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

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Care Prices Revealed and Information to Consumers Explained Transparency Act'' or the ''Health Care PRICE Transparency Act 2.0''.

SEC. 2. STRENGTHENING HOSPITAL PRICE TRANSPARENCY REQUIREMENTS.

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

''(e) STANDARD HOSPITAL CHARGES.—

''(1) IN GENERAL.—

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

''(i) all of the hospital's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such hospital; and

''(ii) information in a consumer-friendly format (as specified by the Secretary)—

''(I) on the hospital's prices (including the information described in subparagraph (B)) for as many of the

Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services through December 31, 2024, after which the hospital's prices shall include all shoppable services; and

"(II) that includes, with respect to each Centers for Medicare & Medicaid Services-specified shoppable service that is not furnished by the hospital, an indication that such service is not so furnished.

"(B) STANDARD CHARGES DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a hospital, the following:

"(i) A plain language description of each item or service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

"(ii) The gross charge, as applicable, expressed as a dollar amount, for each such item or service, when provided in, as applicable, the inpatient setting and outpatient department setting.

"(iii) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the hospital from self-pay individuals for such item or service, expressed as a dollar amount, as

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

''(iv) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the hospital also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be required to determine and disclose the negotiated charge.

"(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, expressed as a non-zero dollar amount.

"(vi) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

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

compiling and making public prices pursuant to subparagraph (A)(ii). Such methods and formats—

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

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

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

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

"(2) NO DEEMED COMPLIANCE.—The availability of a price estimator tool shall not be considered to deem compliance with or otherwise vitiate the requirements of paragraph (2)(A)(ii) or any other requirements of this section. Furthermore, the

use of an estimator tool shall not be used for purposes of compliance with any provisions in this Section.

''(3) MONITORING COMPLIANCE.—The Secretary shall, in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each hospital's compliance with this subsection is reviewed not less frequently than once every year.

''(4) ATTESTATION.—A senior official from each hospital (the Chief Executive Officer, Chief Financial Officer, or an official of equivalent seniority) shall attest to the accuracy and completeness of the disclosures made in accordance with the hospital price transparency requirements set forth in this regulation. Such attestation shall be deemed to be material to payment from the Federal Government to the hospital.

''(5) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a hospital that fails to comply with the requirements of this subsection, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit

to such hospital a notification of such determination, which shall include a request for a corrective action plan to comply with such requirements.

''(B) CIVIL MONETARY PENALTY.—

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

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

''(II) in the case of a hospital with more than 30 beds but fewer than 101 beds, $10 per bed per day

(or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $12.50 per bed per day);

''(III) in the case of a hospital with more than 100 beds but fewer than 301 beds, $15 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $17.50 per bed per day);

''(IV) in the case of a hospital with more than 300 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

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

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

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

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

"(III) the limitation on the increase of any penalty applied under clause (iii) pursuant to the amounts specified in subclause (II) of such clause.

"(iii) PERSISTENT NONCOMPLIANCE.—

"(I) IN GENERAL.—In the case of a hospital that the Secretary has determined to be knowingly and willfully noncompliant with the provisions of this subsection two or more times during a 1-year period, the Secretary may increase any penalty otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

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

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

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

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

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

"(v) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1128A (other than subsections (a) and (b) of such section) shall apply to a civil monetary penalty imposed under this subparagraph

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

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

''(6) DEFINITIONS.—For purposes of this subsection:

''(A) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the minimum charge that the hospital accepts from an individual who pays cash, or cash equivalent, for a hospital-furnished item or service.

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

''(C) HOSPITAL.—The term 'hospital' means a hospital (as defined in section 1861(e) of the Social Security Act), a critical access hospital (as defined in section 1861(mmm)(1) of the Social Security Act), or a rural emergency hospital (as defined in section 1861(kkk) of the Social Security Act), together with any

parent, subsidiary, or other affiliated provider or supplier of health care items and services without regard to whether such parent, subsidiary, or other affiliated provider or supplier operates under separate licensure, certification, or designation.

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

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

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

(b) EFFECTIVE DATE.—

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

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

(c) CONTINUED APPLICABILITY OF STATE LAW.—The provisions of this Act shall not supersede any provision of State law that establishes, implements, or continues in effect any requirement or prohibition related to health care price transparency, except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of this Act.

SEC. 3. INCREASING PRICE TRANSPARENCY OF CLINICAL DIAGNOSTIC LABORATORY TESTS UNDER THE MEDICARE PROGRAM.

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

''(f) CLINICAL DIAGNOSTIC LABORATORY PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1, 2025, any applicable laboratory that receives payment from a group health plan or health insurance

issuer for furnishing any specified clinical diagnostic laboratory test shall—

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

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

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

"(A) A plain language description of each item or service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

''(B) The gross charge, as applicable, expressed as a dollar amount, for each such item or service.

''(C) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the laboratory from self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the laboratory's charity care policy). The laboratory shall accept the discounted cash price as payment in full from any patient that chooses to pay in cash without regard to the patient's coverage.

''(D) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting

and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the clinical diagnostic laboratory also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be required to determine and disclose the negotiated charge.

''(E) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, expressed as a non-zero dollar amount.

''(F) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this sub-

paragraph shall be made available as determined appropriate by the Secretary.

"(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2025, the Secretary shall establish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format—

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

"(B) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (e));

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

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

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

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

''(5) ENFORCEMENT.—

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

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

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

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

ring in 2025 or a subsequent year, the Secretary may through notice and comment rulemaking increase the per day limitation on civil monetary penalties under subparagraph (A)(ii).

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

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

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

''(A) APPLICABLE LABORATORY.—The term 'applicable laboratory' has the meaning given such term in section 414.502, of title 42, Code of Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges and prices for specified clinical di-

agnostic laboratory tests furnished by such laboratory are made available by a hospital pursuant to subsection (e).

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

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

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

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

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

SEC. 4. IMAGING TRANSPARENCY.

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

''(g) IMAGING SERVICES PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1, 2025, each provider of services and supplier that receives payment from a group health plan or health insurance issuer for furnishing a specified imaging service, other than such a provider or supplier with respect to which standard charges and prices for such services furnished by such provider or supplier are made available by a hospital pursuant to subsection (e), shall—

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

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

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

''(A) A plain language description of each item or service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the diagnosis-related group, the National Drug Code, and other nationally recognized identifier.

''(B) The gross charge, as applicable, expressed as a dollar amount, for each such item or service.

''(C) The discounted cash price, as applicable, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the provider of services or supplier from self-pay indi-

viduals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the provider of services or supplier's charity care policy). The provider of services or supplier shall accept the discounted cash price as payment in full from any patient that chooses to pay in cash without regard to the patient's coverage.

''(D) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the provider or supplier also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be re-

quired to determine and disclose the negotiated charge.

''(E) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, expressed as a non-zero dollar amount.

''(F) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection. In the case of standard charges and prices for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be made available as determined appropriate by the Secretary.

''(3) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2025, the Secretary shall establish a standard, uniform method and format for providers of services and suppliers to use in making public information described in paragraph (2). Any such method and format—

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

"(B) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (e));

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

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

"(4) MONITORING COMPLIANCE.—The Secretary shall, through notice and comment rulemaking and in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection.

"(5) ENFORCEMENT.—

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

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

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

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

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

was failing to comply with such paragraph) during which such failure to comply or failure to submit is ongoing.

''(B) INCREASE AUTHORITY.—In applying this paragraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the amount of the civil monetary penalty under subparagraph (A)(iii).

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

''(D) NO AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for violation of this subsection.

''(E) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to

compliance with the provisions of this subsection to providers of services and suppliers requesting such assistance.

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

"(6) SPECIFIED IMAGING SERVICE DEFINED.—the term 'specified imaging service' means an imaging service that is a Centers for Medicare & Medicaid Services-specified shoppable service (as described in subsection (e))."

SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY REQUIREMENTS.

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

"(h) AMBULATORY SURGERY CENTER TRANSPARENCY.—

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

shall comply with the price transparency requirement described in paragraph (2).

''(2) REQUIREMENT DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), the price transparency requirement described in this subsection is, with respect to a specified ambulatory surgical center, that such surgical center in accordance with a method and format established by the Secretary under subparagraph (C)), compile and make public (without subscription and free of charge), for each year—

''(i) one or more lists, in a machine-readable format specified by the Secretary, of the ambulatory surgical center's standard charges (including the information described in subparagraph (B)) for each item and service furnished by such surgical center;

''(ii) information in a consumer-friendly format (as specified by the Secretary) on the ambulatory surgical center's prices (including the information described in subparagraph (B)) for as many of the Centers for Medicare & Medicaid Services-

specified shoppable services included on the list described in subsection (e) that are furnished by such surgical center, and as many additional ambulatory surgical center-selected shoppable services (or all such additional services, if such surgical center furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services; and

''(iii) with respect to each Centers for Medicare & Medicaid Services-specified shoppable service (as described in clause (ii)) that is not furnished by the ambulatory surgical center, an indication that such service is not so furnished.

''(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is, with respect to standard charges and prices, as applicable, made public by a specified ambulatory surgical center, the following:

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

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

''(ii) The gross charge, expressed as a dollar amount, for each such item or service.

''(iii) The discounted cash price, expressed as a dollar amount, for each such item or service (or, in the case no discounted cash price is available for an item or service, the minimum cash price accepted by the specified ambulatory surgical center from self-pay individuals for such item or service when provided in such settings for the previous three years, expressed as a dollar amount, as well as, with respect to prices made public pursuant to subparagraph (A)(ii), a link to a consumer-friendly document that clearly explains the provider of services or supplier's charity care policy). The specified ambulatory surgical center shall accept the discounted cash price as payment in full from any patient that chooses to pay in

cash without regard to the patient's coverage.

''(iv) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service when provided in, as applicable, the inpatient setting and outpatient department setting. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the ambulatory surgical center also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be required to determine and disclose the negotiated charge.

''(v) The de-identified maximum and minimum negotiated charges, as applicable, for each such item or service, expressed as a non-zero dollar amount.

''(vi) Any other additional information the Secretary may require for the purpose

of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service, except information that is duplicative of any other reporting requirement under this subsection.

''(C) UNIFORM METHOD AND FORMAT.—Not later than January 1, 2025, the Secretary shall establish a standard, uniform method and format for specified ambulatory surgical centers to use in making public standard charges pursuant to subparagraph (A)(i) and a standard, uniform method and format for such centers to use in making public prices pursuant to subparagraph (A)(ii). Any such method and format—

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

''(ii) may be similar to any template made available by the Centers for Medicare & Medicaid Services (as described in subsection (e));

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

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

"(3) NO DEEMED COMPLIANCE.—The availability of a price estimator tool shall not be considered to deem compliance with or otherwise vitiate the requirements of this subsection (aa). Furthermore, the use of an estimator tool shall not be used for purposes of compliance with any provisions in this subsection.

"(4) MONITORING COMPLIANCE.—The Secretary shall, in consultation with the Inspector General of the Department of Health and Human Services, establish a process to monitor compliance with this subsection. Such process shall ensure that each specified ambulatory surgical center's compliance with this subsection is reviewed not less frequently than once every year.

"(5) ENFORCEMENT.—

"(A) IN GENERAL.—In the case of a specified ambulatory surgical center that fails to

comply with the requirements of this subsection—

"(i) the Secretary shall notify such ambulatory surgical center of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

"(ii) upon request of the Secretary, the ambulatory surgical center shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such requirements.

"(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—A specified ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of an ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be

subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such hospital was not complying with such requirements) during which such failure is ongoing (not to exceed $300 per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to violations occurring in 2027 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to a specified ambulatory surgical center under clause (i).

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

"(iv) NO AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for violation of this subsection.

"(6) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to specified ambulatory surgical centers requesting such assistance.

"(7) DEFINITIONS.—For purposes of this section:

"(A) DISCOUNTED CASH PRICE.—The term 'discounted cash price' means the charge that applies to an individual who pays cash, or cash equivalent, for a item or service furnished by an ambulatory surgical center.

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

"(C) GROUP HEALTH PLAN; GROUP HEALTH INSURANCE COVERAGE; INDIVIDUAL HEALTH INSURANCE COVERAGE.—The terms

'group health plan', 'group health insurance coverage', and 'individual health insurance coverage' have the meaning given such terms in section 2791 of the Public Health Service Act.

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

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

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

"(G) THIRD PARTY PAYER.—The term 'third party payer' means an entity that is, by statute, contract, or agreement, legally respon-

sible for payment of a claim for a health care item or service.''.

SEC. 6. STRENGTHENING HEALTH COVERAGE TRANSPARENCY REQUIREMENTS.

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

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

''(i) IN GENERAL.—The Exchange'';

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

(A) by striking ''participating provider'' and inserting ''provider'';

(B) by inserting ''shall include the information specified in clause (ii) and'' after ''such information'';

(C) by striking ''an Internet website'' and inserting ''a self-service tool that meets the requirements of clause (iii)''; and

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

vidual) that meets such requirements as the Secretary may specify.''; and

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

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

''(I) If such provider is a participating provider with respect to such item or service, the in-network rate (as defined in subparagraph (F)) for such item or service.

''(II) If such provider is not described in subclause (I), the maximum allowed amount for such item or service.

''(III) The amount of cost sharing (including deductibles, copayments, and coinsurance) that the individual will incur for such item or service (which, in the case such item or service is to be furnished by a pro-

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

''(IV) The amount the individual has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to separate individuals enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

''(V) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such individual has accrued towards such limitation with respect to such item or service.

''(VI) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applica-

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

''(iii) SELF-SERVICE TOOL.—For purposes of clause (i), a self-service tool established by a health plan meets the requirements of this clause if such tool—

''(I) is based on an internet website;

''(II) provides for real-time responses to requests described in such clause;

''(III) is updated in a manner such that information provided through such tool is timely and accurate;

''(IV) allows such a request to be made with respect to an item or service furnished by—

''(aa) a specific provider that is a participating provider with respect to such item or service;

''(bb) all providers that are participating providers with re-

spect to such plan and such item or service; or

''(cc) a provider that is not described in item (bb);

''(V) provides that such a request may be made with respect to an item or service through use of the billing code for such item or service or through use of a descriptive term for such item or service; and

''(VI) holds a member harmless for the amount of any difference in excess of the amount of the individual's responsibility generated by the self-service tool and the amount ultimately billed or charged to the individual.''.

(b) DISCLOSURE OF ADDITIONAL INFORMATION.—Section 1311(e)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)) is amended by adding at the end the following new subparagraphs:

''(E) RATE AND PAYMENT INFORMATION.—

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

after, each health plan shall submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, the rate and payment information described in clause (ii) in accordance with clause (iii).

''(ii) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of clause (i), the rate and payment information described in this clause is, with respect to a health plan, the following:

''(I) With respect to each item or service for which benefits are available under such plan (expressed as a dollar amount), including prescription drugs, identified by CPT, HCPCS, DRG, NDC, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a brief description of the item or service, the in-network rate in effect as of the date of the submission of such information with each provider (identified by national provider identifier) that is a participating pro-

vider with respect to such item or service, other than such a rate in effect with a provider that has submitted no claims for such item or service to such plan.

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

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

''(bb) The historical net price paid by such plan (net of rebates, discounts, and price concessions) (expressed as a dollar amount) for such drug dispensed or administered during the 90-

day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that has submitted no claims for such drug to such plan.

''(III) With respect to each item or service for which benefits are available under such plan (expressed as a dollar amount), identified by CPT, DRG, HCPCS, NDC, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a brief description of the item or service, the amount billed or charged by the provider, and the amount allowed by the plan, for each such item or service furnished during the 90-day period beginning 180 days before such date

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

''(iii) MANNER OF SUBMISSION.—Rate and payment information required to be submitted and made available under this subparagraph shall be so submitted and so made available as follows:

''(I) Information shall be contained in 3 separate machine-readable files corresponding to the information described in each of subclauses (I) through (III) of clause (ii) that meet such requirements as specified by the Secretary through rulemaking, in consultation with the Secretaries of Labor and the Treasury to apply comparable requirements to group health plans and to entities providing benefit

management or other third-party administration services on a contractual basis with a group health plan.

''(II) Requirements specified by the Secretary through rulemaking shall ensure that:

''(aa) Such files are limited to an appropriate size, are made available in a widely available format that allows for information contained in such files to be compared across health plans, and are accessible to individuals at no cost and without the need to establish a user account or provider other credentials.

''(bb) The rates, amounts, and prices to be disclosed include contractual terms containing calculation formulae, pricing methodologies, and other information necessary to determine the dollar value of reimbursement.

"(cc) Each such file includes each of the following data elements:

"(AA) A numerical identifier for the group health plan and/or health insurance issuer (such as a Health Insurance Oversight System identifier).

"(BB) A plain-language description of the item or service (including, for drugs, the proprietary and non-proprietary name assigned).

"(CC) The billing code, including any applicable modifiers, associated with such item or service, including the Healthcare Common Procedure Coding System code, diagnosis-related group, national drug code, or other commonly recognized code set.

"(DD) The place of service code.

"(EE) The National Provider Identifier or provider Tax Identification Number.

"(III) The rate and payment information disclosed under subclauses (I) through (III) of clause (ii) shall be separately delineated for each item or service, regardless of whether such item or service is reimbursed as a part of a bundle, episode, or other grouping of items and services.

"(IV) An officer or executive of competent authority shall attest to the accuracy and completeness of information submitted and made available under this subparagraph. Such attestation shall be deemed material to payments from the Federal Government received by the group health plan or health insurance issuer.

"(V) Regulations promulgated pursuant to this section shall provide that:

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

"(bb) The Secretary of Labor shall audit the three machine-readable files required by subparagraph (E)(ii) posted by no fewer than 200 group health plans or service providers furnishing third-party administrator services to a group health plan.

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

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

''(iv) USER GUIDE.—Each health plan shall make available to the public instructions written in plain language explaining how individuals may search for information described in clause (ii) in files submitted in accordance with clause (iii).

''(F) DEFINITIONS.—In this paragraph:

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

''(ii) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service. If the rate is based on an algorithm, percentage of another amount, or other formula or criteria, the health plan also shall disclose such algorithm, percentage, formula, or criteria as

set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be required to determine and disclose the negotiated rate.

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

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

(c) EFFECTIVE DATE.—

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

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

the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158) before January 1, 2025.

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

(a) GROUP HEALTH PLAN ACCESS TO INFORMATION.—

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

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

''(i) allows the responsible group health plan access to all claims and encounter information, and any documentation supporting claim payments, including, but not limited to, medical records and policy documents, or data described in section 724(a)(1)(B) to—

''(I) enable such entity to comply with the terms of the plan and any applicable law; and

''(II) determine the accuracy or reasonableness of payment; and

''(ii) does not—

''(I) unreasonably limit or delay access to such information or data;

''(II) limit the volume of claims and encounter information or data that the group health plan may access during an audit;

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

''(aa) payment calculations and formulas;

"(bb) quality measures;

"(cc) contract terms;

"(dd) payment amounts;

"(ee) measurement periods for all incentives; and

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

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

"(V) limit the right of the group health plan to select an auditor or define audit scope or frequency;

"(VI) otherwise limit or unduly delay the group health plan from accessing claims and encounter information or data in a daily batch.

''(VII) limit the disclosure of fees charged to the group health plan related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees;

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

''(IX) limit public disclosure of de-identified or aggregate information.

''(D) PRIVACY REQUIREMENTS.—Covered Service Providers shall provide information under this paragraph in a manner consistent with the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA). This subparagraph shall not be read to abridge or limit the disclosure requirements under this paragraph or to impose additional privacy or security requirements on Covered Service Providers or plan sponsors.

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

under this paragraph may disclose such information only to the entity from which the information or data was received, the group health plan or plan sponsor to which the information or data pertains, or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations, or as otherwise permitted by the HIPAA Privacy Rule (45 CFR parts 160 and 164, subparts A and E).

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

''(i) Institutional, professional, and dental claims received from a healthcare provider shall be made available to the group health plan as ASC X12N 837 files. The files shall be unmodified copies of the files sent from the provider. In the event that paper claims are sent by the provider, they shall be converted to the ASC X12N 837 electronic format. Files shall be accessible to the plan at no cost to the group health plan.

''(ii) All claim payment (or EFT, electronic funds transfer) and electronic remit-

tance advice (ERA) notices sent by a Covered Service Provider shall be made available to the group health plan as ASC X12N 835 files. The files shall be unmodified copies of the files sent by the Covered Service Provider to the healthcare provider. Files shall be accessible at no cost to the group health plan.

''(iii) The contractual terms containing calculation formulae, pricing methodologies, and other information used to determine the dollar value of reimbursement.

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

(2) CIVIL ENFORCEMENT.—

(A) IN GENERAL.—Subsection (c) of section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new paragraph: ''(13) In the case of an agreement between a group health plan and a health care provider (including a health care facility),

network or association of providers, service provider offering access to a network of providers, third-party administrator, or pharmacy benefit manager, that violates the provisions of section 724, the Secretary may assess a civil penalty against such provider, network or association, service provider offering access to a network of providers, third-party administrator, pharmacy benefit manager, or other service provider in the amount of $10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.

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

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

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

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

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

(4) TECHNICAL AMENDMENT.—Clause (i) of section 408(b)(2)(B) of such Act is amended by striking ''this clause'' and inserting ''this paragraph''.

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

''(3) ATTESTATION.—

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

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

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

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

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

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

er such plan or issuer was limited or prevented from auditing, reviewing, or otherwise accessing such information or data;

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

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

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

SEC. 8. PREEMPTION ONLY IN EVENT OF CONFLICT.

The provisions of sections 2 through 5 of this Act (including the amendments made by such sections) shall not supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition related to health care price transparency, except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of

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

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