

119TH CONGRESS
2D SESSION

S. _____

To expand access to and lower the cost of health care.

IN THE SENATE OF THE UNITED STATES

Mr. WARNER introduced the following bill; which was read twice and referred
to the Committee on _____

A BILL

To expand access to and lower the cost of health care.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health for the Commonwealth through Affordability, Re-
6 form, and Expansion Act of 2026” or the “Health CARE
7 Act of 2026”.

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

Sec. 1. Short title; table of contents.

TITLE I—RESTORING HEALTH CARE AND LOWERING COSTS

Sec. 101. Repeal of reconciliation health provisions.

Sec. 102. Permanent extension of enhanced tax credit.

2

Sec. 103. Promoting consumer outreach and education.

TITLE II—PATHWAY TO UNIVERSAL COVERAGE

Sec. 201. Establishment of health plan.

Sec. 202. Availability of plan.

Sec. 203. Affordability.

Sec. 204. Participating providers.

Sec. 205. Provider payment rates.

Sec. 206. No effect on Medicare benefits or Medicare trust funds.

TITLE III—STRENGTHENING MEDICAID

Sec. 301. Increased FMAP for medical assistance to newly eligible individuals.

Sec. 302. Supporting State Medicaid programs through economic downturns.

TITLE IV—LOWERING DRUG COSTS

Sec. 401. Expanding Medicare Drug price negotiation.

Sec. 402. Application of prescription drug inflation rebates to drugs furnished in the commercial market.

Sec. 403. Establishing an out-of-pocket limit on expenditures for prescription drugs under group health plans and group and individual health insurance coverage.

Sec. 404. Requirements with respect to cost-sharing for insulin products.

TITLE V—ENSURING QUALITY HEALTH INSURANCE AND REMOVING BARRIERS TO CARE

Sec. 501. Required exceptions process for medication step therapy protocols.

Sec. 502. Establishing requirements with respect to the use of prior authorization under Medicare Advantage plans.

Sec. 503. Special enrollment period for provider terminations.

Sec. 504. Providing coverage for hearing care under the Medicare program.

TITLE VI—LOWERING THE COST OF CARE

Sec. 601. Strengthening hospital price transparency.

Sec. 602. Clinical diagnostic laboratory price transparency.

Sec. 603. Imaging services price transparency.

Sec. 604. Ambulatory surgical center price transparency.

Sec. 605. Strengthening health coverage transparency requirements.

Sec. 606. Increasing group health plan access to health data.

Sec. 607. Oversight of administrative service providers.

Sec. 608. State preemption only in event of conflict.

Sec. 609. Requirement for explanation of benefits.

Sec. 610. Transparency in billing.

Sec. 611. Technical amendments.

Sec. 612. Implementation and enforcement funding.

TITLE VII—REFORMING PBMS AND PROTECTING PHARMACIES

Sec. 701. Ensuring accurate payments to pharmacies under Medicaid.

Sec. 702. Preventing the use of abusive spread pricing in Medicaid.

1 **TITLE I—RESTORING HEALTH**
2 **CARE AND LOWERING COSTS**

3 **SEC. 101. REPEAL OF RECONCILIATION HEALTH PROVI-**
4 **SIONS.**

5 (a) IN GENERAL.—Except as provided in subsection
6 (b), subtitle B of title VII of the Act titled “An Act to
7 provide for reconciliation pursuant to title II of H. Con.
8 Res. 14” (Public Law 119–21) is repealed and any law
9 or regulation referred to in such subtitle shall be applied
10 as if such subtitle and the amendments made by such sub-
11 title had not been enacted.

12 (b) EXCEPTIONS.—Subsection (a) shall not apply to
13 the provisions of and amendments made by sections
14 71202, 71306, and 71401 of such Act.

15 (c) RESCISSION.—

16 (1) OBBBA IMPLEMENTATION FUNDING.—The
17 unobligated amounts appropriated under the fol-
18 lowing provisions of the Act titled “An Act to pro-
19 vide for reconciliation pursuant to title II of H. Con.
20 Res. 14” (Public Law 119–21) are hereby rescinded:

21 (A) Section 71101(b).

22 (B) Section 71107(c).

23 (C) Section 71109(c).

24 (D) Section 71110(b).

25 (E) Section 71112(e).

1 (F) Section 71113(c).

2 (G) Section 71115(c).

3 (H) Section 71116(e).

4 (I) Section 71118(b).

5 (J) Subsections (e) and (f) of section
6 71119.

7 (K) Section 71120(c).

8 (L) Section 71121(b).

9 (2) TITLE XIX FUNDING.—The unobligated
10 amounts appropriated under section 1902(uu)(3) of
11 the Social Security Act (42 U.S.C. 1396a(uu)(3)),
12 as repealed by subsection (a), are hereby rescinded.

13 **SEC. 102. PERMANENT EXTENSION OF ENHANCED TAX**
14 **CREDIT.**

15 (a) IN GENERAL.—Subparagraph (A) of section
16 36B(c)(1) of the Internal Revenue Code of 1986 is amend-
17 ed by striking “but does not exceed 400 percent”.

18 (b) APPLICABLE PERCENTAGES.—

19 (1) IN GENERAL.—Subparagraph (A) of section
20 36B(b)(3) of the Internal Revenue Code of 1986 is
21 amended to read as follows:

22 “(A) APPLICABLE PERCENTAGE.—The ap-
23 plicable percentage for any taxable year shall be
24 the percentage such that the applicable percent-
25 age for any taxpayer whose household income is

1 within an income tier specified in the following
 2 table shall increase, on a sliding scale in a lin-
 3 ear manner, from the initial premium percent-
 4 age to the final premium percentage specified in
 5 such table for such income tier:

“In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 150 percent	0	0
150 percent up to 200 percent	0	2.0
200 percent up to 250 percent	2.0	4.0
250 percent up to 300 percent	4.0	6.0
300 percent up to 400 percent	6.0	8.5
400 percent and higher	8.5	8.5.”.

6 (2) CONFORMING AMENDMENTS RELATING TO
 7 AFFORDABILITY OF COVERAGE.—

8 (A) Paragraph (1) of section 36B(c) of
 9 such Code is amended by striking subparagraph
 10 (E).

11 (B) Subparagraph (C) of section 36B(c)(2)
 12 of such Code is amended by striking clause (iv).

13 (C) Paragraph (4) of section 36B(c) of
 14 such Code is amended by striking subparagraph
 15 (F).

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply to taxable years beginning after
 18 December 31, 2026.

1 **SEC. 103. PROMOTING CONSUMER OUTREACH AND EDU-**
2 **CATION.**

3 (a) IN GENERAL.—Section 1311(i) of the Patient
4 Protection and Affordable Care Act (42 U.S.C. 18031(i))
5 is amended—

6 (1) in paragraph (2), by adding at the end the
7 following new subparagraph:

8 “(C) SELECTION OF RECIPIENTS.—In the
9 case of an Exchange established and operated
10 by the Secretary within a State pursuant to sec-
11 tion 1321(c), in awarding grants under para-
12 graph (1), the Exchange shall—

13 “(i) select entities to receive such
14 grants based on an entity’s demonstrated
15 capacity to carry out each of the duties
16 specified in paragraph (3);

17 “(ii) not take into account whether or
18 not the entity has demonstrated how the
19 entity will provide information to individ-
20 uals relating to group health plans offered
21 by a group or association of employers or
22 short-term limited duration insurance (as
23 defined by the Secretary for purposes of
24 section 2791(b)(5) of the Public Health
25 Service Act); and

1 “(iii) ensure that, each year, the Ex-
2 change awards such a grant to—

3 “(I) at least one entity described
4 in this paragraph that is a community
5 and consumer-focused nonprofit
6 group; and

7 “(II) at least one entity described
8 in subparagraph (B), which may in-
9 clude another community and con-
10 sumer-focused nonprofit group in ad-
11 dition to any such group awarded a
12 grant pursuant to subclause (I).

13 In awarding such grants, an Exchange may
14 consider an entity’s record with respect to
15 waste, fraud, and abuse for purposes of main-
16 taining the integrity of such Exchange.”;

17 (2) in paragraph (3)—

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

20 “(C) facilitate enrollment, including with
21 respect to individuals with limited English pro-
22 ficiency and individuals with chronic illnesses,
23 in qualified health plans, State Medicaid plans
24 under title XIX of the Social Security Act, and

1 State child health plans under title XXI of such
2 Act;”;

3 (B) in subparagraph (D), by striking
4 “and” at the end;

5 (C) in subparagraph (E), by striking the
6 period at the end and inserting “; and”;

7 (D) by inserting after subparagraph (E)
8 the following new subparagraph:

9 “(F) provide referrals to community-based
10 organizations that address social needs related
11 to health outcomes.”; and

12 (E) by adding at the end the following
13 flush text:

14 “The duties specified in the preceding sentence may
15 be carried out by such a navigator at any time dur-
16 ing a year.”;

17 (3) in paragraph (4)(A)—

18 (A) in the matter preceding clause (i), by
19 striking “not”;

20 (B) in clause (i)—

21 (i) by inserting “not” before “be”;
22 and

23 (ii) by striking “; or” and inserting a
24 semicolon;

25 (C) in clause (ii)—

1 (i) by inserting “not” before “re-
2 ceive”; and

3 (ii) by striking the period and insert-
4 ing a semicolon; and

5 (D) by adding at the end the following new
6 clauses:

7 “(iii) maintain physical presence in
8 the State of the Exchange so as to allow
9 in-person assistance to consumers; and

10 “(iv) receive opioid specific education
11 and training that ensures the navigator
12 can best educate individuals on qualified
13 health plans offered through an Exchange,
14 specifically coverage under such plans for
15 opioid health care treatment.”; and

16 (4) in paragraph (6)—

17 (A) by striking “Grants under” and insert-
18 ing the following:

19 “(A) STATE EXCHANGES.—Grants under”;
20 and

21 (B) by adding at the end the following new
22 subparagraph:

23 “(B) FEDERAL EXCHANGES.—For pur-
24 poses of carrying out this subsection, with re-
25 spect to an Exchange established and operated

1 by the Secretary within a State pursuant to sec-
2 tion 1321(c), the Secretary shall obligate
3 \$100,000,000 out of amounts collected through
4 the user fees on participating health insurance
5 issuers pursuant to section 156.50 of title 45,
6 Code of Federal Regulations (or any successor
7 regulations), for fiscal year 2027 and each sub-
8 sequent fiscal year. Such amount for a fiscal
9 year shall remain available until expended.”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 this section shall apply with respect to plan years begin-
12 ning on or after January 1, 2027.

13 **TITLE II—PATHWAY TO** 14 **UNIVERSAL COVERAGE**

15 **SEC. 201. ESTABLISHMENT OF HEALTH PLAN.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services (referred to in this title as the “Sec-
18 retary”) shall establish a coordinated and low-cost health
19 plan (referred to in this title as the “health plan”) to pro-
20 vide access to quality health care for enrollees.

21 (b) INDIVIDUAL MARKET AVAILABILITY.—The Sec-
22 retary shall make the health plan available in the indi-
23 vidual market for plan year 2028 and each subsequent
24 plan year.

1 (c) RULEMAKING.—The Secretary may promulgate
2 such regulations as may be necessary to carry out this
3 title.

4 (d) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as may be
6 necessary to carry out this title.

7 **SEC. 202. AVAILABILITY OF PLAN.**

8 (a) ELIGIBILITY.—An individual shall be eligible to
9 enroll in the health plan if such individual, for the entire
10 period for which enrollment is sought—

11 (1) is a qualified individual within the meaning
12 of section 1312 of the Patient Protection and Af-
13 fordable Care Act (42 U.S.C. 18032);

14 (2) is not eligible for benefits under the Medi-
15 care program under title XVIII of the Social Secu-
16 rity Act (42 U.S.C. 1395 et seq.); and

17 (3) is not otherwise eligible for, or has been
18 otherwise offered, employer-sponsored health care
19 coverage.

20 (b) EXCHANGES.—The health plan shall be made
21 available through the Exchanges, including the Small
22 Business Health Options Program Exchange.

1 **SEC. 203. AFFORDABILITY.**

2 The Secretary shall ensure that coverage options for
3 the health plan are not more costly than comparable op-
4 tions offered on the Exchange in the applicable market.

5 **SEC. 204. PARTICIPATING PROVIDERS.**

6 (a) REQUIREMENT TO PARTICIPATE IN ORDER TO
7 BE ENROLLED UNDER MEDICARE.—Beginning January
8 1, 2028, the Secretary may require a health care provider
9 enrolled under the Medicare program under section
10 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j))
11 to be a participating provider under the health plan.

12 (b) REQUIREMENT TO PARTICIPATE IN ORDER TO
13 PARTICIPATE IN MEDICAID.—Beginning January 1, 2028,
14 the Secretary may require a health care provider under
15 a State Medicaid plan under title XIX of the Social Secu-
16 rity Act (42 U.S.C. 1396 et seq.) to also be a participating
17 provider under the health plan.

18 **SEC. 205. PROVIDER PAYMENT RATES.**

19 The Secretary shall set competitive provider payment
20 rates under the health plan using the best information
21 publicly available and data otherwise accessible to the Sec-
22 retary. The Secretary shall give consideration to existing
23 provider payment rates for commercial health plans and
24 provider costs to deliver care, giving special consideration
25 to increased costs for providers to deliver care in rural
26 and medically underserved areas.

1 **SEC. 206. NO EFFECT ON MEDICARE BENEFITS OR MEDI-**
2 **CARE TRUST FUNDS.**

3 Nothing in this title shall—

4 (1) affect the benefits available under title
5 XVIII of the Social Security Act (42 U.S.C. 1395 et
6 seq.); or

7 (2) impact the Federal Hospital Insurance
8 Trust Fund under section 1817 of the Social Secu-
9 rity Act (42 U.S.C. 1395i) or the Federal Supple-
10 mentary Medical Insurance Trust Fund under sec-
11 tion 1841 of the Social Security Act (42 U.S.C.
12 1395t) (including the Medicare Prescription Drug
13 Account within such Trust Fund).

14 **TITLE III—STRENGTHENING**
15 **MEDICAID**

16 **SEC. 301. INCREASED FMAP FOR MEDICAL ASSISTANCE TO**
17 **NEWLY ELIGIBLE INDIVIDUALS.**

18 (a) IN GENERAL.—Section 1905 of the Social Secu-
19 rity Act (42 U.S.C. 1396d) is amended—

20 (1) in subsection (y)(1)—

21 (A) in subparagraph (A), by striking
22 “2014, 2015, and 2016” and inserting “each of
23 the first 3 consecutive 12-month periods in
24 which the State provides medical assistance to
25 newly eligible individuals”;

1 (B) in subparagraph (B), by striking
2 “2017” and inserting “the fourth consecutive
3 12-month period in which the State provides
4 medical assistance to newly eligible individuals”;

5 (C) in subparagraph (C), by striking
6 “2018” and inserting “the fifth consecutive 12-
7 month period in which the State provides med-
8 ical assistance to newly eligible individuals”;

9 (D) in subparagraph (D), by striking
10 “2019” and inserting “the sixth consecutive 12-
11 month period in which the State provides med-
12 ical assistance to newly eligible individuals”;
13 and

14 (E) in subparagraph (E), by striking
15 “2020 and each year thereafter” and inserting
16 “the seventh consecutive 12-month period in
17 which the State provides medical assistance to
18 newly eligible individuals and each such period
19 thereafter”; and

20 (2) in subsection (z)(2)(B)(i)(II), by inserting
21 “(as in effect on the day before the enactment of the
22 Health CARE Act of 2026)” after “subsection
23 (y)(1)”.

24 (b) RETROACTIVE APPLICATION.—The amendments
25 made by subsection (a)(1) shall take effect as if included

1 in the enactment of Public Law 111–148 and shall apply
2 to amounts expended by any State for medical assistance
3 for newly eligible individuals described in subclause (VIII)
4 of section 1902(a)(10)(A)(i) of the Social Security Act
5 under a State Medicaid plan (or a waiver of such plan)
6 during the period before the date of enactment of this Act.

7 **SEC. 302. SUPPORTING STATE MEDICAID PROGRAMS**
8 **THROUGH ECONOMIC DOWNTURNS.**

9 (a) IN GENERAL.—Section 1905 of the Social Secu-
10 rity Act (42 U.S.C. 1396d) is amended—

11 (1) in subsection (b), by striking “and (ii)” and
12 inserting “(ii), and (ll)”; and

13 (2) by adding at the end the following new sub-
14 section:

15 “(ll) INCREASED FMAP DURING ECONOMIC
16 DOWNTURNS.—

17 “(1) IN GENERAL.—If a fiscal quarter that be-
18 gins on or after January 1, 2026, is an economic
19 downturn quarter (as defined in paragraph (2)) with
20 respect to a State, then the Federal medical assist-
21 ance percentage determined for each State for such
22 quarter under subsection (b) shall be equal to the
23 percentage determined for the State and quarter
24 under paragraph (3).

25 “(2) ECONOMIC DOWNTURN QUARTER.—

1 “(A) IN GENERAL.—

2 “(i) IN GENERAL.—In this subsection,
3 the term ‘economic downturn quarter’
4 means, with respect to a State, a fiscal
5 quarter during which the State’s unem-
6 ployment rate for the quarter exceeds the
7 percentage determined for the State and
8 quarter under clause (ii).

9 “(ii) THRESHOLD PERCENTAGE.—The
10 percentage determined under this clause
11 for a State and fiscal quarter is the per-
12 centage equal to the lower of—

13 “(I) the State unemployment
14 rate at the 20th percentile of the dis-
15 tribution of the State’s quarterly un-
16 employment rates for the 60-quarter
17 period preceding the quarter involved,
18 increased by 1 percentage point; and

19 “(II) the State’s average quar-
20 terly unemployment rate for the 12-
21 quarter period preceding the quarter
22 involved, increased by 1 percentage
23 point.

24 “(B) UNEMPLOYMENT DATA.—

1 “(i) IN GENERAL.—Except as pro-
2 vided in clause (ii), for purposes of deter-
3 mining unemployment rates for a State
4 and a quarter under this paragraph, the
5 Secretary shall use data from the Local
6 Area Unemployment Statistics from the
7 Bureau of Labor Statistics.

8 “(ii) APPLICATION TO CERTAIN TER-
9 RITORIES.—In the case of the Virgin Is-
10 lands, Guam, the Northern Mariana Is-
11 lands, American Samoa, or any other juris-
12 diction for which suitable data from the
13 Local Area Unemployment Statistics from
14 the Bureau of Labor Statistics are unavail-
15 able, the Secretary shall use data from the
16 U–3 unemployment measure of the Bureau
17 of Labor Statistics to make any necessary
18 determinations under subparagraph (A).

19 “(3) INCREASED FMAP DURING ECONOMIC
20 DOWNTURN QUARTER.—

21 “(A) IN GENERAL.—During a fiscal quar-
22 ter that is an economic downturn quarter with
23 respect to a State, the Federal medical assist-
24 ance percentage for the State and quarter de-

1 terminated under subsection (b) shall be equal
2 to—

3 “(i) the Federal medical assistance
4 percentage determined for the State and
5 quarter under subsection (b) without re-
6 gard to this subsection; increased by

7 “(ii) the number of percentage points
8 (rounded to the nearest tenth of a percent-
9 age point) equal to the product of—

10 “(I) the number of percentage
11 points (rounded to the nearest tenth
12 of a percentage point) by which the
13 unemployment rate for the State and
14 quarter exceeds the percentage deter-
15 mined for the State and quarter
16 under paragraph (2)(A)(ii); and

17 “(II) 4.8.

18 “(B) RULES OF APPLICATION.—The fol-
19 lowing rules shall apply with respect to the Fed-
20 eral medical assistance percentage determined
21 for a State and an economic downturn quarter
22 under this subsection:

23 “(i) SCOPE OF APPLICATION.—Such
24 Federal medical assistance percentage shall
25 not apply for purposes of—

1 “(I) disproportionate share hos-
2 pital payments described in section
3 1923;

4 “(II) payments under part D of
5 title IV; or

6 “(III) any payments under this
7 title that are based on a Federal med-
8 ical assistance percentage determined
9 for a State under subsection (aa) (but
10 only to the extent that such Federal
11 medical assistance percentage is high-
12 er than the economic recovery
13 FMAP).

14 “(ii) LIMITATION.—In no case shall—

15 “(I) the Federal medical assist-
16 ance percentage determined for a
17 State and quarter pursuant to this
18 subsection exceed 95 percent; or

19 “(II) any increase to the Federal
20 medical assistance percentage deter-
21 mined for a State and quarter pursu-
22 ant to this subsection result in the ap-
23 plication of a Federal medical assist-
24 ance percentage that exceeds 95 per-
25 cent.

1 “(iii) APPLICATION TO CHIP.—Not-
2 withstanding the first sentence of section
3 2105(b), the application of this subsection
4 may result in the enhanced FMAP of a
5 State for a fiscal year under such section
6 exceeding 85 percent, but in no case may
7 the application of this subsection before
8 application of the second sentence of such
9 section result in the enhanced FMAP of
10 the State exceeding 95 percent.

11 “(4) ADVANCE PAYMENT; RETROSPECTIVE AD-
12 JUSTMENT.—

13 “(A) IN GENERAL.—Prior to the beginning
14 of the second fiscal quarter that begins after
15 the date of enactment of this subsection, and
16 each subsequent fiscal quarter, the Secretary
17 shall, with respect to each State—

18 “(i) make an initial determination,
19 based on the projections made for the
20 State and quarter under subparagraph
21 (B), as to—

22 “(I) whether the application of
23 this subsection is expected to result in
24 the application of a higher Federal
25 medical assistance percentage for the

21

1 State and quarter than the percentage
2 that would otherwise apply without re-
3 gard to this subsection; and

4 “(II) if the application of this
5 subsection is expected to result in
6 such a higher Federal medical assist-
7 ance percentage for the State and
8 quarter, what such higher percentage
9 is expected to be; and

10 “(ii) if the Secretary determines under
11 clause (i) that the application of this sub-
12 section is expected to result in the applica-
13 tion of a higher Federal medical assistance
14 percentage for the State and quarter than
15 the percentage that would otherwise apply
16 without regard to this subsection—

17 “(I) apply such higher Federal
18 medical assistance percentage of the
19 State for purposes of making pay-
20 ments to the State for amounts ex-
21 pended during such quarter as med-
22 ical assistance under the State plan;
23 and

24 “(II) take into account such
25 higher Federal medical assistance per-

1 centage of the State for purposes of
2 calculating the enhanced FMAP for
3 the State and quarter under section
4 2105(b).

5 “(B) PROJECTION OF STATE UNEMPLOY-
6 MENT RATES.—Prior to the beginning of the
7 second fiscal quarter that begins after the date
8 of enactment of this subsection, and each subse-
9 quent fiscal quarter, the Secretary, acting
10 through the Chief Actuary of the Centers for
11 Medicare & Medicaid Services, shall, using the
12 most recently available data described in para-
13 graph (2)(B), make projections with respect
14 to—

15 “(i) the unemployment rates for each
16 State for such quarter;

17 “(ii) the threshold percentages de-
18 scribed in paragraph (2)(A)(ii) for each
19 State for such quarter; and

20 “(iii) the national unemployment rate
21 for such quarter.

22 “(C) RETROSPECTIVE ADJUSTMENT.—As
23 soon as practicable after final unemployment
24 data becomes available for a fiscal quarter for
25 which the Secretary made an initial determina-

1 tion under this paragraph, the Secretary shall,
2 with respect to each State—

3 “(i) make a final determination with
4 respect to the application of this subsection
5 for purposes of determining the Federal
6 medical assistance percentage and en-
7 hanced FMAP of the State for the quarter;
8 and

9 “(ii) in accordance with section
10 1903(d)(2) and section 2105(e), reduce or
11 increase the amount payable to the State
12 under section 1903(a) or section 2105 for
13 a subsequent fiscal quarter to the extent of
14 any overpayment or underpayment under
15 either such section which the Secretary de-
16 termines was made as a result of an incor-
17 rect initial determination under subpara-
18 graph (A)(i) with respect to the application
19 of this subsection for purposes of deter-
20 mining the Federal medical assistance per-
21 centage and enhanced FMAP of the State
22 for such prior fiscal quarter.

23 “(5) RETROSPECTIVE APPLICATION OF OVER-
24 THE-LIMIT FMAP INCREASES.—

1 “(A) IN GENERAL.—If a State has excess
2 percentage points with respect to an economic
3 downturn quarter and an applicable FMAP (as
4 determined under subparagraph (B)), the State
5 may elect to apply such excess percentage
6 points to increase such applicable FMAP for
7 one or more quarters during the look-back pe-
8 riod for the State and economic downturn quar-
9 ter in accordance with this paragraph.

10 “(B) EXCESS PERCENTAGE POINTS.—For
11 purposes of this paragraph, the number of ex-
12 cess percentage points for a State, economic
13 downturn quarter, and an applicable FMAP
14 shall be equal to the number of percentage
15 points by which—

16 “(i) the applicable FMAP for the
17 State and quarter (after application of
18 paragraph (3) but without regard to sub-
19 paragraph (B)(ii) of such paragraph); ex-
20 ceeds

21 “(ii) 95 percent.

22 “(C) EFFECT OF APPLICATION OF EXCESS
23 PERCENTAGE POINTS.—If a State elects to
24 apply excess percentage points to an applicable
25 FMAP to a quarter during a look-back period

1 under this paragraph, the Secretary shall deter-
2 mine the additional amount of payment under
3 section 1903(a) to which the State would have
4 been entitled for such quarter if the applicable
5 FMAP (as so increased) had been in effect for
6 such quarter, and shall treat such additional
7 amount as an underpayment for such quarter.

8 “(D) DISTRIBUTION OF EXCESS PERCENT-
9 AGE POINTS.—A State that has excess percent-
10 age points with respect to an economic down-
11 turn quarter and applicable FMAP may elect to
12 divide such points among more than 1 quarter
13 during the look-back period for such State and
14 quarter provided that no excess percentage
15 point (or fraction of an excess percentage point)
16 is applied to the applicable FMAP of more than
17 1 quarter.

18 “(E) LIMITATIONS.—

19 “(i) NO INCREASES OVER 100 PER-
20 CENT.—A State may not increase an appli-
21 cable FMAP for any quarter during a look-
22 back period under this paragraph if such
23 increase would result in the applicable
24 FMAP for such quarter exceeding 100 per-
25 cent.

26

1 “(ii) SCOPE OF APPLICATION.—Any
2 increase to an applicable FMAP of a State
3 for a fiscal quarter under this paragraph—

4 “(I) shall only apply with respect
5 to payments for amounts expended by
6 the State for medical assistance for
7 services furnished during such quarter
8 to which such applicable FMAP is ap-
9 plicable; and

10 “(II) shall not apply with respect
11 to payments described in paragraph
12 (3)(B)(i).

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

14 “(i) APPLICABLE FMAP.—The term
15 ‘applicable FMAP’ means, with respect to
16 a State and fiscal quarter—

17 “(I) the Federal medical assist-
18 ance percentage determined for the
19 State and quarter under subsection
20 (b);

21 “(II) the Federal medical assist-
22 ance percentage applicable under sub-
23 section (y);

1 “(III) the Federal medical assist-
2 ance percentage applicable under sub-
3 section (z)(2);

4 “(IV) the Federal medical assist-
5 ance percentage determined for the
6 State and quarter under subsection
7 (ff); or

8 “(V) the enhanced FMAP deter-
9 mined for the State and quarter
10 under section 2105(b).

11 “(ii) LOOK-BACK PERIOD.—The term
12 ‘look-back period’ means, with respect to a
13 State and a fiscal quarter that is an eco-
14 nomic downturn quarter for the State, the
15 period of 4 fiscal quarters that ends with
16 the fourth quarter which precedes the most
17 recent fiscal quarters that was not an eco-
18 nomic downturn quarter for the State.

19 “(6) REQUIREMENT FOR ALL STATES.—This
20 subsection shall not apply to a State with respect to
21 a fiscal quarter, if—

22 “(A) eligibility standards, methodologies,
23 or procedures under the State plan or a waiver
24 of such plan are more restrictive during such
25 quarter than the eligibility standards, meth-

1 odologies, or procedures, respectively, under
2 such plan (or waiver) as in effect on the last
3 day of the most recent fiscal quarter that was
4 not an economic downturn quarter for the
5 State;

6 “(B) the amount of any premium imposed
7 by the State pursuant to section 1916 or 1916A
8 during such quarter, with respect to an indi-
9 vidual enrolled under such plan (or waiver), ex-
10 ceeds the amount of such premium as of the
11 date described in subparagraph (A); or

12 “(C) the State fails to provide that an in-
13 dividual who is enrolled for benefits under such
14 plan (or waiver) as of the date described in sub-
15 paragraph (A) or enrolls for benefits under
16 such plan (or waiver) during the period begin-
17 ning with such date and ending with the day
18 before the first day of the next quarter that is
19 not an economic downturn quarter for the State
20 shall be treated as eligible for such benefits for
21 not less than 12 months after such date or (if
22 later) the date that such individual so enrolls
23 unless the individual requests a voluntary ter-
24 mination of eligibility or the individual ceases to
25 be a resident of the State.”.

1 (b) EXCLUSION OF ECONOMIC DOWNTURN FMAP
2 INCREASES FROM TERRITORIAL CAPS; SPECIAL RULE
3 FOR CHIP ALLOTMENTS.—

4 (1) EXCLUSION FROM TERRITORIAL CAPS.—
5 Section 1108 of the Social Security Act (42 U.S.C.
6 1308) is amended—

7 (A) in subsection (f), in the matter pre-
8 ceding paragraph (1), by striking “subsections
9 (g) and (h)” and inserting “subsections (g),
10 (h), and (j)”; and

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

12 “(j) EXCLUSION FROM CAPS OF AMOUNTS ATTRIB-
13 UTABLE TO ECONOMIC DOWNTURN FMAP.—Any pay-
14 ment made to a territory for a fiscal year in which the
15 Federal medical assistance percentage for the territory is
16 determined under section 1905(l) shall not be taken into
17 account for purposes of applying payment limits under
18 subsections (f) and (g) to the extent that such payment
19 exceeds the amount of the payment that would have been
20 made to the territory for the year if the Federal medical
21 assistance percentage for the territory had been deter-
22 mined without regard to such section.”.

23 (2) CHIP ALLOTMENTS.—Section 2104(m) of
24 the Social Security Act (42 U.S.C. 1397dd(m)) is
25 amended—

1 (A) in paragraph (2)(B), in the matter
2 preceding clause (i), by striking “paragraphs
3 (5), (7), and (12)” and inserting “paragraphs
4 (5), (7), (12), and (13)”; and

5 (B) by adding at the end the following new
6 paragraph:

7 “(13) SPECIAL RULE FOR ADJUSTING ALLOT-
8 MENTS DURING FISCAL YEARS WITH ECONOMIC
9 DOWNTURN QUARTERS.—

10 “(A) IN GENERAL.—If a fiscal quarter is
11 determined under section 1905(l) to be an eco-
12 nomic downturn quarter with respect to a State
13 then, as soon as practicable after such deter-
14 mination, the Secretary shall increase the allot-
15 ment for the State and the fiscal year in which
16 such fiscal quarter occurs in accordance with
17 subparagraph (B).

18 “(B) AMOUNT OF INCREASE.—

19 “(i) IN GENERAL.—The amount of an
20 increase to the allotment of a State de-
21 scribed in subparagraph (A) for a fiscal
22 year shall be equal to the amount by which
23 Federal payments made to the State for
24 the preceding fiscal year under this title
25 would have been increased (without regard

1 to whether such payments would exceed
2 the amount of the State's allotment for
3 such preceding fiscal year) if the enhanced
4 FMAP determined for the State for such
5 preceding fiscal year had been increased to
6 the same extent that the State's enhanced
7 FMAP for the fiscal year involved is ex-
8 pected to be increased as a result of the
9 application of section 1905(11) relative to
10 the enhanced FMAP that would apply to
11 the State for the fiscal year involved with-
12 out the application of such section.

13 “(ii) INCLUSION OF PROJECTED IN-
14 CREASES.—In increasing the allotment of a
15 State for a fiscal year under this para-
16 graph, the Secretary may base the calcula-
17 tion of such increase on projections made
18 by the Secretary with respect to—

19 “(I) the number of fiscal quar-
20 ters during such fiscal year that will
21 be economic downturn quarters; and

22 “(II) the effect that the applica-
23 tion of section 1905(11) is expected to
24 have on the enhanced FMAP of the
25 State for such fiscal year.

1 “(C) DISREGARD OF INCREASED PAY-
2 MENTS FOR PURPOSES OF FUTURE ALLOT-
3 MENTS.—Any Federal payment made to a State
4 under this title for a fiscal year in which the
5 Federal medical assistance percentage for the
6 State is determined under section 1905(l) shall
7 be disregarded when determining the allotment
8 of the State for any subsequent year, including
9 for purposes of applying this paragraph, to the
10 extent that such payment exceeds the amount
11 of the payment that would have been made to
12 the State for the year if the Federal medical as-
13 sistance percentage for the State and year had
14 been determined without regard to such sec-
15 tion.”.

16 **TITLE IV—LOWERING DRUG**
17 **COSTS**

18 **SEC. 401. EXPANDING MEDICARE DRUG PRICE NEGOTIA-**
19 **TION.**

20 (a) IN GENERAL.—Section 1192(a) of the Social Se-
21 curity Act (42 U.S.C. 1320f–1(a)) is amended—

22 (1) in paragraph (3), by striking “and” at the
23 end;

24 (2) in paragraph (4)—

1 (A) by striking “or a subsequent year”;

2 and

3 (B) by striking the period at the end and

4 inserting “; and”; and

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

6 “(5) with respect to the initial price applica-
7 bility year 2030, 30 negotiation-eligible drugs de-
8 scribed in subparagraph (A) or (B) of subsection
9 (d)(1) with respect to such year (or, all (if such
10 number is less than 30) such negotiation-eligible
11 drugs with respect to such year);

12 “(6) with respect to the initial price applica-
13 bility year 2031, 40 negotiation-eligible drugs de-
14 scribed in subparagraph (A) or (B) of subsection
15 (d)(1) with respect to such year (or, all (if such
16 number is less than 40) such negotiation-eligible
17 drugs with respect to such year); and

18 “(7) with respect to the initial price applica-
19 bility year 2032 or a subsequent year, 50 negotia-
20 tion-eligible drugs described in subparagraph (A) or
21 (B) of subsection (d)(1).”.

22 (b) EXPANSION OF DEFINITION OF MAXIMUM FAIR
23 PRICE ELIGIBLE INDIVIDUAL.—Section 1191(c)(2) of the
24 Social Security Act (42 U.S.C. 1320f(c)(2)) is amended—

1 (1) in subparagraph (A), by inserting “, or a
2 participant, beneficiary, or enrollee who is enrolled
3 under a group health plan or health insurance cov-
4 erage offered in the group or individual market (as
5 such terms are defined in section 2791 of the Public
6 Health Service Act) with respect to which there is in
7 effect an agreement with the Secretary under section
8 1197 with respect to such selected drug as so fur-
9 nished or dispensed” after “such selected drug”; and

10 (2) in subparagraph (B), by inserting “, or a
11 participant, beneficiary, or enrollee who is enrolled
12 under a group health plan or health insurance cov-
13 erage offered in the group or individual market (as
14 such terms are defined in section 2791 of the Public
15 Health Service Act) with respect to which there is in
16 effect an agreement with the Secretary under section
17 1197 with respect to such selected drug as so fur-
18 nished or administered” after “such selected drug”.

19 (c) APPLICATION OF ADMINISTRATIVE PROCEDURES
20 TO NEW MAXIMUM FAIR PRICE ELIGIBLE INDIVID-
21 UALS.—Section 1196(a)(3) of the Social Security Act (42
22 U.S.C. 1320f–5(a)(3)) is amended—

23 (1) in subparagraph (A), by striking “and” at
24 the end;

1 (2) in subparagraph (B), by striking the period
2 and inserting “; and”; and

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

5 “(C) maximum fair price eligible individ-
6 uals not described in subparagraph (A) or
7 (B).”.

8 (d) HEALTH INSURER AGREEMENTS.—Part E of
9 title XI of the Social Security Act (42 U.S.C. 1320f et
10 seq.) is amended—

11 (1) by redesignating sections 1197 and 1198 as
12 sections 1198 and 1199, respectively; and

13 (2) by inserting after section 1196 the following
14 new section:

15 **“SEC. 1197. VOLUNTARY PARTICIPATION BY OTHER**
16 **HEALTH PLANS.**

17 “(a) AGREEMENT TO PARTICIPATE UNDER PRO-
18 GRAM.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 under the program under this part the Secretary
21 shall be treated as having in effect an agreement
22 with a group health plan or health insurance issuer
23 offering group or individual health insurance cov-
24 erage (as such terms are defined in section 2791 of
25 the Public Health Service Act), with respect to a

1 price applicability period and a selected drug with
2 respect to such period—

3 “(A) in the case such selected drug fur-
4 nished or dispensed at a pharmacy or by mail
5 order service if coverage is provided under such
6 plan or coverage during such period for such se-
7 lected drug as so furnished or dispensed; and

8 “(B) in the case such selected drug fur-
9 nished or administered by a hospital, physician,
10 or other provider of services or supplier if cov-
11 erage is provided under such plan or coverage
12 during such period for such selected drug as so
13 furnished or administered.

14 “(2) OPTING OUT OF AGREEMENT.—The Sec-
15 retary shall not be treated as having in effect an
16 agreement under the program under this part with
17 a group health plan or health insurance issuer offer-
18 ing group or individual health insurance coverage
19 with respect to a price applicability period and a se-
20 lected drug with respect to such period if such a
21 plan or issuer affirmatively elects, through a process
22 specified by the Secretary, not to participate under
23 the program with respect to such period and drug.

24 “(b) PUBLICATION OF ELECTION.—With respect to
25 each price applicability period and each selected drug with

1 respect to such period, the Secretary, the Secretary of
2 Labor, and the Secretary of the Treasury, as applicable,
3 shall make public a list of each group health plan and each
4 health insurance issuer offering group or individual health
5 insurance coverage, with respect to which coverage is pro-
6 vided under such plan or coverage for such drug, that has
7 elected under subsection (a) not to participate under the
8 program with respect to such period and drug.”.

9 (e) APPLICATION TO GROUP HEALTH PLANS AND
10 HEALTH INSURANCE COVERAGE.—

11 (1) PHSA.—Part D of title XXVII of the Pub-
12 lic Health Service Act (42 U.S.C. 300gg–111 et
13 seq.) is amended by adding at the end the following
14 new section:

15 **“SEC. 2799A–12. DRUG PRICE NEGOTIATION PROGRAM AND**
16 **APPLICATION OF MAXIMUM FAIR PRICES.**

17 “(a) IN GENERAL.—In the case of a group health
18 plan or health insurance issuer offering group or indi-
19 vidual health insurance coverage that is treated under sec-
20 tion 1197 of the Social Security Act as having in effect
21 an agreement with the Secretary under the Drug Price
22 Negotiation Program under part E of title XI of such Act,
23 with respect to a price applicability period (as defined in
24 section 1191(b) of such Act) and a selected drug (as de-
25 fined in section 1192(c) of such Act) with respect to such

1 period for which coverage is provided under such plan or
2 coverage—

3 “(1) the provisions of such part shall apply—

4 “(A) in the case the drug is furnished or
5 dispensed at a pharmacy or by a mail order
6 service, to such plan or coverage, and to the
7 participants, beneficiaries, and enrollees en-
8 rolled under such plan or coverage, during such
9 period, with respect to such selected drug, in
10 the same manner as such provisions apply to
11 prescription drug plans and MA–PD plans, and
12 to participants, beneficiaries, and enrollees en-
13 rolled under such prescription drug plans and
14 MA–PD plans during such period; and

15 “(B) in the case the drug is furnished or
16 administered by a hospital, physician, or other
17 provider of services or supplier, to such plan or
18 coverage, and to the participants, beneficiaries,
19 and enrollees enrolled under such plan or cov-
20 erage, and to hospitals, physicians, and other
21 providers of services and suppliers during such
22 period, with respect to such drug in the same
23 manner as such provisions apply to the Sec-
24 retary, to participants, beneficiaries, and enroll-
25 ees entitled to benefits under part A of title

1 XVIII or enrolled under part B of such title,
2 and to hospitals, physicians, and other pro-
3 viders and suppliers participating under title
4 XVIII during such period;

5 “(2) the plan or issuer shall apply any cost-
6 sharing responsibilities under such plan or coverage,
7 with respect to such selected drug, by substituting
8 an amount not more than the maximum fair price
9 negotiated under such part E of title XI for such
10 drug in lieu of the drug price upon which the cost-
11 sharing would have otherwise applied, and such cost-
12 sharing responsibilities with respect to such selected
13 drug may not exceed such maximum fair price; and

14 “(3) the Secretary shall apply the provisions of
15 such part E to such plan, issuer, and coverage, such
16 participants, beneficiaries, and enrollees so enrolled
17 in such plans and coverage, and such hospitals, phy-
18 sicians, and other providers and suppliers partici-
19 pating in such plans and coverage.

20 “(b) NOTIFICATION REGARDING NONPARTICIPATION
21 IN DRUG PRICE NEGOTIATION PROGRAM.—A group
22 health plan or a health insurance issuer offering group or
23 individual health insurance coverage shall publicly dis-
24 close, in a manner and in accordance with a process speci-
25 fied by the Secretary, any election made under section

1 1197 of the Social Security Act by such plan or issuer
2 to not participate in the Drug Price Negotiation Program
3 under part E of title XI of such Act with respect to a
4 selected drug (as defined in section 1192(c) of such Act)
5 for which coverage is provided under such plan or coverage
6 before the beginning of the plan year for which such elec-
7 tion was made.”.

8 (2) ERISA.—

9 (A) IN GENERAL.—Subpart B of part 7 of
10 subtitle B of title I of the Employee Retirement
11 Income Security Act of 1974 (29 U.S.C. 1185
12 et seq.) is amended by adding at the end the
13 following new section:

14 **“SEC. 727. DRUG PRICE NEGOTIATION PROGRAM AND AP-**
15 **PLICATION OF MAXIMUM FAIR PRICES.**

16 “(a) IN GENERAL.—In the case of a group health
17 plan or health insurance issuer offering group health in-
18 surance coverage that is treated under section 1197 of the
19 Social Security Act as having in effect an agreement with
20 the Secretary of Health and Human Services under the
21 Drug Price Negotiation Program under part E of title XI
22 of such Act, with respect to a price applicability period
23 (as defined in section 1191(b) of such Act) and a selected
24 drug (as defined in section 1192(c) of such Act) with re-

1 spect to such period for which coverage is provided under
2 such plan or coverage—

3 “(1) the provisions of such part shall apply, as
4 applicable—

5 “(A) in the case the drug is furnished or
6 dispensed at a pharmacy or by a mail order
7 service, to such plan or coverage, and to the
8 participants and beneficiaries enrolled under
9 such plan or coverage, during such period, with
10 respect to such selected drug, in the same man-
11 ner as such provisions apply to prescription
12 drug plans and MA–PD plans, and to partici-
13 pants and beneficiaries enrolled under such pre-
14 scription drug plans and MA–PD plans during
15 such period; and

16 “(B) in the case the drug is furnished or
17 administered by a hospital, physician, or other
18 provider of services or supplier, to the group
19 health plan or coverage offered by an issuer, to
20 the participants and beneficiaries enrolled
21 under such plans or coverage, and to hospitals,
22 physicians, and other providers of services and
23 suppliers during such period, with respect to
24 such drug in the same manner as such provi-
25 sions apply to the Secretary of Health and

1 Human Services, to participants and bene-
2 ficiaries entitled to benefits under part A of
3 title XVIII or enrolled under part B of such
4 title, and to hospitals, physicians, and other
5 providers and suppliers participating under title
6 XVIII during such period;

7 “(2) the plan or issuer shall apply any cost-
8 sharing responsibilities under such plan or coverage,
9 with respect to such selected drug, by substituting
10 an amount not more than the maximum fair price
11 negotiated under such part E of title XI for such
12 drug in lieu of the drug price upon which the cost-
13 sharing would have otherwise applied, and such cost-
14 sharing responsibilities with respect to such selected
15 drug may not exceed such maximum fair price; and

16 “(3) the Secretary shall apply the provisions of
17 such part E to such plan, issuer, and coverage, and
18 such participants and beneficiaries so enrolled in
19 such plans.

20 “(b) NOTIFICATION REGARDING NONPARTICIPATION
21 IN DRUG PRICE NEGOTIATION PROGRAM.—A group
22 health plan or a health insurance issuer offering group
23 health insurance coverage shall publicly disclose in a man-
24 ner and in accordance with a process specified by the Sec-
25 retary any election made under section 1197 of the Social

1 Security Act by the plan or issuer to not participate in
2 the Drug Price Negotiation Program under part E of title
3 XI of such Act with respect to a selected drug (as defined
4 in section 1192(c) of such Act) for which coverage is pro-
5 vided under such plan or coverage before the beginning
6 of the plan year for which such election was made.”.

7 (B) APPLICATION TO RETIREE AND CER-
8 TAIN SMALL GROUP HEALTH PLANS.—Section
9 732(a) of the Employee Retirement Income Se-
10 curity Act of 1974 (29 U.S.C. 1191a(a)) is
11 amended by striking “and 726” and inserting
12 “726, and 727”.

13 (C) CLERICAL AMENDMENT.—The table of
14 contents in section 1 of such Act is amended by
15 inserting after the item relating to section 726
16 the following new item:

“Sec. 727. Drug Price Negotiation Program and application of maximum fair
prices.”.

17 (3) IRC.—

18 (A) IN GENERAL.—Subchapter B of chap-
19 ter 100 of the Internal Revenue Code of 1986
20 is amended by adding at the end the following
21 new section:

1 **“SEC. 9827. DRUG PRICE NEGOTIATION PROGRAM AND AP-**
2 **PLICATION OF MAXIMUM FAIR PRICES.**

3 “(a) IN GENERAL.—In the case of a group health
4 plan that is treated under section 1197 of the Social Secu-
5 rity Act as having in effect an agreement with the Sec-
6 retary of Health and Human Services under the Drug
7 Price Negotiation Program under part E of title XI of
8 such Act, with respect to a price applicability period (as
9 defined in section 1191(b) of such Act) and a selected
10 drug (as defined in section 1192(c) of such Act) with re-
11 spect to such period for which coverage is provided under
12 such plan—

13 “(1) the provisions of such part shall apply, as
14 applicable—

15 “(A) if coverage of such selected drug is
16 provided under such plan if the drug is fur-
17 nished or dispensed at a pharmacy or by a mail
18 order service, to the plan, and to the partici-
19 pants and beneficiaries enrolled under such
20 plan during such period, with respect to such
21 selected drug, in the same manner as such pro-
22 visions apply to prescription drug plans and
23 MA–PD plans, and to participants and bene-
24 ficiaries enrolled under such prescription drug
25 plans and MA–PD plans during such period;
26 and

1 “(B) if coverage of such selected drug is
2 provided under such plan if the drug is fur-
3 nished or administered by a hospital, physician,
4 or other provider of services or supplier, to the
5 plan, to the participants and beneficiaries en-
6 rolled under such plan, and to hospitals, physi-
7 cians, and other providers of services and sup-
8 pliers during such period, with respect to such
9 drug in the same manner as such provisions
10 apply to the Secretary of Health and Human
11 Services, to participants and beneficiaries enti-
12 tled to benefits under part A of title XVIII or
13 enrolled under part B of such title, and to hos-
14 pitals, physicians, and other providers and sup-
15 pliers participating under title XVIII during
16 such period;

17 “(2) the plan shall apply any cost-sharing re-
18 sponsibilities under such plan, with respect to such
19 selected drug, by substituting an amount not more
20 than the maximum fair price negotiated under such
21 part E of title XI for such drug in lieu of the drug
22 price upon which the cost-sharing would have other-
23 wise applied, and such cost-sharing responsibilities
24 with respect to such selected drug may not exceed
25 such maximum fair price; and

1 “(3) the Secretary shall apply the provisions of
2 such part E to such plan and such participants and
3 beneficiaries so enrolled in such plan.

4 “(b) NOTIFICATION REGARDING NONPARTICIPATION
5 IN DRUG PRICE NEGOTIATION PROGRAM.—A group
6 health plan shall publicly disclose in a manner and in ac-
7 cordance with a process specified by the Secretary any
8 election made under section 1197 of the Social Security
9 Act by the plan to not participate in the Drug Price Nego-
10 tiation Program under part E of title XI of such Act with
11 respect to a selected drug (as defined in section 1192(c)
12 of such Act) for which coverage is provided under such
13 plan before the beginning of the plan year for which such
14 election was made.”.

15 (B) APPLICATION TO RETIREE AND CER-
16 TAIN SMALL GROUP HEALTH PLANS.—Section
17 9831(a)(2) of the Internal Revenue Code of
18 1986 is amended by inserting “or 9827” after
19 “section 9826”.

20 (C) CLERICAL AMENDMENT.—The table of
21 sections for subchapter B of chapter 100 of the
22 Internal Revenue Code of 1986 is amended by
23 adding at the end the following new item:

“Sec. 9827. Drug Price Negotiation Program and application of maximum fair
prices.”.

1 **SEC. 402. APPLICATION OF PRESCRIPTION DRUG INFLA-**
2 **TION REBATES TO DRUGS FURNISHED IN**
3 **THE COMMERCIAL MARKET.**

4 (a) PART B DRUGS.—

5 (1) APPLICATION OF PRESCRIPTION DRUG IN-
6 FLATION REBATES TO DRUGS FURNISHED IN THE
7 COMMERCIAL MARKET.—Section 1847A(i) of the So-
8 cial Security Act (42 U.S.C. 1395w–3a(i)) is amend-
9 ed—

10 (A) in paragraph (1)(A)(i), by striking
11 “units” and inserting “billing units”;

12 (B) in paragraph (2)(A), by striking “for
13 which payment is made under this part” and
14 inserting “that would be payable under this
15 part if such drug were furnished to an indi-
16 vidual enrolled under this part”; and

17 (C) in paragraph (3)—

18 (i) in subparagraph (A)(i), by striking
19 “units” and inserting “billing units”; and

20 (ii) by striking subparagraph (B) and
21 inserting the following:

22 “(B) TOTAL NUMBER OF BILLING
23 UNITS.—For purposes of subparagraph (A)(i),
24 the total number of billing units with respect to
25 a part B rebatable drug is determined as fol-
26 lows:

1 “(i) Determine the total number of
2 units equal to—

3 “(I) the total number of units, as
4 reported under subsection (c)(1)(B),
5 for each National Drug Code of such
6 drug during the calendar quarter that
7 is 2 calendar quarters prior to the cal-
8 endar quarter as described in sub-
9 paragraph (A), minus

10 “(II) the total number of units
11 with respect to each National Drug
12 Code of such drug for which payment
13 was made under a State plan under
14 title XIX (or waiver of such plan), as
15 reported by States under section
16 1927(b)(2)(A) for the rebate period
17 that is the same calendar quarter as
18 described in subclause (I).

19 “(ii) Convert the units determined
20 under clause (i) to billing units for the bill-
21 ing and payment code of such drug, using
22 a methodology similar to the methodology
23 used under this section, by dividing the
24 units determined under clause (i) for each
25 National Drug Code of such drug by the

1 billing unit for the billing and payment
2 code of such drug.

3 “(iii) Compute the sum of the billing
4 units for each National Drug Code of such
5 drug in clause (ii).”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply with respect to cal-
8 endar quarters beginning after the date of the enact-
9 ment of this Act.

10 (b) COVERED PART D DRUGS.—

11 (1) APPLICATION OF PRESCRIPTION DRUG IN-
12 FLATION REBATES TO DRUGS FURNISHED IN THE
13 COMMERCIAL MARKET.—Section 1860D–14B of the
14 Social Security Act (42 U.S.C. 1395w–114b) is
15 amended—

16 (A) in subsection (b)—

17 (i) in paragraph (1)—

18 (I) in subparagraph (A)(i), by
19 striking “the total number of units”
20 and all that follows through the semi-
21 colon and inserting the following: “the
22 total number of units that are used to
23 calculate the average manufacturer
24 price of such dosage form and
25 strength with respect to such part D

1 rebatable drug, as reported by the
2 manufacturer of such drug under sec-
3 tion 1927 for each month, with re-
4 spect to such period;” and

5 (II) by striking subparagraph (B)
6 and inserting the following:

7 “(B) EXCLUDED UNITS.—For purposes of
8 subparagraph (A)(i), the Secretary shall exclude
9 from the total number of units for a dosage
10 form and strength with respect to a part D
11 rebatable drug, with respect to an applicable pe-
12 riod, the following:

13 “(i) Units of each dosage form and
14 strength of such part D rebatable drug for
15 which payment was made under a State
16 plan under title XIX (or waiver of such
17 plan), as reported by States under section
18 1927(b)(2)(A).

19 “(ii) Units of each dosage form and
20 strength of such part D rebatable drug for
21 which a rebate is paid under section
22 1847A(i).

23 “(iii) Beginning with plan year 2028,
24 units of each dosage form and strength of
25 such part D rebatable drug for which the

1 manufacturer provides a discount under
2 the program under section 340B of the
3 Public Health Service Act.”; and

4 (ii) in paragraph (6), by striking “IN-
5 FORMATION” and all that follows through
6 “rebatable covered part D drug dispensed”
7 and inserting the following: “AMP RE-
8 PORTS.—The Secretary shall provide for a
9 method and process under which, in the
10 case of a manufacturer of a part D
11 rebatable drug that submits revisions to in-
12 formation submitted under section 1927 by
13 the manufacturer with respect to such
14 drug”; and

15 (B) by striking subsection (d) and insert-
16 ing the following:

17 “(d) INFORMATION.—For purposes of carrying out
18 this section, the Secretary shall use information submitted
19 by manufacturers under section 1927(b)(3) and informa-
20 tion submitted by States under section 1927(b)(2)(A).”.

21 (2) EFFECTIVE DATE.—The amendments made
22 by this subsection shall apply with respect to appli-
23 cable periods (as defined in section 1860D–
24 14B(g)(7) of the Social Security Act (42 U.S.C.

1 1395w–114b(g)(7))) beginning after the date of the
2 enactment of this Act.

3 **SEC. 403. ESTABLISHING AN OUT-OF-POCKET LIMIT ON EX-**
4 **PENDITURES FOR PRESCRIPTION DRUGS**
5 **UNDER GROUP HEALTH PLANS AND GROUP**
6 **AND INDIVIDUAL HEALTH INSURANCE COV-**
7 **ERAGE.**

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

10 (1) in section 2707, by adding at the end the
11 following new subsection:

12 “(e) SUNSET.—The preceding provisions of this sec-
13 tion shall not apply with respect to plan years beginning
14 on or after January 1, 2028.”; and

15 (2) in part D, as amended by section 401, by
16 adding at the end the following new section:

17 **“SEC. 2799A-13. COMPREHENSIVE COVERAGE.**

18 “(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS
19 PACKAGE.—A health insurance issuer that offers health
20 insurance coverage in the individual or small group market
21 shall ensure that such coverage includes the essential
22 health benefits package required under section 1302(a) of
23 the Patient Protection and Affordable Care Act.

24 “(b) COST-SHARING LIMITATION.—

“(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall ensure that—

4 “(A) any annual cost-sharing imposed
5 under the plan or coverage (including any such
6 cost-sharing so imposed with respect to pre-
7 scription drugs) does not exceed the dollar
8 amounts specified in paragraph (2); and

9 “(B) any annual cost-sharing imposed
10 under the plan or coverage with respect to pre-
11 scription drugs does not exceed the dollar
12 amounts specified in paragraph (3).

13 “(2) LIMITATION ON OVERALL OUT-OF-POCKET
14 COST-SHARING.—For purposes of paragraph (1)(A),
15 the dollar amounts specified in this paragraph are
16 the following:

17 “(A) With respect to self-only coverage—

“(i) for plan years beginning in 2028,
the dollar amount in effect under section
1302(c)(1) of the Patient Protection and
Affordable Care Act for such coverage for
plan years beginning in 2014, increased by
an amount equal to the product of that
amount and the premium adjustment per-

1 centage specified in paragraph (4) of such
2 section for the calendar year; and

3 “(ii) for plan years beginning in 2029
4 or a subsequent year, the dollar amount in
5 effect under this subparagraph for plan
6 years beginning in 2027, increased by an
7 amount equal to the product of that
8 amount the premium adjustment percent-
9 age specified in paragraph (4) for the cal-
10 endar year.

11 “(B) With respect to coverage other than
12 self-only coverage, for plan years beginning in
13 2028 or a subsequent year, twice the amount in
14 effect under subparagraph (A) for such plan
15 year.

16 If the amount of any increase under subparagraph
17 (A) is not a multiple of \$50, such increase shall be
18 rounded to the next lowest multiple of \$50.

19 “(3) LIMITATION ON PRESCRIPTION DRUG OUT-
20 OF-POCKET COST-SHARING.—For purposes of para-
21 graph (1)(B), the dollar amounts specified in this
22 paragraph are the following:

23 “(A) With respect to self-only coverage—

24 “(i) for plan years beginning in 2028,
25 \$2,000; and

1 “(ii) for plan years beginning in 2029
2 or a subsequent year, the dollar amount in
3 effect under this subparagraph for plan
4 years beginning in 2028, increased by an
5 amount equal to the product of that
6 amount and the premium adjustment per-
7 centage under paragraph (4) for the cal-
8 endar year.

9 “(B) With respect to coverage other than
10 self-only coverage, for plan years beginning in
11 2028 or a subsequent year, twice the amount in
12 effect under subparagraph (A) for such plan
13 year.

14 If the amount of any increase under subparagraph
15 (A) is not a multiple of \$50, such increase shall be
16 rounded to the next lowest multiple of \$50.

17 “(4) PREMIUM ADJUSTMENT PERCENTAGE.—
18 For purposes of paragraphs (2)(A)(ii) and (3)(A)(ii),
19 the premium adjustment percentage for any cal-
20 endar year is the percentage (if any) by which the
21 average per capita premium for health insurance
22 coverage in the United States for the preceding cal-
23 endar year (as estimated by the Secretary no later
24 than October 1 of such preceding calendar year) ex-

1 ceeds such average per capita premium for 2026 (as
2 determined by the Secretary).

3 “(5) COST-SHARING.—In this section:

4 “(A) IN GENERAL.—The term ‘cost-shar-
5 ing’ includes—

6 “(i) deductibles, coinsurance, copay-
7 ments, or similar charges; and

8 “(ii) any other expenditure required of
9 an insured individual which is a qualified
10 medical expense (within the meaning of
11 section 223(d)(2) of the Internal Revenue
12 Code of 1986) with respect to essential
13 health benefits covered under the plan or
14 coverage.

15 “(B) EXCEPTIONS.—Such term does not
16 include premiums, balance billing amounts for
17 non-network providers, or spending for non-cov-
18 ered services.

19 “(6) IMPLEMENTATION.—The Secretary may
20 implement the provisions of this subsection by sub-
21 regulatory guidance, interim final rule, or otherwise.

22 “(c) CHILD-ONLY PLANS.—If a health insurance
23 issuer offers health insurance coverage in any level of cov-
24 erage specified under section 1302(d) of the Patient Pro-
25 tection and Affordable Care Act, the issuer shall also offer

1 such coverage in that level as a plan in which the only
2 enrollees are individuals who, as of the beginning of a plan
3 year, have not attained the age of 21.

4 “(d) DENTAL ONLY.—This section shall not apply to
5 a plan described in section 1311(d)(2)(B)(ii) of the Pa-
6 tient Protection and Affordable Care Act.”.

7 (b) ERISA.—

8 (1) IN GENERAL.—Subpart B of part 7 of sub-
9 title B of title I of the Employee Retirement Income
10 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
11 amended by section 401, is further amended by add-
12 ing at the end the following new section:

13 **“SEC. 728. COMPREHENSIVE COVERAGE.**

14 “(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS
15 PACKAGE.—A health insurance issuer that offers health
16 insurance coverage in the small group market shall ensure
17 that such coverage includes the essential health benefits
18 package required under section 1302(a) of the Patient
19 Protection and Affordable Care Act.

20 “(b) COST-SHARING LIMITATION.—

21 “(1) IN GENERAL.—A group health plan and a
22 health insurance issuer offering group health insur-
23 ance coverage shall ensure that—

24 “(A) any annual cost-sharing imposed
25 under the plan or coverage (including any such

1 cost-sharing so imposed with respect to pre-
2 scription drugs) does not exceed the dollar
3 amounts specified in paragraph (2); and

4 “(B) any annual cost-sharing imposed
5 under the plan or coverage with respect to pre-
6 scription drugs does not exceed the dollar
7 amounts specified in paragraph (3).

8 “(2) LIMITATION ON OVERALL OUT-OF-POCKET
9 COST-SHARING.—For purposes of paragraph (1)(A),
10 the dollar amounts specified in this paragraph are
11 the following:

12 “(A) With respect to self-only coverage—
13 “(i) for plan years beginning in 2028,
14 the dollar amount in effect under section
15 1302(c)(1) of the Patient Protection and
16 Affordable Care Act for such coverage for
17 plan years beginning in 2014, increased by
18 an amount equal to the product of that
19 amount and the premium adjustment per-
20 centage specified in paragraph (4) of such
21 section for the calendar year; and

22 “(ii) for plan years beginning in 2029
23 or a subsequent year, the dollar amount in
24 effect under this subparagraph for plan
25 years beginning in 2028, increased by an

1 amount equal to the product of that
2 amount the premium adjustment percent-
3 age specified in paragraph (4) for the cal-
4 endar year.

5 “(B) With respect to coverage other than
6 self-only coverage, for plan years beginning in
7 2028 or a subsequent year, twice the amount in
8 effect under subparagraph (A) for such plan
9 year.

10 If the amount of any increase under subparagraph
11 (A) is not a multiple of \$50, such increase shall be
12 rounded to the next lowest multiple of \$50.

13 “(3) LIMITATION ON PRESCRIPTION DRUG OUT-
14 OF-POCKET COST-SHARING.—For purposes of para-
15 graph (1)(B), the dollar amounts specified in this
16 paragraph are the following:

17 “(A) With respect to self-only coverage—

18 “(i) for plan years beginning in 2028,
19 \$2,000; and

20 “(ii) for plan years beginning in 2029
21 or a subsequent year, the dollar amount in
22 effect under this subparagraph for plan
23 years beginning in 2028, increased by an
24 amount equal to the product of that
25 amount and the premium adjustment per-

percentage under paragraph (4) for the calendar year.

“(B) With respect to coverage other than self-only coverage, for plan years beginning in 2028 or a subsequent year, twice the amount in effect under subparagraph (A) for such plan year.

8 If the amount of any increase under subparagraph
9 (A) is not a multiple of \$50, such increase shall be
10 rounded to the next lowest multiple of \$50.

“(4) PREMIUM ADJUSTMENT PERCENTAGE.—
For purposes of paragraphs (2)(A)(ii) and (3)(A)(ii),
the premium adjustment percentage for any cal-
endar year is the percentage (if any) by which the
average per capita premium for health insurance
coverage in the United States for the preceding cal-
endar year (as estimated by the Secretary no later
than October 1 of such preceding calendar year) ex-
ceeds such average per capita premium for 2027 (as
determined by the Secretary).

21 “(5) COST-SHARING.—In this section:

22 “(A) IN GENERAL.—The term ‘cost-shar-

23 ing’ includes—

24 “(i) deductibles, coinsurance, copay-
25 ments, or similar charges; and

1 “(ii) any other expenditure required of
2 an insured individual which is a qualified
3 medical expense (within the meaning of
4 section 223(d)(2) of the Internal Revenue
5 Code of 1986) with respect to essential
6 health benefits covered under the plan or
7 coverage.

8 “(B) EXCEPTIONS.—Such term does not
9 include premiums, balance billing amounts for
10 non-network providers, or spending for non-cov-
11 ered services.

12 “(6) IMPLEMENTATION.—The Secretary may
13 implement the provisions of this subsection by sub-
14 regulatory guidance, interim final rule, or otherwise.

15 “(c) CHILD-ONLY PLANS.—If a health insurance
16 issuer offers health insurance coverage in any level of cov-
17 erage specified under section 1302(d) of the Patient Pro-
18 tection and Affordable Care Act, the issuer shall also offer
19 such coverage in that level as a plan in which the only
20 enrollees are individuals who, as of the beginning of a plan
21 year, have not attained the age of 21.

22 “(d) DENTAL ONLY.—This section shall not apply to
23 a plan described in section 1311(d)(2)(B)(ii) of the Pa-
24 tient Protection and Affordable Care Act.”.

1 (2) CLERICAL AMENDMENT.—The table of con-
2 tents in section 1 of such Act, as amended by sec-
3 tion 401, is further amended by inserting after the
4 item relating to section 727 the following new item:

“Sec. 728. Comprehensive coverage.”.

5 (c) IRC.—

6 (1) IN GENERAL.—Subchapter B of chapter
7 100 of the Internal Revenue Code of 1986, as
8 amended by section 401, is further amended by add-
9 ing at the end the following new section:

10 **“SEC. 9828. COMPREHENSIVE COVERAGE.**

11 “(a) COST-SHARING LIMITATION.—

12 “(1) IN GENERAL.—A group health plan shall
13 ensure that—

14 “(A) any annual cost-sharing imposed
15 under the plan (including any such cost-sharing
16 so imposed with respect to prescription drugs)
17 does not exceed the dollar amounts specified in
18 paragraph (2); and

19 “(B) any annual cost-sharing imposed
20 under the plan with respect to prescription
21 drugs does not exceed the dollar amounts speci-
22 fied in paragraph (3).

23 “(2) LIMITATION ON OVERALL OUT-OF-POCKET
24 COST-SHARING.—For purposes of paragraph (1)(A),

1 the dollar amounts specified in this paragraph are
2 the following:

3 “(A) With respect to self-only coverage—

4 “(i) for plan years beginning in 2028,
5 the dollar amount in effect under section
6 1302(c)(1) of the Patient Protection and
7 Affordable Care Act for such coverage for
8 plan years beginning in 2014, increased by
9 an amount equal to the product of that
10 amount and the premium adjustment per-
11 centage specified in paragraph (4) of such
12 section for the calendar year; and

13 “(ii) for plan years beginning in 2029
14 or a subsequent year, the dollar amount in
15 effect under this subparagraph for plan
16 years beginning in 2028, increased by an
17 amount equal to the product of that
18 amount the premium adjustment percent-
19 age specified in paragraph (4) for the cal-
20 endar year.

21 “(B) With respect to coverage other than
22 self-only coverage, for plan years beginning in
23 2028 or a subsequent year, twice the amount in
24 effect under subparagraph (A) for such plan
25 year.

1 If the amount of any increase under subparagraph
2 (A) is not a multiple of \$50, such increase shall be
3 rounded to the next lowest multiple of \$50.

4 “(3) LIMITATION ON PRESCRIPTION DRUG OUT-
5 OF-POCKET COST-SHARING.—For purposes of para-
6 graph (1)(B), the dollar amounts specified in this
7 paragraph are the following:

8 “(A) With respect to self-only coverage—

9 “(i) for plan years beginning in 2028,
10 \$2,000; and

11 “(ii) for plan years beginning in 2029
12 or a subsequent year, the dollar amount in
13 effect under this subparagraph for plan
14 years beginning in 2028, increased by an
15 amount equal to the product of that
16 amount and the premium adjustment per-
17 centage under paragraph (4) for the cal-
18 endar year.

19 “(B) With respect to coverage other than
20 self-only coverage, for plan years beginning in
21 2028 or a subsequent year, twice the amount in
22 effect under subparagraph (A) for such plan
23 year.

1 If the amount of any increase under subparagraph
2 (A) is not a multiple of \$50, such increase shall be
3 rounded to the next lowest multiple of \$50.

4 “(4) PREMIUM ADJUSTMENT PERCENTAGE.—
5 For purposes of paragraphs (2)(A)(ii) and (3)(A)(ii),
6 the premium adjustment percentage for any cal-
7 endar year is the percentage (if any) by which the
8 average per capita premium for health insurance
9 coverage in the United States for the preceding cal-
10 endar year (as estimated by the Secretary no later
11 than October 1 of such preceding calendar year) ex-
12 ceeds such average per capita premium for 2026 (as
13 determined by the Secretary).

14 “(5) COST-SHARING.—In this section:

15 “(A) IN GENERAL.—The term ‘cost-shar-
16 ing’ includes—

17 “(i) deductibles, coinsurance, copay-
18 ments, or similar charges; and

19 “(ii) any other expenditure required of
20 an insured individual which is a qualified
21 medical expense (within the meaning of
22 section 223(d)(2) of the Internal Revenue
23 Code of 1986) with respect to essential
24 health benefits covered under the plan.

“(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

“(6) IMPLEMENTATION.—The Secretary may implement the provisions of this subsection by sub-regulatory guidance, interim final rule, or otherwise.

8 “(b) **DENTAL ONLY.**—This section shall not apply to
9 a plan described in section 1311(d)(2)(B)(ii) of the Pa-
10 tient Protection and Affordable Care Act.”.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended by adding at the end the following new item:

“Sec. 9828. Comprehensive coverage.”.

(d) CONFORMING AMENDMENTS.—The Patient Protection and Affordable Care Act (Public Law 111–148) is amended—

19 (1) in section 1302—

(A) in subsection (a)(2), by inserting “with respect to plan years beginning before January 1, 2027,” before “limits cost-sharing”; and

23 (B) in subsection (e)(1)(B)(i)—

(i) by inserting “(or, with respect to
plan years beginning on or after January

1 1, 2028, in effect under section 2799A–
2 13(b)(1)(A)) of the Public Health Service
3 Act)” after “subsection (c)(1)”; and

4 (ii) by inserting “and except, with re-
5 spect to plan years beginning on or after
6 January 1, 2028, in the case of an indi-
7 vidual who has incurred cost-sharing ex-
8 penses with respect to prescription drugs
9 in an amount equal to the annual limita-
10 tion in effect under section 2799A–
11 13(b)(1)(B) of such Act, for benefits con-
12 sisting of prescription drugs” after “sec-
13 tion 2713”; and

14 (2) in section 1402(c)(1)(A), by inserting “(or,
15 with respect to plan years beginning on or after Jan-
16 uary 1, 2028, the applicable out-of-pocket limit
17 under section 2799A–13(b)(1)(A) of the Public
18 Health Service Act)” after “section 1302(c)(1)”.

19 (e) EFFECTIVE DATE.—The amendments made by
20 this section shall apply with respect to plan years begin-
21 ning on or after January 1, 2028.

22 **SEC. 404. REQUIREMENTS WITH RESPECT TO COST-SHAR-**
23 **ING FOR INSULIN PRODUCTS.**

24 (a) PHSA.—Part D of title XXVII of the Public
25 Health Service Act (42 U.S.C. 300gg–111 et seq.), as

1 amended by section 403, is further amended by adding
2 at the end the following new section:

3 **“SEC. 2799A-14. REQUIREMENTS WITH RESPECT TO COST-**
4 **SHARING FOR CERTAIN INSULIN PRODUCTS.**

5 “(a) IN GENERAL.—For plan years beginning on or
6 after January 1, 2028, a group health plan or health in-
7 surance issuer offering group or individual health insur-
8 ance coverage shall provide coverage of selected insulin
9 products, and with respect to such products, shall not—

10 “(1) apply any deductible; or

11 “(2) impose any cost-sharing in excess of the
12 lesser of, per 30-day supply—

13 “(A) \$35; or

14 “(B) the amount equal to 25 percent of
15 the negotiated price of the selected insulin prod-
16 uct net of all price concessions received by or on
17 behalf of the plan or coverage, including price
18 concessions received by or on behalf of third-
19 party entities providing services to the plan or
20 coverage, such as pharmacy benefit manage-
21 ment services.

22 “(b) DEFINITIONS.—In this section:

23 “(1) SELECTED INSULIN PRODUCTS.—The term
24 ‘selected insulin products’ means at least one of each
25 dosage form (such as vial, pump, or inhaler dosage

1 forms) of each different type (such as rapid-acting,
2 short-acting, intermediate-acting, long-acting, ultra
3 long-acting, and premixed) of insulin (as defined
4 below), when available, as selected by the group
5 health plan or health insurance issuer.

6 “(2) INSULIN DEFINED.—The term ‘insulin’
7 means insulin that is licensed under subsection (a)
8 or (k) of section 351 and continues to be marketed
9 under such section.

10 “(c) OUT-OF-NETWORK PROVIDERS.—Nothing in
11 this section requires a plan or issuer that has a network
12 of providers to provide benefits for selected insulin prod-
13 ucts described in this section that are delivered by an out-
14 of-network provider, or precludes a plan or issuer that has
15 a network of providers from imposing higher cost-sharing
16 than the levels specified in subsection (a) for selected insu-
17 lin products described in this section that are delivered
18 by an out-of-network provider.

19 “(d) RULE OF CONSTRUCTION.—Subsection (a) shall
20 not be construed to require coverage of, or prevent a group
21 health plan or health insurance coverage from imposing
22 cost-sharing other than the levels specified in subsection
23 (a) on, insulin products that are not selected insulin prod-
24 ucts, to the extent that such coverage is not otherwise re-

1 quired and such cost-sharing is otherwise permitted under
2 Federal and applicable State law.

3 “(e) APPLICATION OF COST-SHARING TOWARDS
4 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS.—Any
5 cost-sharing payments made pursuant to subsection (a)(2)
6 shall be counted toward any deductible or out-of-pocket
7 maximum that applies under the plan or coverage.”.

8 (b) ERISA.—

9 (1) IN GENERAL.—Subpart B of part 7 of sub-
10 title B of title I of the Employee Retirement Income
11 Security Act of 1974 (29 U.S.C. 1185 et seq.), as
12 amended by section 403, is further amended by add-
13 ing at the end the following new section:

14 **“SEC. 729. REQUIREMENTS WITH RESPECT TO COST-SHAR-**
15 **ING FOR CERTAIN INSULIN PRODUCTS.**

16 “(a) IN GENERAL.—For plan years beginning on or
17 after January 1, 2028, a group health plan or health in-
18 surance issuer offering group health insurance coverage
19 shall provide coverage of selected insulin products, and
20 with respect to such products, shall not—

21 “(1) apply any deductible; or

22 “(2) impose any cost-sharing in excess of the
23 lesser of, per 30-day supply—

24 “(A) \$35; or

1 “(B) the amount equal to 25 percent of
2 the negotiated price of the selected insulin prod-
3 uct net of all price concessions received by or on
4 behalf of the plan or coverage, including price
5 concessions received by or on behalf of third-
6 party entities providing services to the plan or
7 coverage, such as pharmacy benefit manage-
8 ment services.

9 “(b) DEFINITIONS.—In this section:

10 “(1) SELECTED INSULIN PRODUCTS.—The term
11 ‘selected insulin products’ means at least one of each
12 dosage form (such as vial, pump, or inhaler dosage
13 forms) of each different type (such as rapid-acting,
14 short-acting, intermediate-acting, long-acting, ultra
15 long-acting, and premixed) of insulin (as defined
16 below), when available, as selected by the group
17 health plan or health insurance issuer.

18 “(2) INSULIN DEFINED.—The term ‘insulin’
19 means insulin that is licensed under subsection (a)
20 or (k) of section 351 of the Public Health Service
21 Act (42 U.S.C. 262) and continues to be marketed
22 under such section.

23 “(c) OUT-OF-NETWORK PROVIDERS.—Nothing in
24 this section requires a plan or issuer that has a network
25 of providers to provide benefits for selected insulin prod-

1 ucts described in this section that are delivered by an out-
2 of-network provider, or precludes a plan or issuer that has
3 a network of providers from imposing higher cost-sharing
4 than the levels specified in subsection (a) for selected insu-
5 lin products described in this section that are delivered
6 by an out-of-network provider.

7 “(d) RULE OF CONSTRUCTION.—Subsection (a) shall
8 not be construed to require coverage of, or prevent a group
9 health plan or health insurance coverage from imposing
10 cost-sharing other than the levels specified in subsection
11 (a) on, insulin products that are not selected insulin prod-
12 ucts, to the extent that such coverage is not otherwise re-
13 quired and such cost-sharing is otherwise permitted under
14 Federal and applicable State law.

15 “(e) APPLICATION OF COST-SHARING TOWARDS
16 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS.—Any
17 cost-sharing payments made pursuant to subsection (a)(2)
18 shall be counted toward any deductible or out-of-pocket
19 maximum that applies under the plan or coverage.”.

20 (2) CLERICAL AMENDMENT.—The table of con-
21 tents in section 1 of such Act is amended by insert-
22 ing after the item relating to section 728 (as in-
23 serted by section 403) the following new item:

 “Sec. 729. Requirements with respect to cost-sharing for certain insulin prod-
 ucts.”.

24 (c) IRC.—

1 (1) IN GENERAL.—Subchapter B of chapter
2 100 of the Internal Revenue Code of 1986, as
3 amended by section 403, is further amended by add-
4 ing at the end the following new section:

5 **“SEC. 9829. REQUIREMENTS WITH RESPECT TO COST-SHAR-**
6 **ING FOR CERTAIN INSULIN PRODUCTS.**

7 “(a) IN GENERAL.—For plan years beginning on or
8 after January 1, 2028, a group health plan shall provide
9 coverage of selected insulin products, and with respect to
10 such products, shall not—

11 “(1) apply any deductible; or

12 “(2) impose any cost-sharing in excess of the
13 lesser of, per 30-day supply—

14 “(A) \$35; or

15 “(B) the amount equal to 25 percent of
16 the negotiated price of the selected insulin prod-
17 uct net of all price concessions received by or on
18 behalf of the plan, including price concessions
19 received by or on behalf of third-party entities
20 providing services to the plan, such as phar-
21 macy benefit management services.

22 “(b) DEFINITIONS.—In this section:

23 “(1) SELECTED INSULIN PRODUCTS.—The term
24 ‘selected insulin products’ means at least one of each
25 dosage form (such as vial, pump, or inhaler dosage

1 forms) of each different type (such as rapid-acting,
2 short-acting, intermediate-acting, long-acting, ultra
3 long-acting, and premixed) of insulin (as defined
4 below), when available, as selected by the group
5 health plan.

6 “(2) INSULIN DEFINED.—The term ‘insulin’
7 means insulin that is licensed under subsection (a)
8 or (k) of section 351 of the Public Health Service
9 Act (42 U.S.C. 262) and continues to be marketed
10 under such section.

11 “(c) OUT-OF-NETWORK PROVIDERS.—Nothing in
12 this section requires a plan that has a network of providers
13 to provide benefits for selected insulin products described
14 in this section that are delivered by an out-of-network pro-
15 vider, or precludes a plan that has a network of providers
16 from imposing higher cost-sharing than the levels specified
17 in subsection (a) for selected insulin products described
18 in this section that are delivered by an out-of-network pro-
19 vider.

20 “(d) RULE OF CONSTRUCTION.—Subsection (a) shall
21 not be construed to require coverage of, or prevent a group
22 health plan from imposing cost-sharing other than the lev-
23 els specified in subsection (a) on, insulin products that are
24 not selected insulin products, to the extent that such cov-
25 erage is not otherwise required and such cost-sharing is

1 otherwise permitted under Federal and applicable State
2 law.

3 “(e) APPLICATION OF COST-SHARING TOWARDS
4 DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS.—Any
5 cost-sharing payments made pursuant to subsection (a)(2)
6 shall be counted toward any deductible or out-of-pocket
7 maximum that applies under the plan.”.

8 (2) CLERICAL AMENDMENT.—The table of sec-
9 tions for subchapter B of chapter 100 of the Inter-
10 nal Revenue Code of 1986, as amended by section
11 403, is further amended by adding at the end the
12 following new item:

“Sec. 9829. Requirements with respect to cost-sharing for certain insulin prod-
ucts.”.

13 (d) NO EFFECT ON OTHER COST-SHARING.—Section
14 1302(d)(2) of the Patient Protection and Affordable Care
15 Act (42 U.S.C. 18022(d)(2)) is amended by adding at the
16 end the following new subparagraph:

17 “(D) SPECIAL RULE RELATING TO INSU-
18 LIN COVERAGE.—The exemption of coverage of
19 selected insulin products (as defined in section
20 2799A–14(b) of the Public Health Service Act)
21 from the application of any deductible pursuant
22 to section 2799A–14(a)(1) of such Act, section
23 729(a)(1) of the Employee Retirement Income
24 Security Act of 1974, or section 9829(a)(1) of

1 the Internal Revenue Code of 1986 shall not be
2 considered when determining the actuarial value
3 of a qualified health plan under this sub-
4 section.”.

5 (e) COVERAGE OF CERTAIN INSULIN PRODUCTS
6 UNDER CATASTROPHIC PLANS.—Section 1302(e) of the
7 Patient Protection and Affordable Care Act (42 U.S.C.
8 18022(e)) is amended by adding at the end the following
9 new paragraph:

10 “(4) COVERAGE OF CERTAIN INSULIN PROD-
11 UCTS.—

12 “(A) IN GENERAL.—Notwithstanding para-
13 graph (1)(B)(i), a health plan described in
14 paragraph (1) shall provide coverage of selected
15 insulin products, in accordance with section
16 2799A–14 of the Public Health Service Act, for
17 a plan year before an enrolled individual has in-
18 curred cost-sharing expenses in an amount
19 equal to the annual limitation in effect under
20 subsection (c)(1) for the plan year.

21 “(B) TERMINOLOGY.—For purposes of
22 subparagraph (A)—

23 “(i) the term ‘selected insulin prod-
24 ucts’ has the meaning given such term in

1 section 2799A–14(b) of the Public Health
2 Service Act; and

3 “(ii) the requirements of section
4 2799A–14 of such Act shall be applied by
5 deeming each reference in such section to
6 ‘individual health insurance coverage’ to be
7 a reference to a plan described in para-
8 graph (1).”.

9 **TITLE V—ENSURING QUALITY**
10 **HEALTH INSURANCE AND RE-**
11 **MOVING BARRIERS TO CARE**

12 **SEC. 501. REQUIRED EXCEPTIONS PROCESS FOR MEDICA-**
13 **TION STEP THERAPY PROTOCOLS.**

14 (a) REQUIRED EXCEPTIONS PROCESS FOR MEDICA-
15 TION STEP THERAPY PROTOCOLS.—The Employee Re-
16 tirement Income Security Act of 1974 is amended by in-
17 serting after section 713 of such Act (29 U.S.C. 1185b)
18 the following new section:

19 **“SEC. 713A. REQUIRED EXCEPTIONS PROCESS FOR MEDI-**
20 **CATION STEP THERAPY PROTOCOLS.**

21 “(a) IN GENERAL.—In the case of a group health
22 plan or health insurance issuer offering coverage offered
23 in connection with such a plan that provides coverage of
24 a prescription drug pursuant to a medication step therapy
25 protocol, the plan or issuer shall—

1 “(1) implement a clear, prompt, and trans-
2 parent process for a participant or beneficiary (or
3 the prescribing health care provider (referred to in
4 this section as the ‘prescriber’) on behalf of the par-
5 ticipant or beneficiary) to request an exception to
6 such medication step therapy protocol, pursuant to
7 subsection (b); and

8 “(2) where the participant or beneficiary or
9 prescriber’s request for an exception to the medica-
10 tion step therapy protocols satisfies the criteria and
11 requirements of subsection (b), cover the requested
12 drug in accordance with the terms established by the
13 plan or coverage for patient cost-sharing rates or
14 amounts at the beginning of the plan year.

15 “(b) CIRCUMSTANCES FOR EXCEPTION APPROVAL.—
16 The circumstances requiring an exception to a medication
17 step therapy protocol, pursuant to a request under sub-
18 section (a), are any of the following:

19 “(1) Any treatments otherwise required under
20 the protocol, or treatments in the same pharma-
21 cological class or having the same mechanism of ac-
22 tion, including treatments provided prior to the ef-
23 fective date of the participant’s or beneficiary’s cov-
24 erage under the plan or coverage, have been ineffec-
25 tive in the treatment of the disease or condition of

1 the participant or beneficiary, when prescribed con-
2 sistent with clinical indications, clinical guidelines, or
3 other peer-reviewed evidence, based on the pre-
4 scribing health care professional's judgement or rel-
5 evant information provided by the participant or
6 beneficiary (including the medical records of the par-
7 ticipant or beneficiary).

8 “(2) Delay of effective treatment would lead to
9 severe or irreversible consequences, or worsen dis-
10 ease progression or a comorbidity and the treatment
11 otherwise required under the protocol is reasonably
12 expected by the prescriber to be ineffective based
13 upon the documented physical or mental characteris-
14 tics of the participant or beneficiary and the known
15 characteristics of such treatment.

16 “(3) Any treatments otherwise required under
17 the protocol are contraindicated for the participant
18 or beneficiary or have caused, or are likely to cause,
19 based on clinical, peer-reviewed evidence, an adverse
20 reaction or other physical or mental harm to the
21 participant or beneficiary.

22 “(4) Any treatment otherwise required under
23 the protocol has prevented, will prevent, or is likely
24 to prevent a participant or beneficiary from achiev-
25 ing or maintaining reasonable and safe functional

1 ability in performing occupational responsibilities or
2 activities of daily living (as defined in section
3 441.505 of title 42, Code of Federal Regulations (or
4 successor regulations)).

5 “(5) The participant or beneficiary is stable for
6 his or her disease or condition on the prescription
7 drug or drugs selected by the prescriber and has
8 previously received approval for coverage of the rel-
9 evant drug or drugs for the disease or condition by
10 any public or private health plan.

11 “(6) Other circumstances, as determined by the
12 Secretary.

13 “(c) REQUIREMENT OF A CLEAR PROCESS.—

14 “(1) IN GENERAL.—The process required by
15 subsection (a) shall—

16 “(A) provide the prescriber or participant
17 or beneficiary an opportunity to present such
18 prescriber’s clinical rationale and relevant med-
19 ical information for the group health plan or
20 health insurance issuer to evaluate such request
21 for exception;

22 “(B) develop and use a standard form and
23 instructions for the request of an exception
24 under subsection (b), available in paper and

1 electronic forms, and allow for submission of
2 such form by paper and electronic means;

3 “(C) provide both paper and electronic
4 means for the submission of requests for addi-
5 tional information;

6 “(D) clearly set forth all required informa-
7 tion and the specific criteria that will be used
8 to determine whether an exception is warranted,
9 which may require disclosure of—

10 “(i) the medical history or other
11 health records of the participant or bene-
12 ficiary demonstrating that the participant
13 or beneficiary seeking an exception—

14 “(I) has tried other drugs in-
15 cluded in the drug therapy class with-
16 out success; or

17 “(II) has taken the requested
18 drug for a clinically appropriate
19 amount of time to establish stability,
20 in relation to the condition being
21 treated and prescription guidelines
22 given by the prescribing physician; or

23 “(ii) other clinical information that
24 may be relevant to conducting the excep-
25 tion review;

1 “(E) not require the submission of any in-
2 formation or supporting documentation beyond
3 what is strictly necessary (as determined by the
4 Secretary) to determine whether a circumstance
5 listed in subsection (b) exists;

6 “(F) clearly outline conditions under which
7 an exception request warrants expedited resolu-
8 tion from the group health plan or health insur-
9 ance issuer, pursuant to subsection (d)(2); and

10 “(G) allow a representative of a participant
11 or beneficiary, which may include a designated
12 third-party advocate, to act on behalf of the
13 participant or beneficiary.

14 “(2) AVAILABILITY OF PROCESS INFORMA-
15 TION.—The group health plan or health insurance
16 issuer shall make information regarding the process
17 required under subsection (a) readily available in the
18 relevant plan materials, including the summary of
19 benefits and, if available, on the website of the group
20 health plan or health insurance issuer. Such infor-
21 mation shall include—

22 “(A) the requirements for requesting an
23 exception to a medication step therapy protocol
24 pursuant to this section; and

1 “(B) any forms, supporting information,
2 and contact information, as appropriate.

3 “(d) TIMING FOR DETERMINATION OF EXCEP-
4 TION.—The process required under subsection (a)(1) shall
5 provide for the disposition of requests received under such
6 paragraph in accordance with the following:

7 “(1) Subject to paragraph (2), not later than
8 72 hours after receiving an initial exception request,
9 the plan or issuer shall respond to the participant or
10 beneficiary and, if applicable, the requesting pre-
11 scriber with either a determination of exception eligi-
12 bility or a request for additional required informa-
13 tion strictly necessary to make a determination of
14 whether the conditions specified in subsection (b)
15 are met. The plan or issuer shall respond to the par-
16 ticipant or beneficiary and, if applicable, the request-
17 ing prescriber, with a determination of exception eli-
18 gibility no later than 72 hours after receipt of the
19 additional required information.

20 “(2) In the case of a request under cir-
21 cumstances in which the applicable medication step
22 therapy protocol may seriously jeopardize the life or
23 health of the participant or beneficiary, may jeop-
24 ardize the ability of the participant or beneficiary to
25 regain maximum function, or may subject the partic-

1 participant or beneficiary to severe pain that cannot be
2 adequately managed without the treatment that is
3 the subject of the request, the plan or issuer shall
4 conduct a review of the request and respond to the
5 participant or beneficiary and, if applicable, the re-
6 questing prescriber, with either a determination of
7 exception eligibility or a request for additional re-
8 quired information strictly necessary to make a de-
9 termination of whether the conditions specified in
10 subsection (b) are met, in accordance with the fol-
11 lowing:

12 “(A) If the plan or issuer can make a de-
13 termination of exception eligibility without addi-
14 tional information, such determination shall be
15 made on an expedited basis, and no later than
16 24 hours after receipt of such request.

17 “(B) If the plan or issuer requires addi-
18 tional information before making a determina-
19 tion of exception eligibility, the plan or issuer
20 shall respond to the participant or beneficiary
21 and, if applicable, the requesting prescriber,
22 with a request for such information within 24
23 hours of the request for a determination, and
24 shall respond with a determination of exception
25 eligibility as quickly as the condition or disease

1 requires, and no later than 24 hours after re-
2 ceipt of the additional required information.

3 “(e) DURATION OF A GRANT.—If an exception to a
4 medication step therapy protocol is granted under this sec-
5 tion to a participant or beneficiary, coverage for the re-
6 quested drug shall remain in effect with respect to such
7 participant or beneficiary for not less than one year.

8 “(f) MEDICATION STEP THERAPY PROTOCOL.—In
9 this section, the term ‘medication step therapy protocol’
10 means a drug therapy utilization management protocol or
11 program under which a group health plan or health insur-
12 ance issuer offering group health insurance coverage of
13 prescription drugs requires a participant or beneficiary to
14 try an alternative preferred prescription drug or drugs be-
15 fore the plan or health insurance issuer approves coverage
16 for the non-preferred drug therapy prescribed.

17 “(g) CLARIFICATION.—This section shall apply with
18 respect to any group health plan or health insurance cov-
19 erage offered in connection with such a plan that provides
20 coverage of a prescription drug pursuant to a policy that
21 meets the definition of the term ‘medication step therapy
22 protocol’ in subsection (f), regardless of whether such pol-
23 icy is described by such group health plan or health insur-
24 ance coverage as a step therapy protocol.

25 “(h) REPORTING.—

1 “(1) REPORTING TO THE SECRETARY.—Not
2 later than 3 years after the date of enactment of the
3 Health CARE Act of 2026, and not later than Octo-
4 ber 1 of each year thereafter, each group health plan
5 and health insurance issuer offering group health in-
6 surance coverage shall report to the Secretary, in
7 such manner as the Secretary shall require, the fol-
8 lowing:

9 “(A) The number of step therapy exception
10 requests received for each exception cir-
11 cumstance described in paragraphs (1) through
12 (6) of subsection (b), and the numbers of such
13 requests for each such circumstance that
14 were—

15 “(i) approved;

16 “(ii) denied, and the reasons for the
17 denials;

18 “(iii) initially denied and appealed;

19 and

20 “(iv) initially denied and then subse-
21 quently reversed by internal appeals or ex-
22 ternal reviews.

23 “(B) The number of times a plan or issuer
24 requested additional information in response to
25 a step therapy exception request, by exception

1 circumstance described in paragraphs (1)
2 through (6) of subsection (b).

3 “(C) The number of exception requests
4 submitted by participants or beneficiaries, and
5 the number of exception requests submitted by
6 prescribers, by medical specialty.

7 “(D) The medical conditions for which
8 participants and beneficiaries were granted ex-
9 ceptions due to the likelihood that switching
10 from a prescription drug will likely cause an ad-
11 verse reaction by, or physical or mental harm
12 to, the participant or beneficiary, as described
13 in subsection (b)(3).

14 “(E) The entities responsible for providing
15 pharmacy benefit management services for the
16 group health plan or health insurance coverage.

17 “(2) INFORMATION.—A group health plan or
18 health insurance issuer offering group health insur-
19 ance coverage shall not enter into a contract with a
20 third-party administrator or an entity providing
21 pharmacy benefit management services on behalf of
22 the plan or coverage that prevents the plan or issuer
23 from obtaining from the third-party administrator or
24 the entity providing pharmacy benefit management
25 services any information needed for the plan or

1 issuer to comply with the reporting requirements
2 under paragraph (1).

3 “(3) REPORTS TO CONGRESS.—Not later than
4 3 years after the date of enactment of the Health
5 CARE Act of 2026, and not later than October 1 of
6 each year thereafter, the Secretary shall submit to
7 Congress, and make publicly available, a report that
8 contains a summary and analysis of the information
9 reported under paragraph (1), including an analysis
10 of, with respect to requests for exceptions under this
11 section, approvals, and denials, including the reasons
12 for denials; appeals and external reviews; and
13 trends, if any, in exception requests by medical spe-
14 cialty or medical condition.”.

15 (b) CLERICAL AMENDMENT.—The table of contents
16 in section 1 of the Employee Retirement Income Security
17 Act of 1974 (29 U.S.C. 1001 et seq.) is amended by in-
18 serting after the item relating to section 713 the following
19 new item:

“Sec. 713A. Required exceptions process for medication step therapy proto-
cols.”.

20 (c) EFFECTIVE DATE.—

21 (1) IN GENERAL.—The amendment made by
22 subsection (a) applies with respect to plan years be-
23 ginning with the first plan year that begins at least

1 6 months after the date of the enactment of this
2 Act.

3 (2) REGULATIONS.—Not later than 6 months
4 after the date of the enactment of this Act, the Sec-
5 retary of Labor shall issue final regulations, through
6 notice and comment rulemaking, to implement the
7 provisions of section 713A of the Employee Retire-
8 ment Income Security Act of 1974, as added by sub-
9 section (a).

10 **SEC. 502. ESTABLISHING REQUIREMENTS WITH RESPECT**
11 **TO THE USE OF PRIOR AUTHORIZATION**
12 **UNDER MEDICARE ADVANTAGE PLANS.**

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

16 “(o) PRIOR AUTHORIZATION REQUIREMENTS.—

17 “(1) IN GENERAL.—In the case of a Medicare
18 Advantage plan that imposes any prior authorization
19 requirement with respect to any applicable item or
20 service (as defined in paragraph (5)) during a plan
21 year, such plan shall—

22 “(A) beginning with plan years beginning
23 on or after January 1, 2029—

1 “(i) establish the electronic prior au-
2 thorization program described in para-
3 graph (2); and

4 “(ii) meet the enrollee protection
5 standards specified pursuant to paragraph
6 (4); and

7 “(B) beginning with plan years beginning
8 on or after January 1, 2028, meet the trans-
9 parency requirements specified in paragraph
10 (3).

11 “(2) ELECTRONIC PRIOR AUTHORIZATION PRO-
12 GRAM.—

13 “(A) IN GENERAL.—For purposes of para-
14 graph (1)(A), the electronic prior authorization
15 program described in this paragraph is a pro-
16 gram that provides for the secure electronic
17 transmission of—

18 “(i) a prior authorization request
19 from a provider or supplier to a Medicare
20 Advantage plan with respect to an applica-
21 ble item or service to be furnished to an in-
22 dividual and a response, in accordance with
23 this paragraph, from such plan to such
24 provider or supplier; and

1 “(ii) any supporting documentation
2 relating to such request or response.

3 “(B) ELECTRONIC TRANSMISSION.—

4 “(i) EXCLUSIONS.—For purposes of
5 this paragraph, a facsimile, a proprietary
6 payer portal that does not meet standards
7 specified by the Secretary, or an electronic
8 form shall not be treated as an electronic
9 transmission described in subparagraph
10 (A).

11 “(ii) STANDARDS.—An electronic
12 transmission described in subparagraph
13 (A) shall comply with applicable technical
14 standards and other requirements to pro-
15 mote the standardization and streamlining
16 of electronic transactions adopted by the
17 Secretary.

18 “(3) TRANSPARENCY REQUIREMENTS.—

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

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

1 “(I) A list of all applicable items
2 and services that were subject to a
3 prior authorization requirement under
4 the plan during the previous plan
5 year.

6 “(II) The percentage and number
7 of specified requests (as defined in
8 subparagraph (F)) approved during
9 the previous plan year by the plan in
10 an initial determination and the per-
11 centage and number of specified re-
12 quests denied during such plan year
13 by such plan in an initial determina-
14 tion (both in the aggregate and cat-
15 egorized by each item and service).

16 “(III) The percentage and num-
17 ber of specified requests that were de-
18 nied during the previous plan year by
19 the plan in an initial determination
20 and that were subsequently appealed.

21 “(IV) The number of appeals of
22 specified requests resolved during the
23 preceding plan year, and the percent-
24 age and number of such resolved ap-
25 peals that resulted in approval of the

1 furnishing of the item or service that
2 was the subject of such request, cat-
3 egorized by each applicable item and
4 service and categorized by each level
5 of appeal (including judicial review).

6 “(V) The percentage and number
7 of specified requests that were denied,
8 and the percentage and number of
9 specified requests that were approved,
10 by the plan during the previous plan
11 year through the utilization of deci-
12 sion support technology, artificial in-
13 telligence technology, machine-learn-
14 ing technology, clinical decision-mak-
15 ing technology, or any other tech-
16 nology specified by the Secretary.

17 “(VI) The average and the me-
18 dian amount of time (in hours) that
19 elapsed during the previous plan year
20 between the submission of a specified
21 request to the plan and a determina-
22 tion by the plan with respect to such
23 request for each such item and serv-
24 ice, excluding any such requests that
25 were not submitted with the medical

1 or other documentation required to be
2 submitted by the plan.

3 “(VII) The percentage and num-
4 ber of specified requests that were ex-
5 cluded from the calculation described
6 in subclause (VI) based on the plan’s
7 determination that such requests were
8 not submitted with the medical or
9 other documentation required to be
10 submitted by the plan.

11 “(VIII) Information on each oc-
12 currence during the previous plan
13 year in which, during a surgical or
14 medical procedure involving the fur-
15 nishing of an applicable item or serv-
16 ice with respect to which such plan
17 had approved a prior authorization re-
18 quest, the provider or supplier fur-
19 nishing such item or service deter-
20 mined that a different or additional
21 item or service was medically nec-
22 essary, including a specification of
23 whether such plan subsequently ap-
24 proved the furnishing of such dif-
25 ferent or additional item or service.

1 “(IX) A disclosure and descrip-
2 tion of any technology described in
3 subclause (V) that the plan utilized
4 during the previous plan year in mak-
5 ing determinations with respect to
6 specified requests.

7 “(X) The number of grievances
8 (as described in subsection (f)) re-
9 ceived by such plan during the pre-
10 vious plan year that were related to a
11 prior authorization requirement.

12 “(XI) Such other information as
13 the Secretary determines appropriate.

14 “(ii) The plan shall provide—

15 “(I) to each provider or supplier
16 who seeks to enter into a contract
17 with such plan to furnish applicable
18 items and services under such plan,
19 the list described in clause (i)(I) and
20 any policies or procedures used by the
21 plan for making determinations with
22 respect to prior authorization re-
23 quests;

24 “(II) to each such provider and
25 supplier that enters into such a con-

1 tract, access to the criteria used by
2 the plan for making such determina-
3 tions and an itemization of the med-
4 ical or other documentation required
5 to be submitted by a provider or sup-
6 plier with respect to such a request;
7 and

8 “(III) to an enrollee of the plan,
9 upon request, access to the criteria
10 used by the plan for making deter-
11 minations with respect to prior au-
12 thorization requests for an item or
13 service.

14 “(B) OPTION FOR PLAN TO PROVIDE CER-
15 TAIN ADDITIONAL INFORMATION.—As part of
16 the information described in subparagraph
17 (A)(i) provided to the Secretary during a plan
18 year, a Medicare Advantage plan may elect to
19 include information regarding the percentage
20 and number of specified requests made with re-
21 spect to an individual and an item or service
22 that were denied by the plan during the pre-
23 ceding plan year in an initial determination
24 based on such requests failing to demonstrate
25 that such individuals met the clinical criteria

1 established by such plan to receive such items
2 or services.

3 “(C) REGULATIONS.—The Secretary shall,
4 through notice and comment rulemaking, estab-
5 lish requirements for Medicare Advantage plans
6 regarding the provision of—

7 “(i) access to criteria described in
8 subparagraph (A)(ii)(II) to providers of
9 services and suppliers in accordance with
10 such subparagraph; and

11 “(ii) access to such criteria to enroll-
12 ees in accordance with subparagraph
13 (A)(ii)(III).

14 “(D) PUBLICATION OF INFORMATION.—
15 The Secretary shall publish information de-
16 scribed in subparagraph (A)(i) and subpara-
17 graph (B) on a public website of the Centers
18 for Medicare & Medicaid Services. Such infor-
19 mation shall be so published on an individual
20 plan level and may in addition be aggregated in
21 such manner as determined appropriate by the
22 Secretary.

23 “(E) MEDPAC REPORT.—Not later than 3
24 years after the date information is first sub-
25 mitted under subparagraph (A)(i), the Medicare

1 Payment Advisory Commission shall submit to
2 Congress a report on such information that in-
3 cludes a descriptive analysis of the use of prior
4 authorization. As appropriate, the Commission
5 should report on statistics including the fre-
6 quency of appeals and overturned decisions.
7 The Commission shall provide recommenda-
8 tions, as appropriate, on any improvement that
9 should be made to the electronic prior author-
10 ization programs of Medicare Advantage plans.

11 “(F) SPECIFIED REQUEST DEFINED.—For
12 purposes of this paragraph, the term ‘specified
13 request’ means a prior authorization request
14 made with respect to an applicable item or serv-
15 ice.

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

22 “(A) the adoption of transparent prior au-
23 thorization programs developed in consultation
24 with enrollees and with providers and suppliers
25 with contracts in effect with such plans for fur-

1 nishing such items and services under such
2 plans;

3 “(B) allowing for the waiver or modifica-
4 tion of prior authorization requirements based
5 on the performance of such providers and sup-
6 pliers in demonstrating compliance with such
7 requirements, such as adherence to evidence-
8 based medical guidelines and other quality cri-
9 teria; and

10 “(C) conducting annual reviews of such
11 items and services for which prior authorization
12 requirements are imposed under such plans
13 through a process that takes into account input
14 from enrollees and from providers and suppliers
15 with such contracts in effect and is based on
16 consideration of prior authorization data from
17 previous plan years and analyses of current cov-
18 erage criteria.

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

25 “(6) REPORTS TO CONGRESS.—

1 “(A) GAO.—Not later than January 1,
2 2033, the Comptroller General of the United
3 States shall submit to Congress a report con-
4 taining an evaluation of the implementation of
5 the requirements of this subsection and an
6 analysis of issues in implementing such require-
7 ments faced by Medicare Advantage plans.

8 “(B) HHS.—

9 “(i) THE SECRETARY.—Not later than
10 the end of the fifth plan year beginning
11 after the date of the enactment of this sub-
12 section, and biennially thereafter through
13 the date that is 10 years after such date
14 of enactment, the Secretary shall submit to
15 Congress a report containing a description
16 of the information submitted under para-
17 graph (3)(A)(i) during—

18 “(I) in the case of the first such
19 report, the fourth plan year beginning
20 after the date of the enactment of this
21 subsection; and

22 “(II) in the case of a subsequent
23 report, the 2 plan years preceding the
24 year of the submission of such report.

1 “(ii) CMS.—Not later than January
2 1, 2029, the Centers for Medicare & Med-
3 icaid Services and the Office of National
4 Coordinator for Health Information Tech-
5 nology shall submit to Congress and pub-
6 lish on the internet website of the Centers
7 for Medicare & Medicaid Services a report
8 that—

9 “(I) defines the term ‘real-time
10 decision’ and details how the defini-
11 tion for such term may be updated
12 based on any technological advances;

13 “(II) using the data submitted to
14 the Secretary under paragraph
15 (3)(A)(i), details a process for real-
16 time decisions for routinely approved
17 items and services for purposes of the
18 electronic prior authorization program
19 described in paragraph (2); and

20 “(III) includes an analysis of—

21 “(aa) items and services
22 that are routinely approved;

23 “(bb) items and services
24 identified in item (aa) that could
25 be eligible for real-time decisions;

1 “(cc) whether establishing
2 real-time decisions for such items
3 and services could—

4 “(AA) improve enrollee
5 access to benefits under this
6 part;

7 “(BB) produce oper-
8 ational efficiencies for pro-
9 viders and suppliers and
10 Medicare Advantage plans;
11 and

12 “(CC) reduce health
13 disparities for Medicare Ad-
14 vantage enrollees in rural
15 and low-income commu-
16 nities; and

17 “(dd) how determinations of
18 routinely approved items and
19 services made solely through au-
20 tomation and artificial intel-
21 ligence by Medicare Advantage
22 plans impact patient access, in-
23 cluding disparities in access for
24 rural and low-income bene-
25 ficiaries.”.

1 (b) PROVIDING THE SECRETARY AUTHORITY TO EN-
2 FORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZA-
3 TION REQUESTS SUBMITTED UNDER PART C.—Section
4 1852(g) of the Social Security Act (42 U.S.C. 1395w-
5 22(g)) is amended—

6 (1) in paragraph (1)(A), by inserting “and in
7 accordance with any timeframe established by the
8 Secretary under paragraph (6)” after “paragraph
9 (3)”;

10 (2) in paragraph (3)(B)(iii), by inserting “(with
11 respect to prior authorization requests submitted on
12 or after the first day of the third plan year begin-
13 ning after the date of the enactment of the Health
14 CARE Act of 2026, any timeframe established by
15 the Secretary under paragraph (6))” after “72
16 hours”; and

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

19 “(6) TIMEFRAME FOR RESPONSE TO PRIOR AU-
20 THORIZATION REQUESTS.—Subject to paragraph
21 (3), the Secretary may establish, for purposes of an
22 organization determination made with respect to a
23 prior authorization request for an item or service to
24 be furnished to an individual, timeframes, such as
25 24 hours, for the organization to notify the enrollee

1 (and the physician involved, as appropriate) of such
2 determination for—

3 “(A) a request for expedited determination
4 described in paragraph (3)(A);

5 “(B) a real time decision for routinely ap-
6 proved items and services; and

7 “(C) any other prior authorization re-
8 quest.”.

9 **SEC. 503. SPECIAL ENROLLMENT PERIOD FOR PROVIDER**
10 **TERMINATIONS.**

11 Section 1851(e)(4) of the Social Security Act (42
12 U.S.C. 1395w-21(e)(4)) is amended—

13 (1) by redesignating subparagraph (D) as sub-
14 paragraph (E); and

15 (2) by inserting after subparagraph (C) the fol-
16 lowing new subparagraph:

17 “(D) the individual demonstrates or the
18 Secretary or organization determines that the
19 individual is assigned to, currently receiving
20 care from, or has received care in the previous
21 3 months from, a provider of services or sup-
22 plier that is terminated from the provider net-
23 work of the plan;”.

1 **SEC. 504. PROVIDING COVERAGE FOR HEARING CARE**
2 **UNDER THE MEDICARE PROGRAM.**

3 (a) PROVISION OF AUDIOLOGY SERVICES BY QUALI-
4 FIED AUDIOLOGISTS AND QUALIFIED HEARING AID PRO-
5 FESSIONALS.—

6 (1) IN GENERAL.—Section 1861(ll) of the So-
7 cial Security Act (42 U.S.C. 1395x(ll)) is amend-
8 ed—

9 (A) in paragraph (3)—

10 (i) by inserting “(and, beginning Jan-
11 uary 1, 2028, such aural rehabilitation and
12 treatment services)” after “assessment
13 services”;

14 (ii) by inserting “, and, beginning on
15 January 1, 2028, such hearing assessment
16 services furnished by a qualified hearing
17 aid professional,” after “by a qualified au-
18 diologist”; and

19 (iii) by striking “the audiologist” and
20 inserting “the audiologist or qualified hear-
21 ing aid professional”; and

22 (B) in paragraph (4), by adding at the end
23 the following new subparagraph:

24 “(C) The term ‘qualified hearing aid profes-
25 sional’ means, with respect to hearing assessment

1 services described in paragraph (3), an individual
2 who—

3 “(i) is licensed or registered as a hearing
4 aid dispenser, hearing aid specialist, hearing in-
5 strument dispenser, or related professional by
6 the State in which the individual furnishes such
7 services; and

8 “(ii) meets such other requirements as the
9 Secretary determines appropriate (including re-
10 quirements relating to educational certifications
11 or accreditations), taking into account any addi-
12 tional requirements for hearing aid specialists,
13 hearing aid dispensers, and hearing instrument
14 dispensers established by Medicare Advantage
15 organizations under part C, State plans (or
16 waivers of such plans) under title XIX, and the
17 group health plans and health insurance issuers
18 (as such terms are defined in section 2791 of
19 the Public Health Service Act).”.

20 (2) PAYMENT FOR QUALIFIED HEARING AID
21 PROFESSIONALS.—Section 1833(a)(1) of the Social
22 Security Act (42 U.S.C. 1395l(a)(1)) is amended—
23 (A) by striking “and” before “(HH)”; and
24 (B) by inserting before the semicolon at
25 the end the following: “and (II) with respect to

1 hearing assessment services (as described in
2 paragraph (3) of section 1861(ll)) furnished by
3 a qualified hearing aid professional (as defined
4 in paragraph (4)(C) of such section), the
5 amounts paid shall be equal to 80 percent of
6 the lesser of the actual charge for such services
7 or 85 percent of the amount for such services
8 determined under the payment basis determined
9 under section 1848”.

10 (b) COVERAGE OF HEARING AIDS.—

11 (1) INCLUSION OF HEARING AIDS AS PROS-
12 THETIC DEVICES.—Section 1861(s)(8) of the Social
13 Security Act (42 U.S.C. 1395x(s)(8)) is amended by
14 inserting “, and including hearing aids (as described
15 in section 1834(h)(7)) furnished on or after January
16 1, 2028, to individuals diagnosed with moderately
17 severe, severe, or profound hearing loss” before the
18 semicolon at the end.

19 (2) PAYMENT LIMITATIONS FOR HEARING
20 AIDS.—Section 1834(h) of the Social Security Act
21 (42 U.S.C. 1395m(h)) is amended by adding at the
22 end the following new paragraphs:

23 “(6) PAYMENT ONLY ON AN ASSIGNMENT-RE-
24 LATED BASIS.—Payment for hearing aids for which
25 payment may be made under this part may be made

1 only on an assignment-related basis. The provisions
2 of section 1842(b)(18)(B) shall apply to hearing aids
3 in the same manner as they apply to services fur-
4 nished by a practitioner described in subsection
5 (b)(18)(C).

6 “(7) LIMITATIONS FOR HEARING AIDS.—Pay-
7 ment may be made under this part with respect to
8 an individual, with respect to hearing aids furnished
9 on or after January 1, 2028—

10 “(A) not more than once per ear during a
11 5-year period;

12 “(B) only for types of such hearing aids
13 that are determined appropriate by the Sec-
14 retary; and

15 “(C) only if furnished pursuant to a writ-
16 ten order of a physician, qualified audiologist
17 (as defined in section 1861(ll)(4)), qualified
18 hearing aid professional (as so defined), physi-
19 cian assistant, nurse practitioner, or clinical
20 nurse specialist.”.

21 (3) APPLICATION OF COMPETITIVE ACQUISI-
22 TION.—

23 (A) IN GENERAL.—Section 1834(h)(1)(H)
24 of the Social Security Act (42 U.S.C.
25 1395m(h)(1)(H)) is amended—

1 (i) in the header, by inserting “AND
2 HEARING AIDS” after “ORTHOTICS”;

3 (ii) in the matter preceding clause (i),
4 by inserting “, or of hearing aids described
5 in paragraph (2)(E) of such section,” after
6 “2011,”; and

7 (iii) in clause (i), by inserting “or
8 such hearing aids” after “such orthotics”.

9 (B) CONFORMING AMENDMENT.—

10 (i) IN GENERAL.—Section 1847(a)(2)
11 of the Social Security Act (42 U.S.C.
12 1395w-3(a)(2)) is amended by adding at
13 the end the following new subparagraph:

14 “(E) HEARING AIDS.—Hearing aids de-
15 scribed in section 1861(s)(8) for which payment
16 would otherwise be made under section
17 1834(h).”.

18 (ii) EXEMPTION OF CERTAIN ITEMS
19 FROM COMPETITIVE ACQUISITION.—Sec-
20 tion 1847(a)(7) of the Social Security Act
21 (42 U.S.C. 1395w-3(a)(7)) is amended by
22 adding at the end the following new sub-
23 paragraph:

24 “(C) CERTAIN HEARING AIDS.—Those
25 items and services described in paragraph

1 (2)(E) if furnished by a physician or other
2 practitioner (as defined by the Secretary) to the
3 physician's or practitioner's own patients as
4 part of the physician's or practitioner's profes-
5 sional service.”.

6 (4) INCLUSION OF QUALIFIED AUDIOLOGISTS
7 AND QUALIFIED HEARING AID PROFESSIONALS AS
8 CERTAIN PRACTITIONERS TO RECEIVE PAYMENT ON
9 AN ASSIGNMENT-RELATED BASIS.—Section
10 1842(b)(18)(C) of the Social Security Act (42
11 U.S.C. 1395u(b)(18)(C)), is amended by adding at
12 the end the following new clauses:

13 “(ix) Beginning on January 1, 2028,
14 a qualified audiologist (as defined in sec-
15 tion 1861(ll)(4)(B)).

16 “(x) A qualified hearing aid profes-
17 sional (as defined in section
18 1861(ll)(4)(C)).”.

19 (c) EXCLUSION MODIFICATION.—Section 1862(a)(7)
20 of the Social Security Act (42 U.S.C. 1395y(a)(7)) is
21 amended by inserting “(except such hearing aids or exami-
22 nations therefor as described in and otherwise allowed
23 under section 1861(s)(8))” after “hearing aids or exami-
24 nations therefor”.

1 (d) INCLUSION AS EXCEPTED MEDICAL TREAT-
2 MENT.—Section 1821(b)(5)(A) of the Social Security Act
3 (42 U.S.C. 1395i–5(b)(5)(A)) is amended—

4 (1) in clause (ii), by striking “or”;

5 (2) in clause (iii), by striking the period and in-
6 serting “, or”; and

7 (3) by adding at the end the following new
8 clause:

9 “(iv) consisting of audiology services
10 described in subsection (ll)(3) of section
11 1861, or hearing aids described in sub-
12 section (s)(8) of such section, that are pay-
13 able under part B as a result of the
14 amendments made by the Health CARE
15 Act of 2026.”.

16 (e) RURAL HEALTH CLINICS AND FEDERALLY
17 QUALIFIED HEALTH CENTERS.—

18 (1) CLARIFYING COVERAGE OF AUDIOLOGY
19 SERVICES AS PHYSICIANS’ SERVICES.—Section
20 1861(aa)(1)(A) of the Social Security Act (42
21 U.S.C. 1395x(aa)(1)(A)) is amended by inserting
22 “(including audiology services (as defined in sub-
23 section (ll)(3)))” after “physicians’ services”.

24 (2) INCLUSION OF QUALIFIED AUDIOLOGISTS
25 AND QUALIFIED HEARING AID PROFESSIONALS AS

1 RHC AND FQHC PRACTITIONERS.—Section
2 1861(aa)(1)(B) of the Social Security Act (42
3 U.S.C. 1395x(aa)(1)(B)) is amended by inserting
4 “or by a qualified audiologist or a qualified hearing
5 aid professional (as such terms are defined in sub-
6 section (ll)),” after “(as defined in subsection
7 (hh)(1)),”.

8 (3) TEMPORARY PAYMENT RATES FOR CERTAIN
9 SERVICES UNDER THE RHC AIR AND FQHC PPS.—

10 (A) AIR.—Section 1833 of the Social Se-
11 curity Act (42 U.S.C. 1395l) is amended—

12 (i) in subsection (a)(3)(A), by insert-
13 ing “(which shall, in the case of audiology
14 services (as defined in section 1861(ll)(3)),
15 in lieu of any limits on reasonable charges
16 otherwise applicable, be based on the rates
17 payable for such services under the pay-
18 ment basis determined under section 1848
19 until such time as the Secretary deter-
20 mines sufficient data has been collected to
21 otherwise apply such limits (or January 1,
22 2034, if no such determination has been
23 made as of such date))” after “may pre-
24 scribe in regulations”; and

1 (ii) by adding at the end the following
2 new subsection:

3 “(ee) DISREGARD OF COSTS ATTRIBUTABLE TO CER-
4 TAIN SERVICES FROM CALCULATION OF RHC AIR.—
5 Payments for rural health clinic services other than audi-
6 ology services (as defined in section 1861(ll)(3)) under the
7 methodology for all-inclusive rates (established by the Sec-
8 retary) under subsection (a)(3) shall not take into account
9 the costs of such services while rates for such services are
10 based on rates payable for such services under the pay-
11 ment basis established under section 1848.”.

12 (B) PPS.—Section 1834(o) of the Social
13 Security Act (42 U.S.C. 1395m(o)) is amended
14 by adding at the end the following new para-
15 graph:

16 “(6) TEMPORARY PAYMENT RATES BASED ON
17 PFS FOR CERTAIN SERVICES.—The Secretary shall,
18 in establishing payment rates for audiology services
19 (as defined in section 1861(ll)(3)) that are Federally
20 qualified health center services under the prospective
21 payment system established under this subsection, in
22 lieu of the rates otherwise applicable under such sys-
23 tem, base such rates on rates payable for such serv-
24 ices under the payment basis established under sec-
25 tion 1848 until such time as the Secretary deter-

1 mines sufficient data has been collected to otherwise
2 establish rates for such services under such system
3 (or January 1, 2034, if no such determination has
4 been made as of such date). Payments for Federally
5 qualified health center services other than such audi-
6 ology services under such system shall not take into
7 account the costs of such services while rates for
8 such services are based on rates payable for such
9 services under the payment basis established under
10 section 1848.”.

11 (f) IMPLEMENTATION.—

12 (1) IN GENERAL.—In addition to amounts oth-
13 erwise available, there is appropriated to the Sec-
14 retary of Health and Human Services for fiscal year
15 2027, out of any money in the Treasury not other-
16 wise appropriated, \$370,000,000, to remain avail-
17 able until expended, for purposes of implementing
18 the amendments made by this section during the pe-
19 riod beginning on January 1, 2027, and ending on
20 September 30, 2036.

21 (2) PROGRAM INSTRUCTION.—The Secretary of
22 Health and Human Services shall implement the
23 provisions of, and the amendments made by, this
24 section for 2027 and 2028 by program instruction.

1 **TITLE VI—LOWERING THE COST**
2 **OF CARE**

3 **SEC. 601. STRENGTHENING HOSPITAL PRICE TRANS-**
4 **PARENCY.**

5 Title XXVII of the Public Health Service Act is
6 amended by inserting after section 2718 (42 U.S.C.
7 300gg-18) the following:

8 **“SEC. 2718A. PROVIDER PRICE TRANSPARENCY.**

9 “(a) DEFINITIONS.—In this section:

10 “(1) APPLICABLE IMAGING SERVICE PRO-
11 VIDER.—The term ‘applicable imaging provider’
12 means a provider of services or supplier who fur-
13 nishes any imaging services to patients, including an
14 independent diagnostic testing facility, an outpatient
15 diagnostic facility, and any other imaging center
16 designated by the Secretary, except that such term
17 does not include an imaging service provider with re-
18 spect to which standard charges for specified imag-
19 ing service provider services furnished by such serv-
20 ice provider are made available by a hospital pursu-
21 ant to subsection (b) or specified ambulatory sur-
22 gical center pursuant to subsection (e).

23 “(2) APPLICABLE LABORATORY.—The term
24 ‘applicable laboratory’ means a ‘laboratory’ as such
25 term is defined in section 493.2, of title 42, Code of

1 Federal Regulations (or a successor regulation), ex-
2 cept that such term does not include a laboratory
3 with respect to which standard charges for specified
4 clinical diagnostic laboratory tests furnished by such
5 laboratory are made available by a hospital pursuant
6 to subsection (b) or specified ambulatory surgical
7 center pursuant to subsection (e).

8 “(3) DISCOUNTED CASH PRICE.—

9 “(A) IN GENERAL.—The term ‘discounted
10 cash price’ means the minimum charge ex-
11 pressed as a dollar amount, subject to subpara-
12 graph (B), that the applicable service provider
13 subject to this section accepts from an indi-
14 vidual who pays cash, or cash equivalent, for a
15 furnished item or service, without regard to
16 health insurance coverage, as payment in full.

17 “(B) EXCLUSIONS.—For purposes of sub-
18 paragraph (A), the minimum charge described
19 in such subparagraph, with respect to a fur-
20 nished item or service, as applicable, shall be
21 calculated without taking into account any fi-
22 nancial assistance, including assistance attrib-
23 utable to charity care (in the case of a hospital,
24 as such term is used for purposes of hospital
25 cost reporting under title XVIII of the Social

1 Security Act), or third-party assistance for such
2 item or service.

3 “(4) EXTRAORDINARY COLLECTION ACTIONS.—

4 The term ‘extraordinary collection action’ has the
5 meaning given such term for purposes of section
6 501(r) of the Internal Revenue Code of 1986.

7 “(5) GROSS CHARGE.—The term ‘gross charge’

8 means the charge for an individual item or service
9 that is reflected on a hospital’s chargemaster or
10 similar list of prices facilitated by any other pro-
11 vider, as defined by the Secretary, absent any dis-
12 counts.

13 “(6) HOSPITAL.—The term ‘hospital’ means an

14 institution in any State in which State or applicable
15 local law provides for the licensing of hospitals, that
16 is licensed as a hospital pursuant to such law or is
17 approved, by the agency of such State or locality re-
18 sponsible for licensing hospitals, as meeting the
19 standards established for such licensing. For pur-
20 poses of this paragraph, the term ‘State’ includes
21 each of the several States, the District of Columbia,
22 Puerto Rico, the Virgin Islands, Guam, American
23 Samoa, and the Northern Mariana Islands.

24 “(7) PAYER-SPECIFIC NEGOTIATED CHARGE.—

25 The term ‘payer-specific negotiated charge’ means

1 the charge that a hospital has negotiated with a
2 third-party payer for an item or service.

3 “(8) SHOPPABLE SERVICE.—The term
4 ‘shoppable service’ means a service that can be
5 scheduled by a healthcare consumer in advance.
6 Such services are routinely provided in non-urgent
7 situations that do not require immediate action or
8 attention to the patient, thus allowing patients to
9 price shop and schedule a service at a time that is
10 convenient for them.

11 “(9) SPECIFIED AMBULATORY SURGICAL CEN-
12 TER.—The term ‘specified ambulatory surgical cen-
13 ter’ means any distinct entity that operates exclu-
14 sively for the purpose of providing surgical services
15 to patients not requiring hospitalization and in
16 which the expected duration of services would not
17 exceed 24 hours following an admission, except that
18 such term does not include a surgical center with re-
19 spect to which standard charges for specified ambu-
20 latory surgical center services furnished by such sur-
21 gical center are made available by a hospital pursu-
22 ant to subsection (b).

23 “(10) SPECIFIED CLINICAL DIAGNOSTIC LAB-
24 ORATORY TEST.—The term ‘specified clinical diag-
25 nostic laboratory test’ means any clinical diagnostic

1 laboratory test or service that is provided by the ap-
2 plicable laboratory, excluding advanced diagnostic
3 laboratory tests (as defined in section 1834A(d)(5)
4 of the Social Security Act).

5 “(11) SPECIFIED IMAGING SERVICE.—The term
6 ‘specified imaging service’ has the meaning given to
7 the term ‘radiology and certain other imaging serv-
8 ices’ for purposes of section 411.351 of title 42,
9 Code of Federal Regulations (or successor regula-
10 tions).

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

15 “(b) HOSPITAL PRICE TRANSPARENCY.—

16 “(1) IN GENERAL.—Beginning January 1 of
17 the year that begins on or after the date that is 1
18 year after the date of enactment of the Health
19 CARE Act of 2026, each hospital shall, in accord-
20 ance with a method and format established by the
21 Secretary under paragraph (3), on a quarterly basis
22 (if there have been any changes to the standard
23 charges described in subparagraph (2) compile and
24 make publicly available on an internet website (with-
25 out subscription and free of charge)—

1 “(A) all of the hospital’s standard charges
2 for each item and service furnished by such
3 hospital in a machine-readable format (or a
4 successor technology specified by the Sec-
5 retary);

6 “(B) all of the hospital’s standard charges
7 in a consumer-friendly format (as specified by
8 the Secretary), that includes—

9 “(i) as many of the Centers for Medi-
10 care & Medicaid Services-specified
11 shoppable services that are furnished by
12 the hospital, and as many additional hos-
13 pital-selected shoppable services (or all
14 such additional services, if such hospital
15 furnishes fewer than 300 shoppable serv-
16 ices) as may be necessary for a combined
17 total of at least 300 shoppable services
18 through the January 1 described in this
19 subparagraph, after which the hospital
20 shall include all shoppable services that the
21 hospital furnishes; and

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

1 the hospital, an indication that such serv-
2 ice is not so furnished; and

3 “(C) the name and business address for
4 each person or entity that, with respect to the
5 hospital—

6 “(i) has an ownership or investment
7 interest;

8 “(ii) has a controlling interest;

9 “(iii) is a management services orga-
10 nization; or

11 “(iv) is a significant equity investor.

12 “(2) STANDARD CHARGES DEFINED.—For pur-
13 poses of paragraph (1), the term ‘standard charges’
14 means the following:

15 “(A) A plain language description of each
16 item and service, accompanied by any applicable
17 billing codes, including modifiers, using com-
18 monly recognized billing code sets, including—

19 “(i) the Diagnosis Related Group;

20 “(ii) the Healthcare Common Proce-
21 dure Coding System code;

22 “(iii) the National Drug Code; and

23 “(iv) other applicable identifiers as de-
24 termined by the Secretary (or successor
25 code sets).

1 “(B) The gross charge, expressed as a dol-
2 lar amount, for each such item or service, when
3 provided in, as applicable, the inpatient setting
4 and outpatient department setting.

5 “(C) The discounted cash price.

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

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

23 “(F) The amount of any facility fee, as de-
24 fined by the Secretary, or add-on charges that
25 will be part of the final payment amount, in ad-

1 dition to any information that might help the
2 patient understand when a facility fee or add-
3 on charge may apply and how to avoid such
4 charges.

5 “(G) Any other additional information the
6 Secretary may require for the purpose of im-
7 proving the accuracy of, or enabling consumers
8 to easily understand and compare, standard
9 charges for an item or service, except informa-
10 tion that is duplicative of any other reporting
11 requirement under this subsection. In the case
12 of standard charges for an item or service in-
13 cluded as part of a bundled, per diem, episodic,
14 or other similar arrangement, the information
15 described in this subparagraph shall be made
16 available as determined appropriate by the Sec-
17 retary.

18 “(3) UNIFORM METHOD AND FORMAT.—The
19 Secretary shall establish a standard, uniform method
20 and format for hospitals to use in compiling and
21 making public information described in paragraph
22 (1). Such method and format shall—

23 “(A) include a machine-readable format
24 (or successor technology specified by the Sec-
25 retary) containing the information described in

1 paragraph (2) for all items and services fur-
2 nished by each hospital;

3 “(B) meet such standards as determined
4 appropriate by the Secretary in order to ensure
5 the accessibility and usability of such charges;
6 and

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

10 “(4) NO DEEMED COMPLIANCE.—Hospitals
11 may offer a price estimator tool, but the availability
12 of such a price estimator tool shall not be considered
13 to deem compliance with or otherwise vitiate the re-
14 quirements of paragraph (1)(B) or any other re-
15 quirements of this subsection.

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

23 “(6) ATTESTATION.—A senior official from
24 each hospital (the Chief Executive Officer, Chief Fi-
25 nancial Officer, or an official of equivalent seniority)

1 shall attest to the accuracy and completeness of the
2 disclosures, and any other attestations as required
3 by the Secretary, made in accordance with the hos-
4 pital price transparency requirements based on cri-
5 teria established by the Secretary.

6 “(7) ENFORCEMENT.—

7 “(A) IN GENERAL.—In the case of a hos-
8 pital that fails to comply with the requirements
9 of this subsection, not later than 30 days after
10 the date on which the Secretary determines
11 such failure exists, the Secretary shall notify
12 such hospital of such determination, which shall
13 include a request for a corrective action plan if
14 applicable to comply with such requirements.

15 “(B) CIVIL MONETARY PENALTY.—

16 “(i) IN GENERAL.—In addition to any
17 other enforcement actions or penalties that
18 may apply under another provision of law,
19 a hospital that has received a request for
20 a corrective action plan under subpara-
21 graph (A) and fails to comply with the re-
22 quirements of this subsection by the date
23 that is 90 days after such request is made
24 shall be subject to a civil monetary penalty
25 of an amount specified by the Secretary for

1 each day (beginning on the day the hos-
2 pital was first out of compliance, as deter-
3 mined by the Secretary) during which such
4 failure was ongoing. Such amount shall not
5 exceed—

6 “(I) in the case of a specified
7 hospital with 30 or fewer beds, \$300
8 per day (or, in the case of such a hos-
9 pital that has been noncompliant with
10 such requirements for a 1-year period
11 or longer, beginning with the first day
12 following such 1-year period, \$400 per
13 day);

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

23 “(III) in the case of a specified
24 hospital with more than 100 beds but
25 fewer than 201 beds, \$17.50 per bed

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

7 “(IV) in the case of a specified
8 hospital with more than 200 beds but
9 fewer than 501 beds, \$20 per bed per
10 day (or, in the case of such a hospital
11 that has been noncompliant with such
12 requirements for a 1-year period or
13 longer, beginning with the first day
14 following such 1-year period, \$25 per
15 bed per day); and

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

24 “(ii) INCREASE AUTHORITY.—In ap-
25 plying this subparagraph with respect to

1 hospitals that fail to comply in 2028 or a
2 subsequent year, the Secretary may
3 through notice and comment rulemaking
4 increase—

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

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

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

17 “(iii) PERSISTENT NONCOMPLI-
18 ANCE.—

19 “(I) IN GENERAL.—In the case
20 of a hospital that the Secretary has
21 determined to be noncompliant with
22 the provisions of this subsection two
23 or more times during a 1-year period
24 (as determined by the Secretary), the
25 Secretary may increase any penalty

1 otherwise applicable under this sub-
2 paragraph by the amount specified in
3 subclause (II) with respect to such
4 hospital and may require such hos-
5 pital to complete such additional cor-
6 rective actions plans as the Secretary
7 may specify.

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

12 “(aa) with more than 30
13 beds but fewer than 101 beds, an
14 amount that is not less than
15 \$500,000 and not more than
16 \$1,000,000;

17 “(bb) with more than 100
18 beds but fewer than 301 beds, an
19 amount that is greater than
20 \$1,000,000 and not more than
21 \$2,000,000;

22 “(cc) with more than 300
23 beds but fewer than 501 beds, an
24 amount that is greater than

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1 \$2,000,000 and not more than
2 \$4,000,000; and
3 “(dd) with more than 500
4 beds, and amount that is not less
5 than \$5,000,000 and not more
6 than \$10,000,000.

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

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

22 “(C) NO AUTHORITY TO WAIVE OR RE-
23 DUCE PENALTY.—The Secretary shall not grant
24 or extend any waiver, delay, tolling, or other
25 mitigation of a civil monetary penalty for failing

1 to comply with the requirements of this sub-
2 section except where the Secretary determines
3 that imposing the maximum civil monetary pen-
4 alty, including penalties for persistent non-
5 compliance, will disrupt hospital operations in a
6 manner that impacts patient care. The Sec-
7 retary may request documentation in such form
8 and manner as the Secretary may require in
9 order to evaluate impact on hospital operations.

10 “(D) PROHIBITION ON EXTRAORDINARY
11 COLLECTION.—In addition to civil monetary
12 penalties applicable under subparagraph (B)
13 and any other enforcement actions or penalties
14 that may apply under any other provision of
15 law, for a hospital that has received a request
16 for a corrective action plan under subparagraph
17 (A) and fails to comply with the requirements
18 of this subsection by the date that is 90 days
19 after such request, that hospital or any other
20 person or entity collecting on behalf of the hos-
21 pital shall—

22 “(i) not take any extraordinary collec-
23 tion actions against any patient or patient
24 guarantor for debt incurred by any patient
25 on the date or dates of service when the

1 hospital was not in compliance with the re-
2 quirements of this subsection;

3 “(ii) cease any extraordinary collec-
4 tion actions that have begun against any
5 patient or patient guarantor for debt in-
6 curred by any patient on the date or dates
7 of service when the hospital was not in
8 compliance with the requirements of this
9 subsection; and

10 “(iii) not take any extraordinary col-
11 lection actions against any patient or pa-
12 tient guarantor for debt incurred by any
13 patient on the date or dates of service
14 when the hospital was not in compliance
15 with the requirements of this subsection
16 after the hospital comes back into compli-
17 ance with the requirements of this sub-
18 section.

19 “(8) RULEMAKING.—

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

24 “(B) OWNERSHIP INFORMATION.—In pro-
25 mulgating regulations under this paragraph, the

1 Secretary shall define the individuals and orga-
2 nizations that must be disclosed under para-
3 graph (1)(C) in a manner that harmonizes dis-
4 closure requirements with requirements estab-
5 lished under section 1124 of the Social Security
6 Act and prioritizes the disclosure of individuals
7 and organizations whose ownership or manage-
8 ment relationship with a hospital impacts oper-
9 ational, financial, or clinical decision making for
10 such hospital.”.

11 **SEC. 602. CLINICAL DIAGNOSTIC LABORATORY PRICE**
12 **TRANSPARENCY.**

13 Section 2718A of the Public Health Service Act, as
14 added by section 601, is amended by adding at the end
15 the following:

16 “(c) CLINICAL DIAGNOSTIC LABORATORY PRICE
17 TRANSPARENCY.—

18 “(1) IN GENERAL.—Beginning January 1 of
19 the year that begins on or after the date that is 1
20 year after the date of enactment of the Health
21 CARE Act of 2026, an applicable laboratory shall,
22 on a quarterly basis (if there have been any changes
23 to the standard charges described in paragraph (2))
24 compile and make publicly available on an internet
25 website (without subscription and free of charge)—

1 “(A) the standard charges described in
2 paragraph (2) with respect to each specified
3 clinical diagnostic laboratory test that such lab-
4 oratory so furnishes; and

5 “(B) the name and business address for
6 each person or entity that, with respect to the
7 laboratory—

8 “(i) has an ownership or investment
9 interest;

10 “(ii) has a controlling interest;

11 “(iii) is a management services orga-
12 nization; or

13 “(iv) is a significant equity investor.

14 “(2) STANDARD CHARGES DEFINED.—For pur-
15 poses of paragraph (1), the term ‘standard charges’
16 means, with respect to an applicable laboratory and
17 a specified clinical diagnostic laboratory test, the fol-
18 lowing:

19 “(A) A plain language description of each
20 item or service, accompanied by any applicable
21 billing codes (including modifiers that materi-
22 ally change the price for insurers or providers,
23 and that materially change out-of-pocket costs
24 for consumers) using commonly recognized bill-
25 ing code sets, including—

1 “(i) the Healthcare Common Proce-
2 dure Coding System code;

3 “(ii) the National Drug Code; or

4 “(iii) other applicable identifier as de-
5 termined by the Secretary (or successor
6 code sets).

7 “(B) The gross charge expressed as a dol-
8 lar amount, for each such test.

9 “(C) The discounted cash price.

10 “(D) The payer-specific negotiated
11 charges, expressed as a dollar amount and
12 clearly associated with the name of the applica-
13 ble third-party payer and name of each plan,
14 that apply to each such test. If the charges are
15 based on an algorithm, percentage of another
16 amount, or other formula or criteria, the appli-
17 cable laboratory also shall disclose such algo-
18 rithm, percentage, formula, or criteria as set
19 forth in its contract and any other information
20 necessary to determine the negotiated charge as
21 a dollar amount.

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

1 “(F) Any other additional information the
2 Secretary may require for the purpose of im-
3 proving the accuracy of, or enabling consumers
4 to easily understand and compare, standard
5 charges for an item or service, except informa-
6 tion that is duplicative of any other reporting
7 requirement under this section. In the case of
8 standard charges for an item or service in-
9 cluded as part of a bundled, per diem, episodic,
10 or other similar arrangement, the information
11 described in this subparagraph shall be made
12 available as determined appropriate by the Sec-
13 retary.

14 “(3) UNIFORM METHOD AND FORMAT.—The
15 Secretary shall establish a standard, uniform method
16 and format for applicable laboratories to use in com-
17 piling and making public information pursuant to
18 paragraph (1). Such method and format shall—

19 “(A) include a machine-readable format
20 (or a successor technology specified by the Sec-
21 retary) containing the information described in
22 paragraph (2) for all specified clinical diag-
23 nostic laboratory tests furnished by each labora-
24 tory and the ownership information described in
25 paragraph (1)(B);

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

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

8 “(4) MONITORING COMPLIANCE.—The Sec-
9 retary shall, in consultation with the Inspector Gen-
10 eral of the Department of Health and Human Serv-
11 ices, establish a process to monitor compliance with
12 this subsection. Such process shall ensure that each
13 applicable laboratory’s compliance with this sub-
14 section is reviewed not less frequently than once
15 every year.

16 “(5) INCLUSION OF ANCILLARY SERVICES.—
17 Any charge for a specified clinical diagnostic labora-
18 tory test furnished by an applicable laboratory made
19 publicly available in accordance with paragraph (1)
20 shall include the charge for any ancillary item or
21 service (such as specimen collection services, speci-
22 men transport, centrifugation, aliquoting, labeling,
23 requisition processing, and standard result reporting
24 services) that would customarily and routinely be

1 furnished by such laboratory as part of such test, as
2 specified by the Secretary.

3 “(6) ATTESTATION.—A senior official from
4 each clinical diagnostic laboratory (the Chief Execu-
5 tive Officer, Chief Financial Officer, or an official of
6 equivalent seniority) shall attest to the accuracy and
7 completeness of the disclosures, and any other attes-
8 tations as required by the Secretary, made in ac-
9 cordance with the clinical laboratory price trans-
10 parency requirements based on criteria established
11 by the Secretary.

12 “(7) ENFORCEMENT.—

13 “(A) IN GENERAL.—In the case of an ap-
14 plicable laboratory that fails to comply with the
15 requirements of this subsection—

16 “(i) the Secretary shall notify such
17 laboratory of such failure not later than 30
18 days after the date on which the Secretary
19 determines such failure exists; and

20 “(ii) upon request of the Secretary,
21 such laboratory shall submit to the Sec-
22 retary, not later than 45 days after the
23 date of such request, a corrective action
24 plan to comply with such requirements.

25 “(B) CIVIL MONETARY PENALTY.—

1 “(i) IN GENERAL.—An applicable lab-
2 oratory that has received a notification
3 under subparagraph (A)(i) and fails to
4 comply with the requirements of this sub-
5 section by the date that is 90 days after
6 such notification (or, in the case of an ap-
7 plicable laboratory that has submitted a
8 corrective action plan described in subpara-
9 graph (A)(ii) in response to a request so
10 described, by the date that is 90 days after
11 such submission) shall be subject to a civil
12 monetary penalty of an amount specified
13 by the Secretary for each day (beginning
14 with the day on which the Secretary first
15 determined that such laboratory was not
16 complying with such requirements) during
17 which such failure is ongoing (not to ex-
18 ceed \$300 per day).

19 “(ii) INCREASE AUTHORITY.—In ap-
20 plying this subparagraph with respect to
21 an applicable laboratory that fails to com-
22 ply with the requirements of this sub-
23 section in 2028 or a subsequent year, the
24 Secretary may through notice and com-
25 ment rulemaking increase the limitation on

1 the per day amount of any penalty applica-
2 ble to an applicable laboratory under
3 clause (i).

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

13 “(iv) NO AUTHORITY TO WAIVE OR
14 REDUCE PENALTY.—The Secretary shall
15 not grant or extend any waiver, delay, toll-
16 ing, or other mitigation of a civil monetary
17 penalty for failing to comply with the re-
18 quirements of this subsection except where
19 the Secretary determines that imposing the
20 maximum civil monetary penalty will dis-
21 rupt applicable laboratory operations in a
22 manner that impacts patient care. The
23 Secretary may request documentation in
24 such form and manner as the Secretary

1 may require in order to evaluate impact on
2 applicable laboratory operations.

3 “(8) PROVISION OF TECHNICAL ASSISTANCE.—

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

8 “(9) RULEMAKING.—

9 “(A) IN GENERAL.—The Secretary shall
10 implement this subsection through notice and
11 comment rulemaking in accordance with section
12 553 of title 5, United States Code.

13 “(B) OWNERSHIP INFORMATION.—In pro-
14 mulgating regulations under this paragraph, the
15 Secretary shall define the individuals and orga-
16 nizations that must be disclosed under para-
17 graph (1)(B) in a manner that harmonizes dis-
18 closure requirements with requirements estab-
19 lished under section 1124 of the Social Security
20 Act and prioritizes the disclosure of individuals
21 and organizations whose ownership or manage-
22 ment relationship with a laboratory impacts
23 operational, financial, or clinical decision mak-
24 ing for such laboratory.”.

1 **SEC. 603. IMAGING SERVICES PRICE TRANSPARENCY.**

2 Section 2718A of the Public Health Service Act, as
3 amended by section 602, is further amended by adding
4 at the end the following:

5 “(d) IMAGING SERVICES PRICE TRANSPARENCY.—

6 “(1) IN GENERAL.—Beginning January 1 of
7 the year that begins on or after the date that is 1
8 year after the date of enactment of the Health
9 CARE Act of 2026, each applicable imaging service
10 provider shall, on a quarterly basis (if there have
11 been any changes to the standard charges described
12 in paragraph (2)) compile and make publicly avail-
13 able on an internet website (without subscription
14 and free of charge)—

15 “(A) the standard charges described in
16 paragraph (2) with respect to each such speci-
17 fied imaging service provided by such provider;
18 and

19 “(B) the name and business address for
20 each person or entity that, with respect to the
21 imaging services provider—

22 “(i) has an ownership or investment
23 interest;

24 “(ii) has a controlling interest;

25 “(iii) is a management services orga-
26 nization; or

1 “(iv) is a significant equity investor.

2 “(2) STANDARD CHARGES DEFINED.—For pur-
3 poses of paragraph (1), the term ‘standard charges’,
4 with respect to an applicable imaging service pro-
5 vider and a specified imaging service, means the fol-
6 lowing:

7 “(A) A plain language description of each
8 item or service, accompanied by any applicable
9 billing codes (including modifiers that materi-
10 ally change the price for insurers or providers,
11 and that materially change out-of-pocket costs
12 for consumers) using commonly recognized bill-
13 ing code sets, including—

14 “(i) the Healthcare Common Proce-
15 dure Coding System code;

16 “(ii) the National Drug Code; or

17 “(iii) other applicable identifier as de-
18 termined by the Secretary (or successor
19 code sets).

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

22 “(C) The discounted cash price.

23 “(D) The payer-specific negotiated
24 charges, expressed as a dollar amount and
25 clearly associated with the name of the applica-

1 ble third-party payer and name of each plan,
2 that apply to each such service. If the charges
3 are based on an algorithm, percentage of an-
4 other amount, or other formula or criteria, the
5 provider or supplier also shall disclose such al-
6 gorithm, percentage, formula, or criteria as set
7 forth in its contract and any other information
8 necessary to determine the negotiated charge as
9 a dollar amount.

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

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

1 “(3) UNIFORM METHOD AND FORMAT.—The
2 Secretary shall establish a standard, uniform method
3 and format for applicable imaging service providers
4 to use in making public information described in
5 paragraph (1). Any such method and format shall—

6 “(A) include a machine-readable format
7 (as specified by the Secretary) containing the
8 information described in paragraph (2) for all
9 specified imaging services furnished by each ap-
10 plicable imaging service provider and ownership
11 information described in paragraph (1)(B);

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

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

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

24 “(5) ATTESTATION.—A senior official from
25 each specified imaging service provider (the Chief

1 Executive Officer, Chief Financial Officer, or an of-
2 ficial of equivalent seniority) shall attest to the accu-
3 racy and completeness of the disclosures, and any
4 other attestations as required by the Secretary,
5 made in accordance with the imaging service pro-
6 vider price transparency requirements based on cri-
7 teria established by the Secretary.

8 “(6) ENFORCEMENT.—

9 “(A) IN GENERAL.—In the case of a speci-
10 fied imaging service provider that fails to com-
11 ply with the requirements of this subsection—

12 “(i) the Secretary shall notify such
13 imaging service provider of such failure not
14 later than 30 days after the date on which
15 the Secretary determines such failure ex-
16 ists; and

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

23 “(B) CIVIL MONETARY PENALTY.—

24 “(i) IN GENERAL.—A specified imag-
25 ing service provider that has received a no-

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

18 “(ii) INCREASE AUTHORITY.—In ap-
19 plying this subparagraph with respect to a
20 specified imaging service provider that fails
21 to comply with the requirements of this
22 subsection in 2028 or a subsequent year,
23 the Secretary may through notice and com-
24 ment rulemaking increase the limitation on
25 the per day amount of any penalty applica-

1 ble to a specified imaging service provider
2 under clause (i).

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

12 “(iv) NO AUTHORITY TO WAIVE OR
13 REDUCE PENALTY.—The Secretary shall
14 not grant or extend any waiver, delay, toll-
15 ing, or other mitigation of a civil monetary
16 penalty for failing to comply with the re-
17 quirements of this subsection except where
18 the Secretary determines that imposing the
19 maximum civil monetary penalty will dis-
20 rupt specified imaging service provider op-
21 erations in a manner that impacts patient
22 care. The Secretary may request docu-
23 mentation in such form and manner as the
24 Secretary may require in order to evaluate

1 impact on specified imaging service pro-
2 vider operations.

3 “(7) PROVISION OF TECHNICAL ASSISTANCE.—

4 The Secretary shall, to the extent practicable, pro-
5 vide technical assistance relating to compliance with
6 the provisions of this subsection to providers of serv-
7 ices and suppliers requesting such assistance.

8 “(8) RULEMAKING.—

9 “(A) IN GENERAL.—The Secretary shall
10 implement this subsection through notice and
11 comment rulemaking in accordance with section
12 553 of title 5, United States Code.

13 “(B) OWNERSHIP INFORMATION.—In pro-
14 mulgating regulations under this paragraph, the
15 Secretary shall define the individuals and orga-
16 nizations that must be disclosed under para-
17 graph (1)(B) in a manner that harmonizes dis-
18 closure requirements with requirements estab-
19 lished under section 1124 of the Social Security
20 Act and prioritizes the disclosure of individuals
21 and organizations whose ownership or manage-
22 ment relationship with an imaging service pro-
23 vider impacts operational, financial, or clinical
24 decision making for such imaging service pro-
25 vider.”.

1 SEC. 604. AMBULATORY SURGICAL CENTER PRICE TRANS-
2 PARENCY.

Section 2718A of the Public Health Service Act, as amended by section 603, is further amended by adding at the end the following:

6 “(e) AMBULATORY SURGICAL CENTER PRICE TRANS-
7 PARENCY.—

8 “(1) IN GENERAL.—Beginning January 1 of
9 the year that begins on or after the date that is 1
10 year after the date of enactment of the Health
11 CARE Act of 2026, each specified ambulatory sur-
12 gical center shall, on a quarterly basis (if there have
13 been any changes to the standard charges described
14 in paragraph (2)), compile and make publicly avail-
15 able on an internet website (without subscription
16 and free of charge)—

“(A) the standard charges described in paragraph (2) with respect to each specified service furnished by such surgical center; and

20 “(B) the name and business address for
21 each person or entity that, with respect to the
22 ambulatory surgical center—

23 “(i) has an ownership or investment
24 interest;

25 “(ii) has a controlling interest;

1 “(iii) is a management services orga-
2 nization; or

3 “(iv) is a significant equity investor.

4 “(2) STANDARD CHARGES DEFINED.—For pur-
5 poses of paragraph (1), the term ‘standard charges’
6 with respect to standard charges and prices made
7 public by a specified ambulatory surgical center
8 means the following:

9 “(A) A plain language description of each
10 item or service, accompanied by any applicable
11 billing codes (including modifiers that materi-
12 ally change the price for insurers or providers,
13 and that materially change out-of-pocket costs
14 for consumers) using commonly recognized bill-
15 ing code sets, including—

16 “(i) the Healthcare Common Proce-
17 dure Coding System code;

18 “(ii) the National Drug Code; or

19 “(iii) other applicable identifier as de-
20 termined by the Secretary (or successor
21 code sets).

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

24 “(C) The discounted cash price.

1 “(D) The payer-specific negotiated
2 charges, expressed as a dollar amount and
3 clearly associated with the name of the applica-
4 ble third party payer and name of each plan,
5 that apply to each such item or service. If the
6 charges are based on an algorithm, percentage
7 of another amount, or other formula or criteria,
8 the ambulatory surgical center also shall dis-
9 close such algorithm, percentage, formula, or
10 criteria as set forth in its contract and any
11 other information necessary to determine the
12 negotiated charge as a dollar amount.

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

16 “(F) Any other additional information the
17 Secretary may require for the purpose of im-
18 proving the accuracy of, or enabling consumers
19 to easily understand and compare, standard
20 charges and prices for an item or service. In the
21 case of standard charges for an item or service
22 included as part of a bundled, per diem, epi-
23 sodic, or other similar arrangement, the infor-
24 mation described in this subparagraph shall be

1 made available as determined appropriate by
2 the Secretary.

3 “(3) UNIFORM METHOD AND FORMAT.—The
4 Secretary shall establish a standard, uniform method
5 and format for specified ambulatory surgical centers
6 to use in compiling and making public information
7 pursuant to paragraph (1). Such method and format
8 shall—

9 “(A) include a machine-readable format
10 (or a successor technology specified by the Sec-
11 retary) containing the information described in
12 paragraph (2) for all specified services fur-
13 nished by each ambulatory surgical center and
14 for the ownership information described in
15 paragraph (1)(B);

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

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

23 “(4) MONITORING COMPLIANCE.—The Sec-
24 retary shall, in consultation with the Inspector Gen-
25 eral of the Department of Health and Human Serv-

1 ices, establish a process to monitor compliance with
2 this subsection. Such process shall ensure that each
3 specified ambulatory surgical center’s compliance
4 with this subsection is reviewed not less frequently
5 than once every year.

6 “(5) ATTESTATION.—A senior official from
7 each specified ambulatory surgical center (the Chief
8 Executive Officer, Chief Financial Officer, or an of-
9 ficial of equivalent seniority) shall attest to the accu-
10 racy and completeness of the disclosures, and any
11 other attestations as required by the Secretary,
12 made in accordance with the ambulatory center price
13 transparency requirements based on criteria estab-
14 lished by the Secretary.

15 “(6) ENFORCEMENT.—

16 “(A) IN GENERAL.—In the case of a speci-
17 fied ambulatory surgical center that fails to
18 comply with the requirements of this sub-
19 section—

20 “(i) the Secretary shall notify such
21 ambulatory surgical center of such failure
22 not later than 30 days after the date on
23 which the Secretary determines such fail-
24 ure exists; and

1 “(ii) upon request of the Secretary,
2 such ambulatory surgical center shall sub-
3 mit to the Secretary, not later than 45
4 days after the date of such request, a cor-
5 rective action plan to comply with such re-
6 quirements.

7 “(B) CIVIL MONETARY PENALTY.—

8 “(i) IN GENERAL.—A specified ambu-
9 latory surgical center that has received a
10 notification under subparagraph (A)(i) and
11 fails to comply with the requirements of
12 this subsection by the date that is 90 days
13 after such notification (or, in the case of a
14 specified ambulatory surgical center that
15 has submitted a corrective action plan de-
16 scribed in subparagraph (A)(ii) in response
17 to a request so described, by the date that
18 is 90 days after such submission) shall be
19 subject to a civil monetary penalty of an
20 amount specified by the Secretary for each
21 day (beginning with the day on which the
22 Secretary first determined that such ambu-
23 latory surgical center was not complying
24 with such requirements) during which such

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

3 “(ii) INCREASE AUTHORITY.—In ap-
4 plying this subparagraph with respect to a
5 specified ambulatory surgical center that
6 fails to comply with the requirements of
7 this subsection in 2028 or a subsequent
8 year, the Secretary may through notice
9 and comment rulemaking increase the limi-
10 tation on the per day amount of any pen-
11 alty applicable to a specified ambulatory
12 surgical center under clause (i).

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

22 “(iv) NO AUTHORITY TO WAIVE OR
23 REDUCE PENALTY.—The Secretary shall
24 not grant or extend any waiver, delay, toll-
25 ing, or other mitigation of a civil monetary

1 penalty for failing to comply with the re-
2 quirements of this subsection except where
3 the Secretary determines that imposing the
4 maximum civil monetary penalty will dis-
5 rupt specified ambulatory surgical center
6 operations in a manner that impacts pa-
7 tient care. The Secretary may request doc-
8 umentation in such form and manner as
9 the Secretary may require in order to
10 evaluate impact on specified ambulatory
11 surgical center operations.

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

17 “(8) RULEMAKING.—

18 “(A) IN GENERAL.—The Secretary shall
19 implement this subsection through notice and
20 comment rulemaking in accordance with section
21 553 of title 5, United States Code.

22 “(B) OWNERSHIP INFORMATION.—In pro-
23 mulgating regulations under this paragraph, the
24 Secretary shall define the individuals and orga-
25 nizations that must be disclosed under para-

1 graph (1)(B) in a manner that harmonizes dis-
2 closure requirements with requirements estab-
3 lished under section 1124 of the Social Security
4 Act and prioritizes the disclosure of individuals
5 and organizations whose ownership or manage-
6 ment relationship with an ambulatory surgical
7 center impacts operational, financial, or clinical
8 decision making for such ambulatory surgical
9 center.

10 “(f) CONTINUED APPLICABILITY OF STATE LAW.—
11 The provisions of this section shall not supersede any pro-
12 vision of State law that establishes, implements, or con-
13 tinues in effect any requirement or prohibition related to
14 health care price transparency, except to the extent that
15 such requirement or prohibition prevents the application
16 of a requirement or prohibition of this section.”.

17 **SEC. 605. STRENGTHENING HEALTH COVERAGE TRANS-**
18 **PARENCY REQUIREMENTS.**

19 (a) TRANSPARENCY IN COVERAGE.—Section 2715A
20 of the Public Health Service Act (42 U.S.C. 300gg–15a)
21 is amended—

22 (1) by striking “A Group health” and inserting
23 the following:

24 “(a) IN GENERAL.—A group health”; and

25 (2) by ending at the end the following:

1 “(b) ADDITIONAL TRANSPARENCY REQUIRE-
2 MENTS.—

3 “(1) SPECIFIED INFORMATION REQUIRED.—

4 “(A) IN GENERAL.—A group health plan
5 or health insurance issuer offering coverage in
6 the individual or group market shall provide to
7 each participant, beneficiary, or enrollee, at the
8 time of enrollment in the plan or coverage, the
9 information described in subparagraph (B).

10 “(B) INFORMATION REQUIRED.—For pur-
11 poses of subparagraph (A), the information
12 specified in this subparagraph is, with respect
13 to benefits available under the plan or coverage
14 for an item or service furnished by a health
15 care provider, the following (or other informa-
16 tion as determined appropriate by the Sec-
17 retary):

18 “(i) If such provider is an in-network
19 provider with respect to such item or serv-
20 ice, the in-network rate (as defined in
21 paragraph (5)) for such item or service.

22 “(ii) If such provider is not described
23 in clause (i), the out-of-network allowed
24 amount (as such term is defined for pur-
25 poses of section 147.210(a)(2)(xvii) of title

1 45, Code of Federal Regulation) for such
2 item or service that the plan or coverage
3 will pay without regard to the amount in
4 clause (iii).

5 “(iii) The amount of cost-sharing li-
6 ability (including deductibles, copayments,
7 and coinsurance) that the individual will
8 incur for such item or service based on the
9 information available to the plan or cov-
10 erage at the time the request is made
11 (which, in the case such item or service is
12 to be furnished by a provider described in
13 clause (ii), shall be calculated using the
14 maximum amount described in such
15 clause).

16 “(iv) The accumulated amounts with
17 respect to any deductible or out-of-pocket
18 maximum under the plan or coverage re-
19 flected in the plan’s or coverage’s records
20 at the time the request is made (broken
21 down, in the case separate deductibles or
22 maximums apply to separate individuals
23 enrolled in the plan or coverage, by such
24 separate deductibles or maximums, in ad-

1 dition to any cumulative deductible or
2 maximum).

3 “(v) In the case such plan or coverage
4 imposes any frequency or volume limita-
5 tions with respect to such item or service
6 (excluding medical necessity determina-
7 tions), the amount that such individual has
8 accrued towards such limitation with re-
9 spect to such item or service reflected in
10 the plan’s or coverage’s records at the time
11 the request is made.

12 “(vi) Information about any utiliza-
13 tion management requirements, such as
14 prior authorization, concurrent review, step
15 therapy, fail first, or similar requirements
16 applicable to coverage of such item or serv-
17 ice under such plan or coverage, including
18 information regarding utilization manage-
19 ment practices and determinations, includ-
20 ing aggregate information related to ap-
21 proval and denial rates, associated
22 timelines, and appeals, as determined ap-
23 propriate by the Secretary.

24 “(C) SELF-SERVICE TOOL .—For purposes
25 of subparagraph (A), a self-service tool estab-

1 lished by a health plan meets the requirements
2 of this subparagraph if such tool—

3 “(i) is based on an internet website;

4 “(ii) provides for real-time responses
5 to requests described in such subpara-
6 graph;

7 “(iii) is updated in a manner such
8 that the information is accurate based on
9 the information available to the plan or
10 coverage at the time the request is made;

11 “(iv) allows such a request to be made
12 for information with respect to an item or
13 service furnished by—

14 “(I) a specific provider that is an
15 in-network provider with respect to
16 such item or service; or

17 “(II) all providers that are in-
18 network providers with respect to such
19 plan or coverage and such item or
20 service;

21 “(v) provides that such a request may
22 be made for information with respect to an
23 item or service through use of—

24 “(I) the billing code for such
25 item or service; or

1 “(II) through use of a descriptive
2 term for such item or service; and

3 “(vi) is made available in plain lan-
4 guage, without subscription or other fee.

5 “(D) NONDUPLICATION.—A group health
6 plan or health insurance issuers shall be
7 deemed to be in compliance with this paragraph
8 if such plan or issuer has a tool in place under
9 section 2799A–4.

10 “(2) RATE AND PAYMENT INFORMATION.—

11 “(A) IN GENERAL.—Beginning January 1
12 of the year that begins on or after the date that
13 is 1 year after the date of enactment of the
14 Health CARE Act of 2026, and every quarter
15 thereafter (if there have been any changes to
16 the rate and payment information described in
17 subparagraphs (B) and (C), each group health
18 plan or health insurance issuer offering cov-
19 erage in the group or individual market shall
20 make available to the public, the rate and pay-
21 ment information described in subparagraph
22 (B) in accordance with subparagraph (C).

23 “(B) RATE AND PAYMENT INFORMATION
24 DESCRIBED.—For purposes of subparagraph
25 (A), the rate and payment information de-

1 scribed in this subparagraph is, with respect to
2 a plan or coverage, the following:

3 “(i) With respect to each item or serv-
4 ice for which benefits are available under
5 such plan or coverage, excluding those in-
6 cluded in clause (ii), identified by CPT,
7 HCPCS, DRG, or other applicable nation-
8 ally recognized identifier, including any ap-
9 plicable code modifiers, and accompanied
10 by a plain language description of the item
11 or service, the in-network rate (expressed
12 as a dollar amount or percentage of
13 charges, unless otherwise specified by the
14 Secretary), including the individual and
15 total amounts for any bundled rates, in ef-
16 fect as of the date of the submission of
17 such information with each provider (iden-
18 tified by national provider identifier) that
19 is an in-network provider with respect to
20 such item or service, other than such a
21 rate in effect with a provider that an issuer
22 has determined based on factors deter-
23 mined by the Secretary (such as medical
24 specialty) that it is unlikely that the pro-

1 vider would be reimbursed for the item or
2 service.

3 “(ii) With respect to each drug and
4 biologic (identified by National Drug Code,
5 J-code, or other commonly recognized bill-
6 ing code used for drugs) for which benefits
7 are available under such plan or coverage,
8 the in-network rate (expressed as a dollar
9 amount or percentage of charges, unless
10 otherwise specified by the Secretary) in ef-
11 fect as of the first day of the quarter in
12 which such information is made public
13 with each pharmacy or other prescription
14 drug dispenser that is an in-network phar-
15 macy or other prescription drug dispenser
16 with respect to such drug.

17 “(iii) With respect to each item or
18 service for which benefits are available
19 under such plan or coverage (expressed as
20 a dollar amount), identified by CPT, DRG,
21 HCPCS, or other applicable nationally rec-
22 ognized identifier, including any applicable
23 code modifiers, and accompanied by a brief
24 description of the item or service, the
25 amount billed or charged by the provider,

1 and the amount allowed by the plan or cov-
2 erage, for each such item or service fur-
3 nished during a representative lookback
4 window established by the Secretary by
5 each provider that was an out-of-network
6 provider with respect to such item or serv-
7 ice, broken down by each such provider
8 (identified by national provider identifier),
9 other than items and services with respect
10 to which not fewer than 11 claims for such
11 item or service were submitted to such
12 plan during such period.

13 “(C) MANNER OF SUBMISSION.—Rate and
14 payment information required to be submitted
15 and made available under this paragraph shall
16 be so submitted and so made available as fol-
17 lows:

18 “(i) Information shall be contained in
19 at least 3 separate machine-readable files
20 corresponding to the information described
21 in each of clauses (i) through (iii) of sub-
22 paragraph (B) that meet such require-
23 ments as specified by the Secretary
24 through rulemaking, in consultation with
25 the Secretaries of Labor and the Treasury,

1 to apply comparable requirements to group
2 health plans and health insurance coverage
3 and to entities providing benefit manage-
4 ment or other third-party administration
5 services on a contractual basis with a
6 group health plan or coverage.

7 “(ii) Requirements specified by the
8 Secretary through rulemaking (or subregu-
9 latory guidance) shall ensure the following:

10 “(I) Such files are made available
11 in a widely available format that al-
12 lows for information contained in such
13 files to be compared across plans and
14 coverage and are freely accessible to
15 individuals at no cost and without the
16 need to establish a user account or
17 provide other credentials.

18 “(II) Each such file includes each
19 of the following data elements:

20 “(aa) A numerical identifier
21 for the group health plan or
22 health insurance issuer (such as
23 a Health Insurance Oversight
24 System identifier).

1 “(bb) A plain-language de-
2 scription of the item or service
3 (including, for drugs, the propri-
4 etary and nonproprietary name
5 assigned).

6 “(cc) The billing code, in-
7 cluding any applicable modifiers,
8 associated with such item or
9 service, including the Healthcare
10 Common Procedure Coding Sys-
11 tem code, diagnosis-related
12 group, national drug code, or
13 other commonly recognized code
14 set.

15 “(dd) The place of service
16 code.

17 “(ee) The National Provider
18 Identifier and provider Tax Identi-
19 fication Number.

20 “(iii) The rate and payment informa-
21 tion disclosed under clauses (i) through
22 (iii) of subparagraph (B) shall be sepa-
23 rately delineated for each item or service,
24 regardless of whether such item or service
25 is reimbursed as a part of a bundle, epi-

1 sode, or other grouping of items and serv-
2 ices.

3 “(iv) An officer or executive of com-
4 petent authority shall attest to the accu-
5 racy and completeness of information sub-
6 mitted and made available under this sub-
7 paragraph. In the case of a plan or cov-
8 erage that relies on a third-party adminis-
9 trator or other service provider to compile
10 the information submitted and made avail-
11 able under this subparagraph, such plan or
12 coverage may satisfy the requirement
13 under this clause by obtaining such an at-
14 testation from the third-party adminis-
15 trator or other service provider. Such at-
16 testation shall be subject to enforcement
17 under paragraph (6).

18 “(3) OWNERSHIP INFORMATION.—Beginning
19 January 1 of the year that begins on or after the
20 date that is 1 year after the date of enactment of
21 the Health CARE Act of 2026, and every quarter
22 thereafter (if there have been any changes in the re-
23 quired information), each group health plan or
24 health insurance issuer offering coverage in the indi-
25 vidual or group market shall submit to the Sec-

1 retary, the applicable State authority, and make
2 available to the public, the name and business ad-
3 dress of each person or entity that, with respect to
4 such plan or coverage—

5 “(A) has an ownership or investment inter-
6 est;

7 “(B) has a controlling interest;

8 “(C) is a management services organiza-
9 tion; or

10 “(D) is a significant equity investor.

11 “(4) ENFORCEMENT.—

12 “(A) IN GENERAL.—Each year, the Sec-
13 retary shall audit the machine-readable files re-
14 quired by paragraph (2)(B) posted by not fewer
15 than 50 group health plans or health insurance
16 issuers for compliance with format and accessi-
17 bility standards.

18 “(B) NOTIFICATION AND REQUEST FOR
19 CORRECTIVE ACTION.—In the case of a group
20 health plan or health insurance issuer that fails
21 to comply with the requirements of this para-
22 graph, not later than 30 days after the date on
23 which the Secretary determines such failure ex-
24 ists, the Secretary shall submit to such plan or
25 issuer a notification of such determination,

1 which shall include a request for a corrective
2 action plan to comply with such requirements.

3 “(C) CIVIL MONETARY PENALTY.—A plan
4 or issuer that has received a request for a cor-
5 rective action plan under subparagraph (B) and
6 fails to comply with the requirements of this
7 paragraph by the date that is 30 days after
8 such request is made shall be subject to a civil
9 monetary penalty of an amount specified by the
10 Secretary for each day (beginning with the day
11 on which such health plan or health insurance
12 issuer was failing to comply with such para-
13 graph) during which such failure was ongoing.
14 Such amount shall not exceed \$300 per partici-
15 pant, beneficiary, or covered individual per day
16 or \$10,000,000, whichever is lesser.

17 “(5) DEFINITIONS.—In this subsection:

18 “(A) IN-NETWORK PROVIDER.—The term
19 ‘in-network provider’ has the meaning given
20 such term in section 54.9815-2715A1(a)(2)(xii)
21 of title 26, Code of Federal Regulations.

22 “(B) IN-NETWORK RATE.—The term ‘in-
23 network rate’ means, with respect to a health
24 plan and an item or service furnished by a pro-
25 vider that is a participating provider with re-

1 spect to such plan and item or service, the con-
2 tracted rate in effect between such plan and
3 such provider for such item or service. If the
4 rate is based on an algorithm, percentage of an-
5 other amount, or other formula or criteria, the
6 health plan also shall disclose such algorithm,
7 percentage, formula, or criteria as set forth in
8 its contract and any other terms, schedules, ex-
9 hibits, data, or other information referenced in
10 any such contract as shall be required to deter-
11 mine and disclose the negotiated rate.

12 “(6) RULEMAKING.—

“(A) IN GENERAL.—The Secretary shall implement this subsection through notice and comment rulemaking in accordance with section 553 of title 5, United States Code. The Secretary may implement the manner of submission of data described in paragraph (2)(C) through subregulatory guidance.

20 “(B) REGULATIONS.—Regulations promul-
21 gated pursuant to this subsection shall provide
22 the following:

23 “(i) The Secretary shall annually
24 audit the machine-readable files required
25 by paragraph (2)(B) posted by not fewer

1 than 50 group health plans or health in-
2 surance issuers for compliance with format
3 and accessibility standards.

4 “(ii) The Secretary of Labor shall an-
5 nually audit the machine-readable files re-
6 quired by paragraph (2)(B) posted by not
7 fewer than 250 group health plans or serv-
8 ice providers furnishing third-party admin-
9 istrator services to a group health plan for
10 compliance with format and accessibility
11 standards.

12 “(iii) The Secretary of Health and
13 Human Services, in conjunction with the
14 Secretary of Labor and the Secretary of
15 the Treasury, shall annually issue a report
16 to Congress that includes findings, conclu-
17 sions, and enforcement actions taken based
18 on audits of the machine-readable files.
19 Such report shall be provided no later than
20 July 1 following the calendar year during
21 which the audits were completed. The Sec-
22 retary of Health and Human Services shall
23 make such report to Congress accessible to
24 the public.”.

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 subsections (a) and (b) shall apply beginning Janu-
3 ary 1 of the year that begins on or after the date
4 that is 1 year after the date of enactment of the
5 Health CARE Act of 2026.

6 (2) CONTINUED APPLICABILITY OF RULES FOR
7 PREVIOUS YEARS.—Nothing in the amendments
8 made by this section may be construed as affecting
9 the applicability of the rule entitled “Transparency
10 in Coverage” published by the Department of the
11 Treasury, the Department of Labor, and the De-
12 partment of Health and Human Services on Novem-
13 ber 12, 2020 (85 Fed. Reg. 72158), or amendments
14 made to such rule that are applicable before the date
15 of enactment of the Health CARE Act of 2026.

16 **SEC. 606. INCREASING GROUP HEALTH PLAN ACCESS TO**
17 **HEALTH DATA.**

18 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
19 TION.—

20 (1) IN GENERAL.—Section 2799A–9 of the
21 Public Health Service Act (42 U.S.C. 300gg–119) is
22 amended by adding at the end the following:

23 “(1) GROUP HEALTH PLAN ACCESS TO INFOR-
24 MATION.—

1 “(A) IN GENERAL.—No contract or ar-
2 rangement for services, and no extension or re-
3 newal of such contract or arrangement, between
4 a group health plan that is offered by a speci-
5 fied large employer or that is a specified large
6 plan (as such terms are defined in subpara-
7 graph (F)) and a health care provider (which
8 for purposes of this subparagraph, includes a
9 health care facility), network or association of
10 providers, service provider offering access to a
11 network of providers, third-party administrator,
12 health insurance issuer offering group or indi-
13 vidual health insurance coverage, or pharmacy
14 benefit manager, or any entity acting as an
15 intermediary between the group health plan and
16 the health care provider, network association of
17 providers, service provider offering access to a
18 network or association of providers (including a
19 licensed health insurance issuer or third-party
20 administrator), or pharmacy benefit manager
21 (collectively referred to in this subsection as
22 ‘Covered Service Providers’), is reasonable with-
23 in the meaning of this subsection unless such
24 contract or arrangement—

1 “(i) allows the responsible plan fidu-
2 ciary (as that term is defined in section
3 408(b)(2)(B)(ii)(I)(ee)) access to all claims
4 and encounter information or data, and
5 any documentation supporting claim pay-
6 ments, including, but not limited to, med-
7 ical records and policy documents, or infor-
8 mation or data described in subsection
9 (a)(1)(B) to—

10 “(I) comply with applicable law;

11 and

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

14 “(ii) does not—

15 “(I) unreasonably limit or delay
16 access, as determined by the Secretary
17 but in any event not longer than 15
18 days, after a request for access by a
19 plan fiduciary to such information or
20 data;

21 “(II) limit the volume of claims
22 and encounter information or data
23 that the group health plan, the plan
24 sponsor, the plan administrator, or a
25 business associate of such plan may

1 access during an audit or pursuant to
2 any request for such information or
3 data;

4 “(III) limit the disclosure of pric-
5 ing terms for value-based payment ar-
6 rangements or capitated payment ar-
7 rangements, including—

8 “(aa) payment calculations
9 and formulas;

10 “(bb) quality measures;

11 “(cc) contract terms;

12 “(dd) payment amounts;

13 “(ee) measurement periods
14 for all incentives; and

15 “(ff) other payment meth-
16 odologies used by an entity, in-
17 cluding a health care provider
18 (including a health care facility),
19 network or association of pro-
20 viders, service provider offering
21 access to a network of providers,
22 third-party administrator, or
23 pharmacy benefit manager;

1 “(IV) limit the disclosure of over-
2 payments and overpayment recovery
3 terms;

4 “(V) limit the right of the group
5 health plan, the plan sponsor, or the
6 plan administrator of such plan to se-
7 lect an auditor or define audit scope
8 or frequency;

9 “(VI) otherwise limit or unduly
10 delay the group health plan, the plan
11 sponsor, the plan administrator, or a
12 business associate of such plan from
13 accessing claims and encounter infor-
14 mation or data;

15 “(VII) limit the disclosure of fees
16 charged to the group health plan re-
17 lated to plan administration and
18 claims processing, including renegoti-
19 ation fees, access fees, repricing fees,
20 or enhanced review fees;

21 “(VIII) limit the right of the
22 group health plan, the plan sponsor,
23 or the plan administrator to request
24 action on any suspect claim payments;

1 “(IX) limit public disclosure of
2 de-identified or aggregate information;

3 “(X) limit the disclosure of, with
4 respect to a provider that files claims
5 under such plan, whether a Covered
6 Service Provider—

7 “(aa) has an ownership or
8 investment interest;

9 “(bb) has a controlling in-
10 terest;

11 “(cc) is a management serv-
12 ices organization; or

13 “(dd) is a significant equity
14 investor; or

15 “(XI) limit the disclosure of the
16 name and address of each person or
17 entity that, with respect to the health
18 plan service provider—

19 “(aa) has an ownership or
20 investment interest;

21 “(bb) has a controlling in-
22 terest; or

23 “(cc) is a significant equity
24 investor.

1 “(B) MANNER OF PROVIDING INFORMA-
2 TION OR DATA.—

3 “(i) IN GENERAL.—A Covered Service
4 Provider shall provide information or data
5 under this subsection in a manner con-
6 sistent with the privacy regulations pro-
7 mulgated under section 13402(a) of the
8 Health Information Technology for Eco-
9 nomic and Clinical Health Act (42 U.S.C.
10 17932(a)) and consistent with the privacy
11 regulations promulgated under the Health
12 Insurance Portability and Accountability
13 Act of 1996 in part 160 and subparts A
14 and E of part 164 of title 45, Code of Fed-
15 eral Regulations (or successor regulations)
16 (referred to in this paragraph as the
17 ‘HIPAA privacy regulations’) and shall re-
18 strict the use and disclosure of such infor-
19 mation according to such privacy regula-
20 tions and such HIPAA privacy regulations.
21 A Covered Service Provider shall not be re-
22 quired to disclose information or data
23 under this subsection that could reasonably
24 identify a participant or beneficiary
25 through individually identifiable health in-

1 formation (as such term is defined under
2 HIPAA privacy regulations).

3 “(ii) ADDITIONAL REQUIREMENTS.—
4 In carrying out this subsection, a Covered
5 Service Provider shall comply with section
6 164.504(f) of title 45, Code of Federal
7 Regulations (or a successor regulation).

8 “(iii) RULE OF CONSTRUCTION.—

9 “(I) IN GENERAL.—Nothing in
10 this subsection shall be construed to
11 modify the requirements for the cre-
12 ation, receipt, maintenance, or trans-
13 mission of protected health informa-
14 tion under the HIPAA privacy regula-
15 tions.

16 “(II) CIVIL RIGHTS LAWS.—

17 Nothing in this subsection shall be
18 construed to affect the application of
19 any Federal or State privacy or civil
20 rights law, including the HIPAA pri-
21 vacy regulations, the Genetic Informa-
22 tion Nondiscrimination Act of 2008
23 (Public Law 110–233) (including the
24 amendments made by such Act), the
25 Americans with Disabilities Act of

1 1990 (42 U.S.C. 12101 et seq.), sec-
2 tion 504 of the Rehabilitation Act of
3 1973 (29 U.S.C. 794), section 1557
4 of the Patient Protection and Afford-
5 able Care Act (42 U.S.C. 18116), title
6 VI of the Civil Rights Act of 1964 (42
7 U.S.C. 2000d), and title VII of the
8 Civil Rights Act of 1964 (42 U.S.C.
9 2000e).

10 “(iv) WRITTEN NOTICE.—Each plan
11 year, a Covered Service Provider shall pro-
12 vide to each participant or beneficiary writ-
13 ten notice informing the participant or
14 beneficiary of the requirement that Cov-
15 ered Service Providers respond to requests
16 to submit information or data under para-
17 graph (1), as applicable, which may include
18 incorporating such notification in plan doc-
19 uments provided to the participant or ben-
20 eficiary, or providing individual notifica-
21 tion.

22 “(v) CLARIFICATION REGARDING PUB-
23 LIC DISCLOSURE OF INFORMATION.—Noth-
24 ing in this subsection shall prevent a Cov-
25 ered Service Provider from placing reason-

1 able restrictions on the public disclosure of
2 the information or data described in para-
3 graph (1), except that such Provider may
4 not restrict disclosure of such report to the
5 Department of Health and Human Serv-
6 ices, the Department of Labor, or the De-
7 partment of the Treasury.

8 “(vi) LIMITATION.—This paragraph
9 shall not be construed to abridge or limit
10 the disclosure requirements under this sub-
11 section or to impose additional privacy or
12 security requirements on Covered Service
13 Providers or plan sponsors.

14 “(C) LIMITATION ON DISCLOSURE.—A
15 group health plan receiving information or data
16 under this subsection may disclose such infor-
17 mation only in a manner that is consistent with
18 HIPAA and the privacy and security regula-
19 tions promulgated thereunder, regardless of
20 their direct or indirect applicability to the plan
21 or any entities that could be or are business as-
22 sociates. A group health plan (and any business
23 associate or other entity acting on behalf of
24 such plan) may use such information or data
25 only for purposes of plan administration and

1 may not sell, license, or otherwise commercially
2 exploit such information or data or provide such
3 information or data to any third party that may
4 take such action.

5 “(D) REQUIREMENTS OF INFORMATION.—
6 Information made available under this sub-
7 section shall conform to the following stand-
8 ards:

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

14 “(I) Institutional, professional,
15 and dental claims shall be in ASC
16 X12N 837D format or any subse-
17 quent standard as established by the
18 Secretary.

19 “(II) Pharmacy claims shall be in
20 the National Council for Prescription
21 Drug Programs (NCPDP) format or
22 any subsequent standard as estab-
23 lished by the Secretary.

24 “(III) The files shall be unmodi-
25 fied copies of the files sent from the

1 provider, or, upon request, delivered
2 in a machine readable format. In the
3 event that paper claims are sent by
4 the provider, they shall be converted
5 to the appropriate standard electronic
6 format. Files shall be accessible to the
7 plan at no cost to the group health
8 plan.

9 “(ii) All claim payment (or EFT, elec-
10 tronic funds transfer) and electronic remit-
11 tance advice (ERA) notices sent by a Cov-
12 ered Service Provider shall be made avail-
13 able to the group health plan as ASC
14 X12N 835 files (or any other format as
15 identified by the Secretary) in accordance
16 with standards adopted by regulation
17 under HIPAA. The files shall be unmodi-
18 fied copies of the files sent by the Covered
19 Service Provider to the healthcare pro-
20 vider. Files shall be accessible at no cost to
21 the group health plan.

22 “(iii) The contractual terms con-
23 taining payment calculations and formulas,
24 pricing methodologies, and other informa-
25 tion used to determine the dollar value of

1 reimbursement, in a format as specified by
2 the Secretary.

3 “(iv) All non-claim costs shall be
4 itemized and made available to the group
5 health plan as requested through a web-
6 based portal, through an application pro-
7 gram interface (API), through a
8 downloadable Comma-Separated Value
9 (CSV) file, and, as appropriate, through
10 other downloadable machine-readable file
11 types.

12 “(E) IMPLEMENTATION.—The Secretary
13 shall implement this subsection through notice
14 and comment rulemaking in accordance with
15 section 553 of title 5, United States Code.

16 “(F) DEFINITIONS.—

17 “(i) IN GENERAL.—The provisions of
18 sections 408 and 410 of the Employee Re-
19 tirement Income Security Act of 1974 shall
20 apply with respect to terms used under
21 this subsection.

22 “(ii) SPECIFIED LARGE EMPLOYER.—
23 In this subsection, the term ‘specified large
24 employer’ means, in connection with a
25 group health plan (including group health

1 insurance coverage offered in connection
2 with such a plan) established or main-
3 tained by a single employer, with respect
4 to a calendar year or a plan year, as appli-
5 cable, an employer who employed an aver-
6 age of at least 50 employees on business
7 days during the preceding calendar year or
8 plan year and who employs at least 1 em-
9 ployee on the first day of the calendar year
10 or plan year.

11 “(iii) SPECIFIED LARGE PLAN.—In
12 this subsection, the term ‘specified large
13 plan’ means a group health plan (including
14 group health insurance coverage offered in
15 connection with such a plan) established or
16 maintained by a plan sponsor described in
17 clause (ii) or (iii) of section 3(16)(B) of
18 the Employee Retirement Income Security
19 Act of 1974 that had an average of at
20 least 50 participants on business days dur-
21 ing the preceding calendar year or plan
22 year, as applicable.”.

23 (2) CIVIL ENFORCEMENT.—

24 (A) CIVIL ENFORCEMENT.—Subsection (c)
25 of section 502 of such Act (29 U.S.C. 1132) is

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

3 “(13)(A) In the case of an agreement between
4 a group health plan (as defined in section 733(a)),
5 the plan sponsor of such plan (as defined in section
6 3(16)(B)), or the plan administrator of such plan
7 (as defined in section 3(16)(A)) and a health care
8 provider (which, for purposes of this paragraph, in-
9 cludes a health care facility), network or association
10 of providers, service provider offering access to a
11 network or association of providers, third-party ad-
12 ministrator, or pharmacy benefit manager, that vio-
13 lates the provisions of section 724(b), the Secretary
14 may assess a civil penalty against such provider, net-
15 work or association, service provider offering access
16 to a network or association of providers, third-party
17 administrator, pharmacy benefit manager, or other
18 service provider in the amount of up to \$10,000 for
19 each day during which such violation continues.
20 Such penalty shall be in addition to other penalties
21 as may be prescribed by law.

22 “(B) Nothing in subparagraph (A) shall be con-
23 strued to permit the Secretary to regulate health
24 care providers acting in their capacity as medical or-

1 ganizations furnishing items and services to pa-
2 tients.”.

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

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

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

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

17 (C) TECHNICAL AMENDMENTS.—Section
18 408(b)(2)(B) of such Act (29 U.S.C.
19 1108(b)(2)) is amended—

20 (i) in clause (i), by striking “this
21 clause” and inserting “this paragraph”;
22 and

23 (ii) by adding at the end the fol-
24 lowing:

1 “(xi) A contract or arrangement shall
2 not be reasonable under this subparagraph
3 if it fails to comply with section 724(b).”.

4 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
5 ITY INFORMATION.—Section 2799A–9(a)(4) of the Public
6 Health Service Act (42 U.S.C. 300gg–119(a)(4)) is
7 amended to read as follows:

8 “(4) ATTESTATION.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (C), a group health plan or health insur-
11 ance issuer offering group health insurance cov-
12 erage shall annually submit to the Secretary an
13 attestation that such plan or issuer of such cov-
14 erage is in compliance with the requirements of
15 this subsection. Such attestation shall also in-
16 clude a statement verifying that—

17 “(i) the information or data described
18 under subparagraphs (A) and (B) of para-
19 graph (1) is available upon request and
20 provided to the group health plan, the plan
21 sponsor, the plan administrator, or the
22 business associate of such plan, or the
23 issuer, as applicable, in a timely manner;
24 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 sponsor, the
5 plan administrator, a business associate of
6 such plan, or the issuer from auditing, re-
7 viewing, or otherwise accessing such infor-
8 mation.

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

15 “(C) EXCEPTION.—In the case of a group
16 health plan or health insurance issuer offering
17 group health insurance coverage that is unable
18 to obtain the information or data needed to
19 submit the attestation required under subpara-
20 graph (A), such plan or issuer may submit a
21 written statement in lieu of such attestation
22 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, the plan sponsor, or the plan
2 administrator or issuer was limited or pre-
3 vented from auditing, reviewing, or other-
4 wise accessing such information or data;

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

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

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

22 **SEC. 607. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
23 **VIDERS.**

24 (a) PHSA AMENDMENT.—Part D of title XXVII of
25 the Public Health Service Act (42 U.S.C. 300gg–111 et

1 seq.), as amended by section 404, is amended by adding
2 at the end the following:

3 **“SEC. 2799A–15. OVERSIGHT OF ADMINISTRATIVE SERVICE**
4 **PROVIDERS.**

5 “(a) IN GENERAL.—For plan years beginning on or
6 after January 1 of the year that begins on or after the
7 date that is 1 year after the date of enactment of the
8 Health CARE Act of 2026, no agreement between a group
9 health plan that is offered by a specified large employer
10 or that is a specified large plan (as such terms are defined
11 in section 2799A–11(f)) or a health insurance issuer offer-
12 ing individual or group health coverage (that makes an
13 election subject to subsection (b)(5)) and a health insur-
14 ance issuer that is operating as a third-party adminis-
15 trator, a health care provider, network or association of
16 providers, third-party administrator, service provider of-
17 fering access to a network of providers, pharmacy benefit
18 managers, or any other third party (each referred to in
19 this section as a ‘health plan service provider’) is permis-
20 sible if such agreement limits (or delays beyond the appli-
21 cable reporting period described in subsection (b)(1)) the
22 disclosure of information to such group health plans and
23 health insurance issuers in a manner that prevents any
24 health plan service provider from providing the informa-
25 tion described in subsection (b)).

1 “(b) REQUIRED DISCLOSURES.—

2 “(1) CONTENTS AND FREQUENCY.—With re-
3 spect to plan years beginning on or after the date
4 that is 1 year after the date of enactment of this
5 section, not less frequently than quarterly, a health
6 plan service provider shall provide to the group
7 health or the health insurance issuer offering indi-
8 vidual or group health insurance coverage the fol-
9 lowing information at no cost to the plan or issuer:

10 “(A) The information described in section
11 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
12 119(a)(1)(B)).

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

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

10 “(D) The total amount paid or expected to
11 be paid by the health plan service provider to
12 its subcontractors in rebates, fees, contractual
13 arrangements, and all other remuneration for
14 administrative and other services.

15 “(E) All payment data, calculation meth-
16 odologies, and reconciliation information related
17 to alternative compensation arrangements, in-
18 cluding accountable care organizations, value-
19 based programs, shared savings programs, in-
20 centive compensation, bundled payments, capi-
21 tation arrangements, performance payments,
22 and any other reimbursement or payment mod-
23 els, where the group health plan paid fees, in-
24 curred obligations, or made payments in con-

1 nection with the group health plan or issuer re-
2 lated to such arrangements.

3 “(F) Whether, with respect to a provider
4 that files claims under such plan or coverage,
5 the health plan service provider—

6 “(i) has an ownership or investment
7 interest;

8 “(ii) has a controlling interest;

9 “(iii) is a management services orga-
10 nization; or

11 “(iv) is a significant equity investor.

12 “(G) The name and business address for
13 each person or entity that, with respect to the
14 health plan service provider—

15 “(i) has an ownership or investment
16 interest;

17 “(ii) has a controlling interest; or

18 “(iii) is a significant equity investor.

19 “(2) MANNER OF PROVIDING INFORMATION OR
20 DATA.—

21 “(A) IN GENERAL.—A health plan service
22 provider shall provide information or data
23 under paragraph (1) in a manner consistent
24 with the privacy regulations promulgated under
25 section 13402(a) of the Health Information

1 Technology for Economic and Clinical Health
2 Act (42 U.S.C. 17932(a)) and consistent with
3 the privacy regulations promulgated under the
4 Health Insurance Portability and Accountability
5 Act of 1996 in part 160 and subparts A and E
6 of part 164 of title 45, Code of Federal Regula-
7 tions (or successor regulations) (referred to in
8 this paragraph as the ‘HIPAA privacy regula-
9 tions’) and shall restrict the use and disclosure
10 of such information according to such privacy
11 regulations and such HIPAA privacy regula-
12 tions.

13 “(B) ADDITIONAL REQUIREMENTS.—In
14 carrying out this subsection, a health plan serv-
15 ice provider shall comply with section
16 164.504(f) of title 45, Code of Federal Regula-
17 tions (or a successor regulation).

18 “(C) RULE OF CONSTRUCTION.—

19 “(i) IN GENERAL.—Nothing in this
20 subsection shall be construed to modify the
21 requirements for the creation, receipt,
22 maintenance, or transmission of protected
23 health information under the HIPAA pri-
24 vacy regulations.

1 “(ii) CIVIL RIGHTS LAWS.—Nothing
2 in this subsection shall be construed to af-
3 fect the application of any Federal or State
4 privacy or civil rights law, including the
5 HIPAA privacy regulations, the Genetic
6 Information Nondiscrimination Act of
7 2008 (Public Law 110–233) (including the
8 amendments made by such Act), the Amer-
9 icans with Disabilities Act of 1990 (42
10 U.S.C. 12101 et seq.), section 504 of the
11 Rehabilitation Act of 1973 (29 U.S.C.
12 794), section 1557 of the Patient Protec-
13 tion and Affordable Care Act (42 U.S.C.
14 18116), title VI of the Civil Rights Act of
15 1964 (42 U.S.C. 2000d), and title VII of
16 the Civil Rights Act of 1964 (42 U.S.C.
17 2000e).

18 “(D) WRITTEN NOTICE.—Each plan year,
19 a health plan service provider shall provide to
20 each participant or beneficiary written notice
21 informing the participant or beneficiary of the
22 requirement for health plan service providers to
23 submit information or data under paragraph
24 (1), as applicable, which may include incor-
25 porating such notification in plan documents

1 provided to the participant or beneficiary, or
2 providing individual notification.

3 “(E) CLARIFICATION REGARDING PUBLIC
4 DISCLOSURE OF INFORMATION.—Nothing in
5 this subsection shall prevent a health plan serv-
6 ice provider from placing reasonable restrictions
7 on the public disclosure of the information or
8 data described in paragraph (1), except that
9 such provider may not restrict disclosures under
10 subsection (b)(1) to the Department of Health
11 and Human Services, the Department of Labor,
12 or the Department of the Treasury.

13 “(F) LIMITATION.—This paragraph shall
14 not be construed to abridge or limit the disclo-
15 sure requirements under this subsection or to
16 impose additional privacy or security require-
17 ments on health plan service providers or plan
18 sponsors.

19 “(3) DISCLOSURE AND REDISCLOSURE.—

20 “(A) IN GENERAL.—A group health plan
21 or health insurance issuer offering individual or
22 group coverage receiving information under
23 paragraph (1) may disclose such information
24 only—

1 “(i) to the entity from which the in-
2 formation was received or to that entity’s
3 business associates as defined in section
4 160.103 of title 45, Code of Federal Regu-
5 lations (or successor regulations); or

6 “(ii) as permitted by the HIPAA Pri-
7 vacy Rule (45 C.F.R. part 160 and sub-
8 parts A and E of part 164).

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

17 “(C) LIMITATION ON USE OF INFORMA-
18 TION.—A group health plan or health insurance
19 issuer (and any business associate or other enti-
20 ty acting on behalf of such plan) may use infor-
21 mation or data under this paragraph only for
22 purposes of plan administration and may not
23 sell, license, or otherwise commercially exploit
24 such information or data or provide such infor-

1 mation or data to any third party that may
2 take such action.

3 “(D) RULE OF CONSTRUCTION.—Nothing
4 in this section shall be construed to prevent a
5 group health plan, a health insurance issuer, or
6 a health plan service provider providing services
7 with respect to such a plan, from placing rea-
8 sonable restrictions on the public disclosure of
9 the information described in paragraph (1), ex-
10 cept that such plan or entity may not restrict
11 disclosure of such information to the Depart-
12 ment of Health and Human Services, the De-
13 partment of Labor, the Department of the
14 Treasury, or the Comptroller General of the
15 United States.

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

1 section, except that nothing in this section shall
2 be construed to limit the Secretary's existing
3 authority under this Act.

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

7 “(A) All claims from a healthcare provider
8 shall be made to the group health plan in ac-
9 cordance with standards adopted under HIPAA
10 as described in subpart K of part 162 of title
11 45, Code of Federal Regulations, as follows:

12 “(i) Institutional, professional, and
13 dental claims and adjustments to these
14 claims shall be provided to the group
15 health plan or health insurance issuer in
16 the ASC X12N 837 format.

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

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

1 Such data shall be provided at no cost to
2 the group health plan.

3 “(B) All claim payment (or EFT, elec-
4 tronic funds transfer) and electronic remittance
5 advice (ERA) information sent by a health plan
6 service provider shall be provided to the group
7 health plan or health insurance issuer in the
8 ASC X12N 835 format, in accordance with
9 standards and operating rules adopted under
10 HIPAA at subpart P of part 162 of title 45,
11 Code of Federal Regulations, unmodified from
12 the form in which it was transmitted to the
13 healthcare provider. Such information shall be
14 provided at no cost to the group health plan.

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

21 “(5) OPT-IN FOR HEALTH INSURANCE COV-
22 ERAGE.—In the case of a health insurance issuer of-
23 fering coverage in the individual or group market,
24 such issuer may, on an annual basis, for plan years
25 beginning on or after the effective date of this sec-

1 tion, elect to require a health plan service provider
2 to submit to such issuer a report that includes all
3 of the information described in paragraph (1).

4 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
5 provision in an agreement that unduly delays or limits a
6 group health plan or issuer’s access to information de-
7 scribed in this section or that restricts the format or tim-
8 ing of the provision of such information in a manner that
9 is inconsistent with the requirements of this section shall
10 be prohibited and, if a group health plan or issuer enters
11 into such agreement, shall be deemed void as against pub-
12 lic policy.

13 “(d) REGULATIONS.—The Secretary shall implement
14 this section through notice and comment rulemaking in
15 accordance with section 553 of title 5, United States
16 Code.”.

17 (b) PENALTY.—Section 2723(b) of the Public Health
18 Service Act (42 U.S.C. 300gg–22(b)) is amended by add-
19 ing at the end the following:

20 “(4) ENFORCEMENT AUTHORITY RELATING TO
21 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
22 standing any provisions to the contrary, the Sec-
23 retary may assess a penalty against a health plan
24 service provider, as defined in section 2799A–15(a),
25 of \$100,000 per day for each violation of such sec-

1 tion, pursuant to substantially similar processes and
2 procedures as those set forth in section
3 2723(b)(2)(D) through (G).”.

4 (c) ERISA AMENDMENTS.—

5 (1) IN GENERAL.—Section 502(c) of the Em-
6 ployee Retirement Income Security Act of 1974 (29
7 U.S.C. 1132(c)) is amended by adding at the end
8 the following new paragraph:

9 “(14) The Secretary may assess a civil penalty
10 against any person of \$100,000 per day for each vio-
11 lation by any person of section 2799A–15 of the
12 Public Health Service Act.”.

13 (2) TECHNICAL AMENDMENT.—Paragraph (6)
14 of section 502(a) of the Employee Retirement In-
15 come Security Act of 1974 (29 U.S.C. 1132(a)) is
16 amended by striking “or (9)” and inserting “(9),
17 (13), or (14)”.

18 **SEC. 608. STATE PREEMPTION ONLY IN EVENT OF CON-**
19 **FLICT.**

20 The provisions of section 2718A of the Public Health
21 Service Act (as added and amended by this Act) shall not
22 be construed to supersede any provision of State law which
23 establishes, implements, or continues in effect any require-
24 ment or prohibition related to health care price trans-
25 parency, including for hospitals, clinical diagnostic labora-

1 tories, provider of specified imaging services, and ambula-
2 tory surgical centers (as such terms are defined in section
3 2718A(a) of the Public Health Service Act), except to the
4 extent that such requirement or prohibition prevents the
5 application of a requirement or prohibition of such sec-
6 tions (or such amendments). Nothing in this section shall
7 be construed to affect group health plans established
8 under the Employee Retirement Income Security Act of
9 1974, or alter the application of section 514 of such Act
10 (29 U.S.C. 1144).

11 **SEC. 609. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

12 (a) **ADVANCED EXPLANATION OF BENEFITS.**—Sec-
13 tion 2799A–1(f) of the Public Health Service Act (42
14 U.S.C. 300gg–111(f)) is amended—

15 (1) in paragraph (1)—

16 (A) by striking subparagraph (C) and in-
17 serting the following:

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

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

3 (B) by adding at the end the following

4 “(I) A notification that the recipient may
5 be held harmless, in certain circumstances, if
6 the information in the advanced explanation of
7 benefits does not match the amount the recipi-
8 ent is billed.”; and

9 (2) by adding at the end the following

10 “(3) HOLD HARMLESS.—

11 “(A) IN GENERAL.—For plan years begin-
12 ning on or after the date that is 1 year after
13 the date on which the Secretary implements
14 this section, a participant, beneficiary, or en-
15 rollee shall be held harmless for any amount
16 that is substantially in excess (as defined by the
17 Secretary in a manner consistent with the proc-
18 ess described in section 2799B–7) of the esti-
19 mate generated by the advanced explanation of
20 benefits.

21 “(B) NO PATIENT RESPONSIBILITY FOR
22 EXCESS CHARGES.—A group health plan or a
23 health insurance issuer in the group or indi-
24 vidual market shall not hold a participant, ben-
25 eficiary, or enrollee responsible for excess

1 charges described in this paragraph if such ex-
2 cess is the result of coverage or payment deter-
3 minations that differ from projections made in
4 the advanced explanation of benefits at the time
5 such explanation was generated.

6 “(C) SUBSTANTIAL EXCESS.—A partici-
7 pant, beneficiary, or enrollee shall not be held
8 harmless for excess amounts if such amounts
9 reflect the cost of medically necessary items or
10 services furnished based on unforeseen cir-
11 cumstances that could not have reasonably been
12 anticipated by the provider or facility at the
13 time the good faith estimate was generated or
14 by the plan or issuer at the time the advanced
15 explanation of benefits was generated.”.

16 (b) GOOD FAITH ESTIMATES.—Section 2799B–6 of
17 the Public Health Service Act (42 U.S.C. 300gg–136) is
18 amended—

19 (1) by striking “Each health care” and insert-
20 ing the following:

21 “(a) IN GENERAL.—Each health care”; and

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

23 “(b) HOLD HARMLESS.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after the date that is 1 year after the date on

1 which the Secretary implements section 2799A–1(f),
2 if an individual enrolled in a group health plan or
3 health insurance coverage (and seeks to have a claim
4 for an item or service submitted to such plan or cov-
5 erage) is responsible for any amount that is substan-
6 tially in excess (as defined by the Secretary in a
7 manner consistent the process described in section
8 2799B–7) of the estimate generated in the advanced
9 explanation of benefits described in section 2799A–
10 1(f) because the final charges for items and services
11 were substantially in excess of the good faith esti-
12 mate provided to the plan or coverage under this
13 section, a provider shall not bill the patient for
14 amounts substantially in excess of the advanced ex-
15 planation of benefits.

16 “(2) SUBSTANTIAL EXCESS.—An individual
17 seeking to have a claim for an item or service cov-
18 ered by a group health plan or health insurance cov-
19 erage shall not be held harmless for excess amounts
20 if such amounts reflect the cost of medically nec-
21 essary items or services furnished based on unfore-
22 seen circumstances that could not have reasonably
23 been anticipated by the provider or facility at the
24 time the good faith estimate was generated or by the

1 plan or issuer at the time the advanced explanation
2 of benefits was generated.”.

3 (c) EXPLANATION OF BENEFITS.—Section 2799A–1
4 of the Public Health Service Act (42 U.S.C. 300gg–111)
5 is amended by adding at the end the following:

6 “(g) EXPLANATION OF BENEFITS.—

7 “(1) IN GENERAL.—For plan years beginning
8 on January 1 of the year that begins on or after the
9 date that is 1 year after the date of enactment of
10 the Health CARE Act of 2026, each group health
11 plan, or a health insurance issuer offering group or
12 individual health insurance coverage shall, within 45
13 days of receiving the information necessary to decide
14 a claim for payment (as defined by the Secretary)
15 for an item or service under the plan or coverage for
16 which liability under the plan or coverage has been
17 determined, provide to the participant, beneficiary,
18 or enrollee (through mail or electronic means, as re-
19 quested by the participant, beneficiary, or enrollee)
20 a notification (in clear and understandable language
21 and utilizing substantially the same format as the
22 advanced explanation of benefits required by sub-
23 section (f) to enable comparison when an advanced
24 explanation of benefits is provided) including the fol-
25 lowing:

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

6 “(B) An itemized explanation of benefits
7 that includes the following:

8 “(i) A plain language description of
9 each item or service.

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

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

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

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

1 plan or coverage (as of the date of such
2 notification).

3 “(vi) The type of site of each item or
4 service, including office, facility, or emer-
5 gency room.

6 “(vii) If applicable, a description of
7 any discrepancies that exist between the
8 services outlined in a patient’s advanced
9 explanation of benefits and the explanation
10 of benefits.

11 “(viii) The amount of any facility fee
12 or other patient charges that were added
13 to the final payment amount, together with
14 a plain language explanation of the fee, if
15 applicable.

16 “(C) If the provider or facility is a partici-
17 pating provider or facility with respect to the
18 plan or coverage with respect to the furnishing
19 of such item or service, the contracted rate
20 under such plan or coverage for such item or
21 service.

22 “(D) The charges submitted by the pro-
23 vider or facility for each item or service.

24 “(E) Information pertaining to plan type,
25 as defined the Secretary.

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

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

11 **SEC. 610. TRANSPARENCY IN BILLING.**

12 (a) **IN GENERAL.**—Part E of title XXVII of the Pub-
13 lic Health Service Act (42 U.S.C. 300gg–131 et seq.) is
14 amended by adding at the end the following:

15 **“SEC. 2799B–10. PATIENT ACCESS TO COMPLETE BILLING**
16 **INFORMATION.**

17 “(a) **REQUIREMENTS.**—

18 “(1) **NOTICE OF RIGHT OF ACCESS TO**
19 **ITEMIZED BILLS; IN GENERAL.**—A health care pro-
20 vider or health care facility that requests payment
21 from an individual for providing a health care item
22 or service to the patient shall include with such re-
23 quest a written notice of the individual’s right to re-
24 quest an itemized bill as part of the individual’s des-
25 ignated record set under section 164.524 of title 45,

1 Code of Federal Regulations (or a successor regula-
2 tion).

3 “(2) REQUIRED INFORMATION.—A notice under
4 paragraph (1) shall provide—

5 “(A) a phone number and internet website
6 where an individual can make a request for ac-
7 cess to their itemized bill;

8 “(B) information about the availability of
9 language-assistance services for individuals with
10 limited English proficiency (LEP); and

11 “(C) information about the health care
12 provider’s or health care facility’s charity care
13 policies and instructions on how to apply for
14 charity care.

15 “(3) COLLECTIONS ACTIONS.—

16 “(A) IN GENERAL.—A health care provider
17 or health care facility shall not bill or take any
18 collections actions against an individual—

19 “(i) for any provided health care item
20 or service unless the health care provider
21 or health care facility has complied with
22 paragraph (1) or section 13405(e)(4) of
23 the HITECH Act; or

24 “(ii) with respect to any items or serv-
25 ices for which the amount appearing on an

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

18 “(B) PROVIDER REQUIREMENT.—If a pro-
19 vider fails to provide a documentation as re-
20 quired under subparagraph (A)(ii) in the case
21 of items or services, the good faith estimate de-
22 scribed in such subparagraph with respect to
23 such items or services shall be binding.

24 “(b) FAILURE TO COMPLY.—

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

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

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

19 (b) STANDARDS FOR ACCESSING ITEMIZED BILLS.—
20 Section 13405(e) of the HITECH Act (42 U.S.C.
21 17935(e)) is amended—

22 (1) in paragraph (2), by striking “and” at the
23 end;

24 (2) in paragraph (3), by striking the period and
25 inserting “; and”; and

1 (3) by adding at the end, the following:

2 “(4) if the individual makes a request only for
3 an itemized copy of a bill for services provided, the
4 covered entity or business associate shall—

5 “(A) make such protected health informa-
6 tion available within 30 days of such request;

7 “(B) not impose any fee for providing such
8 individual a copy of their information; and

9 “(C) include in such itemized bill, a plain
10 language description of each distinct health
11 care item or service, all applicable billing codes
12 for each distinct item or service, including
13 modifiers, using standard and commonly recog-
14 nized billing code sets, the price and billed
15 amount, if different, of each distinct item or
16 service.”.

17 **SEC. 611. TECHNICAL AMENDMENTS.**

18 (a) ERISA.—Section 715(a)(1) of the Employee Re-
19 tirement Income Security Act of 1974 (29 U.S.C.
20 1185d(a)(1)) is amended by inserting “and parts D and
21 E of title XXVII of the Public Health Service Act (as
22 amended by title VI the Health CARE Act of 2026)” after
23 “Affordable Care Act”).

24 (b) INTERNAL REVENUE CODE.—Section 9815(a)(1)
25 of the Internal Revenue Code of 1986 is amended by in-

1 serting “and parts D and E of title XXVII of the Public
2 Health Service Act (as amended by title VI of the Health
3 CARE Act of 2026)” after “Affordable Care Act)”.

4 **SEC. 612. IMPLEMENTATION AND ENFORCEMENT FUNDING.**

5 (a) APPROPRIATION FOR SECRETARY OF LABOR.—
6 There are authorized to be appropriated, such sums as
7 may be necessary for fiscal year 2027, and each subse-
8 quent fiscal year, to enable the Secretary of Labor to carry
9 out this Act and the amendments made by this Act, in-
10 cluding enforcement activities.

11 (b) APPROPRIATION FOR THE SECRETARY OF
12 HEALTH AND HUMAN SERVICES.—There are authorized
13 to be appropriated, such sums as may be necessary for
14 fiscal year 2027, and each subsequent fiscal year, to en-
15 able the Secretary of Health and Human Services to carry
16 out the amendments made by this Act, including imple-
17 mentation and enforcement activities.

18 **TITLE VII—REFORMING PBMS**
19 **AND PROTECTING PHARMACIES**

20 **SEC. 701. ENSURING ACCURATE PAYMENTS TO PHAR-**
21 **MACIES UNDER MEDICAID.**

22 (a) IN GENERAL.—Section 1927(f) of the Social Se-
23 curity Act (42 U.S.C. 1396r–8(f)) is amended—

24 (1) in paragraph (1)(A)—

1 (A) by redesignating clause (ii) as clause
2 (iii); and

3 (B) by striking “and” after the semicolon
4 at the end of clause (i) and all that precedes it
5 through “(1)” and inserting the following:

6 “(1) DETERMINING PHARMACY ACTUAL ACQUI-
7 SITION COSTS.—The Secretary shall conduct a sur-
8 vey of retail community pharmacy drug prices and
9 applicable non-retail pharmacy drug prices to deter-
10 mine national average drug acquisition cost bench-
11 marks (as such term is defined by the Secretary) as
12 follows:

13 “(A) USE OF VENDOR.—The Secretary
14 may contract services for—

15 “(i) with respect to retail community
16 pharmacies, the determination of retail
17 survey prices of the national average drug
18 acquisition cost for covered outpatient
19 drugs that represent a nationwide average
20 of consumer purchase prices for such
21 drugs, net of all discounts, rebates, and
22 other price concessions (to the extent any
23 information with respect to such discounts,
24 rebates, and other price concessions is

1 available) based on a monthly survey of
2 such pharmacies;

3 “(ii) with respect to applicable non-re-
4 tail pharmacies—

5 “(I) the determination of survey
6 prices, separate from the survey prices
7 described in clause (i), of the non-re-
8 tail national average drug acquisition
9 cost for covered outpatient drugs that
10 represent a nationwide average of con-
11 sumer purchase prices for such drugs,
12 net of all discounts, rebates, and other
13 price concessions (to the extent any
14 information with respect to such dis-
15 counts, rebates, and other price con-
16 cessions is available) based on a
17 monthly survey of such pharmacies;
18 and

19 “(II) at the discretion of the Sec-
20 retary, for each type of applicable
21 non-retail pharmacy, the determina-
22 tion of survey prices, separate from
23 the survey prices described in clause
24 (i) or subclause (I) of this clause, of
25 the national average drug acquisition

1 cost for such type of pharmacy for
2 covered outpatient drugs that rep-
3 resent a nationwide average of con-
4 sumer purchase prices for such drugs,
5 net of all discounts, rebates, and other
6 price concessions (to the extent any
7 information with respect to such dis-
8 counts, rebates, and other price con-
9 cessions is available) based on a
10 monthly survey of such pharmacies;
11 and”;

12 (2) in subparagraph (B) of paragraph (1), by
13 striking “subparagraph (A)(ii)” and inserting “sub-
14 paragraph (A)(iii)”;

15 (3) in subparagraph (D) of paragraph (1), by
16 striking clauses (ii) and (iii) and inserting the fol-
17 lowing:

18 “(ii) The vendor must update the Sec-
19 retary no less often than monthly on the
20 survey prices for covered outpatient drugs.

21 “(iii) The vendor must differentiate,
22 in collecting and reporting survey data, for
23 all cost information collected, whether a
24 pharmacy is a retail community pharmacy
25 or an applicable non-retail pharmacy, in-

1 cluding whether such pharmacy is an affil-
2 iate (as defined in subsection (k)(13)),
3 and, in the case of an applicable non-retail
4 pharmacy, which type of applicable non-re-
5 tail pharmacy it is using the relevant phar-
6 macy type indicators included in the guid-
7 ance required by subsection (d)(2) of sec-
8 tion 701 of the Health CARE Act of
9 2026.”;

10 (4) by adding at the end of paragraph (1) the
11 following:

12 “(F) SURVEY REPORTING.—In order to
13 meet the requirement of section 1902(a)(54), a
14 State shall require that any retail community
15 pharmacy or applicable non-retail pharmacy in
16 the State that receives any payment, reimburse-
17 ment, administrative fee, discount, rebate, or
18 other price concession related to the dispensing
19 of covered outpatient drugs to individuals re-
20 ceiving benefits under this title, regardless of
21 whether such payment, reimbursement, admin-
22 istrative fee, discount, rebate, or other price
23 concession is received from the State or a man-
24 aged care entity or other specified entity (as
25 such terms are defined in section

1 1903(m)(9)(D)) directly or from a pharmacy
2 benefit manager or another entity that has a
3 contract with the State or a managed care enti-
4 ty or other specified entity (as so defined), shall
5 respond to surveys conducted under this para-
6 graph.

7 “(G) SURVEY INFORMATION.—Information
8 on national drug acquisition prices obtained
9 under this paragraph shall be made publicly
10 available in a form and manner to be deter-
11 mined by the Secretary and shall include at
12 least the following:

13 “(i) The monthly response rate to the
14 survey including a list of pharmacies not in
15 compliance with subparagraph (F).

16 “(ii) The sampling methodology and
17 number of pharmacies sampled monthly.

18 “(iii) Information on price concessions
19 to pharmacies, including discounts, re-
20 bates, and other price concessions, to the
21 extent that such information may be pub-
22 licly released and has been collected by the
23 Secretary as part of the survey.

24 “(H) PENALTIES.—

1 “(i) IN GENERAL.—Subject to clauses
2 (ii), (iii), and (iv), the Secretary shall en-
3 force the provisions of this paragraph with
4 respect to a pharmacy through the estab-
5 lishment of civil money penalties applicable
6 to a retail community pharmacy or an ap-
7 plicable non-retail pharmacy.

8 “(ii) BASIS FOR PENALTIES.—The
9 Secretary shall impose a civil money pen-
10 alty established under this subparagraph
11 on a retail community pharmacy or appli-
12 cable non-retail pharmacy if—

13 “(I) the retail pharmacy or appli-
14 cable non-retail pharmacy refuses or
15 otherwise fails to respond to a request
16 for information about prices in con-
17 nection with a survey under this sub-
18 section;

19 “(II) knowingly provides false in-
20 formation in response to such a sur-
21 vey; or

22 “(III) otherwise fails to comply
23 with the requirements established
24 under this paragraph.

1 “(iii) PARAMETERS FOR PEN-
2 ALTIES.—

3 “(I) IN GENERAL.—A civil money
4 penalty established under this sub-
5 paragraph may be assessed with re-
6 spect to each violation, and with re-
7 spect to each non-compliant retail
8 community pharmacy (including a
9 pharmacy that is part of a chain) or
10 non-compliant applicable non-retail
11 pharmacy (including a pharmacy that
12 is part of a chain), in an amount not
13 to exceed \$100,000 for each such vio-
14 lation.

15 “(II) CONSIDERATIONS.—In de-
16 termining the amount of a civil money
17 penalty imposed under this subpara-
18 graph, the Secretary may consider the
19 size, business structure, and type of
20 pharmacy involved, as well as the type
21 of violation and other relevant factors,
22 as determined appropriate by the Sec-
23 retary.

24 “(iv) RULE OF APPLICATION.—The
25 provisions of section 1128A (other than

1 subsections (a) and (b)) shall apply to a
2 civil money penalty under this subpara-
3 graph in the same manner as such provi-
4 sions apply to a civil money penalty or pro-
5 ceeding under section 1128A(a).

6 “(I) LIMITATION ON USE OF APPLICABLE
7 NON-RETAIL PHARMACY PRICING INFORMA-
8 TION.—No State shall use pricing information
9 reported by applicable non-retail pharmacies
10 under subparagraph (A)(ii) to develop or inform
11 payment methodologies for retail community
12 pharmacies.”;

13 (5) in paragraph (2)—

14 (A) in subparagraph (A), by inserting “,
15 including payment rates and methodologies for
16 determining ingredient cost reimbursement
17 under managed care entities or other specified
18 entities (as such terms are defined in section
19 1903(m)(9)(D)),” after “under this title”; and

20 (B) in subparagraph (B), by inserting
21 “and the basis for such dispensing fees” before
22 the semicolon;

23 (6) by redesignating paragraph (4) as para-
24 graph (5);

1 (7) by inserting after paragraph (3) the fol-
2 lowing new paragraph:

3 “(4) OVERSIGHT.—

4 “(A) IN GENERAL.—The Inspector General
5 of the Department of Health and Human Serv-
6 ices shall conduct periodic studies of the survey
7 data reported under this subsection, as appro-
8 priate, including with respect to substantial
9 variations in acquisition costs or other applica-
10 ble costs, as well as with respect to how internal
11 transfer prices and related party transactions
12 may influence the costs reported by pharmacies
13 that are affiliates (as defined in subsection
14 (k)(13)) or are owned by, controlled by, or re-
15 lated under a common ownership structure with
16 a wholesaler, distributor, or other entity that
17 acquires covered outpatient drugs relative to
18 costs reported by pharmacies not affiliated with
19 such entities. The Inspector General shall pro-
20 vide periodic updates to Congress on the results
21 of such studies, as appropriate, in a manner
22 that does not disclose trade secrets or other
23 proprietary information.

24 “(B) APPROPRIATION.—There is appro-
25 priated to the Inspector General of the Depart-

1 ment of Health and Human Services, out of
2 any money in the Treasury not otherwise ap-
3 propriated, \$5,000,000 for fiscal year 2027, to
4 remain available until expended, to carry out
5 this paragraph.”; and

6 (8) in paragraph (5), as so redesignated—

7 (A) by inserting “, and \$9,000,000 for fis-
8 cal year 2027 and each fiscal year thereafter,”
9 after “2010”; and

10 (B) by inserting “Funds appropriated
11 under this paragraph for fiscal year 2027 and
12 any subsequent fiscal year shall remain avail-
13 able until expended.” after the period.

14 (b) DEFINITIONS.—Section 1927(k) of the Social Se-
15 curity Act (42 U.S.C. 1396r–8(k)) is amended—

16 (1) in the matter preceding paragraph (1), by
17 striking “In the section” and inserting “In this sec-
18 tion”; and

19 (2) by adding at the end the following new
20 paragraphs:

21 “(12) APPLICABLE NON-RETAIL PHARMACY.—

22 The term ‘applicable non-retail pharmacy’ means a
23 pharmacy that is licensed as a pharmacy by the
24 State and that is not a retail community pharmacy,
25 including a pharmacy that dispenses prescription

1 medications to patients primarily through mail and
2 specialty pharmacies. Such term does not include
3 nursing home pharmacies, long-term care facility
4 pharmacies, hospital pharmacies, clinics, charitable
5 or not-for-profit pharmacies, government phar-
6 macies, or low dispensing pharmacies (as defined by
7 the Secretary).

8 “(13) AFFILIATE.—The term ‘affiliate’ means
9 any entity that is owned by, controlled by, or related
10 under a common ownership structure with a phar-
11 macy benefit manager or a managed care entity or
12 other specified entity (as such terms are defined in
13 section 1903(m)(9)(D)).”.

14 (c) EFFECTIVE DATE.—

15 (1) IN GENERAL.—Subject to paragraph (2),
16 the amendments made by this section shall take ef-
17 fect on the first day of the first quarter that begins
18 on or after the date that is 6 months after the date
19 of enactment of this Act.

20 (2) DELAYED APPLICATION TO APPLICABLE
21 NON-RETAIL PHARMACIES.—The pharmacy survey
22 requirements established by the amendments to sec-
23 tion 1927(f) of the Social Security Act (42 U.S.C.
24 1396r–8(f)) made by this section shall apply to re-
25 tail community pharmacies beginning on the effec-

1 tive date described in paragraph (1), but shall not
2 apply to applicable non-retail pharmacies until the
3 first day of the first quarter that begins on or after
4 the date that is 18 months after the date of enact-
5 ment of this Act.

6 (d) IDENTIFICATION OF APPLICABLE NON-RETAIL
7 PHARMACIES.—

8 (1) IN GENERAL.—Not later than January 1,
9 2028, the Secretary of Health and Human Services
10 shall, in consultation with stakeholders as appro-
11 priate, publish guidance specifying pharmacies that
12 meet the definition of applicable non-retail phar-
13 macies (as such term is defined in subsection
14 (k)(12) of section 1927 of the Social Security Act
15 (42 U.S.C. 1396r–8), as added by subsection (b)),
16 and that will be subject to the survey requirements
17 under subsection (f)(1) of such section, as amended
18 by subsection (a).

19 (2) INCLUSION OF PHARMACY TYPE INDICA-
20 TORS.—The guidance published under paragraph (1)
21 shall include pharmacy type indicators to distinguish
22 between different types of applicable non-retail phar-
23 macies, such as pharmacies that dispense prescrip-
24 tions primarily through the mail and pharmacies
25 that dispense prescriptions that require special han-

1 dling or distribution. An applicable non-retail phar-
2 macy may be identified through multiple pharmacy
3 type indicators.

4 (e) IMPLEMENTATION.—

5 (1) IN GENERAL.—Notwithstanding any other
6 provision of law, the Secretary of Health and
7 Human Services may implement the amendments
8 made by this section by program instruction or oth-
9 erwise.

10 (2) NONAPPLICATION OF ADMINISTRATIVE PRO-
11 CEDURE ACT.—Implementation of the amendments
12 made by this section shall be exempt from the re-
13 quirements of section 553 of title 5, United States
14 Code.

15 (f) NONAPPLICATION OF PAPERWORK REDUCTION
16 ACT.—Chapter 35 of title 44, United States Code, shall
17 not apply to any data collection undertaken by the Sec-
18 retary of Health and Human Services under section
19 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)),
20 as amended by this section.

21 **SEC. 702. PREVENTING THE USE OF ABUSIVE SPREAD PRIC-**
22 **ING IN MEDICAID.**

23 (a) IN GENERAL.—Section 1927 of the Social Secu-
24 rity Act (42 U.S.C. 1396r–8) is amended—

1 (1) in subsection (e), by adding at the end the
2 following new paragraph:

3 “(6) TRANSPARENT PRESCRIPTION DRUG PASS-
4 THROUGH PRICING REQUIRED.—

“(A) IN GENERAL.—A contract between the State and a pharmacy benefit manager (referred to in this paragraph as a ‘PBM’), or a contract between the State and a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D) and collectively referred to in this paragraph as the ‘entity’) that includes provisions making the entity responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or entity, is based on a transparent prescription drug pass-through pricing model under which—

21 “(i) any payment made by the entity
22 or the PBM (as applicable) for such a
23 drug—

24 “(I) is limited to—

25 “(aa) ingredient cost; and

1 “(bb) a professional dis-
2 pensing fee that is not less than
3 the professional dispensing fee
4 that the State would pay if the
5 State were making the payment
6 directly in accordance with the
7 State plan;

8 “(II) is passed through in its en-
9 tirety (except as reduced under Fed-
10 eral or State laws and regulations in
11 response to instances of waste, fraud,
12 or abuse) by the entity or PBM to the
13 pharmacy or provider that dispenses
14 the drug; and

15 “(III) is made in a manner that
16 is consistent with sections 447.502,
17 447.512, 447.514, and 447.518 of
18 title 42, Code of Federal Regulations
19 (or any successor regulation) as if
20 such requirements applied directly to
21 the entity or the PBM, except that
22 any payment by the entity or the
23 PBM for the ingredient cost of such
24 drug purchased by a covered entity
25 (as defined in subsection (a)(5)(B))

1 may exceed the actual acquisition cost
2 (as defined in 447.502 of title 42,
3 Code of Federal Regulations, or any
4 successor regulation) for such drug
5 if—

6 “(aa) such drug was subject
7 to an agreement under section
8 340B of the Public Health Serv-
9 ice Act;

10 “(bb) such payment for the
11 ingredient cost of such drug does
12 not exceed the maximum pay-
13 ment that would have been made
14 by the entity or the PBM for the
15 ingredient cost of such drug if
16 such drug had not been pur-
17 chased by such covered entity;
18 and

19 “(cc) such covered entity re-
20 ports to the Secretary (in a form
21 and manner specified by the Sec-
22 retary), on an annual basis and
23 with respect to payments for the
24 ingredient costs of such drugs so
25 purchased by such covered entity

1 that are in excess of the actual
2 acquisition costs for such drugs,
3 the aggregate amount of such ex-
4 cess;

5 “(ii) payment to the entity or the
6 PBM (as applicable) for administrative
7 services performed by the entity or PBM is
8 limited to an administrative fee that re-
9 flects the fair market value (as defined by
10 the Secretary) of such services;

11 “(iii) the entity or the PBM (as appli-
12 cable) makes available to the State, and
13 the Secretary upon request in a form and
14 manner specified by the Secretary, all costs
15 and payments related to covered outpatient
16 drugs and accompanying administrative
17 services (as described in clause (ii)) in-
18 curred, received, or made by the entity or
19 the PBM, broken down (as specified by the
20 Secretary), to the extent such costs and
21 payments are attributable to an individual
22 covered outpatient drug, by each such
23 drug, including any ingredient costs, pro-
24 fessional dispensing fees, administrative
25 fees (as described in clause (ii)), post-sale

1 and post-invoice fees, discounts, or related
2 adjustments such as direct and indirect re-
3 muneration fees, and any and all other re-
4 muneration, as defined by the Secretary;
5 and

6 “(iv) any form of spread pricing
7 whereby any amount charged or claimed by
8 the entity or the PBM (as applicable) that
9 exceeds the amount paid to the pharmacies
10 or providers on behalf of the State or enti-
11 ty, including any post-sale or post-invoice
12 fees, discounts, or related adjustments
13 such as direct and indirect remuneration
14 fees or assessments, as defined by the Sec-
15 retary, (after allowing for an administra-
16 tive fee as described in clause (ii)) is not
17 allowable for purposes of claiming Federal
18 matching payments under this title.

19 “(B) PUBLICATION OF INFORMATION.—

20 The Secretary shall publish, not less frequently
21 than on an annual basis and in a manner that
22 does not disclose the identity of a particular
23 covered entity or organization, information re-
24 ceived by the Secretary pursuant to subpara-
25 graph (A)(iii)(III) that is broken out by State

1 and by each of the following categories of cov-
2 ered entity within each such State:

3 “(i) Covered entities described in sub-
4 paragraph (A) of section 340B(a)(4) of the
5 Public Health Service Act.

6 “(ii) Covered entities described in sub-
7 paragraphs (B) through (K) of such sec-
8 tion.

9 “(iii) Covered entities described in
10 subparagraph (L) of such section.

11 “(iv) Covered entities described in
12 subparagraph (M) of such section.

13 “(v) Covered entities described in sub-
14 paragraph (N) of such section.

15 “(vi) Covered entities described in
16 subparagraph (O) of such section.”; and

17 (2) in subsection (k), as amended by section
18 701(b), by adding at the end the following new para-
19 graph:

20 “(14) PHARMACY BENEFIT MANAGER.—The
21 term ‘pharmacy benefit manager’ means any person
22 or entity that, either directly or through an inter-
23 mediary, acts as a price negotiator or group pur-
24 chaser on behalf of a State, managed care entity (as
25 defined in section 1903(m)(9)(D)), or other specified

1 entity (as so defined), or manages the prescription
2 drug benefits provided by a State, managed care en-
3 tity, or other specified entity, including the proc-
4 essing and payment of claims for prescription drugs,
5 the performance of drug utilization review, the proc-
6 essing of drug prior authorization requests, the man-
7 aging of appeals or grievances related to the pre-
8 scription drug benefits, contracting with pharmacies,
9 controlling the cost of covered outpatient drugs, or
10 the provision of services related thereto. Such term
11 includes any person or entity that acts as a price ne-
12 gotiator (with regard to payment amounts to phar-
13 macies and providers for a covered outpatient drug
14 or the net cost of the drug) or group purchaser on
15 behalf of a State, managed care entity, or other
16 specified entity or that carries out 1 or more of the
17 other activities described in the preceding sentence,
18 irrespective of whether such person or entity calls
19 itself a pharmacy benefit manager.”.

20 (b) CONFORMING AMENDMENTS.—Section 1903(m)
21 of such Act (42 U.S.C. 1396b(m)) is amended—

22 (1) in paragraph (2)(A)(xiii)—

23 (A) by striking “and (III)” and inserting
24 “(III)”;

1 (B) by inserting before the period at the
2 end the following: “, and (IV) if the contract in-
3 cludes provisions making the entity responsible
4 for coverage of covered outpatient drugs, the
5 entity shall comply with the requirements of
6 section 1927(e)(6)”;

7 (C) by moving the margin 2 ems to the
8 left; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(10) No payment shall be made under this
12 title to a State with respect to expenditures incurred
13 by the State for payment for services provided by an
14 other specified entity (as defined in paragraph
15 (9)(D)(iii)) unless such services are provided in ac-
16 cordance with a contract between the State and such
17 entity which satisfies the requirements of paragraph
18 (2)(A)(xiii).”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to contracts between States and
21 managed care entities, other specified entities, or phar-
22 macy benefit managers that have an effective date begin-
23 ning on or after the date that is 18 months after the date
24 of enactment of this Act.

25 (d) IMPLEMENTATION.—

1 (1) IN GENERAL.—Notwithstanding any other
2 provision of law, the Secretary of Health and
3 Human Services may implement the amendments
4 made by this section by program instruction or otherwise.
5

6 (2) NONAPPLICATION OF ADMINISTRATIVE PRO-
7 CEDURE ACT.—Implementation of the amendments
8 made by this section shall be exempt from the re-
9 quirements of section 553 of title 5, United States
10 Code.

11 (e) NONAPPLICATION OF PAPERWORK REDUCTION
12 ACT.—Chapter 35 of title 44, United States Code, shall
13 not apply to any data collection undertaken by the Sec-
14 retary of Health and Human Services under section
15 1927(e) of the Social Security Act (42 U.S.C. 1396r-
16 8(e)), as amended by this section.