSURE OF INFORMATION.—Nothing in  
14 this section prevents a health insurance issuer  
15 offering group health insurance coverage or an  
16 entity providing pharmacy benefits management  
17 services on behalf of a group health plan from  
18 placing reasonable restrictions on the public dis-  
19 closure of the information contained in a report  
20 described in paragraph (1), except that such  
21 issuer or entity may not restrict disclosure of  
22 such report to the Department of Health and  
23 Human Services, the Department of Labor, the  
24 Department of the Treasury, the Comptroller

1           General of the United States, or applicable  
2           State agencies.

3           “(C) LIMITED FORM OF REPORT.—The  
4           Secretary shall define through rulemaking a  
5           limited form of the report under paragraph (1)  
6           required of plan sponsors who are drug manu-  
7           facturers, drug wholesalers, or other direct par-  
8           ticipants in the drug supply chain, in order to  
9           prevent anti-competitive behavior.

10          “(4) REPORT TO GAO.—A group health plan or  
11          health insurance issuer offering group health insur-  
12          ance coverage, or an entity providing pharmacy ben-  
13          efits management services on behalf of a group  
14          health plan shall submit to the Comptroller General  
15          of the United States each of the first 4 reports sub-  
16          mitted to a plan sponsor under paragraph (1) with  
17          respect to such coverage or plan, and other such re-  
18          ports as requested, in accordance with the privacy  
19          requirements under paragraph (2), the disclosure  
20          and redisclosure standards under paragraph (3), the  
21          standards specified pursuant to paragraph (5), and  
22          such other information that the Comptroller General  
23          determines necessary to carry out the study under  
24          section 103(d) of the Health Care Price Trans-  
25          parency Act of 2023.

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

7           “(c) ENFORCEMENT.—

8           “(1) IN GENERAL.—Notwithstanding section  
9 502, the Secretary, in consultation with the Sec-  
10 retary of Health and Human Services and the Sec-  
11 retary of the Treasury, shall enforce this section.

12           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
13 TION.—A health insurance issuer or an entity pro-  
14 viding pharmacy benefits management services that  
15 violates subsection (a) or fails to provide information  
16 required under subsection (b) shall be subject to a  
17 civil monetary penalty in the amount of \$10,000 for  
18 each day during which such violation continues or  
19 such information is not disclosed or reported.

20           “(3) FALSE INFORMATION.—A health insurance  
21 issuer or entity providing pharmacy benefits man-  
22 agement services that knowingly provides false infor-  
23 mation under this section shall be subject to a civil  
24 money penalty in an amount not to exceed \$100,000  
25 for each item of false information. Such civil money

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

3 “(4) PROCEDURE.—The provisions of section  
4 1128A of the Social Security Act, other than sub-  
5 section (a) and (b) and the first sentence of sub-  
6 section (c)(1) of such section shall apply to civil  
7 monetary penalties under this subsection in the  
8 same manner as such provisions apply to a penalty  
9 or proceeding under section 1128A of the Social Se-  
10 curity Act.

11 “(5) WAIVERS.—The Secretary may waive pen-  
12 alties under paragraph (2), or extend the period of  
13 time for compliance with a requirement of this sec-  
14 tion, for an entity in violation of this section that  
15 has made a good-faith effort to comply with this sec-  
16 tion.

17 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
18 tion shall be construed to permit a health insurance issuer,  
19 group health plan, or other entity to restrict disclosure to,  
20 or otherwise limit the access of, the Secretary of Labor  
21 to a report described in subsection (b)(1) or information  
22 related to compliance with subsection (a) or (b) by such  
23 issuer, plan, or other entity subject to such subsections.

1 “(e) DEFINITION.—In this section, the term ‘whole-  
2 sale acquisition cost’ has the meaning given such term in  
3 section 1847A(c)(6)(B) of the Social Security Act.”; and

4 (B) in section 502 (29 U.S.C. 1132)—

5 (i) in subsection (a)—

6 (I) in paragraph (6), by striking  
7 “or (9)” and inserting “(9), or (13)”;

8 (II) in paragraph (10), by strik-  
9 ing at the end “or”;

10 (III) in paragraph (11), at the  
11 end by striking the period and insert-  
12 ing “; or”; and

13 (IV) by adding at the end the fol-  
14 lowing new paragraph:

15 “(12) by the Secretary, in consultation with the  
16 Secretary of Health and Human Services, and the  
17 Secretary of the Treasury, to enforce section 726.”;

18 (ii) in subsection (b)(3), by inserting  
19 “and subsections (a)(12) and (c)(13)” be-  
20 fore “, the Secretary is not”; and

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

23 “(13) SECRETARIAL ENFORCEMENT AUTHORITY  
24 RELATING TO OVERSIGHT OF PHARMACY BENEFITS  
25 MANAGER SERVICES.—

1           “(A) FAILURE TO PROVIDE TIMELY INFOR-  
2 MATION.—The Secretary, in consultation with  
3 the Secretary of Health and Human Services  
4 and the Secretary of the Treasury, may impose  
5 a penalty against any group health plan or  
6 health insurance issuer offering group health  
7 insurance coverage, or entity providing phar-  
8 macy benefits management services on behalf of  
9 such plan or coverage, that violates section  
10 726(a) or fails to provide information required  
11 under section 726(b), in the amount of \$10,000  
12 for each day during which such violation con-  
13 tinues or such information is not disclosed or  
14 reported.

15           “(B) FALSE INFORMATION.—The Sec-  
16 retary, in consultation with the Secretary of  
17 Health and Human Services and the Secretary  
18 of the Treasury, may impose a penalty against  
19 a group health plan or health insurance issuer  
20 offering group health coverage, or an entity  
21 providing pharmacy benefits management serv-  
22 ices on behalf of such plan or coverage, that  
23 knowingly provides false information under sec-  
24 tion 726 in an amount not to exceed \$100,000  
25 for each item of false information. Such penalty

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

3 “(C) WAIVERS.—The Secretary may waive  
4 penalties under subparagraph (A), or extend  
5 the period of time for compliance with a re-  
6 quirement of section 726, for an entity in viola-  
7 tion of such section that has made a good-faith  
8 effort to comply with such section.”.

9 (2) CLERICAL AMENDMENT.—The table of con-  
10 tents in section 1 of the Employee Retirement In-  
11 come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
12 is amended by inserting after the item relating to  
13 section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefits manager services.”.

14 (d) GAO STUDY.—

15 (1) IN GENERAL.—Not later than 3 years after  
16 the date of enactment of this Act, the Comptroller  
17 General of the United States shall submit to Con-  
18 gress a report on—

19 (A) pharmacy networks of group health  
20 plans, health insurance issuers, and entities  
21 providing pharmacy benefits management serv-  
22 ices under such group health plan or group or  
23 individual health insurance coverage, including  
24 networks that have pharmacies that are under  
25 common ownership (in whole or part) with

1 group health plans, health insurance issuers, or  
2 entities providing pharmacy benefits manage-  
3 ment services or pharmacy benefits administra-  
4 tive services under group health plan or group  
5 or individual health insurance coverage;

6 (B) as it relates to pharmacy networks  
7 that include pharmacies under common owner-  
8 ship described in subparagraph (A)—

9 (i) whether such networks are de-  
10 signed to encourage enrollees of a plan or  
11 coverage to use such pharmacies over other  
12 network pharmacies for specific services or  
13 drugs, and if so, the reasons the networks  
14 give for encouraging use of such phar-  
15 macies; and

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

20 (C) whether group health plans and health  
21 insurance issuers offering group or individual  
22 health insurance coverage have options to elect  
23 different network pricing arrangements in the  
24 marketplace with entities that provide phar-  
25 macy benefits management services, the preva-



1           lence of electing such different network pricing  
2           arrangements;

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

8           (E) the degree to which mail order, spe-  
9           cialty, or retail pharmacies that dispense pre-  
10          scription drugs to an enrollee in a group health  
11          plan or health insurance coverage that are  
12          under common ownership (in whole or part)  
13          with group health plans, health insurance  
14          issuers, or entities providing pharmacy benefits  
15          management services or pharmacy benefits ad-  
16          ministrative services under group health plan or  
17          group or individual health insurance coverage  
18          receive reimbursement that is greater than the  
19          median price charged to the group health plan  
20          or health insurance issuer when the same drug  
21          is dispensed to enrollees in the plan or coverage  
22          by other pharmacies included in the pharmacy  
23          network of that plan, issuer, or entity that are  
24          not wholly or partially owned by the health in-

1 insurance issuer or entity providing pharmacy  
2 benefits management services.

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

10 (3) DEFINITIONS.—In this subsection, the  
11 terms “group health plan”, “health insurance cov-  
12 erage”, and “health insurance issuer” have the  
13 meanings given such terms in section 2791 of the  
14 Public Health Service Act (42 U.S.C. 300gg–91).

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

17 (a) INITIAL REPORT.—Not later than December 31,  
18 2024, the Comptroller General of the United States shall  
19 submit to the Committees (as defined in subsection (d))  
20 an initial report that—

21 (1) identifies and describes health care trans-  
22 parency tools and Federal health care reporting re-  
23 quirements (as described in subsection (d)) that are  
24 in effect as of the date of the submission of such ini-  
25 tial report, including the frequency of reports with

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

3           (2) reviews how such reporting requirements  
4       are enforced;

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

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

12           (B) assisted health insurance plan spon-  
13       sors and fiduciaries improve benefits, lower  
14       health care costs for plan participants, and  
15       meet fiduciary requirements;

16           (4) includes recommendations to the Commit-  
17       tees, the Secretary of Health and Human Services,  
18       the Secretary of Labor, and the Secretary of the  
19       Treasury to—

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

22           (B) streamline Federal health care report-  
23       ing requirements to eliminate duplicative re-  
24       quirements and reduce the burden on entities

1 required to submit reports pursuant to such  
2 provisions;

3 (C) improve the accuracy and efficiency of  
4 such reports while maintaining the integrity  
5 and usability of the data provided by such re-  
6 ports;

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

9 (E) ensure that the data and information  
10 reported is comparable and usable to con-  
11 sumers, including patients, plan sponsors, and  
12 policy makers.

13 (b) FINAL REPORT.—Not later than December 31,  
14 2028, the Comptroller General of the United States shall  
15 submit to the Committees a report that includes—

16 (1) the information provided in the initial re-  
17 port, along with any updates to such information;  
18 and

19 (2) any new information with respect to health  
20 care transparency tools that have been released fol-  
21 lowing the submission of such initial report, or new  
22 reporting requirements in effect as of the date of the  
23 submission of the final report.

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

1 Comptroller General of the United States, in consultation  
2 with the Secretary of Health and Human Services, health  
3 care provider groups, and patient advocacy groups, shall  
4 submit to the Committees a report that includes rec-  
5 ommendations to expand price transparency reporting re-  
6 quirements to additional care settings, with an emphasis  
7 on settings where shoppable services (as defined in sub-  
8 section (d)) are furnished.

9 (d) DEFINITIONS.—In this section:

10 (1) COMMITTEES.—The term “Committees”  
11 means the Committee on Ways and Means, the  
12 Committee on Energy and Commerce, and the Com-  
13 mittee on Education and the Workforce of the  
14 House of Representatives, and the Committee on Fi-  
15 nance and the Committee on Health, Education,  
16 Labor, and Pensions of the Senate.

17 (2) FEDERAL HEALTH CARE REPORTING RE-  
18 QUIREMENTS.—The term “Federal health care re-  
19 porting requirements” includes regulatory and statu-  
20 tory requirements with respect to the reporting and  
21 publication of health care price, cost access, and  
22 quality data, including requirements established by  
23 the Consolidated Appropriations Act of 2021 (Public  
24 Law 116–260), this Act, and other reporting and  
25 publication requirements with respect to trans-

1       parency in health care as identified by the Comp-  
2       troller General of the United States.

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

8   **SEC. 105. REPORT ON INTEGRATION IN MEDICARE.**

9       (a) REQUIRED MA AND PDP REPORTING.—

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

13           “(6) REQUIRED DISCLOSURE OF CERTAIN IN-  
14       FORMATION RELATING TO HEALTH CARE PROVIDER  
15       OWNERSHIP.—

16           “(A) IN GENERAL.—For plan year 2025  
17       and for every third plan year thereafter, each  
18       MA organization offering an MA plan under  
19       this part during such plan year shall submit to  
20       the Secretary, at a time and in a manner speci-  
21       fied by the Secretary—

22           “(i) the taxpayer identification num-  
23       ber for each health care provider that was  
24       a specified health care provider with re-

1           spect to such organization during such  
2           year;

3           “(ii) the total amount of incentive-  
4           based payments made to, and the total  
5           amount of shared losses recoupments col-  
6           lected from, such specified health care pro-  
7           viders during such plan year; and

8           “(iii) the total amount of incentive-  
9           based payments made to, and the total  
10          amount of shared losses recoupments col-  
11          lected from, providers of services and sup-  
12          pliers not described in clause (ii) during  
13          such plan year.

14          “(B) DEFINITION.—For purposes of this  
15          paragraph, the term ‘specified health care pro-  
16          vider’ means, with respect to an MA organiza-  
17          tion and a plan year, a provider of services or  
18          supplier with respect to which such organization  
19          (or any person with an ownership or control in-  
20          terest (as defined in section 1124(a)(3)) in such  
21          organization) is a person with an ownership or  
22          control interest (as so defined).”.

23          (2) PRESCRIPTION DRUG PLANS.—Section  
24          1860D–12(b) of the Social Security Act (42 U.S.C.

1 1395w-112(b)) is amended by adding at the end the  
2 following new paragraph:

3 “(9) PROVISION OF INFORMATION RELATING TO  
4 PHARMACY OWNERSHIP.—

5 “(A) IN GENERAL.—For plan year 2025  
6 and for every third plan year thereafter, each  
7 PDP sponsor offering a prescription drug plan  
8 under this part during such plan year shall sub-  
9 mit to the Secretary, at a time and in a manner  
10 specified by the Secretary, the taxpayer identi-  
11 fication number and National Provider Identifi-  
12 fier for each pharmacy that was a specified  
13 pharmacy with respect to such sponsor during  
14 such year.

15 “(B) DEFINITION.—For purposes of this  
16 paragraph, the term ‘specified pharmacy’  
17 means, with respect to an PDP sponsor offering  
18 a prescription drug plan and a plan year, a  
19 pharmacy with respect to which—

20 “(i) such sponsor (or any person with  
21 an ownership or control interest (as de-  
22 fined in section 1124(a)(3)) in such spon-  
23 sor) is a person with an ownership or con-  
24 trol interest (as so defined); or



1                   “(ii) a pharmacy benefit manager of-  
2                   fering services under such plan (or any  
3                   person with an ownership or control inter-  
4                   est (as so defined) in such sponsor) is a  
5                   person with an ownership or control inter-  
6                   est (as so defined).”.

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

11 **“SEC. 1899D. REPORTS ON VERTICAL INTEGRATION UNDER**  
12 **MEDICARE.**

13           “(a) IN GENERAL.—Not later than June 15, 2029,  
14 and every 3 years thereafter, the Medicare Payment Advi-  
15 sory Commission shall submit to Congress a report on the  
16 state of vertical integration in the health care sector dur-  
17 ing the applicable year with respect to entities partici-  
18 pating in the Medicare program, including health care pro-  
19 viders, pharmacies, prescription drug plan sponsors, Medi-  
20 care Advantage organizations, and pharmacy benefit man-  
21 agers. Such report shall include—

22                   “(1) with respect to Medicare Advantage orga-  
23                   nizations, the evaluation described in subsection (b);

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

1 comparisons and evaluations described in subsection  
2 (c);

3 “(3) with respect to Medicare Advantage plans  
4 under which benefits are available for physician-ad-  
5 ministered drugs, the information described in sub-  
6 section (d); and

7 “(4) the identifications described in subsection  
8 (e); and

9 “(5) an analysis of the impact of such integra-  
10 tion on health care access, price, quality, and out-  
11 comes.

12 “(b) MEDICARE ADVANTAGE ORGANIZATIONS.—For  
13 purposes of subsection (a)(1), the evaluation described in  
14 this subsection is, with respect to Medicare Advantage or-  
15 ganizations and an applicable year, an evaluation, taking  
16 into account patient acuity and the types of areas serviced  
17 by such organization, of—

18 “(1) the average number of qualifying diag-  
19 noses made during such year with respect to enroll-  
20 ees of a Medicare Advantage plan offered by such  
21 organization who, during such year, received a  
22 health risk assessment from a specified health care  
23 provider;

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

1           “(3) any relationship between such risk scores  
2           for such enrollees receiving such an assessment from  
3           such a provider during such year and incentive pay-  
4           ments made to such providers;

5           “(4) the average risk score for enrollees of such  
6           plan who received any item or service from a speci-  
7           fied health care provider during such year;

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

12          “(6) any relationship between the risk scores of  
13          enrollees under such plan that have received any  
14          item or service from a specified provider and incen-  
15          tive payments made under the plan to specified pro-  
16          viders.

17          “(c) PRESCRIPTION DRUG PLANS.—For purposes of  
18          subsection (a)(2), the comparisons and evaluations de-  
19          scribed in this subsection are, with respect to prescription  
20          drug plans and an applicable year, the following:

21                 “(1) For each covered part D drug for which  
22                 benefits are available under such a plan, a compari-  
23                 son of the average negotiated rate in effect with  
24                 specified pharmacies with such rates in effect for in-

1 network pharmacies that are not specified phar-  
2 macies.

3 “(2) Comparisons of the following:

4 “(A) The total amount paid by pharmacy  
5 benefit managers to specified pharmacies for  
6 covered part D drugs and the total amount so  
7 paid to pharmacies that are not specified phar-  
8 macies for such drugs.

9 “(B) The total amount paid by such spon-  
10 sors to specified pharmacy benefit managers as  
11 reimbursement for covered part D drugs and  
12 the total amount so paid to pharmacy benefit  
13 managers that are not specified pharmacy ben-  
14 efit managers as such reimbursement.

15 “(C) Fees paid under by plan to specified  
16 pharmacy benefit managers compared to such  
17 fees paid to pharmacy benefit managers that  
18 are not specified pharmacy benefit managers.

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

1           “(4) To the extent that the available data per-  
2           mits, an evaluation of fees charged by rebate  
3           aggregators that are affiliated with plan sponsors.

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

9           “(1) With respect to each such plan, an identi-  
10          fication of each drug for which benefits were avail-  
11          able under such plan only when administered by a  
12          health care provider that acquired such drug from  
13          an affiliated pharmacy.

14          “(2) An evaluation of the difference between  
15          the total number of drugs administered by a health  
16          care provider that were acquired from affiliated  
17          pharmacies compared to the number of such drugs  
18          so administered that were acquired from pharmacies  
19          other than affiliated pharmacies, and an evaluation  
20          of the difference in payments for such drugs so ad-  
21          ministered when acquired from a specified pharmacy  
22          and when acquired from a pharmacy that is not a  
23          specified pharmacy.

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

1 a delay attributable to an affiliated pharmacy com-  
2 pared to the dollar value of all such drugs that were  
3 not so administered because of a delay attributable  
4 to pharmacy that is not an affiliated pharmacy.

5 “(4) The number of enrollees administered such  
6 a drug that was acquired from an affiliated phar-  
7 macy.

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

11 “(e) IDENTIFICATIONS.—For purposes of subsection  
12 (a)(4), the identifications described in this subsection are,  
13 with respect to an applicable year, identifications of each  
14 health care entity participating under the Medicare pro-  
15 gram with respect to which another health care entity so  
16 participating is a person with an ownership or control in-  
17 terest (as defined in section 1124(a)(3)).

18 “(f) DEFINITIONS.—In this section:

19 “(1) AFFILIATED PHARMACY.—The term ‘affili-  
20 ated pharmacy’ means, with respect to a Medicare  
21 Advantage plan offered by a Medicare Advantage or-  
22 ganization, a pharmacy with respect to which such  
23 organization (or any person with an ownership or  
24 control interest (as defined in section 1124(a)(3)) in

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

3 “(2) APPLICABLE YEAR.—The term ‘applicable  
4 year’ means, with respect to a report submitted  
5 under subsection (a), the first calendar year begin-  
6 ning at least 4 years prior to the date of the submis-  
7 sion of such report.

8 “(3) COVERED PART D DRUG.—The term ‘cov-  
9 ered part D drug’ has the meaning given such term  
10 in section 1860D–2(e).

11 “(4) DIRECT AND INDIRECT REMUNERATION.—  
12 The term ‘direct and indirect remuneration’ has the  
13 meaning given such term in section 423.308 of title  
14 42, Code of Federal Regulations (or any successor  
15 regulation).

16 “(5) QUALIFYING DIAGNOSIS.—The term ‘quali-  
17 fying diagnosis’ means, with respect to an enrollee of  
18 a Medicare Advantage plan, a diagnosis that is  
19 taken into account in calculating a risk score for  
20 such enrollee under the risk adjustment methodology  
21 established by the Secretary pursuant to section  
22 1853(a)(3).

23 “(6) RISK SCORE.—The term ‘risk score’  
24 means, with respect to an enrollee of a Medicare Ad-

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

3 “(7) PHYSICIAN-ADMINISTERED DRUG.—The  
4 term ‘physician-administered drug’ means a drug  
5 furnished to an individual that, had such individual  
6 been enrolled under part B and not enrolled under  
7 part C, would have been payable under section  
8 1842(o).

9 “(8) SPECIFIED HEALTH CARE PROVIDER.—  
10 The term ‘specified health care provider’ means,  
11 with respect to a Medicare Advantage plan offered  
12 by a Medicare Advantage organization, a health care  
13 provider with respect to which such organization (or  
14 or any person with an ownership or control interest (as  
15 defined in section 1124(a)(3)) in such organization)  
16 is a person with an ownership or control interest (as  
17 so defined).

18 “(9) SPECIFIED PHARMACY.—The term ‘speci-  
19 fied pharmacy’ means, with respect to a prescription  
20 drug plan offered by a prescription drug plan spon-  
21 sor, a pharmacy with respect to which—

22 “(A) such sponsor (or any person with an  
23 ownership or control interest (as defined in sec-  
24 tion 1124(a)(3)) in such sponsor) is a person



1 with an ownership or control interest (as so de-  
2 fined); or

3 “(B) a pharmacy benefit manager offering  
4 services under such plan (or any person with an  
5 ownership or control interest (as so defined) in  
6 such sponsor) is a person with an ownership or  
7 control interest (as so defined).

8 “(10) SPECIFIED PHARMACY BENEFIT MAN-  
9 AGER.—The term ‘specified pharmacy benefit man-  
10 ager’ means, with respect to a prescription drug  
11 plan offered by a prescription drug plan sponsor, a  
12 pharmacy benefit manager with respect to which  
13 such sponsor (or any person with an ownership or  
14 control interest (as defined in section 1124(a)(3)) in  
15 such sponsor) is a person with an ownership or con-  
16 trol interest (as so defined).”.

17 **TITLE II—FAIR PRICES FOR**  
18 **PATIENTS**

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

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

23 (1) in subsection (b)—

24 (A) in paragraph (2)(A), by striking “(8)  
25 and (9)” and inserting “(8), (9), and (10)”;

1 (B) in paragraph (9)(B)(ii), by striking  
2 “For a plan year” and inserting “Subject to  
3 paragraph (10), for a plan year”; and

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

6 “(10) LIMITATION ON COST SHARING TO NET  
7 PRICE AMOUNT.—

8 “(A) IN GENERAL.—For a plan year begin-  
9 ning on or after January 1, 2027, the coverage  
10 provides benefits for a supply of a covered part  
11 D drug dispensed by a pharmacy, for costs in  
12 excess of the deductible specified in paragraph  
13 (1) and prior to an individual reaching the out-  
14 of-pocket threshold under paragraph (4), with  
15 cost-sharing for a month’s supply that does not  
16 exceed the average net price for such a supply  
17 of such drug during such plan year (or, if  
18 lower, the applicable cash price for such a sup-  
19 ply of such drug so dispensed by such phar-  
20 macy).

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

22 “(i) APPLICABLE CASH PRICE.—The  
23 term ‘applicable cash price’ means, with  
24 respect to a supply of a covered part D  
25 drug dispensed by a pharmacy, the price

1           that such pharmacy would charge for such  
2           supply of such drug dispensed to an indi-  
3           vidual without benefits for such drug  
4           under any Federal health care program (as  
5           defined in section 1128B), a group health  
6           plan or group or individual health insur-  
7           ance coverage (as such terms are defined  
8           in section 2791 of the Public Health Serv-  
9           ice Act), or the program established under  
10          chapter 89 of title 5, United States Code.

11           “(ii) AVERAGE NET PRICE.—The term  
12          ‘average net price’ means, with respect to  
13          a supply of a covered part D drug, a pre-  
14          scription drug plan, and a plan year, the  
15          average amount paid under such plan (in-  
16          cluding any amounts paid by an individual  
17          enrolled under such plan as cost sharing  
18          for such drug) as payment for such a sup-  
19          ply of such drug dispensed during such  
20          year, less any rebates or other forms of re-  
21          muneration received under such plan with  
22          respect to such drug.”; and

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

1           “(7) COST SHARING LIMITED TO NET PRICE.—  
2           The coverage is provided in accordance with sub-  
3           section (b)(10).”.

4           (b) CONFORMING AMENDMENT TO COST-SHARING  
5           FOR LOW-INCOME INDIVIDUALS.—Section 1860D–  
6           14(a)(1)(D)(iii) of the Social Security Act (42 U.S.C.  
7           1395w–114(a)(1)(D)(iii)) is amended by adding at the  
8           end the following new sentence: “For plan year 2027 and  
9           subsequent plan years, the copayment amount applicable  
10          under this clause to a supply of a covered part D drug  
11          dispensed to the individual may not exceed the amount  
12          provided under section 1860D–2(b)(10).”.

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

16                 (1) an analysis of compliance with the amend-  
17                 ments made by this section;

18                 (2) an analysis of enforcement of such amend-  
19                 ments;

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

22                 (4) recommendations relating to improving pub-  
23                 lic disclosure, and public awareness of, the require-  
24                 ments of such amendments.

1 **SEC. 202. REQUIRING A SEPARATE IDENTIFICATION NUM-**  
2 **BER AND AN ATTESTATION FOR EACH OFF-**  
3 **CAMPUS OUTPATIENT DEPARTMENT OF A**  
4 **PROVIDER.**

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

8 “(23) USE OF UNIQUE HEALTH IDENTIFIERS;  
9 ATTESTATION.—

10 “(A) IN GENERAL.—No payment may be  
11 made under this subsection (or under an appli-  
12 cable payment system pursuant to paragraph  
13 (21)) for items and services furnished on or  
14 after January 1, 2026, by an off-campus out-  
15 patient department of a provider (as defined in  
16 subparagraph (C)) unless—

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

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

1 department is compliant with the require-  
2 ments described in section 413.65 of title  
3 42, Code of Federal Regulations (or a suc-  
4 cessor regulation).

5 “(B) PROCESS FOR SUBMISSION AND RE-  
6 VIEW.—Not later than 1 year after the date of  
7 enactment of this paragraph, the Secretary  
8 shall, through notice and comment rulemaking,  
9 establish a process for each provider with an  
10 off-campus outpatient department of a provider  
11 to submit an attestation pursuant to subpara-  
12 graph (A)(ii), and for the Secretary to review  
13 each such attestation and determine, through  
14 site visits, remote audits, or other means (as  
15 determined appropriate by the Secretary),  
16 whether such department is compliant with the  
17 requirements described in such subparagraph.

18 “(C) OFF-CAMPUS OUTPATIENT DEPART-  
19 MENT OF A PROVIDER DEFINED.—For purposes  
20 of this paragraph, the term ‘off-campus out-  
21 patient department of a provider’ means a de-  
22 partment of a provider (as defined in section  
23 413.65 of title 42, Code of Federal Regulations,  
24 or any successor regulation) that is not lo-  
25 cated—

1 “(i) on the campus (as defined in such  
2 section) of such provider; or

3 “(ii) within the distance (described in  
4 such definition of campus) from a remote  
5 location of a hospital facility (as defined in  
6 such section).”.

7 (b) HHS OIG ANALYSIS.—Not later than January  
8 1, 2030, the Inspector General of the Department of  
9 Health and Human Services shall submit to Congress—

10 (1) an analysis of the process established by the  
11 Secretary of Health and Human Services to conduct  
12 the reviews and determinations described in section  
13 1833(t)(23)(B) of the Social Security Act, as added  
14 by subsection (a) of this section; and

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

17 **SEC. 203. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**  
18 **OUTPATIENT DEPARTMENT SERVICES FUR-**  
19 **NISHED OFF-CAMPUS.**

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

23 “(H) PARITY IN FEE SCHEDULE AMOUNT  
24 FOR CERTAIN SERVICES FURNISHED BY AN

1 OFF-CAMPUS OUTPATIENT DEPARTMENT OF A  
2 PROVIDER.—

3 “(i) IN GENERAL.—Subject to clause  
4 (iii), in the case of specified OPD services  
5 (as defined in clause (v)) that are fur-  
6 nished during 2025 or a subsequent year  
7 by an off-campus outpatient department of  
8 a provider (as defined in clause (iv)) (or,  
9 in the case of an off-campus outpatient de-  
10 partment of a provider that is a hospital  
11 described in section 1886(d)(1)(B)(v), or is  
12 located in a rural area or a health profes-  
13 sional shortage area, such services that are  
14 furnished during 2026 or a subsequent  
15 year), there shall be substituted for the  
16 amount otherwise determined under this  
17 subsection for such service and year an  
18 amount equal to the payment amount that  
19 would have been payable under the applica-  
20 ble payment system under this part (other  
21 than under this subsection) had such serv-  
22 ices been furnished by such a department  
23 subject to such payment system pursuant  
24 to paragraph (21)(C).



1           “(ii) NOT BUDGET NEUTRAL IMPLE-  
2           MENTATION.—In making any budget neu-  
3           trality adjustments under this subsection  
4           for 2025 or a subsequent year, the Sec-  
5           retary shall not take into account the re-  
6           duced expenditures that result from the  
7           application of this subparagraph.

8           “(iii) TRANSITION.—The Secretary  
9           shall provide for a 4-year phase-in of the  
10          application of clause (i), with clause (i)  
11          being fully applicable for specified OPD  
12          services beginning with 2028 (or in the  
13          case of an off-campus outpatient depart-  
14          ment of a provider that is a hospital de-  
15          scribed in section 1886(d)(1)(B)(v), or is  
16          located in a rural area or a health profes-  
17          sional shortage area, beginning with 2029).

18          “(iv) OFF-CAMPUS DEPARTMENT OF A  
19          PROVIDER.—For purposes of this subpara-  
20          graph, the term ‘off-campus outpatient de-  
21          partment of a provider’ means a depart-  
22          ment of a provider (as defined in section  
23          413.65(a)(2) of title 42, Code of Federal  
24          Regulations) that is not located—

1           “(I) on the campus (as such term  
2           is defined in such section) of such  
3           provider; or

4           “(II) within the distance (de-  
5           scribed in such definition of campus)  
6           from a remote location of a hospital  
7           facility (as defined in such section).

8           “(v) OTHER DEFINITIONS.—For pur-  
9           poses of this subparagraph:

10           “(I) DESIGNATED AMBULATORY  
11           PAYMENT CLASSIFICATION GROUP.—  
12           The term ‘designated ambulatory pay-  
13           ment classification group’ means an  
14           ambulatory payment classification  
15           group for drug administration serv-  
16           ices.

17           “(II) HEALTH PROFESSIONAL  
18           SHORTAGE AREA.—The term ‘health  
19           professional shortage area’ has the  
20           meaning given such term in section  
21           332(a)(1)(A) of the Public Health  
22           Service Act.

23           “(III) RURAL AREA.—The term  
24           ‘rural area’ has the meaning given  
25           such term in section 1886(d)(2)(D).

1                   “(IV) SPECIFIED OPD SERV-  
2                   ICES.—The term ‘specified OPD serv-  
3                   ices’ means covered OPD services as-  
4                   signed to a designated ambulatory  
5                   payment classification group.”.

6           (b) IMPLEMENTATION.—Section 1833(t)(12) of the  
7 Social Security Act (42 U.S.C. 1395l(t)(12)) is amend-  
8 ed—

9           (1) in subparagraph (D), by striking “and” at  
10 the end;

11           (2) in subparagraph (E), by striking the period  
12 at the end and inserting “; and”; and

13           (3) by adding at the end the following new sub-  
14 paragraph:

15           “(F) the determination of any payment  
16 amount under paragraph (16)(H), including the  
17 transition under clause (iii) of such para-  
18 graph.”.

1     **TITLE III—PATIENT-FOCUSED**  
2                     **INVESTMENTS**

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

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

9             “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

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

15                     “(A) beginning with the third plan year be-  
16 ginning after the date of the enactment of this  
17 subsection—

18                         “(i) establish the electronic prior au-  
19 thorization program described in para-  
20 graph (2); and

21                         “(ii) meet the enrollee protection  
22 standards specified pursuant to paragraph  
23 (4); and

24                     “(B) beginning with the fourth plan year  
25 beginning after the date of the enactment of

1           this subsection, meet the transparency require-  
2           ments specified in paragraph (3).

3           “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-  
4           GRAM.—

5                   “(A) IN GENERAL.—For purposes of para-  
6           graph (1)(A), the electronic prior authorization  
7           program described in this paragraph is a pro-  
8           gram that provides for the secure electronic  
9           transmission of—

10                           “(i) a prior authorization request  
11                           from a provider of services or supplier to  
12                           a Medicare Advantage plan with respect to  
13                           an applicable item or service to be fur-  
14                           nished to an individual and a response, in  
15                           accordance with this paragraph, from such  
16                           plan to such provider or supplier; and

17                                   “(ii) any attachment relating to such  
18                           request or response.

19           “(B) ELECTRONIC TRANSMISSION.—

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

1 transmission described in subparagraph  
2 (A).

3 “(ii) STANDARDS.—An electronic  
4 transmission described in subparagraph  
5 (A) shall comply with—

6 “(I) applicable technical stand-  
7 ards adopted by the Secretary pursu-  
8 ant to section 1173; and

9 “(II) other requirements to pro-  
10 mote the standardization and stream-  
11 lining of electronic transactions under  
12 this part specified by the Secretary.

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

18 “(C) REAL-TIME DECISIONS.—

19 “(i) IN GENERAL.—Subject to clause  
20 (iv), the program described in subpara-  
21 graph (A) shall provide for real-time deci-  
22 sions (as defined by the Secretary in ac-  
23 cordance with clause (v)) by a Medicare  
24 Advantage plan with respect to prior au-  
25 thorization requests for applicable items

1 and services identified by the Secretary  
2 pursuant to clause (ii) if such requests are  
3 submitted with all medical or other docu-  
4 mentation required by such plan.

5 “(ii) IDENTIFICATION OF ITEMS AND  
6 SERVICES.—

7 “(I) IN GENERAL.—For purposes  
8 of clause (i), the Secretary shall iden-  
9 tify, not later than the date on which  
10 the initial announcement described in  
11 section 1853(b)(1)(B)(i) for the third  
12 plan year beginning after the date of  
13 the enactment of this subsection is re-  
14 quired to be announced, applicable  
15 items and services for which prior au-  
16 thorization requests are routinely ap-  
17 proved.

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

1                   prorate by the Secretary not less fre-  
2                   quently than biennially. The Secretary  
3                   shall announce any such update that  
4                   is to apply with respect to a plan year  
5                   not later than the date on which the  
6                   initial announcement described in sec-  
7                   tion 1853(b)(1)(B)(i) for such plan  
8                   year is required to be announced.

9                   “(iii) REQUEST FOR INFORMATION.—  
10                  The Secretary shall issue a request for in-  
11                  formation for purposes of initially identi-  
12                  fying applicable items and services under  
13                  clause (ii)(I).

14                  “(iv) EXCEPTION FOR EXTENUATING  
15                  CIRCUMSTANCES.—In the case of a prior  
16                  authorization request submitted to a Medi-  
17                  care Advantage plan for an individual en-  
18                  rolled in such plan during a plan year with  
19                  respect to an item or service identified by  
20                  the Secretary pursuant to clause (ii) for  
21                  such plan year, such plan may, in lieu of  
22                  providing a real-time decision with respect  
23                  to such request in accordance with clause  
24                  (i), delay such decision under extenuating  
25                  circumstances (as specified by the Sec-



1           retary), provided that such decision is pro-  
2           vided no later than 72 hours after receipt  
3           of such request (or, in the case that the  
4           provider of services or supplier submitting  
5           such request has indicated that such delay  
6           may seriously jeopardize such individual's  
7           life, health, or ability to regain maximum  
8           function, no later than 24 hours after re-  
9           ceipt of such request).

10           “(v) DEFINITION OF REAL-TIME DECI-  
11           SION.—In establishing the definition of a  
12           real-time decision for purposes of clause  
13           (i), the Secretary shall take into account  
14           current medical practice, technology,  
15           health care industry standards, and other  
16           relevant information relating to how quick-  
17           ly a Medicare Advantage plan may provide  
18           responses with respect to prior authoriza-  
19           tion requests.

20           “(vi) IMPLEMENTATION.—The Sec-  
21           retary shall use notice and comment rule-  
22           making for each of the following:

23                   “(I) Establishing the definition  
24                   of a ‘real-time decision’ for purposes  
25                   of clause (i).

1 “(II) Updating such definition.

2 “(III) Initially identifying appli-  
3 cable items or services pursuant to  
4 clause (ii)(I).

5 “(IV) Updating applicable items  
6 and services so identified as described  
7 in clause (ii)(II).

8 “(3) TRANSPARENCY REQUIREMENTS.—

9 “(A) IN GENERAL.—For purposes of para-  
10 graph (1)(B), the transparency requirements  
11 specified in this paragraph are, with respect to  
12 a Medicare Advantage plan, the following:

13 “(i) The plan, annually and in a man-  
14 ner specified by the Secretary, shall submit  
15 to the Secretary the following information:

16 “(I) A list of all applicable items  
17 and services that were subject to a  
18 prior authorization requirement under  
19 the plan during the previous plan  
20 year.

21 “(II) The percentage and number  
22 of specified requests (as defined in  
23 subparagraph (F)) approved during  
24 the previous plan year by the plan in  
25 an initial determination and the per-

1 centage and number of specified re-  
2 quests denied during such plan year  
3 by such plan in an initial determina-  
4 tion (both in the aggregate and cat-  
5 egorized by each item and service).

6 “(III) The percentage and num-  
7 ber of specified requests submitted  
8 during the previous plan year that  
9 were made with respect to an item or  
10 service identified by the Secretary  
11 pursuant to paragraph (2)(C)(ii) for  
12 such plan year, and the percentage  
13 and number of such requests that  
14 were subject to an exception under  
15 paragraph (2)(C)(iv) (categorized by  
16 each item and service).

17 “(IV) The percentage and num-  
18 ber of specified requests submitted  
19 during the previous plan year that  
20 were made with respect to an item or  
21 service identified by the Secretary  
22 pursuant to paragraph (2)(C)(ii) for  
23 such plan year that were approved  
24 (categorized by each item and serv-  
25 ice).

1           “(V) The percentage and number  
2 of specified requests that were denied  
3 during the previous plan year by the  
4 plan in an initial determination and  
5 that were subsequently appealed.

6           “(VI) The number of appeals of  
7 specified requests resolved during the  
8 preceding plan year, and the percent-  
9 age and number of such resolved ap-  
10 peals that resulted in approval of the  
11 furnishing of the item or service that  
12 was the subject of such request, cat-  
13 egorized by each applicable item and  
14 service and categorized by each level  
15 of appeal (including judicial review).

16           “(VII) The percentage and num-  
17 ber of specified requests that were de-  
18 nied, and the percentage and number  
19 of specified requests that were ap-  
20 proved, by the plan during the pre-  
21 vious plan year through the utilization  
22 of decision support technology, artifi-  
23 cial intelligence technology, machine-  
24 learning technology, clinical decision-

1 making technology, or any other tech-  
2 nology specified by the Secretary.

3 “(VIII) The average and the me-  
4 dian amount of time (in hours) that  
5 elapsed during the previous plan year  
6 between the submission of a specified  
7 request to the plan and a determina-  
8 tion by the plan with respect to such  
9 request for each such item and serv-  
10 ice, excluding any such requests that  
11 were not submitted with the medical  
12 or other documentation required to be  
13 submitted by the plan.

14 “(IX) The percentage and num-  
15 ber of specified requests that were ex-  
16 cluded from the calculation described  
17 in subclause (VIII) based on the  
18 plan’s determination that such re-  
19 quests were not submitted with the  
20 medical or other documentation re-  
21 quired to be submitted by the plan.

22 “(X) Information on each occur-  
23 rence during the previous plan year in  
24 which, during a surgical or medical  
25 procedure involving the furnishing of

1 an applicable item or service with re-  
2 spect to which such plan had ap-  
3 proved a prior authorization request,  
4 the provider of services or supplier  
5 furnishing such item or service deter-  
6 mined that a different or additional  
7 item or service was medically nec-  
8 essary, including a specification of  
9 whether such plan subsequently ap-  
10 proved the furnishing of such dif-  
11 ferent or additional item or service.

12 “(XI) A disclosure and descrip-  
13 tion of any technology described in  
14 subclause (VII) that the plan utilized  
15 during the previous plan year in mak-  
16 ing determinations with respect to  
17 specified requests.

18 “(XII) The number of grievances  
19 (as described in subsection (f)) re-  
20 ceived by such plan during the pre-  
21 vious plan year that were related to a  
22 prior authorization requirement.

23 “(XIII) Such other information  
24 as the Secretary determines appro-  
25 priate.

1 “(ii) The plan shall provide—

2 “(I) to each provider or supplier  
3 who seeks to enter into a contract  
4 with such plan to furnish applicable  
5 items and services under such plan,  
6 the list described in clause (i)(I) and  
7 any policies or procedures used by the  
8 plan for making determinations with  
9 respect to prior authorization re-  
10 quests;

11 “(II) to each such provider and  
12 supplier that enters into such a con-  
13 tract, access to the criteria used by  
14 the plan for making such determina-  
15 tions and an itemization of the med-  
16 ical or other documentation required  
17 to be submitted by a provider or sup-  
18 plier with respect to such a request;  
19 and

20 “(III) to an enrollee of the plan,  
21 upon request, access to the criteria  
22 used by the plan for making deter-  
23 minations with respect to prior au-  
24 thorization requests for an item or  
25 service.

1           “(B) OPTION FOR PLAN TO PROVIDE CER-  
2           TAIN ADDITIONAL INFORMATION.—As part of  
3           the information described in subparagraph  
4           (A)(i) provided to the Secretary during a plan  
5           year, a Medicare Advantage plan may elect to  
6           include information regarding the percentage  
7           and number of specified requests made with re-  
8           spect to an individual and an item or service  
9           that were denied by the plan during the pre-  
10          ceding plan year in an initial determination  
11          based on such requests failing to demonstrate  
12          that such individuals met the clinical criteria  
13          established by such plan to receive such items  
14          or services.

15          “(C) REGULATIONS.—The Secretary shall,  
16          through notice and comment rulemaking, estab-  
17          lish requirements for Medicare Advantage plans  
18          regarding the provision of—

19                 “(i) access to criteria described in  
20                 subparagraph (A)(ii)(II) to providers of  
21                 services and suppliers in accordance with  
22                 such subparagraph; and

23                 “(ii) access to such criteria to enroll-  
24                 ees in accordance with subparagraph  
25                 (A)(ii)(III).



1           “(D) PUBLICATION OF INFORMATION.—  
2           The Secretary shall publish information de-  
3           scribed in subparagraph (A)(i) and subpara-  
4           graph (B) on a public website of the Centers  
5           for Medicare & Medicaid Services. Such infor-  
6           mation shall be so published on an individual  
7           plan level and may in addition be aggregated in  
8           such manner as determined appropriate by the  
9           Secretary.

10           “(E) MEDPAC REPORT.—Not later than 3  
11           years after the date information is first sub-  
12           mitted under subparagraph (A)(i), the Medicare  
13           Payment Advisory Commission shall submit to  
14           Congress a report on such information that in-  
15           cludes a descriptive analysis of the use of prior  
16           authorization. As appropriate, the Commission  
17           should report on statistics including the fre-  
18           quency of appeals and overturned decisions.  
19           The Commission shall provide recommenda-  
20           tions, as appropriate, on any improvement that  
21           should be made to the electronic prior author-  
22           ization programs of Medicare Advantage plans.

23           “(F) SPECIFIED REQUEST DEFINED.—For  
24           purposes of this paragraph, the term ‘specified  
25           request’ means a prior authorization request

1           made with respect to an applicable item or serv-  
2           ice.

3           “(4) ENROLLEE PROTECTION STANDARDS.—  
4           For purposes of paragraph (1)(A)(ii), with respect  
5           to the use of prior authorization by Medicare Advan-  
6           tage plans for applicable items and services, the en-  
7           rollee protection standards specified in this para-  
8           graph are—

9                   “(A) the adoption of transparent prior au-  
10                   thorization programs developed in consultation  
11                   with enrollees and with providers and suppliers  
12                   with contracts in effect with such plans for fur-  
13                   nishing such items and services under such  
14                   plans;

15                   “(B) allowing for the waiver or modifica-  
16                   tion of prior authorization requirements based  
17                   on the performance of such providers and sup-  
18                   pliers in demonstrating compliance with such  
19                   requirements, such as adherence to evidence-  
20                   based medical guidelines and other quality cri-  
21                   teria; and

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

1 from enrollees and from providers and suppliers  
2 with such contracts in effect and is based on  
3 consideration of prior authorization data from  
4 previous plan years and analyses of current cov-  
5 erage criteria.

6 “(5) APPLICABLE ITEM OR SERVICE DE-  
7 FINED.—For purposes of this subsection, the term  
8 ‘applicable item or service’ means, with respect to a  
9 Medicare Advantage plan, any item or service for  
10 which benefits are available under such plan, other  
11 than a covered part D drug.

12 “(6) REPORTS TO CONGRESS.—

13 “(A) GAO.—Not later than the end of the  
14 fourth plan year beginning on or after the date  
15 of the enactment of this subsection, the Comp-  
16 troller General of the United States shall sub-  
17 mit to Congress a report containing an evalua-  
18 tion of the implementation of the requirements  
19 of this subsection and an analysis of issues in  
20 implementing such requirements faced by Medi-  
21 care Advantage plans.

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

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

5 “(i) in the case of the first such re-  
6 port, the fourth plan year beginning after  
7 the date of the enactment of this sub-  
8 section; and

9 “(ii) in the case of a subsequent re-  
10 port, the 2 plan years preceding the year  
11 of the submission of such report.”.

12 (b) ENSURING TIMELY RESPONSES FOR ALL PRIOR  
13 AUTHORIZATION REQUESTS SUBMITTED UNDER PART  
14 C.—Section 1852(g) of the Social Security Act (42 U.S.C.  
15 1395w–22(g)) is amended—

16 (1) in paragraph (1)(A), by inserting “and in  
17 accordance with paragraph (6)” after “paragraph  
18 (3)”;

19 (2) in paragraph (3)(B)(iii), by inserting “(or,  
20 subject to subsection (o), with respect to prior au-  
21 thorization requests submitted on or after the first  
22 day of the third plan year beginning after the date  
23 of the enactment of the **【Improving Seniors’ Timely**  
24 **Access to Care Act of 2023】**, not later than 24  
25 hours)” after “72 hours”.

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

3           “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-  
4 THORIZATION REQUESTS.—Subject to paragraph (3)  
5 and subsection (o), in the case of an organization  
6 determination made with respect to a prior author-  
7 ization request for an item or service to be furnished  
8 to an individual submitted on or after the first day  
9 of the third plan year beginning after the date of the  
10 enactment of this paragraph, the organization shall  
11 notify the enrollee (and the physician involved, as  
12 appropriate) of such determination no later than 7  
13 days (or such shorter timeframe as the Secretary  
14 may specify through notice and comment rule-  
15 making, taking into account enrollee and stakeholder  
16 feedback) after receipt of such request.”.

17       (c) RULE OF CONSTRUCTION.—None of the amend-  
18 ments made by this section may be construed to affect  
19 the finalization of the proposed rule entitled “Medicare  
20 and Medicaid Programs; Patient Protection and Afford-  
21 able Care Act; Advancing Interoperability and Improving  
22 Prior Authorization Processes for Medicare Advantage Or-  
23 ganizations, Medicaid Managed Care Plans, State Med-  
24 icaid Agencies, Children’s Health Insurance Program  
25 (CHIP) Agencies and CHIP Managed Care Entities,

1 Issuers of Qualified Health Plans on the Federally Facili-  
2 tated Exchanges, Merit-Based Incentive Payment System  
3 (MIPS) Eligible Clinicians, and Eligible Hospitals and  
4 Critical Access Hospitals in the Medicare Promoting  
5 Interoperability Program” published on December 13,  
6 2022 (87 Fed. Reg. 76238), or application of such rule  
7 so finalized, for plan years before the third plan year be-  
8 ginning on or after the date of the enactment of this Act.

9 **SEC. 302. EXTENSION OF CERTAIN DIRECT SPENDING RE-**  
10 **DUCTIONS.**

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

14 (1) in clause (i), by striking “; and” and insert-  
15 ing a semicolon;

16 (2) in clause (ii), by striking “second 6 months  
17 in which such order is effective for such fiscal year,  
18 the payment reduction shall be 0 percent.” and in-  
19 sserting “2 month period beginning on the day after  
20 the last day of the period described in clause (i) in  
21 which such order is effective for such fiscal year, the  
22 payment reduction shall be 1.5 percent; and”;

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

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