

118TH CONGRESS
1ST SESSION

S. 3548

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

IN THE SENATE OF THE UNITED STATES

DECEMBER 14, 2023

Mr. BRAUN (for himself, Mr. SANDERS, Ms. SMITH, and Mr. HICKENLOOPER) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Care Prices
5 Revealed and Information to Consumers Explained Trans-
6 parency Act” or the “Health Care PRICE Transparency
7 Act 2.0”.

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

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

6 “(e) STANDARD HOSPITAL CHARGES.—

7 “(1) IN GENERAL.—

8 “(A) DISCLOSURE OF STANDARD
9 CHARGES.—For purposes of paragraph (1), the
10 price transparency requirement described in
11 this paragraph is, with respect to a hospital,
12 that such hospital, in accordance with a method
13 and format established by the Secretary under
14 subparagraph (C), compile and make public
15 (without subscription and free of charge) for
16 each month—

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

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

24 “(I) on the hospital’s prices (in-
25 cluding the information described in
26 subparagraph (B)) for as many of the

1 Centers for Medicare & Medicaid
2 Services-specified shoppable services
3 that are furnished by the hospital,
4 and as many additional hospital-se-
5 lected shoppable services (or all such
6 additional services, if such hospital
7 furnishes fewer than 300 shoppable
8 services) as may be necessary for a
9 combined total of at least 300
10 shoppable services through December
11 31, 2024, after which the hospital’s
12 prices shall include all shoppable serv-
13 ices; and

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

20 “(B) STANDARD CHARGES DESCRIBED.—
21 For purposes of subparagraph (A), the informa-
22 tion described in this subparagraph is, with re-
23 spect to standard charges and prices, as appli-
24 cable, made public by a hospital, the following:

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

11 “(ii) The gross charge, as applicable,
12 expressed as a dollar amount, for each
13 such item or service, when provided in, as
14 applicable, the inpatient setting and out-
15 patient department setting.

16 “(iii) The discounted cash price, as
17 applicable, expressed as a dollar amount,
18 for each such item or service when pro-
19 vided in, as applicable, the inpatient set-
20 ting and outpatient department setting (or,
21 in the case no discounted cash price is
22 available for an item or service, the min-
23 imum cash price accepted by the hospital
24 from self-pay individuals for such item or
25 service, expressed as a dollar amount, as

1 well as, with respect to prices made public
2 pursuant to subparagraph (A)(ii), a link to
3 a consumer-friendly document that clearly
4 explains the hospital’s charity care policy).
5 The hospital shall accept the discounted
6 cash price as payment in full from any pa-
7 tient that chooses to pay in cash without
8 regard to the patient’s coverage.

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

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

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

19 “(C) UNIFORM METHOD AND FORMAT.—
20 Not later than January 1, 2025, the Secretary
21 shall establish a standard, uniform method and
22 format for hospitals to use in compiling and
23 making public standard charges pursuant to
24 subparagraph (A)(i) and a standard, uniform
25 method and format for such hospitals to use in

1 compiling and making public prices pursuant to
2 subparagraph (A)(ii). Such methods and for-
3 mats—

4 “(i) shall, in the case of such method
5 and format for making public standard
6 charges pursuant to subparagraph (A)(i),
7 ensure that such charges are made avail-
8 able in a machine-readable spreadsheet for-
9 mat;

10 “(ii) may be similar to any template
11 made available by the Centers for Medicare
12 & Medicaid Services as of the date of the
13 enactment of this subparagraph;

14 “(iii) shall meet such standards as de-
15 termined appropriate by the Secretary in
16 order to ensure the accessibility and
17 usability of such charges and prices; and

18 “(iv) shall be updated as determined
19 appropriate by the Secretary, in consulta-
20 tion with stakeholders.

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

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

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

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

20 “(5) ENFORCEMENT.—

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

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

5 “(B) CIVIL MONETARY PENALTY.—

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

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

23 “(II) in the case of a hospital
24 with more than 30 beds but fewer
25 than 101 beds, \$10 per bed per day

1 (or, in the case of such a hospital that
2 has been noncompliant with such re-
3 quirements for a 1-year period or
4 longer, beginning with the first day
5 following such 1-year period, \$12.50
6 per bed per day);

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

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

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

9 “(ii) INCREASE AUTHORITY.—In ap-
10 plying this subparagraph with respect to
11 violations occurring in 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 hospital under clause (i)(I);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “(A) DISCOUNTED CASH PRICE.—The
11 term ‘discounted cash price’ means the min-
12 imum charge that the hospital accepts from an
13 individual who pays cash, or cash equivalent,
14 for a hospital-furnished item or service.

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

19 “(C) HOSPITAL.—The term ‘hospital’
20 means a hospital (as defined in section 1861(e)
21 of the Social Security Act), a critical access
22 hospital (as defined in section 1861(mmm)(1)
23 of the Social Security Act), or a rural emer-
24 gency hospital (as defined in section 1861(kkk)
25 of the Social Security Act), together with any

1 parent, subsidiary, or other affiliated provider
2 or supplier of health care items and services
3 without regard to whether such parent, sub-
4 sidiary, or other affiliated provider or supplier
5 operates under separate licensure, certification,
6 or designation.

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

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

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

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—The amendments made by
24 subsection (a) shall apply beginning January 1,
25 2025.

1 (2) CONTINUED APPLICABILITY OF RULES FOR
 2 PREVIOUS YEARS.—Nothing in the amendments
 3 made by this section may be construed as affecting
 4 the applicability of the regulations codified at part
 5 180 of title 45, Code of Federal Regulations, before
 6 January 1, 2025.

7 (c) CONTINUED APPLICABILITY OF STATE LAW.—
 8 The provisions of this Act shall not supersede any provi-
 9 sion of State law that establishes, implements, or con-
 10 tinues in effect any requirement or prohibition related to
 11 health care price transparency, except to the extent that
 12 such requirement or prohibition prevents the application
 13 of a requirement or prohibition of this Act.

14 **SEC. 3. INCREASING PRICE TRANSPARENCY OF CLINICAL**
 15 **DIAGNOSTIC LABORATORY TESTS UNDER**
 16 **THE MEDICARE PROGRAM.**

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

20 “(f) CLINICAL DIAGNOSTIC LABORATORY PRICE
 21 TRANSPARENCY.—

22 “(1) IN GENERAL.—Beginning January 1,
 23 2025, any applicable laboratory that receives pay-
 24 ment from a group health plan or health insurance

1 issuer for furnishing any specified clinical diagnostic
2 laboratory test shall—

3 “(A) make publicly available on an internet
4 website the information described in paragraph
5 (2) with respect to each such specified clinical
6 diagnostic laboratory test that such laboratory
7 so furnishes; and

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

10 “(2) INFORMATION DESCRIBED.—For purposes
11 of paragraph (1), the information described in this
12 paragraph is, with respect to an applicable labora-
13 tory and a specified clinical diagnostic laboratory
14 test, the following:

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

1 “(B) The gross charge, as applicable, ex-
2 pressed as a dollar amount, for each such item
3 or service.

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

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

1 and outpatient department setting. If the
2 charges are based on an algorithm, percentage
3 of another amount, or other formula or criteria,
4 the clinical diagnostic laboratory also shall dis-
5 close such algorithm, percentage, formula, or
6 criteria as set forth in its contract and any
7 other terms, schedules, exhibits, data, or other
8 information referenced in any such contract as
9 shall be required to determine and disclose the
10 negotiated charge.

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

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

1 paragraph shall be made available as deter-
2 mined appropriate by the Secretary.

3 “(3) UNIFORM METHOD AND FORMAT.—Not
4 later than January 1, 2025, the Secretary shall es-
5 tablish a standard, uniform method and format for
6 applicable laboratories to use in compiling and mak-
7 ing public information pursuant to paragraph (1).
8 Such method and format—

9 “(A) shall include a machine-readable
10 spreadsheet format containing the information
11 described in paragraph (2) for all items and
12 services furnished by each laboratory;

13 “(B) may be similar to any template made
14 available by the Centers for Medicare & Med-
15 icaid Services (as described in subsection (e));

16 “(C) shall meet such standards as deter-
17 mined appropriate by the Secretary in order to
18 ensure the accessibility and usability of such in-
19 formation; and

20 “(D) shall be updated as determined ap-
21 propriate by the Secretary, in consultation with
22 stakeholders.

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

1 cable laboratory made publicly available in accord-
2 ance with paragraph (1) shall include the price or
3 rate (as applicable) for any ancillary item or service
4 (such as specimen collection services) that would
5 normally be furnished by such laboratory as part of
6 such test, as specified by the Secretary.

7 “(5) ENFORCEMENT.—

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

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

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

24 “(B) INCREASE AUTHORITY.—In applying
25 this paragraph with respect to violations occur-

1 ring in 2025 or a subsequent year, the Sec-
2 retary may through notice and comment rule-
3 making increase the per day limitation on civil
4 monetary penalties under subparagraph (A)(ii).

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

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

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

19 “(A) APPLICABLE LABORATORY.—The
20 term ‘applicable laboratory’ has the meaning
21 given such term in section 414.502, of title 42,
22 Code of Federal Regulations (or a successor
23 regulation), except that such term does not in-
24 clude a laboratory with respect to which stand-
25 ard charges and prices for specified clinical di-

1 agnostic laboratory tests furnished by such lab-
2 oratory are made available by a hospital pursu-
3 ant to subsection (e).

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

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

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

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

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

6 **SEC. 4. IMAGING TRANSPARENCY.**

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

10 “(g) IMAGING SERVICES PRICE TRANSPARENCY.—

11 “(1) IN GENERAL.—Beginning January 1,
12 2025, each provider of services and supplier that re-
13 ceives payment from a group health plan or health
14 insurance issuer for furnishing a specified imaging
15 service, other than such a provider or supplier with
16 respect to which standard charges and prices for
17 such services furnished by such provider or supplier
18 are made available by a hospital pursuant to sub-
19 section (e), shall—

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

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

3 “(2) INFORMATION DESCRIBED.—For purposes
4 of paragraph (1), the information described in this
5 paragraph is, with respect to a provider of services
6 or supplier and a specified imaging service, the fol-
7 lowing:

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

17 “(B) The gross charge, as applicable, ex-
18 pressed as a dollar amount, for each such item
19 or service.

20 “(C) The discounted cash price, as applica-
21 ble, expressed as a dollar amount, for each such
22 item or service (or, in the case no discounted
23 cash price is available for an item or service,
24 the minimum cash price accepted by the pro-
25 vider of services or supplier from self-pay indi-

1 viduals for such item or service when provided
2 in such settings for the previous three years, ex-
3 pressed as a dollar amount, as well as, with re-
4 spect to prices made public pursuant to sub-
5 paragraph (A)(ii), a link to a consumer-friendly
6 document that clearly explains the provider of
7 services or supplier’s charity care policy). The
8 provider of services or supplier shall accept the
9 discounted cash price as payment in full from
10 any patient that chooses to pay in cash without
11 regard to the patient’s coverage.

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

1 required to determine and disclose the negotiated
2 charge.

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

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

20 “(3) UNIFORM METHOD AND FORMAT.—Not
21 later than January 1, 2025, the Secretary shall es-
22 tablish a standard, uniform method and format for
23 providers of services and suppliers to use in making
24 public information described in paragraph (2). Any
25 such method and format—

1 “(A) shall include a machine-readable
2 spreadsheet format containing the information
3 described in paragraph (2) for all items and
4 services furnished by each provider of services
5 and supplier described in paragraph (1);

6 “(B) may be similar to any template made
7 available by the Centers for Medicare & Med-
8 icaid Services (as described in subsection (e));

9 “(C) shall meet such standards as deter-
10 mined appropriate by the Secretary in order to
11 ensure the accessibility and usability of such in-
12 formation; and

13 “(D) shall be updated as determined ap-
14 propriate by the Secretary, in consultation with
15 stakeholders.

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

22 “(5) ENFORCEMENT.—

23 “(A) IN GENERAL.—In the case that the
24 Secretary determines that a provider of services

1 or supplier is not in compliance with paragraph
2 (1)—

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

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

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

1 was failing to comply with such paragraph)
2 during which such failure to comply or fail-
3 ure to submit is ongoing.

4 “(B) INCREASE AUTHORITY.—In applying
5 this paragraph with respect to violations occur-
6 ring in 2027 or a subsequent year, the Sec-
7 retary may through notice and comment rule-
8 making increase the amount of the civil mone-
9 etary penalty under subparagraph (A)(iii).

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

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

23 “(E) PROVISION OF TECHNICAL ASSIST-
24 ANCE.—The Secretary shall, to the extent prac-
25 ticable, provide technical assistance relating to

1 compliance with the provisions of this sub-
 2 section to providers of services and suppliers re-
 3 questing such assistance.

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

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

15 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
 16 **PARENCY REQUIREMENTS.**

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

20 “(h) AMBULATORY SURGERY CENTER TRANS-
 21 PARENCY.—

22 “(1) IN GENERAL.—Beginning January 1,
 23 2025, each specified ambulatory surgical center that
 24 receives payment from a group health plan or health
 25 insurance issuer for furnishing items and services

1 shall comply with the price transparency require-
2 ment described in paragraph (2).

3 “(2) REQUIREMENT DESCRIBED.—

4 “(A) IN GENERAL.—For purposes of para-
5 graph (1), the price transparency requirement
6 described in this subsection is, with respect to
7 a specified ambulatory surgical center, that
8 such surgical center in accordance with a meth-
9 od and format established by the Secretary
10 under subparagraph (C)), compile and make
11 public (without subscription and free of
12 charge), for each year—

13 “(i) one or more lists, in a machine-
14 readable format specified by the Secretary,
15 of the ambulatory surgical center’s stand-
16 ard charges (including the information de-
17 scribed in subparagraph (B)) for each item
18 and service furnished by such surgical cen-
19 ter;

20 “(ii) information in a consumer-
21 friendly format (as specified by the Sec-
22 retary) on the ambulatory surgical center’s
23 prices (including the information described
24 in subparagraph (B)) for as many of the
25 Centers for Medicare & Medicaid Services-

1 specified shoppable services included on the
2 list described in subsection (e) that are
3 furnished by such surgical center, and as
4 many additional ambulatory surgical cen-
5 ter-selected shoppable services (or all such
6 additional services, if such surgical center
7 furnishes fewer than 300 shoppable serv-
8 ices) as may be necessary for a combined
9 total of at least 300 shoppable services;
10 and

11 “(iii) with respect to each Centers for
12 Medicare & Medicaid Services-specified
13 shoppable service (as described in clause
14 (ii)) that is not furnished by the ambula-
15 tory surgical center, an indication that
16 such service is not so furnished.

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

23 “(i) A description of each item or
24 service, accompanied by, as applicable, the
25 Healthcare Common Procedure Coding

1 System code, the national drug code, or
2 other identifier used or approved by the
3 Centers for Medicare & Medicaid
4 Services.

5 “(ii) The gross charge, expressed as a
6 dollar amount, for each such item or serv-
7 ice.

8 “(iii) The discounted cash price, ex-
9 pressed as a dollar amount, for each such
10 item or service (or, in the case no dis-
11 counted cash price is available for an item
12 or service, the minimum cash price accept-
13 ed by the specified ambulatory surgical
14 center from self-pay individuals for such
15 item or service when provided in such set-
16 tings for the previous three years, ex-
17 pressed as a dollar amount, as well as,
18 with respect to prices made public pursu-
19 ant to subparagraph (A)(ii), a link to a
20 consumer-friendly document that clearly
21 explains the provider of services or sup-
22 plier’s charity care policy). The specified
23 ambulatory surgical center shall accept the
24 discounted cash price as payment in full
25 from any patient that chooses to pay in

1 cash without regard to the patient’s cov-
2 erage.

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

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

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

1 of improving the accuracy of, or enabling
2 consumers to easily understand and com-
3 pare, standard charges and prices for an
4 item or service, except information that is
5 duplicative of any other reporting require-
6 ment under this subsection.

7 “(C) UNIFORM METHOD AND FORMAT.—

8 Not later than January 1, 2025, the Secretary
9 shall establish a standard, uniform method and
10 format for specified ambulatory surgical centers
11 to use in making public standard charges pur-
12 suant to subparagraph (A)(i) and a standard,
13 uniform method and format for such centers to
14 use in making public prices pursuant to sub-
15 paragraph (A)(ii). Any such method and for-
16 mat—

17 “(i) shall, in the case of such charges
18 made public by an ambulatory surgical
19 center, ensure that such charges are made
20 available in a machine-readable format;

21 “(ii) may be similar to any template
22 made available by the Centers for Medicare
23 & Medicaid Services (as described in sub-
24 section (e));

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

5 “(iv) shall be updated as determined
6 appropriate by the Secretary, in consulta-
7 tion with stakeholders.

8 “(3) NO DEEMED COMPLIANCE.—The avail-
9 ability of a price estimator tool shall not be consid-
10 ered to deem compliance with or otherwise vitiate
11 the requirements of this subsection (aa). Further-
12 more, the use of an estimator tool shall not be used
13 for purposes of compliance with any provisions in
14 this subsection.

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

23 “(5) ENFORCEMENT.—

24 “(A) IN GENERAL.—In the case of a speci-
25 fied ambulatory surgical center that fails to

1 comply with the requirements of this sub-
2 section—

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

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

14 “(B) CIVIL MONETARY PENALTY.—

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

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

8 “(ii) INCREASE AUTHORITY.—In ap-
9 plying this subparagraph with respect to
10 violations occurring in 2027 or a subse-
11 quent year, the Secretary may through no-
12 tice and comment rulemaking increase the
13 limitation on the per day amount of any
14 penalty applicable to a specified ambula-
15 tory surgical center under clause (i).

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

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

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

11 “(7) DEFINITIONS.—For purposes of this sec-
12 tion:

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

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

23 “(G) THIRD PARTY PAYER.—The term
24 ‘third party payer’ means an entity that is, by
25 statute, contract, or agreement, legally respon-

1 sible for payment of a claim for a health care
2 item or service.”.

3 **SEC. 6. STRENGTHENING HEALTH COVERAGE TRANS-**
4 **PARENCY REQUIREMENTS.**

5 (a) **TRANSPARENCY IN COVERAGE.**—Section
6 1311(e)(3)(C) of the Patient Protection and Affordable
7 Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

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

10 “(i) **IN GENERAL.**—The Exchange”;

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

12 (A) by striking “participating provider”
13 and inserting “provider”;

14 (B) by inserting “shall include the infor-
15 mation specified in clause (ii) and” after “such
16 information”;

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

20 (D) by striking “and such other” and all
21 that follows through the period and inserting
22 “or, at the option such individual, through a
23 paper or phone disclosure (as selected by such
24 individual and provided at no cost to such indi-

1 vidual) that meets such requirements as the
2 Secretary may specify.”; and

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

5 “(ii) SPECIFIED INFORMATION.—For
6 purposes of clause (i), the information
7 specified in this clause is, with respect to
8 benefits available under a health plan for
9 an item or service furnished by a health
10 care provider, the following:

11 “(I) If such provider is a partici-
12 pating provider with respect to such
13 item or service, the in-network rate
14 (as defined in subparagraph (F)) for
15 such item or service.

16 “(II) If such provider is not de-
17 scribed in subclause (I), the maximum
18 allowed amount for such item or serv-
19 ice.

20 “(III) The amount of cost shar-
21 ing (including deductibles, copay-
22 ments, and coinsurance) that the indi-
23 vidual will incur for such item or serv-
24 ice (which, in the case such item or
25 service is to be furnished by a pro-

1 vider described in subclause (II), shall
2 be calculated using the maximum
3 amount described in such subclause).

4 “(IV) The amount the individual
5 has already accumulated with respect
6 to any deductible or out of pocket
7 maximum under the plan (broken
8 down, in the case separate deductibles
9 or maximums apply to separate indi-
10 viduals enrolled in the plan, by such
11 separate deductibles or maximums, in
12 addition to any cumulative deductible
13 or maximum).

14 “(V) In the case such plan im-
15 poses any frequency or volume limita-
16 tions with respect to such item or
17 service (excluding medical necessity
18 determinations), the amount that such
19 individual has accrued towards such
20 limitation with respect to such item or
21 service.

22 “(VI) Any prior authorization,
23 concurrent review, step therapy, fail
24 first, or similar requirements applica-

1 ble to coverage of such item or service
2 under such plan.

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

7 “(I) is based on an internet
8 website;

9 “(II) provides for real-time re-
10 sponses to requests described in such
11 clause;

12 “(III) is updated in a manner
13 such that information provided
14 through such tool is timely and accu-
15 rate;

16 “(IV) allows such a request to be
17 made with respect to an item or serv-
18 ice furnished by—

19 “(aa) a specific provider
20 that is a participating provider
21 with respect to such item or serv-
22 ice;

23 “(bb) all providers that are
24 participating providers with re-

1 spect to such plan and such item
2 or service; or

3 “(cc) a provider that is not
4 described in item (bb);

5 “(V) provides that such a request
6 may be made with respect to an item
7 or service through use of the billing
8 code for such item or service or
9 through use of a descriptive term for
10 such item or service; and

11 “(VI) holds a member harmless
12 for the amount of any difference in
13 excess of the amount of the individ-
14 ual’s responsibility generated by the
15 self-service tool and the amount ulti-
16 mately billed or charged to the indi-
17 vidual.”.

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

22 “(E) RATE AND PAYMENT INFORMA-
23 TION.—

24 “(i) IN GENERAL.—Not later than
25 January 1, 2025, and every month there-

1 after, each health plan shall submit to the
2 Exchange, the Secretary, the State insur-
3 ance commissioner, and make available to
4 the public, the rate and payment informa-
5 tion described in clause (ii) in accordance
6 with clause (iii).

7 “(ii) RATE AND PAYMENT INFORMA-
8 TION DESCRIBED.—For purposes of clause
9 (i), the rate and payment information de-
10 scribed in this clause is, with respect to a
11 health plan, the following:

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

1 vider with respect to such item or
2 service, other than such a rate in ef-
3 fect with a provider that has sub-
4 mitted no claims for such item or
5 service to such plan.

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

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

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

1 day period beginning 180 days
2 before such date of submission to
3 each provider that was a partici-
4 pating provider with respect to
5 such drug, broken down by each
6 such provider (identified by na-
7 tional provider identifier), other
8 than such an amount paid to a
9 provider that has submitted no
10 claims for such drug to such
11 plan.

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

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

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

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

1 management or other third-party ad-
2 ministration services on a contractual
3 basis with a group health plan.

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

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

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

1 “(cc) Each such file includes
2 each of the following data ele-
3 ments:

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

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

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

1 “(DD) The place of
2 service code.

3 “(EE) The National
4 Provider Identifier or pro-
5 vider Tax Identification
6 Number.

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

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

1 “(V) Regulations promulgated
2 pursuant to this section shall provide
3 that:

4 “(aa) The Secretary shall
5 audit the three machine-readable
6 files required by subparagraph
7 (E)(ii) posted by no fewer than
8 20 group health plans or health
9 insurance issuers.

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

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

1 dited. Such report to Congress
2 shall be accessible to the public.

3 “(iv) USER GUIDE.—Each health plan
4 shall make available to the public instruc-
5 tions written in plain language explaining
6 how individuals may search for information
7 described in clause (ii) in files submitted in
8 accordance with clause (iii).

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

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

14 “(ii) IN-NETWORK RATE.—The term
15 ‘in-network rate’ means, with respect to a
16 health plan and an item or service fur-
17 nished by a provider that is a participating
18 provider with respect to such plan and
19 item or service, the contracted rate in ef-
20 fect between such plan and such provider
21 for such item or service. If the rate is
22 based on an algorithm, percentage of an-
23 other amount, or other formula or criteria,
24 the health plan also shall disclose such al-
25 gorithm, percentage, formula, or criteria as

1 set forth in its contract and any other
2 terms, schedules, exhibits, data, or other
3 information referenced in any such con-
4 tract as shall be required to determine and
5 disclose the negotiated rate.

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

14 “(H) ENFORCEMENT.—Each year, the
15 Secretary shall audit the three machine-read-
16 able files required by subparagraph (E)(ii) post-
17 ed by no fewer than 20 group health plans or
18 health insurance issuers.”.

19 (c) EFFECTIVE DATE.—

20 (1) IN GENERAL.—The amendments made by
21 subsection (a) shall apply beginning January 1,
22 2025.

23 (2) CONTINUED APPLICABILITY OF RULES FOR
24 PREVIOUS YEARS.—Nothing in the amendments
25 made by this section may be construed as affecting

1 the applicability of the rule entitled “Transparency
2 in Coverage” published by the Department of the
3 Treasury, the Department of Labor, and the De-
4 partment of Health and Human Services on Novem-
5 ber 12, 2020 (85 Fed. Reg. 72158) before January
6 1, 2025.

7 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**
8 **HEALTH DATA.**

9 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
10 TION.—

11 (1) IN GENERAL.—Paragraph (2) of section
12 408(b) of the Employee Retirement Income Security
13 Act of 1974 (29 U.S.C. 1108(b)) is amended by
14 adding at the end the following new subparagraphs:

15 “(C) No contract or arrangement for serv-
16 ices between a group health plan and any other
17 entity, including a health care provider (includ-
18 ing a health care facility), network or associa-
19 tion of providers, service provider offering ac-
20 cess to a network of providers, third-party ad-
21 ministrator, or pharmacy benefit manager (col-
22 lectively, ‘Covered Service Providers’), is rea-
23 sonable within the meaning of this paragraph
24 unless such contract or arrangement—

1 “(i) allows the responsible group
2 health plan access to all claims and en-
3 counter information, and any documenta-
4 tion supporting claim payments, including,
5 but not limited to, medical records and pol-
6 icy documents, or data described in section
7 724(a)(1)(B) to—

8 “(I) enable such entity to comply
9 with the terms of the plan and any
10 applicable law; and

11 “(II) determine the accuracy or
12 reasonableness of payment; and

13 “(ii) does not—

14 “(I) unreasonably limit or delay
15 access to such information or data;

16 “(II) limit the volume of claims
17 and encounter information or data
18 that the group health plan may access
19 during an audit;

20 “(III) limit the disclosure of prie-
21 ing terms for value-based payment ar-
22 rangements or capitated payment ar-
23 rangements, including—

24 “(aa) payment calculations
25 and formulas;

1 “(bb) quality measures;
2 “(cc) contract terms;
3 “(dd) payment amounts;
4 “(ee) measurement periods
5 for all incentives; and
6 “(ff) other payment meth-
7 odologies used by an entity, in-
8 cluding a health care provider
9 (including a health care facility),
10 network or association of pro-
11 viders, service provider offering
12 access to a network of providers,
13 third-party administrator, or
14 pharmacy benefit manager;
15 “(IV) limit the disclosure of over-
16 payments and overpayment recovery
17 terms;
18 “(V) limit the right of the group
19 health plan to select an auditor or de-
20 fine audit scope or frequency;
21 “(VI) otherwise limit or unduly
22 delay the group health plan from ac-
23 cessing claims and encounter informa-
24 tion or data in a daily batch.

1 “(VII) limit the disclosure of fees
2 charged to the group health plan re-
3 lated to plan administration and
4 claims processing, including renegoti-
5 ation fees, access fees, repricing fees,
6 or enhanced review fees;

7 “(VIII) limit the right of the
8 group health plan to request action on
9 any suspect claim payments; or

10 “(IX) limit public disclosure of
11 de-identified or aggregate information.

12 “(D) PRIVACY REQUIREMENTS.—Covered
13 Service Providers shall provide information
14 under this paragraph in a manner consistent
15 with the privacy and security regulations pro-
16 mulgated under the Health Insurance Port-
17 ability and Accountability Act (HIPAA). This
18 subparagraph shall not be read to abridge or
19 limit the disclosure requirements under this
20 paragraph or to impose additional privacy or se-
21 curity requirements on Covered Service Pro-
22 viders or plan sponsors.

23 “(E) DISCLOSURE AND REDISCLOSURE;
24 LIMITATION TO BUSINESS ASSOCIATES.—A
25 group health plan receiving information or data

1 under this paragraph may disclose such infor-
2 mation only to the entity from which the infor-
3 mation or data was received, the group health
4 plan or plan sponsor to which the information
5 or data pertains, or to that entity's business as-
6 sociates as defined in section 160.103 of title
7 45, Code of Federal Regulations, or as other-
8 wise permitted by the HIPAA Privacy Rule (45
9 CFR parts 160 and 164, subparts A and E).

10 “(F) DATA STANDARDS.—Information
11 made available under this section shall conform
12 to the following standards:

13 “(i) Institutional, professional, and
14 dental claims received from a healthcare
15 provider shall be made available to the
16 group health plan as ASC X12N 837 files.
17 The files shall be unmodified copies of the
18 files sent from the provider. In the event
19 that paper claims are sent by the provider,
20 they shall be converted to the ASC X12N
21 837 electronic format. Files shall be acces-
22 sible to the plan at no cost to the group
23 health plan.

24 “(ii) All claim payment (or EFT, elec-
25 tronic funds transfer) and electronic remit-

1 tance advice (ERA) notices sent by a Cov-
2 ered Service Provider shall be made avail-
3 able to the group health plan as ASC
4 X12N 835 files. The files shall be unmodi-
5 fied copies of the files sent by the Covered
6 Service Provider to the healthcare pro-
7 vider. Files shall be accessible at no cost to
8 the group health plan.

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

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

19 (2) CIVIL ENFORCEMENT.—

20 (A) IN GENERAL.—Subsection (e) of sec-
21 tion 502 of such Act (29 U.S.C. 1132) is
22 amended by adding at the end the following
23 new paragraph: “(13) In the case of an agree-
24 ment between a group health plan and a health
25 care provider (including a health care facility),

1 network or association of providers, service pro-
2 vider offering access to a network of providers,
3 third-party administrator, or pharmacy benefit
4 manager, that violates the provisions of section
5 724, the Secretary may assess a civil penalty
6 against such provider, network or association,
7 service provider offering access to a network of
8 providers, third-party administrator, pharmacy
9 benefit manager, or other service provider in
10 the amount of \$10,000 for each day during
11 which such violation continues. Such penalty
12 shall be in addition to other penalties as may
13 be prescribed by law.

14 (B) CONFORMING AMENDMENT.—Para-
15 graph (6) of section 502(a) of such Act is
16 amended by striking “or (9)” and inserting
17 “(9), or (13)”.

18 (3) EXISTING PROVISIONS VOID.—Section 410
19 of such Act is amended by adding at the end the fol-
20 lowing:

21 “(c) Any provision in an agreement or instrument
22 shall be void as against public policy if such provision—
23 “(1) unduly delays or limits a group health plan
24 from accessing the claims and encounter information
25 or data described in section 724(a)(1)(B); or

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

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

7 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
8 ITY INFORMATION.—Section 724(a)(3) of the Employee
9 Retirement Income Security Act of 1974 (29 U.S.C.
10 1185m(a)(3)) is amended to read as follows:

11 “(3) ATTESTATION.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (C), the group health plan or health in-
14 surance issuer offering group health insurance
15 coverage shall annually submit to the Secretary
16 an attestation that such plan or issuer of such
17 coverage is in compliance with the requirements
18 of this subsection. Such attestation shall also
19 include a statement verifying that—

20 “(i) the information or data described
21 under subparagraphs (A) and (B) of para-
22 graph (1) is available upon request and
23 provided to the group health plan, the plan
24 administrator, or the issuer in a timely
25 manner; and

1 “(ii) there are no terms in the agree-
2 ment under such paragraph (1) that di-
3 rectly or indirectly restrict or unduly delay
4 a group health plan, the plan adminis-
5 trator, or the issuer from auditing, review-
6 ing, or otherwise accessing such informa-
7 tion, except as permitted under section
8 408(b)(2)(C).

9 “(B) LIMITATION ON SUBMISSION.—Sub-
10 ject to clause (ii), a group health plan or issuer
11 offering group health insurance coverage may
12 not enter into an agreement with a third-party
13 administrator or other service provider to sub-
14 mit the attestation required under subpara-
15 graph (A).

16 “(C) EXCEPTION.—In the case of a group
17 health plan or issuer offering group health in-
18 surance coverage that is unable to obtain the
19 information or data needed to submit the attes-
20 tation required under subparagraph (A), such
21 plan or issuer may submit a written statement
22 in lieu of such attestation that includes—

23 “(i) an explanation of why such plan
24 or issuer was unsuccessful in obtaining
25 such information or data, including wheth-

1 er such plan or issuer was limited or pre-
2 vented from auditing, reviewing, or other-
3 wise accessing such information or data;

4 “(ii) a description of the efforts made
5 by the group health plan to remove any
6 gag clause provisions from the agreement
7 under paragraph (1); and

8 “(iii) a description of any response by
9 the third-party administrator or other serv-
10 ice provider with respect to efforts to com-
11 ply with the attestation requirement under
12 subparagraph (A).”.

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

18 **SEC. 8. PREEMPTION ONLY IN EVENT OF CONFLICT.**

19 The provisions of sections 2 through 5 of this Act
20 (including the amendments made by such sections) shall
21 not supersede any provision of State law which establishes,
22 implements, or continues in effect any requirement or pro-
23 hibition related to health care price transparency, except
24 to the extent that such requirement or prohibition pre-
25 vents the application of a requirement or prohibition of

1 such sections (or amendment). Nothing in this section
2 shall be construed to affect health plans established under
3 the Employee Retirement Income Security Act of 1974.

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