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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health for the Commonwealth through Affordability, Reform, and Expansion Act of 2026'' or the ''Health CARE Act of 2026''.

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

TITLE I—RESTORING HEALTH CARE AND LOWERING COSTS

SEC. 101. REPEAL OF RECONCILIATION HEALTH PROVISIONS.

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 Res. 14'' (Public Law 119–21) is repealed and any law or regulation referred to in such subtitle shall be applied as if such subtitle and the amendments made by such subtitle had not been enacted.

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

(c) RESCISSION.—

(1) OBBBA IMPLEMENTATION FUNDING.—The unobligated amounts appropriated under the following provisions of the Act titled ''An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14'' (Public Law 119–21) are hereby rescinded:

(A) Section 71101(b).

(B) Section 71107(c).

(C) Section 71109(c).

(D) Section 71110(b).

(E) Section 71112(e).

(F) Section 71113(c).

(G) Section 71115(c).

(H) Section 71116(e).

(I) Section 71118(b).

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

(K) Section 71120(c).

(L) Section 71121(b).

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unobligated amounts appropriated under section 1902(uu)(3) of the Social Security Act (42 U.S.C. 1396a(uu)(3)), as repealed by subsection (a), are hereby rescinded.

SEC. 102. PERMANENT EXTENSION OF ENHANCED TAX CREDIT.

(a) IN GENERAL.—Subparagraph (A) of section 36B(c)(1) of the Internal Revenue Code of 1986 is amended by striking ''but does not exceed 400 percent''.

(b) APPLICABLE PERCENTAGES.—

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

''(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is

within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in 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.".

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

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

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

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

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

SEC. 103. PROMOTING CONSUMER OUTREACH AND EDUCATION.

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

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

''(C) SELECTION OF RECIPIENTS.—In the case of an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), in awarding grants under paragraph (1), the Exchange shall—

''(i) select entities to receive such grants based on an entity's demonstrated capacity to carry out each of the duties specified in paragraph (3);

''(ii) not take into account whether or not the entity has demonstrated how the entity will provide information to individuals relating to group health plans offered by a group or association of employers or short-term limited duration insurance (as defined by the Secretary for purposes of section 2791(b)(5) of the Public Health Service Act); and

''(iii) ensure that, each year, the Exchange awards such a grant to—

''(I) at least one entity described in this paragraph that is a community and consumer-focused nonprofit group; and

''(II) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group in addition to any such group awarded a grant pursuant to subclause (I).

In awarding such grants, an Exchange may consider an entity's record with respect to waste, fraud, and abuse for purposes of maintaining the integrity of such Exchange.'';

(2) in paragraph (3)—

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

''(C) facilitate enrollment, including with respect to individuals with limited English proficiency and individuals with chronic illnesses, in qualified health plans, State Medicaid plans under title XIX of the Social Security Act, and

State child health plans under title XXI of such Act;'';

(B) in subparagraph (D), by striking ''and'' at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and'';

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

''(F) provide referrals to community-based organizations that address social needs related to health outcomes.''; and

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

''The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.'';

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking ''not'';

(B) in clause (i)—

(i) by inserting ''not'' before ''be''; and

(ii) by striking ''; or'' and inserting a semicolon;

(C) in clause (ii)—

(i) by inserting ''not'' before ''receive''; and

(ii) by striking the period and inserting a semicolon; and

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

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

''(iv) receive opioid specific education and training that ensures the navigator can best educate individuals on qualified health plans offered through an Exchange, specifically coverage under such plans for opioid health care treatment.''; and

(4) in paragraph (6)—

(A) by striking ''Grants under'' and inserting the following:

''(A) STATE EXCHANGES.—Grants under''; and

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

''(B) FEDERAL EXCHANGES.—For purposes of carrying out this subsection, with respect to an Exchange established and operated

by the Secretary within a State pursuant to section 1321(c), the Secretary shall obligate $100,000,000 out of amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations), for fiscal year 2027 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2027.

TITLE II—PATHWAY TO UNIVERSAL COVERAGE

SEC. 201. ESTABLISHMENT OF HEALTH PLAN.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ''Secretary'') shall establish a coordinated and low-cost health plan (referred to in this title as the ''health plan'') to provide access to quality health care for enrollees.

(b) INDIVIDUAL MARKET AVAILABILITY.—The Secretary shall make the health plan available in the individual market for plan year 2028 and each subsequent plan year.

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

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

SEC. 202. AVAILABILITY OF PLAN.

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

(1) is a qualified individual within the meaning of section 1312 of the Patient Protection and Affordable Care Act (42 U.S.C. 18032);

(2) is not eligible for benefits under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

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

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

SEC. 203. AFFORDABILITY.

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

SEC. 204. PARTICIPATING PROVIDERS.

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

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

SEC. 205. PROVIDER PAYMENT RATES.

The Secretary shall set competitive provider payment rates under the health plan using the best information publicly available and data otherwise accessible to the Secretary. The Secretary shall give consideration to existing provider payment rates for commercial health plans and provider costs to deliver care, giving special consideration to increased costs for providers to deliver care in rural and medically underserved areas.

SEC. 206. NO EFFECT ON MEDICARE BENEFITS OR MEDICARE TRUST FUNDS.

Nothing in this title shall—

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

(2) impact the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) (including the Medicare Prescription Drug Account within such Trust Fund).

TITLE III—STRENGTHENING MEDICAID

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

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (y)(1)—

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

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

(C) in subparagraph (C), by striking ''2018'' and inserting ''the fifth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals'';

(D) in subparagraph (D), by striking ''2019'' and inserting ''the sixth consecutive 12-month period in which the State provides medical assistance to newly eligible individuals''; and

(E) in subparagraph (E), by striking ''2020 and each year thereafter'' and inserting ''the seventh consecutive 12-month period in which the State provides medical assistance to newly eligible individuals and each such period thereafter''; and

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

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

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

SEC. 302. SUPPORTING STATE MEDICAID PROGRAMS THROUGH ECONOMIC DOWNTURNS.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (b), by striking ''and (ii)'' and inserting ''(ii), and (ll)''; and

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

''(ll) INCREASED FMAP DURING ECONOMIC DOWNTURNS.—

''(1) IN GENERAL.—If a fiscal quarter that begins on or after January 1, 2026, is an economic downturn quarter (as defined in paragraph (2)) with respect to a State, then the Federal medical assistance percentage determined for each State for such quarter under subsection (b) shall be equal to the percentage determined for the State and quarter under paragraph (3).

''(2) ECONOMIC DOWNTURN QUARTER.—

"(A) IN GENERAL.—

"(i) IN GENERAL.—In this subsection, the term 'economic downturn quarter' means, with respect to a State, a fiscal quarter during which the State's unemployment rate for the quarter exceeds the percentage determined for the State and quarter under clause (ii).

"(ii) THRESHOLD PERCENTAGE.—The percentage determined under this clause for a State and fiscal quarter is the percentage equal to the lower of—

"(I) the State unemployment rate at the 20th percentile of the distribution of the State's quarterly unemployment rates for the 60-quarter period preceding the quarter involved, increased by 1 percentage point; and

"(II) the State's average quarterly unemployment rate for the 12-quarter period preceding the quarter involved, increased by 1 percentage point.

"(B) UNEMPLOYMENT DATA.—

"(i) IN GENERAL.—Except as provided in clause (ii), for purposes of determining unemployment rates for a State and a quarter under this paragraph, the Secretary shall use data from the Local Area Unemployment Statistics from the Bureau of Labor Statistics.

"(ii) APPLICATION TO CERTAIN TERRITORIES.—In the case of the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, or any other jurisdiction for which suitable data from the Local Area Unemployment Statistics from the Bureau of Labor Statistics are unavailable, the Secretary shall use data from the U–3 unemployment measure of the Bureau of Labor Statistics to make any necessary determinations under subparagraph (A).

"(3) INCREASED FMAP DURING ECONOMIC DOWNTURN QUARTER.—

"(A) IN GENERAL.—During a fiscal quarter that is an economic downturn quarter with respect to a State, the Federal medical assistance percentage for the State and quarter de-

termined under subsection (b) shall be equal to—

"(i) the Federal medical assistance percentage determined for the State and quarter under subsection (b) without regard to this subsection; increased by

"(ii) the number of percentage points (rounded to the nearest tenth of a percentage point) equal to the product of—

"(I) the number of percentage points (rounded to the nearest tenth of a percentage point) by which the unemployment rate for the State and quarter exceeds the percentage determined for the State and quarter under paragraph (2)(A)(ii); and

"(II) 4.8.

"(B) RULES OF APPLICATION.—The following rules shall apply with respect to the Federal medical assistance percentage determined for a State and an economic downturn quarter under this subsection:

"(i) SCOPE OF APPLICATION.—Such Federal medical assistance percentage shall not apply for purposes of—

''(I) disproportionate share hospital payments described in section 1923;

''(II) payments under part D of title IV; or

''(III) any payments under this title that are based on a Federal medical assistance percentage determined for a State under subsection (aa) (but only to the extent that such Federal medical assistance percentage is higher than the economic recovery FMAP).

''(ii) LIMITATION.—In no case shall—

''(I) the Federal medical assistance percentage determined for a State and quarter pursuant to this subsection exceed 95 percent; or

''(II) any increase to the Federal medical assistance percentage determined for a State and quarter pursuant to this subsection result in the application of a Federal medical assistance percentage that exceeds 95 percent.

"(iii) APPLICATION TO CHIP.—Notwithstanding the first sentence of section 2105(b), the application of this subsection may result in the enhanced FMAP of a State for a fiscal year under such section exceeding 85 percent, but in no case may the application of this subsection before application of the second sentence of such section result in the enhanced FMAP of the State exceeding 95 percent.

"(4) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—

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

"(i) make an initial determination, based on the projections made for the State and quarter under subparagraph (B), as to—

"(I) whether the application of this subsection is expected to result in the application of a higher Federal medical assistance percentage for the

State and quarter than the percentage that would otherwise apply without regard to this subsection; and

''(II) if the application of this subsection is expected to result in such a higher Federal medical assistance percentage for the State and quarter, what such higher percentage is expected to be; and

''(ii) if the Secretary determines under clause (i) that the application of this subsection is expected to result in the application of a higher Federal medical assistance percentage for the State and quarter than the percentage that would otherwise apply without regard to this subsection—

''(I) apply such higher Federal medical assistance percentage of the State for purposes of making payments to the State for amounts expended during such quarter as medical assistance under the State plan; and

''(II) take into account such higher Federal medical assistance per-

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

"(B) PROJECTION OF STATE UNEMPLOYMENT RATES.—Prior to the beginning of the second fiscal quarter that begins after the date of enactment of this subsection, and each subsequent fiscal quarter, the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall, using the most recently available data described in paragraph (2)(B), make projections with respect to—

"(i) the unemployment rates for each State for such quarter;

"(ii) the threshold percentages described in paragraph (2)(A)(ii) for each State for such quarter; and

"(iii) the national unemployment rate for such quarter.

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

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

"(i) make a final determination with respect to the application of this subsection for purposes of determining the Federal medical assistance percentage and enhanced FMAP of the State for the quarter; and

"(ii) in accordance with section 1903(d)(2) and section 2105(e), reduce or increase the amount payable to the State under section 1903(a) or section 2105 for a subsequent fiscal quarter to the extent of any overpayment or underpayment under either such section which the Secretary determines was made as a result of an incorrect initial determination under subparagraph (A)(i) with respect to the application of this subsection for purposes of determining the Federal medical assistance percentage and enhanced FMAP of the State for such prior fiscal quarter.

"(5) RETROSPECTIVE APPLICATION OF OVER-THE-LIMIT FMAP INCREASES.—

"(A) IN GENERAL.—If a State has excess percentage points with respect to an economic downturn quarter and an applicable FMAP (as determined under subparagraph (B)), the State may elect to apply such excess percentage points to increase such applicable FMAP for one or more quarters during the look-back period for the State and economic downturn quarter in accordance with this paragraph.

"(B) EXCESS PERCENTAGE POINTS.—For purposes of this paragraph, the number of excess percentage points for a State, economic downturn quarter, and an applicable FMAP shall be equal to the number of percentage points by which—

"(i) the applicable FMAP for the State and quarter (after application of paragraph (3) but without regard to subparagraph (B)(ii) of such paragraph); exceeds

"(ii) 95 percent.

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

under this paragraph, the Secretary shall determine the additional amount of payment under section 1903(a) to which the State would have been entitled for such quarter if the applicable FMAP (as so increased) had been in effect for such quarter, and shall treat such additional amount as an underpayment for such quarter.

''(D) DISTRIBUTION OF EXCESS PERCENTAGE POINTS.—A State that has excess percentage points with respect to an economic downturn quarter and applicable FMAP may elect to divide such points among more than 1 quarter during the look-back period for such State and quarter provided that no excess percentage point (or fraction of an excess percentage point) is applied to the applicable FMAP of more than 1 quarter.

''(E) LIMITATIONS.—

''(i) NO INCREASES OVER 100 PERCENT.—A State may not increase an applicable FMAP for any quarter during a look-back period under this paragraph if such increase would result in the applicable FMAP for such quarter exceeding 100 percent.

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

"(I) shall only apply with respect to payments for amounts expended by the State for medical assistance for services furnished during such quarter to which such applicable FMAP is applicable; and

"(II) shall not apply with respect to payments described in paragraph (3)(B)(i).

"(F) DEFINITIONS.—In this paragraph:

"(i) APPLICABLE FMAP.—The term 'applicable FMAP' means, with respect to a State and fiscal quarter—

"(I) the Federal medical assistance percentage determined for the State and quarter under subsection (b);

"(II) the Federal medical assistance percentage applicable under subsection (y);

"(III) the Federal medical assistance percentage applicable under subsection (z)(2);

"(IV) the Federal medical assistance percentage determined for the State and quarter under subsection (ff); or

"(V) the enhanced FMAP determined for the State and quarter under section 2105(b).

"(ii) LOOK-BACK PERIOD.—The term 'look-back period' means, with respect to a State and a fiscal quarter that is an economic downturn quarter for the State, the period of 4 fiscal quarters that ends with the fourth quarter which precedes the most recent fiscal quarters that was not an economic downturn quarter for the State.

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

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

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

''(B) the amount of any premium imposed by the State pursuant to section 1916 or 1916A during such quarter, with respect to an individual enrolled under such plan (or waiver), exceeds the amount of such premium as of the date described in subparagraph (A); or

''(C) the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date described in subparagraph (A) or enrolls for benefits under such plan (or waiver) during the period beginning with such date and ending with the day before the first day of the next quarter that is not an economic downturn quarter for the State shall be treated as eligible for such benefits for not less than 12 months after such date or (if later) the date that such individual so enrolls unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State.''.

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

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

(A) in subsection (f), in the matter preceding paragraph (1), by striking ''subsections (g) and (h)'' and inserting ''subsections (g), (h), and (j)''; and

(B) by adding at the end the following:

''(j) EXCLUSION FROM CAPS OF AMOUNTS ATTRIBUTABLE TO ECONOMIC DOWNTURN FMAP.—Any payment made to a territory for a fiscal year in which the Federal medical assistance percentage for the territory is determined under section 1905(ll) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) to the extent that such payment exceeds the amount of the payment that would have been made to the territory for the year if the Federal medical assistance percentage for the territory had been determined without regard to such section.''.

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

(A) in paragraph (2)(B), in the matter preceding clause (i), by striking ''paragraphs (5), (7), and (12)'' and inserting ''paragraphs (5), (7), (12), and (13)''; and

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

''(13) SPECIAL RULE FOR ADJUSTING ALLOTMENTS DURING FISCAL YEARS WITH ECONOMIC DOWNTURN QUARTERS.—

''(A) IN GENERAL.—If a fiscal quarter is determined under section 1905(ll) to be an economic downturn quarter with respect to a State then, as soon as practicable after such determination, the Secretary shall increase the allotment for the State and the fiscal year in which such fiscal quarter occurs in accordance with subparagraph (B).

''(B) AMOUNT OF INCREASE.—

''(i) IN GENERAL.—The amount of an increase to the allotment of a State described in subparagraph (A) for a fiscal year shall be equal to the amount by which Federal payments made to the State for the preceding fiscal year under this title would have been increased (without regard

to whether such payments would exceed the amount of the State's allotment for such preceding fiscal year) if the enhanced FMAP determined for the State for such preceding fiscal year had been increased to the same extent that the State's enhanced FMAP for the fiscal year involved is expected to be increased as a result of the application of section 1905(ll) relative to the enhanced FMAP that would apply to the State for the fiscal year involved without the application of such section.

''(ii) INCLUSION OF PROJECTED INCREASES.—In increasing the allotment of a State for a fiscal year under this paragraph, the Secretary may base the calculation of such increase on projections made by the Secretary with respect to—

''(I) the number of fiscal quarters during such fiscal year that will be economic downturn quarters; and

''(II) the effect that the application of section 1905(ll) is expected to have on the enhanced FMAP of the State for such fiscal year.

"(C) DISREGARD OF INCREASED PAYMENTS FOR PURPOSES OF FUTURE ALLOTMENTS.—Any Federal payment made to a State under this title for a fiscal year in which the Federal medical assistance percentage for the State is determined under section 1905(ll) shall be disregarded when determining the allotment of the State for any subsequent year, including for purposes of applying this paragraph, to the extent that such payment exceeds the amount of the payment that would have been made to the State for the year if the Federal medical assistance percentage for the State and year had been determined without regard to such section.".

TITLE IV—LOWERING DRUG COSTS

SEC. 401. EXPANDING MEDICARE DRUG PRICE NEGOTIATION.

(a) IN GENERAL.—Section 1192(a) of the Social Security Act (42 U.S.C. 1320f–1(a)) is amended—

(1) in paragraph (3), by striking "and" at the end;

(2) in paragraph (4)—

(A) by striking ''or a subsequent year''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(5) with respect to the initial price applicability year 2030, 30 negotiation-eligible drugs described in subparagraph (A) or (B) of subsection (d)(1) with respect to such year (or, all (if such number is less than 30) such negotiation-eligible drugs with respect to such year);

''(6) with respect to the initial price applicability year 2031, 40 negotiation-eligible drugs described in subparagraph (A) or (B) of subsection (d)(1) with respect to such year (or, all (if such number is less than 40) such negotiation-eligible drugs with respect to such year); and

''(7) with respect to the initial price applicability year 2032 or a subsequent year, 50 negotiation-eligible drugs described in subparagraph (A) or (B) of subsection (d)(1).''.

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

(1) in subparagraph (A), by inserting ", or a participant, beneficiary, or enrollee who is enrolled under a group health plan or health insurance coverage offered in the group or individual market (as such terms are defined in section 2791 of the Public Health Service Act) with respect to which there is in effect an agreement with the Secretary under section 1197 with respect to such selected drug as so furnished or dispensed'' after ''such selected drug''; and

(2) in subparagraph (B), by inserting ", or a participant, beneficiary, or enrollee who is enrolled under a group health plan or health insurance coverage offered in the group or individual market (as such terms are defined in section 2791 of the Public Health Service Act) with respect to which there is in effect an agreement with the Secretary under section 1197 with respect to such selected drug as so furnished or administered'' after ''such selected drug''.

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

(1) in subparagraph (A), by striking ''and'' at the end;

(2) in subparagraph (B), by striking the period and inserting ''; and''; and

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

''(C) maximum fair price eligible individuals not described in subparagraph (A) or (B).''.

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

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

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

''SEC. 1197. VOLUNTARY PARTICIPATION BY OTHER HEALTH PLANS.

''(a) AGREEMENT TO PARTICIPATE UNDER PROGRAM.—

''(1) IN GENERAL.—Subject to paragraph (2), under the program under this part the Secretary shall be treated as having in effect an agreement with a group health plan or health insurance issuer offering group or individual health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), with respect to a

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

"(A) in the case such selected drug furnished or dispensed at a pharmacy or by mail order service if coverage is provided under such plan or coverage during such period for such selected drug as so furnished or dispensed; and

"(B) in the case such selected drug furnished or administered by a hospital, physician, or other provider of services or supplier if coverage is provided under such plan or coverage during such period for such selected drug as so furnished or administered.

"(2) OPTING OUT OF AGREEMENT.—The Secretary shall not be treated as having in effect an agreement under the program under this part with a group health plan or health insurance issuer offering group or individual health insurance coverage with respect to a price applicability period and a selected drug with respect to such period if such a plan or issuer affirmatively elects, through a process specified by the Secretary, not to participate under the program with respect to such period and drug.

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

respect to such period, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, as applicable, shall make public a list of each group health plan and each health insurance issuer offering group or individual health insurance coverage, with respect to which coverage is provided under such plan or coverage for such drug, that has elected under subsection (a) not to participate under the program with respect to such period and drug.''.

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

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

''SEC. 2799A–12. DRUG PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

''(a) IN GENERAL.—In the case of a group health plan or health insurance issuer offering group or individual health insurance coverage that is treated under section 1197 of the Social Security Act as having in effect an agreement with the Secretary under the Drug Price Negotiation Program under part E of title XI of such Act, with respect to a price applicability period (as defined in section 1191(b) of such Act) and a selected drug (as defined in section 1192(c) of such Act) with respect to such

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

"(1) the provisions of such part shall apply—

"(A) in the case the drug is furnished or dispensed at a pharmacy or by a mail order service, to such plan or coverage, and to the participants, beneficiaries, and enrollees enrolled under such plan or coverage, during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to participants, beneficiaries, and enrollees enrolled under such prescription drug plans and MA–PD plans during such period; and

"(B) in the case the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to such plan or coverage, and to the participants, beneficiaries, and enrollees enrolled under such plan or coverage, and to hospitals, physicians, and other providers of services and suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary, to participants, beneficiaries, and enrollees entitled to benefits under part A of title

XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

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

''(3) the Secretary shall apply the provisions of such part E to such plan, issuer, and coverage, such participants, beneficiaries, and enrollees so enrolled in such plans and coverage, and such hospitals, physicians, and other providers and suppliers participating in such plans and coverage.

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN DRUG PRICE NEGOTIATION PROGRAM.—A group health plan or a health insurance issuer offering group or individual health insurance coverage shall publicly disclose, in a manner and in accordance with a process specified by the Secretary, any election made under section

1197 of the Social Security Act by such plan or issuer to not participate in the Drug Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan or coverage before the beginning of the plan year for which such election was made.''.

(2) ERISA.—

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

''SEC. 727. DRUG PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

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

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

"(1) the provisions of such part shall apply, as applicable—

"(A) in the case the drug is furnished or dispensed at a pharmacy or by a mail order service, to such plan or coverage, and to the participants and beneficiaries enrolled under such plan or coverage, during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to participants and beneficiaries enrolled under such prescription drug plans and MA–PD plans during such period; and

"(B) in the case the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to the group health plan or coverage offered by an issuer, to the participants and beneficiaries enrolled under such plans or coverage, and to hospitals, physicians, and other providers of services and suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary of Health and

Human Services, to participants and beneficiaries entitled to benefits under part A of title XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

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

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

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN DRUG PRICE NEGOTIATION PROGRAM.—A group health plan or a health insurance issuer offering group health insurance coverage shall publicly disclose in a manner and in accordance with a process specified by the Secretary any election made under section 1197 of the Social

Security Act by the plan or issuer to not participate in the Drug Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan or coverage before the beginning of the plan year for which such election was made.''.

(B) APPLICATION TO RETIREE AND CERTAIN SMALL GROUP HEALTH PLANS.—Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''and 726'' and inserting ''726, and 727''.

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

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

(3) IRC.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 9827. DRUG PRICE NEGOTIATION PROGRAM AND APPLICATION OF MAXIMUM FAIR PRICES.

"(a) IN GENERAL.—In the case of a group health plan that is treated under section 1197 of the Social Security Act as having in effect an agreement with the Secretary of Health and Human Services under the Drug Price Negotiation Program under part E of title XI of such Act, with respect to a price applicability period (as defined in section 1191(b) of such Act) and a selected drug (as defined in section 1192(c) of such Act) with respect to such period for which coverage is provided under such plan—

"(1) the provisions of such part shall apply, as applicable—

"(A) if coverage of such selected drug is provided under such plan if the drug is furnished or dispensed at a pharmacy or by a mail order service, to the plan, and to the participants and beneficiaries enrolled under such plan during such period, with respect to such selected drug, in the same manner as such provisions apply to prescription drug plans and MA–PD plans, and to participants and beneficiaries enrolled under such prescription drug plans and MA–PD plans during such period; and

''(B) if coverage of such selected drug is provided under such plan if the drug is furnished or administered by a hospital, physician, or other provider of services or supplier, to the plan, to the participants and beneficiaries enrolled under such plan, and to hospitals, physicians, and other providers of services and suppliers during such period, with respect to such drug in the same manner as such provisions apply to the Secretary of Health and Human Services, to participants and beneficiaries entitled to benefits under part A of title XVIII or enrolled under part B of such title, and to hospitals, physicians, and other providers and suppliers participating under title XVIII during such period;

''(2) the plan shall apply any cost-sharing responsibilities under such plan, with respect to such selected drug, by substituting an amount not more than the maximum fair price negotiated under such part E of title XI for such drug in lieu of the drug price upon which the cost-sharing would have otherwise applied, and such cost-sharing responsibilities with respect to such selected drug may not exceed such maximum fair price; and

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

''(b) NOTIFICATION REGARDING NONPARTICIPATION IN DRUG PRICE NEGOTIATION PROGRAM.—A group health plan shall publicly disclose in a manner and in accordance with a process specified by the Secretary any election made under section 1197 of the Social Security Act by the plan to not participate in the Drug Price Negotiation Program under part E of title XI of such Act with respect to a selected drug (as defined in section 1192(c) of such Act) for which coverage is provided under such plan before the beginning of the plan year for which such election was made.''.

(B) APPLICATION TO RETIREE AND CERTAIN SMALL GROUP HEALTH PLANS.—Section 9831(a)(2) of the Internal Revenue Code of 1986 is amended by inserting ''or 9827'' after ''section 9826''.

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

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

SEC. 402. APPLICATION OF PRESCRIPTION DRUG INFLATION REBATES TO DRUGS FURNISHED IN THE COMMERCIAL MARKET.

(a) PART B DRUGS.—

(1) APPLICATION OF PRESCRIPTION DRUG INFLATION REBATES TO DRUGS FURNISHED IN THE COMMERCIAL MARKET.—Section 1847A(i) of the Social Security Act (42 U.S.C. 1395w–3a(i)) is amended—

(A) in paragraph (1)(A)(i), by striking ''units'' and inserting ''billing units'';

(B) in paragraph (2)(A), by striking ''for which payment is made under this part'' and inserting ''that would be payable under this part if such drug were furnished to an individual enrolled under this part''; and

(C) in paragraph (3)—

(i) in subparagraph (A)(i), by striking ''units'' and inserting ''billing units''; and

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

''(B) TOTAL NUMBER OF BILLING UNITS.—For purposes of subparagraph (A)(i), the total number of billing units with respect to a part B rebatable drug is determined as follows:

"(i) Determine the total number of units equal to—

"(I) the total number of units, as reported under subsection (c)(1)(B), for each National Drug Code of such drug during the calendar quarter that is 2 calendar quarters prior to the calendar quarter as described in subparagraph (A), minus

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

"(ii) Convert the units determined under clause (i) to billing units for the billing and payment code of such drug, using a methodology similar to the methodology used under this section, by dividing the units determined under clause (i) for each National Drug Code of such drug by the

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

''(iii) Compute the sum of the billing units for each National Drug Code of such drug in clause (ii).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to calendar quarters beginning after the date of the enactment of this Act.

(b) COVERED PART D DRUGS.—

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

(A) in subsection (b)—

(i) in paragraph (1)—

(I) in subparagraph (A)(i), by striking ''the total number of units'' and all that follows through the semicolon and inserting the following: ''the total number of units that are used to calculate the average manufacturer price of such dosage form and strength with respect to such part D

rebatable drug, as reported by the manufacturer of such drug under section 1927 for each month, with respect to such period;''; and

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

''(B) EXCLUDED UNITS.—For purposes of subparagraph (A)(i), the Secretary shall exclude from the total number of units for a dosage form and strength with respect to a part D rebatable drug, with respect to an applicable period, the following:

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

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

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

manufacturer provides a discount under the program under section 340B of the Public Health Service Act.''; and

(ii) in paragraph (6), by striking ''INFORMATION'' and all that follows through ''rebatable covered part D drug dispensed'' and inserting the following: ''AMP REPORTS.—The Secretary shall provide for a method and process under which, in the case of a manufacturer of a part D rebatable drug that submits revisions to information submitted under section 1927 by the manufacturer with respect to such drug''; and

(B) by striking subsection (d) and inserting the following:

''(d) INFORMATION.—For purposes of carrying out this section, the Secretary shall use information submitted by manufacturers under section 1927(b)(3) and information submitted by States under section 1927(b)(2)(A).''.

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

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

SEC. 403. ESTABLISHING AN OUT-OF-POCKET LIMIT ON EXPENDITURES FOR PRESCRIPTION DRUGS UNDER GROUP HEALTH PLANS AND GROUP AND INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) PHSA.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

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

''(e) SUNSET.—The preceding provisions of this section shall not apply with respect to plan years beginning on or after January 1, 2028.''; and

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

''SEC. 2799A–13. COMPREHENSIVE COVERAGE.

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

''(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—

''(A) any annual cost-sharing imposed under the plan or coverage (including any such cost-sharing so imposed with respect to prescription drugs) does not exceed the dollar amounts specified in paragraph (2); and

''(B) any annual cost-sharing imposed under the plan or coverage with respect to prescription drugs does not exceed the dollar amounts specified in paragraph (3).

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

''(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-

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

''(ii) for plan years beginning in 2029 or a subsequent year, the dollar amount in effect under this subparagraph for plan years beginning in 2027, increased by an amount equal to the product of that amount the premium adjustment percentage specified in 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.

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

''(3) LIMITATION ON PRESCRIPTION DRUG OUT-OF-POCKET COST-SHARING.—For purposes of paragraph (1)(B), the dollar amounts specified in this paragraph are the following:

''(A) With respect to self-only coverage—

''(i) for plan years beginning in 2028, $2,000; and

"(ii) for plan years beginning in 2029 or a subsequent year, the dollar amount in effect under this subparagraph for plan years beginning in 2028, increased by an amount equal to the product of that amount and the premium adjustment 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.

If the amount of any increase under subparagraph (A) is not a multiple of $50, such increase shall be 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 calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) ex-

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

''(5) COST-SHARING.—In this section:

''(A) IN GENERAL.—The term 'cost-sharing' includes—

''(i) deductibles, coinsurance, copayments, or similar charges; and

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

''(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.

''(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer

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

''(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act.''.

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 401, is further amended by adding at the end the following new section:

''SEC. 728. COMPREHENSIVE COVERAGE.

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

''(b) COST-SHARING LIMITATION.—

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

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

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

"(B) any annual cost-sharing imposed under the plan or coverage with respect to prescription drugs does not exceed the dollar amounts specified in paragraph (3).

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

"(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 percentage specified in paragraph (4) of such section for the calendar year; and

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

amount equal to the product of that amount the premium adjustment percentage specified in 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.

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

''(3) LIMITATION ON PRESCRIPTION DRUG OUT-OF-POCKET COST-SHARING.—For purposes of paragraph (1)(B), the dollar amounts specified in this paragraph are the following:

''(A) With respect to self-only coverage—

''(i) for plan years beginning in 2028, $2,000; and

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

centage 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.

If the amount of any increase under subparagraph (A) is not a multiple of $50, such increase shall be 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 calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2027 (as determined by the Secretary).

''(5) COST-SHARING.—In this section:

''(A) IN GENERAL.—The term 'cost-sharing' includes—

''(i) deductibles, coinsurance, copayments, or similar charges; and

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

"(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.

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

"(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act.".

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

"Sec. 728. Comprehensive coverage.".

(c) IRC.—

(1) IN GENERAL.—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 section:

"SEC. 9828. COMPREHENSIVE COVERAGE.

"(a) COST-SHARING LIMITATION.—

"(1) IN GENERAL.—A group health plan shall ensure that—

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

"(B) any annual cost-sharing imposed under the plan with respect to prescription drugs does not exceed the dollar amounts specified in paragraph (3).

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

the dollar amounts specified in this paragraph are the following:

''(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 percentage specified in paragraph (4) of such section for the calendar year; and

''(ii) for plan years beginning in 2029 or a subsequent year, the dollar amount in effect under this subparagraph for plan years beginning in 2028, increased by an amount equal to the product of that amount the premium adjustment percentage specified in 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.

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

''(3) LIMITATION ON PRESCRIPTION DRUG OUT-OF-POCKET COST-SHARING.—For purposes of paragraph (1)(B), the dollar amounts specified in this paragraph are the following:

''(A) With respect to self-only coverage—

''(i) for plan years beginning in 2028, $2,000; and

''(ii) for plan years beginning in 2029 or a subsequent year, the dollar amount in effect under this subparagraph for plan years beginning in 2028, increased by an amount equal to the product of that amount and the premium adjustment 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.

If the amount of any increase under subparagraph (A) is not a multiple of $50, such increase shall be 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 calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2026 (as determined by the Secretary).

''(5) COST-SHARING.—In this section:

''(A) IN GENERAL.—The term 'cost-sharing' includes—

''(i) deductibles, coinsurance, copayments, or similar charges; and

''(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential 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.

''(b) DENTAL ONLY.—This section shall not apply to a plan described in section 1311(d)(2)(B)(ii) of the Patient 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—

(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

(B) in subsection (e)(1)(B)(i)—

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

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

(ii) by inserting ''and except, with respect to plan years beginning on or after January 1, 2028, in the case of an individual who has incurred cost-sharing expenses with respect to prescription drugs in an amount equal to the annual limitation in effect under section 2799A–13(b)(1)(B) of such Act, for benefits consisting of prescription drugs'' after ''section 2713''; and

(2) in section 1402(c)(1)(A), by inserting ''(or, with respect to plan years beginning on or after January 1, 2028, the applicable out-of-pocket limit under section 2799A–13(b)(1)(A) of the Public Health Service Act)'' after ''section 1302(c)(1)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2028.

SEC. 404. REQUIREMENTS WITH RESPECT TO COST-SHARING FOR INSULIN PRODUCTS.

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

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

"SEC. 2799A–14. REQUIREMENTS WITH RESPECT TO COST-SHARING FOR CERTAIN INSULIN PRODUCTS.

"(a) IN GENERAL.—For plan years beginning on or after January 1, 2028, a group health plan or health insurance issuer offering group or individual health insurance coverage shall provide coverage of selected insulin products, and with respect to such products, shall not—

"(1) apply any deductible; or

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

"(A) $35; or

"(B) the amount equal to 25 percent of the negotiated price of the selected insulin product net of all price concessions received by or on behalf of the plan or coverage, including price concessions received by or on behalf of third-party entities providing services to the plan or coverage, such as pharmacy benefit management services.

"(b) DEFINITIONS.—In this section:

"(1) SELECTED INSULIN PRODUCTS.—The term 'selected insulin products' means at least one of each dosage form (such as vial, pump, or inhaler dosage

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

''(2) INSULIN DEFINED.—The term 'insulin' means insulin that is licensed under subsection (a) or (k) of section 351 and continues to be marketed under such section.

''(c) OUT-OF-NETWORK PROVIDERS.—Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for selected insulin products described in this section that are delivered by an out-of-network provider, or precludes a plan or issuer that has a network of providers from imposing higher cost-sharing than the levels specified in subsection (a) for selected insulin products described in this section that are delivered by an out-of-network provider.

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

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

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

(b) ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 403, is further amended by adding at the end the following new section:

''SEC. 729. REQUIREMENTS WITH RESPECT TO COST-SHARING FOR CERTAIN INSULIN PRODUCTS.

''(a) IN GENERAL.—For plan years beginning on or after January 1, 2028, a group health plan or health insurance issuer offering group health insurance coverage shall provide coverage of selected insulin products, and with respect to such products, shall not—

''(1) apply any deductible; or

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

''(A) $35; or

"(B) the amount equal to 25 percent of the negotiated price of the selected insulin product net of all price concessions received by or on behalf of the plan or coverage, including price concessions received by or on behalf of third-party entities providing services to the plan or coverage, such as pharmacy benefit management services.

"(b) DEFINITIONS.—In this section:

"(1) SELECTED INSULIN PRODUCTS.—The term 'selected insulin products' means at least one of each dosage form (such as vial, pump, or inhaler dosage forms) of each different type (such as rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting, and premixed) of insulin (as defined below), when available, as selected by the group health plan or health insurance issuer.

"(2) INSULIN DEFINED.—The term 'insulin' means insulin that is licensed under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262) and continues to be marketed under such section.

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

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

''(d) RULE OF CONSTRUCTION.—Subsection (a) shall not be construed to require coverage of, or prevent a group health plan or health insurance coverage from imposing cost-sharing other than the levels specified in subsection (a) on, insulin products that are not selected insulin products, to the extent that such coverage is not otherwise required and such cost-sharing is otherwise permitted under Federal and applicable State law.

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

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 728 (as inserted by section 403) the following new item:

''Sec. 729. Requirements with respect to cost-sharing for certain insulin products.''.

(c) IRC.—

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

"SEC. 9829. REQUIREMENTS WITH RESPECT TO COST-SHARING FOR CERTAIN INSULIN PRODUCTS.

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

"(1) apply any deductible; or

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

"(A) $35; or

"(B) the amount equal to 25 percent of the negotiated price of the selected insulin product net of all price concessions received by or on behalf of the plan, including price concessions received by or on behalf of third-party entities providing services to the plan, such as pharmacy benefit management services.

"(b) DEFINITIONS.—In this section:

"(1) SELECTED INSULIN PRODUCTS.—The term 'selected insulin products' means at least one of each dosage form (such as vial, pump, or inhaler dosage

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

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

''(c) OUT-OF-NETWORK PROVIDERS.—Nothing in this section requires a plan that has a network of providers to provide benefits for selected insulin products described in this section that are delivered by an out-of-network provider, or precludes a plan that has a network of providers from imposing higher cost-sharing than the levels specified in subsection (a) for selected insulin products described in this section that are delivered by an out-of-network provider.

''(d) RULE OF CONSTRUCTION.—Subsection (a) shall not be construed to require coverage of, or prevent a group health plan from imposing cost-sharing other than the levels specified in subsection (a) on, insulin products that are not selected insulin products, to the extent that such coverage is not otherwise required and such cost-sharing is

otherwise permitted under Federal and applicable State law.

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

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 403, is further amended by adding at the end the following new item:

''Sec. 9829. Requirements with respect to cost-sharing for certain insulin products.''.

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

''(D) SPECIAL RULE RELATING TO INSULIN COVERAGE.—The exemption of coverage of selected insulin products (as defined in section 2799A–14(b) of the Public Health Service Act) from the application of any deductible pursuant to section 2799A–14(a)(1) of such Act, section 729(a)(1) of the Employee Retirement Income Security Act of 1974, or section 9829(a)(1) of

the Internal Revenue Code of 1986 shall not be considered when determining the actuarial value of a qualified health plan under this subsection.''.

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

''(4) COVERAGE OF CERTAIN INSULIN PRODUCTS.—

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

''(B) TERMINOLOGY.—For purposes of subparagraph (A)—

''(i) the term 'selected insulin products' has the meaning given such term in

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

''(ii) the requirements of section 2799A–14 of such Act shall be applied by deeming each reference in such section to 'individual health insurance coverage' to be a reference to a plan described in paragraph (1).''.

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

SEC. 501. REQUIRED EXCEPTIONS PROCESS FOR MEDICATION STEP THERAPY PROTOCOLS.

(a) REQUIRED EXCEPTIONS PROCESS FOR MEDICATION STEP THERAPY PROTOCOLS.—The Employee Retirement Income Security Act of 1974 is amended by inserting after section 713 of such Act (29 U.S.C. 1185b) the following new section:

''SEC. 713A. REQUIRED EXCEPTIONS PROCESS FOR MEDICATION STEP THERAPY PROTOCOLS.

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

"(1) implement a clear, prompt, and transparent process for a participant or beneficiary (or the prescribing health care provider (referred to in this section as the 'prescriber') on behalf of the participant or beneficiary) to request an exception to such medication step therapy protocol, pursuant to subsection (b); and

"(2) where the participant or beneficiary or prescriber's request for an exception to the medication step therapy protocols satisfies the criteria and requirements of subsection (b), cover the requested drug in accordance with the terms established by the plan or coverage for patient cost-sharing rates or amounts at the beginning of the plan year.

"(b) CIRCUMSTANCES FOR EXCEPTION APPROVAL.—The circumstances requiring an exception to a medication step therapy protocol, pursuant to a request under subsection (a), are any of the following:

"(1) Any treatments otherwise required under the protocol, or treatments in the same pharmacological class or having the same mechanism of action, including treatments provided prior to the effective date of the participant's or beneficiary's coverage under the plan or coverage, have been ineffective in the treatment of the disease or condition of

the participant or beneficiary, when prescribed consistent with clinical indications, clinical guidelines, or other peer-reviewed evidence, based on the prescribing health care professional's judgement or relevant information provided by the participant or beneficiary (including the medical records of the participant or beneficiary).

''(2) Delay of effective treatment would lead to severe or irreversible consequences, or worsen disease progression or a comorbidity and the treatment otherwise required under the protocol is reasonably expected by the prescriber to be ineffective based upon the documented physical or mental characteristics of the participant or beneficiary and the known characteristics of such treatment.

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

''(4) Any treatment otherwise required under the protocol has prevented, will prevent, or is likely to prevent a participant or beneficiary from achieving or maintaining reasonable and safe functional

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

''(5) The participant or beneficiary is stable for his or her disease or condition on the prescription drug or drugs selected by the prescriber and has previously received approval for coverage of the relevant drug or drugs for the disease or condition by any public or private health plan.

''(6) Other circumstances, as determined by the Secretary.

''(c) REQUIREMENT OF A CLEAR PROCESS.—

''(1) IN GENERAL.—The process required by subsection (a) shall—

''(A) provide the prescriber or participant or beneficiary an opportunity to present such prescriber's clinical rationale and relevant medical information for the group health plan or health insurance issuer to evaluate such request for exception;

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

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

"(C) provide both paper and electronic means for the submission of requests for additional information;

"(D) clearly set forth all required information and the specific criteria that will be used to determine whether an exception is warranted, which may require disclosure of—

"(i) the medical history or other health records of the participant or beneficiary demonstrating that the participant or beneficiary seeking an exception—

"(I) has tried other drugs included in the drug therapy class without success; or

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

"(ii) other clinical information that may be relevant to conducting the exception review;

"(E) not require the submission of any information or supporting documentation beyond what is strictly necessary (as determined by the Secretary) to determine whether a circumstance listed in subsection (b) exists;

"(F) clearly outline conditions under which an exception request warrants expedited resolution from the group health plan or health insurance issuer, pursuant to subsection (d)(2); and

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

"(2) AVAILABILITY OF PROCESS INFORMATION.—The group health plan or health insurance issuer shall make information regarding the process required under subsection (a) readily available in the relevant plan materials, including the summary of benefits and, if available, on the website of the group health plan or health insurance issuer. Such information shall include—

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

"(B) any forms, supporting information, and contact information, as appropriate.

"(d) TIMING FOR DETERMINATION OF EXCEPTION.—The process required under subsection (a)(1) shall provide for the disposition of requests received under such paragraph in accordance with the following:

"(1) Subject to paragraph (2), not later than 72 hours after receiving an initial exception request, the plan or issuer shall respond to the participant or beneficiary and, if applicable, the requesting prescriber with either a determination of exception eligibility or a request for additional required information strictly necessary to make a determination of whether the conditions specified in subsection (b) are met. The plan or issuer shall respond to the participant or beneficiary and, if applicable, the requesting prescriber, with a determination of exception eligibility no later than 72 hours after receipt of the additional required information.

"(2) In the case of a request under circumstances in which the applicable medication step therapy protocol may seriously jeopardize the life or health of the participant or beneficiary, may jeopardize the ability of the participant or beneficiary to regain maximum function, or may subject the partic-

ipant or beneficiary to severe pain that cannot be adequately managed without the treatment that is the subject of the request, the plan or issuer shall conduct a review of the request and respond to the participant or beneficiary and, if applicable, the requesting prescriber, with either a determination of exception eligibility or a request for additional required information strictly necessary to make a determination of whether the conditions specified in subsection (b) are met, in accordance with the following:

"(A) If the plan or issuer can make a determination of exception eligibility without additional information, such determination shall be made on an expedited basis, and no later than 24 hours after receipt of such request.

"(B) If the plan or issuer requires additional information before making a determination of exception eligibility, the plan or issuer shall respond to the participant or beneficiary and, if applicable, the requesting prescriber, with a request for such information within 24 hours of the request for a determination, and shall respond with a determination of exception eligibility as quickly as the condition or disease

requires, and no later than 24 hours after receipt of the additional required information.

''(e) DURATION OF A GRANT.—If an exception to a medication step therapy protocol is granted under this section to a participant or beneficiary, coverage for the requested drug shall remain in effect with respect to such participant or beneficiary for not less than one year.

''(f) MEDICATION STEP THERAPY PROTOCOL.—In this section, the term 'medication step therapy protocol' means a drug therapy utilization management protocol or program under which a group health plan or health insurance issuer offering group health insurance coverage of prescription drugs requires a participant or beneficiary to try an alternative preferred prescription drug or drugs before the plan or health insurance issuer approves coverage for the non-preferred drug therapy prescribed.

''(g) CLARIFICATION.—This section shall apply with respect to any group health plan or health insurance coverage offered in connection with such a plan that provides coverage of a prescription drug pursuant to a policy that meets the definition of the term 'medication step therapy protocol' in subsection (f), regardless of whether such policy is described by such group health plan or health insurance coverage as a step therapy protocol.

''(h) REPORTING.—

"(1) REPORTING TO THE SECRETARY.—Not later than 3 years after the date of enactment of the Health CARE Act of 2026, and not later than October 1 of each year thereafter, each group health plan and health insurance issuer offering group health insurance coverage shall report to the Secretary, in such manner as the Secretary shall require, the following:

"(A) The number of step therapy exception requests received for each exception circumstance described in paragraphs (1) through (6) of subsection (b), and the numbers of such requests for each such circumstance that were—

"(i) approved;

"(ii) denied, and the reasons for the denials;

"(iii) initially denied and appealed; and

"(iv) initially denied and then subsequently reversed by internal appeals or external reviews.

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

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

''(C) The number of exception requests submitted by participants or beneficiaries, and the number of exception requests submitted by prescribers, by medical specialty.

''(D) The medical conditions for which participants and beneficiaries were granted exceptions due to the likelihood that switching from a prescription drug will likely cause an adverse reaction by, or physical or mental harm to, the participant or beneficiary, as described in subsection (b)(3).

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

''(2) INFORMATION.—A group health plan or health insurance issuer offering group health insurance coverage shall not enter into a contract with a third-party administrator or an entity providing pharmacy benefit management services on behalf of the plan or coverage that prevents the plan or issuer from obtaining from the third-party administrator or the entity providing pharmacy benefit management services any information needed for the plan or

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

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

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

''Sec. 713A. Required exceptions process for medication step therapy protocols.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) applies with respect to plan years beginning with the first plan year that begins at least

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

(2) REGULATIONS.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Labor shall issue final regulations, through notice and comment rulemaking, to implement the provisions of section 713A of the Employee Retirement Income Security Act of 1974, as added by subsection (a).

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

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

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

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

''(A) beginning with plan years beginning on or after January 1, 2029—

"(i) establish the electronic prior authorization program described in paragraph (2); and

"(ii) meet the enrollee protection standards specified pursuant to paragraph (4); and

"(B) beginning with plan years beginning on or after January 1, 2028, meet the transparency requirements specified in paragraph (3).

"(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

"(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—

"(i) a prior authorization request from a provider or supplier to a Medicare Advantage plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider or supplier; and

''(ii) any supporting documentation relating to such request or response.

''(B) ELECTRONIC TRANSMISSION.—

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

''(ii) STANDARDS.—An electronic transmission described in subparagraph (A) shall comply with applicable technical standards and other requirements to promote the standardization and streamlining of electronic transactions adopted by the Secretary.

''(3) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the transparency requirements specified in this paragraph are, with respect to a Medicare Advantage plan, the following:

''(i) The plan, annually and in a manner specified by the Secretary, shall submit to the Secretary the following information:

''(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan during the previous plan year.

''(II) The percentage and number of specified requests (as defined in subparagraph (F)) approved during the previous plan year by the plan in an initial determination and the percentage and number of specified requests denied during such plan year by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(III) The percentage and number of specified requests that were denied during the previous plan year by the plan in an initial determination and that were subsequently appealed.

''(IV) The number of appeals of specified requests resolved during the preceding plan year, and the percentage and number of such resolved appeals that resulted in approval of the

furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

''(V) The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(VI) The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical

or other documentation required to be submitted by the plan.

''(VII) The percentage and number of specified requests that were excluded from the calculation described in subclause (VI) based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(VIII) Information on each occurrence during the previous plan year in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior authorization request, the provider or supplier furnishing such item or service determined that a different or additional item or service was medically necessary, including a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

''(IX) A disclosure and description of any technology described in subclause (V) that the plan utilized during the previous plan year in making determinations with respect to specified requests.

''(X) The number of grievances (as described in subsection (f)) received by such plan during the previous plan year that were related to a prior authorization requirement.

''(XI) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider or supplier who seeks to enter into a contract with such plan to furnish applicable items and services under such plan, the list described in clause (i)(I) and any policies or procedures used by the plan for making determinations with respect to prior authorization requests;

''(II) to each such provider and supplier that enters into such a con-

tract, access to the criteria used by the plan for making such determinations and an itemization of the medical or other documentation required to be submitted by a provider or supplier with respect to such a request; and

''(III) to an enrollee of the plan, upon request, access to the criteria used by the plan for making determinations with respect to prior authorization requests for an item or service.

''(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of the information described in subparagraph (A)(i) provided to the Secretary during a plan year, a Medicare Advantage plan may elect to include information regarding the percentage and number of specified requests made with respect to an individual and an item or service that were denied by the plan during the preceding plan year in an initial determination based on such requests failing to demonstrate that such individuals met the clinical criteria

established by such plan to receive such items or services.

''(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, establish requirements for Medicare Advantage plans regarding the provision of—

''(i) access to criteria described in subparagraph (A)(ii)(II) to providers of services and suppliers in accordance with such subparagraph; and

''(ii) access to such criteria to enrollees in accordance with subparagraph (A)(ii)(III).

''(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information described in subparagraph (A)(i) and subparagraph (B) on a public website of the Centers for Medicare & Medicaid Services. Such information shall be so published on an individual plan level and may in addition be aggregated in such manner as determined appropriate by the Secretary.

''(E) MEDPAC REPORT.—Not later than 3 years after the date information is first submitted under subparagraph (A)(i), the Medicare

Payment Advisory Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency of appeals and overturned decisions. The Commission shall provide recommendations, as appropriate, on any improvement that should be made to the electronic prior authorization programs of Medicare Advantage plans.

''(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term 'specified request' means a prior authorization request made with respect to an applicable item or service.

''(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(A)(ii), with respect to the use of prior authorization by Medicare Advantage plans for applicable items and services, the enrollee protection standards specified in this paragraph are—

''(A) the adoption of transparent prior authorization programs developed in consultation with enrollees and with providers and suppliers with contracts in effect with such plans for fur-

nishing such items and services under such plans;

''(B) allowing for the waiver or modification of prior authorization requirements based on the performance of such providers and suppliers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

''(C) conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from enrollees and from providers and suppliers with such contracts in effect and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

''(5) APPLICABLE ITEM OR SERVICE DEFINED.—For purposes of this subsection, the term 'applicable item or service' means, with respect to a Medicare Advantage plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) REPORTS TO CONGRESS.—

"(A) GAO.—Not later than January 1, 2033, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by Medicare Advantage plans.

"(B) HHS.—

"(i) THE SECRETARY.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and biennially thereafter through the date that is 10 years after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

"(I) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

"(II) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.

"(ii) CMS.—Not later than January 1, 2029, the Centers for Medicare & Medicaid Services and the Office of National Coordinator for Health Information Technology shall submit to Congress and publish on the internet website of the Centers for Medicare & Medicaid Services a report that—

"(I) defines the term 'real-time decision' and details how the definition for such term may be updated based on any technological advances;

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

"(III) includes an analysis of—

"(aa) items and services that are routinely approved;

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

''(cc) whether establishing real-time decisions for such items and services could—

''(AA) improve enrollee access to benefits under this part;

''(BB) produce operational efficiencies for providers and suppliers and Medicare Advantage plans; and

''(CC) reduce health disparities for Medicare Advantage enrollees in rural and low-income communities; and

''(dd) how determinations of routinely approved items and services made solely through automation and artificial intelligence by Medicare Advantage plans impact patient access, including disparities in access for rural and low-income beneficiaries.''.

(b) PROVIDING THE SECRETARY AUTHORITY TO ENFORCE TIMELY RESPONSES FOR ALL PRIOR AUTHORIZATION REQUESTS SUBMITTED UNDER PART C.—Section 1852(g) of the Social Security Act (42 U.S.C. 1395w–22(g)) is amended—

(1) in paragraph (1)(A), by inserting ''and in accordance with any timeframe established by the Secretary under paragraph (6)'' after ''paragraph (3)'';

(2) in paragraph (3)(B)(iii), by inserting ''(with respect to prior authorization requests submitted on or after the first day of the third plan year beginning after the date of the enactment of the Health CARE Act of 2026, any timeframe established by the Secretary under paragraph (6))'' after ''72 hours''; and

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

''(6) TIMEFRAME FOR RESPONSE TO PRIOR AUTHORIZATION REQUESTS.—Subject to paragraph (3), the Secretary may establish, for purposes of an organization determination made with respect to a prior authorization request for an item or service to be furnished to an individual, timeframes, such as 24 hours, for the organization to notify the enrollee

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

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

"(B) a real time decision for routinely approved items and services; and

"(C) any other prior authorization request.".

SEC. 503. SPECIAL ENROLLMENT PERIOD FOR PROVIDER TERMINATIONS.

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

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C) the following new subparagraph:

"(D) the individual demonstrates or the Secretary or organization determines that the individual is assigned to, currently receiving care from, or has received care in the previous 3 months from, a provider of services or supplier that is terminated from the provider network of the plan;".

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

(a) PROVISION OF AUDIOLOGY SERVICES BY QUALIFIED AUDIOLOGISTS AND QUALIFIED HEARING AID PROFESSIONALS.—

(1) IN GENERAL.—Section 1861(ll) of the Social Security Act (42 U.S.C. 1395x(ll)) is amended—

(A) in paragraph (3)—

(i) by inserting ''(and, beginning January 1, 2028, such aural rehabilitation and treatment services)'' after ''assessment services'';

(ii) by inserting '', and, beginning on January 1, 2028, such hearing assessment services furnished by a qualified hearing aid professional,'' after ''by a qualified audiologist''; and

(iii) by striking ''the audiologist'' and inserting ''the audiologist or qualified hearing aid professional''; and

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

''(C) The term 'qualified hearing aid professional' means, with respect to hearing assessment

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

"(i) is licensed or registered as a hearing aid dispenser, hearing aid specialist, hearing instrument dispenser, or related professional by the State in which the individual furnishes such services; and

"(ii) meets such other requirements as the Secretary determines appropriate (including requirements relating to educational certifications or accreditations), taking into account any additional requirements for hearing aid specialists, hearing aid dispensers, and hearing instrument dispensers established by Medicare Advantage organizations under part C, State plans (or waivers of such plans) under title XIX, and the group health plans and health insurance issuers (as such terms are defined in section 2791 of the Public Health Service Act).".

(2) PAYMENT FOR QUALIFIED HEARING AID PROFESSIONALS.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before "(HH)"; and

(B) by inserting before the semicolon at the end the following: "and (II) with respect to

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

(b) COVERAGE OF HEARING AIDS.—

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

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

''(6) PAYMENT ONLY ON AN ASSIGNMENT-RELATED BASIS.—Payment for hearing aids for which payment may be made under this part may be made

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

''(7) LIMITATIONS FOR HEARING AIDS.—Payment may be made under this part with respect to an individual, with respect to hearing aids furnished on or after January 1, 2028—

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

''(B) only for types of such hearing aids that are determined appropriate by the Secretary; and

''(C) only if furnished pursuant to a written order of a physician, qualified audiologist (as defined in section 1861(ll)(4)), qualified hearing aid professional (as so defined), physician assistant, nurse practitioner, or clinical nurse specialist.''.

(3) APPLICATION OF COMPETITIVE ACQUISITION.—

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

(i) in the header, by inserting ''AND HEARING AIDS'' after ''ORTHOTICS'';

(ii) in the matter preceding clause (i), by inserting '', or of hearing aids described in paragraph (2)(E) of such section,'' after ''2011,''; and

(iii) in clause (i), by inserting ''or such hearing aids'' after ''such orthotics''.

(B) CONFORMING AMENDMENT.—

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

''(E) HEARING AIDS.—Hearing aids described in section 1861(s)(8) for which payment would otherwise be made under section 1834(h).''.

(ii) EXEMPTION OF CERTAIN ITEMS FROM COMPETITIVE ACQUISITION.—Section 1847(a)(7) of the Social Security Act (42 U.S.C. 1395w–3(a)(7)) is amended by adding at the end the following new subparagraph:

''(C) CERTAIN HEARING AIDS.—Those items and services described in paragraph

(2)(E) if furnished by a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service.''.

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

''(ix) Beginning on January 1, 2028, a qualified audiologist (as defined in section 1861(ll)(4)(B)).

''(x) A qualified hearing aid professional (as defined in section 1861(ll)(4)(C)).''.

(c) EXCLUSION MODIFICATION.—Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by inserting ''(except such hearing aids or examinations therefor as described in and otherwise allowed under section 1861(s)(8))'' after ''hearing aids or examinations therefor''.

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

(1) in clause (ii), by striking ''or'';

(2) in clause (iii), by striking the period and inserting '', or''; and

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

''(iv) consisting of audiology services described in subsection (ll)(3) of section 1861, or hearing aids described in subsection (s)(8) of such section, that are payable under part B as a result of the amendments made by the Health CARE Act of 2026.''.

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

(1) CLARIFYING COVERAGE OF AUDIOLOGY SERVICES AS PHYSICIANS' SERVICES.—Section 1861(aa)(1)(A) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(A)) is amended by inserting ''(including audiology services (as defined in subsection (ll)(3)))'' after ''physicians' services''.

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

RHC AND FQHC PRACTITIONERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by inserting ''or by a qualified audiologist or a qualified hearing aid professional (as such terms are defined in subsection (ll)),'' after ''(as defined in subsection (hh)(1)),''.

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

(A) AIR.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(i) in subsection (a)(3)(A), by inserting ''(which shall, in the case of audiology services (as defined in section 1861(ll)(3)), in lieu of any limits on reasonable charges otherwise applicable, be based on the rates payable for such services under the payment basis determined under section 1848 until such time as the Secretary determines sufficient data has been collected to otherwise apply such limits (or January 1, 2034, if no such determination has been made as of such date))'' after ''may prescribe in regulations''; and

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

''(ee) DISREGARD OF COSTS ATTRIBUTABLE TO CERTAIN SERVICES FROM CALCULATION OF RHC AIR.—Payments for rural health clinic services other than audiology services (as defined in section 1861(ll)(3)) under the methodology for all-inclusive rates (established by the Secretary) under subsection (a)(3) shall not take into account the costs of such services while rates for such services are based on rates payable for such services under the payment basis established under section 1848.''.

(B) PPS.—Section 1834(o) of the Social Security Act (42 U.S.C. 1395m(o)) is amended by adding at the end the following new paragraph:

''(6) TEMPORARY PAYMENT RATES BASED ON PFS FOR CERTAIN SERVICES.—The Secretary shall, in establishing payment rates for audiology services (as defined in section 1861(ll)(3)) that are Federally qualified health center services under the prospective payment system established under this subsection, in lieu of the rates otherwise applicable under such system, base such rates on rates payable for such services under the payment basis established under section 1848 until such time as the Secretary deter-

mines sufficient data has been collected to otherwise establish rates for such services under such system (or January 1, 2034, if no such determination has been made as of such date). Payments for Federally qualified health center services other than such audiology services under such system shall not take into account the costs of such services while rates for such services are based on rates payable for such services under the payment basis established under section 1848.''.

(f) IMPLEMENTATION.—

(1) IN GENERAL.—In addition to amounts otherwise available, there is appropriated to the Secretary of Health and Human Services for fiscal year 2027, out of any money in the Treasury not otherwise appropriated, $370,000,000, to remain available until expended, for purposes of implementing the amendments made by this section during the period beginning on January 1, 2027, and ending on September 30, 2036.

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

TITLE VI—LOWERING THE COST OF CARE

SEC. 601. STRENGTHENING HOSPITAL PRICE TRANSPARENCY.

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

"SEC. 2718A. PROVIDER PRICE TRANSPARENCY.

''(a) DEFINITIONS.—In this section:

''(1) APPLICABLE IMAGING SERVICE PROVIDER.—The term 'applicable imaging provider' means a provider of services or supplier who furnishes any imaging services to patients, including an independent diagnostic testing facility, an outpatient diagnostic facility, and any other imaging center designated by the Secretary, except that such term does not include an imaging service provider with respect to which standard charges for specified imaging service provider services furnished by such service provider are made available by a hospital pursuant to subsection (b) or specified ambulatory surgical center pursuant to subsection (e).

''(2) APPLICABLE LABORATORY.—The term 'applicable laboratory' means a 'laboratory' as such term is defined in section 493.2, of title 42, Code of

Federal Regulations (or a successor regulation), except that such term does not include a laboratory with respect to which standard charges for specified clinical diagnostic laboratory tests furnished by such laboratory are made available by a hospital pursuant to subsection (b) or specified ambulatory surgical center pursuant to subsection (e).

''(3) DISCOUNTED CASH PRICE.—

''(A) IN GENERAL.—The term 'discounted cash price' means the minimum charge expressed as a dollar amount, subject to subparagraph (B), that the applicable service provider subject to this section accepts from an individual who pays cash, or cash equivalent, for a furnished item or service, without regard to health insurance coverage, as payment in full.

''(B) EXCLUSIONS.—For purposes of subparagraph (A), the minimum charge described in such subparagraph, with respect to a furnished item or service, as applicable, shall be calculated without taking into account any financial assistance, including assistance attributable to charity care (in the case of a hospital, as such term is used for purposes of hospital cost reporting under title XVIII of the Social

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

''(4) EXTRAORDINARY COLLECTION ACTIONS.—The term 'extraordinary collection action' has the meaning given such term for purposes of section 501(r) of the Internal Revenue Code of 1986.

''(5) GROSS CHARGE.—The term 'gross charge' means the charge for an individual item or service that is reflected on a hospital's chargemaster or similar list of prices facilitated by any other provider, as defined by the Secretary, absent any discounts.

''(6) HOSPITAL.—The term 'hospital' means an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this paragraph, the term 'State' includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(7) PAYER-SPECIFIC NEGOTIATED CHARGE.—The term 'payer-specific negotiated charge' means

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

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

''(9) SPECIFIED AMBULATORY SURGICAL CENTER.—The term 'specified ambulatory surgical center' means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission, except that such term does not include a surgical center with respect to which standard charges for specified ambulatory surgical center services furnished by such surgical center are made available by a hospital pursuant to subsection (b).

''(10) SPECIFIED CLINICAL DIAGNOSTIC LABORATORY TEST.—The term 'specified clinical diagnostic laboratory test' means any clinical diagnostic

laboratory test or service that is provided by the applicable laboratory, excluding advanced diagnostic laboratory tests (as defined in section 1834A(d)(5) of the Social Security Act).

''(11) SPECIFIED IMAGING SERVICE.—The term 'specified imaging service' has the meaning given to the term 'radiology and certain other imaging services' for purposes of section 411.351 of title 42, Code of Federal Regulations (or successor regulations).

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

''(b) HOSPITAL PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, each hospital shall, in accordance with a method and format established by the Secretary under paragraph (3), on a quarterly basis (if there have been any changes to the standard charges described in subparagraph (2) compile and make publicly available on an internet website (without subscription and free of charge)—

"(A) all of the hospital's standard charges for each item and service furnished by such hospital in a machine-readable format (or a successor technology specified by the Secretary);

"(B) all of the hospital's standard charges in a consumer-friendly format (as specified by the Secretary), that includes—

"(i) as many of the Centers for Medicare & Medicaid Services-specified shoppable services that are furnished by the hospital, and as many additional hospital-selected shoppable services (or all such additional services, if such hospital furnishes fewer than 300 shoppable services) as may be necessary for a combined total of at least 300 shoppable services through the January 1 described in this subparagraph, after which the hospital shall include all shoppable services that the hospital furnishes; and

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

the hospital, an indication that such service is not so furnished; and

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

''(i) has an ownership or investment interest;

''(ii) has a controlling interest;

''(iii) is a management services organization; or

''(iv) is a significant equity investor.

''(2) STANDARD CHARGES DEFINED.—For purposes of paragraph (1), the term 'standard charges' means the following:

''(A) A plain language description of each item and service, accompanied by any applicable billing codes, including modifiers, using commonly recognized billing code sets, including—

''(i) the Diagnosis Related Group;

''(ii) the Healthcare Common Procedure Coding System code;

''(iii) the National Drug Code; and

''(iv) other applicable identifiers as determined by the Secretary (or successor code sets).

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

"(C) The discounted cash price.

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

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

"(F) The amount of any facility fee, as defined by the Secretary, or add-on charges that will be part of the final payment amount, in ad-

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

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

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

''(A) include a machine-readable format (or successor technology specified by the Secretary) containing the information described in

paragraph (2) for all items and services furnished by each hospital;

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

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

"(4) NO DEEMED COMPLIANCE.—Hospitals may offer a price estimator tool, but the availability of such a price estimator tool shall not be considered to deem compliance with or otherwise vitiate the requirements of paragraph (1)(B) or any other requirements of this subsection.

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

"(6) ATTESTATION.—A senior official from each hospital (the Chief Executive Officer, Chief Financial Officer, or an official of equivalent seniority)

shall attest to the accuracy and completeness of the disclosures, and any other attestations as required by the Secretary, made in accordance with the hospital price transparency requirements based on criteria established by the Secretary.

''(7) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a hospital that fails to comply with the requirements of this subsection, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall notify such hospital of such determination, which shall include a request for a corrective action plan if applicable to comply with such requirements.

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—In addition to any other enforcement actions or penalties that may apply under another provision of law, a hospital that has received a request for a corrective action plan under subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 90 days after such request is made shall be subject to a civil monetary penalty of an amount specified by the Secretary for

each day (beginning on the day the hospital was first out of compliance, as determined by the Secretary) during which such failure was ongoing. Such amount shall not exceed—

"(I) in the case of a specified hospital with 30 or fewer beds, $300 per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $400 per day);

"(II) in the case of a specified hospital with more than 30 beds but fewer than 101 beds, $12.50 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $15 per bed per day);

"(III) in the case of a specified hospital with more than 100 beds but fewer than 201 beds, $17.50 per bed

per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $20 per bed per day);

''(IV) in the case of a specified hospital with more than 200 beds but fewer than 501 beds, $20 per bed per day (or, in the case of such a hospital that has been noncompliant with such requirements for a 1-year period or longer, beginning with the first day following such 1-year period, $25 per bed per day); and

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

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to

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

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

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

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

"(iii) PERSISTENT NONCOMPLIANCE.—

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

otherwise applicable under this subparagraph by the amount specified in subclause (II) with respect to such hospital and may require such hospital to complete such additional corrective actions plans as the Secretary may specify.

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

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

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

''(cc) with more than 300 beds but fewer than 501 beds, an amount that is greater than

$2,000,000 and not more than $4,000,000; and

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

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

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

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

to comply with the requirements of this subsection except where the Secretary determines that imposing the maximum civil monetary penalty, including penalties for persistent noncompliance, will disrupt hospital operations in a manner that impacts patient care. The Secretary may request documentation in such form and manner as the Secretary may require in order to evaluate impact on hospital operations.

''(D) PROHIBITION ON EXTRAORDINARY COLLECTION.—In addition to civil monetary penalties applicable under subparagraph (B) and any other enforcement actions or penalties that may apply under any other provision of law, for a hospital that has received a request for a corrective action plan under subparagraph (A) and fails to comply with the requirements of this subsection by the date that is 90 days after such request, that hospital or any other person or entity collecting on behalf of the hospital shall—

''(i) not take any extraordinary collection actions against any patient or patient guarantor for debt incurred by any patient on the date or dates of service when the

hospital was not in compliance with the requirements of this subsection;

"(ii) cease any extraordinary collection actions that have begun against any patient or patient guarantor for debt incurred by any patient on the date or dates of service when the hospital was not in compliance with the requirements of this subsection; and

"(iii) not take any extraordinary collection actions against any patient or patient guarantor for debt incurred by any patient on the date or dates of service when the hospital was not in compliance with the requirements of this subsection after the hospital comes back into compliance with the requirements of this subsection.

"(8) 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.

"(B) OWNERSHIP INFORMATION.—In promulgating regulations under this paragraph, the

Secretary shall define the individuals and organizations that must be disclosed under paragraph (1)(C) in a manner that harmonizes disclosure requirements with requirements established under section 1124 of the Social Security Act and prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a hospital impacts operational, financial, or clinical decision making for such hospital.''.

SEC. 602. CLINICAL DIAGNOSTIC LABORATORY PRICE TRANSPARENCY.

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

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

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

''(A) the standard charges described in paragraph (2) with respect to each specified clinical diagnostic laboratory test that such laboratory so furnishes; and

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

''(i) has an ownership or investment interest;

''(ii) has a controlling interest;

''(iii) is a management services organization; or

''(iv) is a significant equity investor.

''(2) STANDARD CHARGES DEFINED.—For purposes of paragraph (1), the term 'standard charges' means, with respect to an applicable laboratory and a specified clinical diagnostic laboratory test, the following:

''(A) A plain language description of each item or service, accompanied by any applicable billing codes (including modifiers that materially change the price for insurers or providers, and that materially change out-of-pocket costs for consumers) using commonly recognized billing code sets, including—

"(i) the Healthcare Common Procedure Coding System code;

"(ii) the National Drug Code; or

"(iii) other applicable identifier as determined by the Secretary (or successor code sets).

"(B) The gross charge expressed as a dollar amount, for each such test.

"(C) The discounted cash price.

"(D) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third-party payer and name of each plan, that apply to each such test. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the applicable laboratory also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other information necessary to determine the negotiated charge as a dollar amount.

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

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

''(3) UNIFORM METHOD AND FORMAT.—The Secretary shall establish a standard, uniform method and format for applicable laboratories to use in compiling and making public information pursuant to paragraph (1). Such method and format shall—

''(A) include a machine-readable format (or a successor technology specified by the Secretary) containing the information described in paragraph (2) for all specified clinical diagnostic laboratory tests furnished by each laboratory and the ownership information described in paragraph (1)(B);

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

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

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

"(5) INCLUSION OF ANCILLARY SERVICES.—Any charge for a specified clinical diagnostic laboratory test furnished by an applicable laboratory made publicly available in accordance with paragraph (1) shall include the charge for any ancillary item or service (such as specimen collection services, specimen transport, centrifugation, aliquoting, labeling, requisition processing, and standard result reporting services) that would customarily and routinely be

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

''(6) ATTESTATION.—A senior official from each clinical diagnostic laboratory (the Chief Executive Officer, Chief Financial Officer, or an official of equivalent seniority) shall attest to the accuracy and completeness of the disclosures, and any other attestations as required by the Secretary, made in accordance with the clinical laboratory price transparency requirements based on criteria established by the Secretary.

''(7) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of an applicable laboratory that fails to comply with the requirements of this subsection—

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

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

''(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—An applicable laboratory that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of an applicable laboratory that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such laboratory was not complying with such requirements) during which such failure is ongoing (not to exceed $300 per day).

"(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to an applicable laboratory that fails to comply with the requirements of this subsection in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on

the per day amount of any penalty applicable to an applicable laboratory under clause (i).

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

''(iv) NO AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for failing to comply with the requirements of this subsection except where the Secretary determines that imposing the maximum civil monetary penalty will disrupt applicable laboratory operations in a manner that impacts patient care. The Secretary may request documentation in such form and manner as the Secretary

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

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

''(9) 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.

''(B) OWNERSHIP INFORMATION.—In promulgating regulations under this paragraph, the Secretary shall define the individuals and organizations that must be disclosed under paragraph (1)(B) in a manner that harmonizes disclosure requirements with requirements established under section 1124 of the Social Security Act and prioritizes the disclosure of individuals and organizations whose ownership or management relationship with a laboratory impacts operational, financial, or clinical decision making for such laboratory.''.

SEC. 603. IMAGING SERVICES PRICE TRANSPARENCY.

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

''(d) IMAGING SERVICES PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, each applicable imaging service provider shall, on a quarterly basis (if there have been any changes to the standard charges described in paragraph (2)) compile and make publicly available on an internet website (without subscription and free of charge)—

''(A) the standard charges described in paragraph (2) with respect to each such specified imaging service provided by such provider; and

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

''(i) has an ownership or investment interest;

''(ii) has a controlling interest;

''(iii) is a management services organization; or

''(iv) is a significant equity investor.

''(2) STANDARD CHARGES DEFINED.—For purposes of paragraph (1), the term 'standard charges', with respect to an applicable imaging service provider and a specified imaging service, means the following:

''(A) A plain language description of each item or service, accompanied by any applicable billing codes (including modifiers that materially change the price for insurers or providers, and that materially change out-of-pocket costs for consumers) using commonly recognized billing code sets, including—

''(i) the Healthcare Common Procedure Coding System code;

''(ii) the National Drug Code; or

''(iii) other applicable identifier as determined by the Secretary (or successor code sets).

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

''(C) The discounted cash price.

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

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

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

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

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

''(A) include a machine-readable format (as specified by the Secretary) containing the information described in paragraph (2) for all specified imaging services furnished by each applicable imaging service provider and ownership information described in paragraph (1)(B);

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

''(C) be updated as determined appropriate by the Secretary, in consultation with stakeholders.

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

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

Executive Officer, Chief Financial Officer, or an official of equivalent seniority) shall attest to the accuracy and completeness of the disclosures, and any other attestations as required by the Secretary, made in accordance with the imaging service provider price transparency requirements based on criteria established by the Secretary.

''(6) ENFORCEMENT.—

''(A) IN GENERAL.—In the case of a specified imaging service provider that fails to comply with the requirements of this subsection—

''(i) the Secretary shall notify such imaging service provider of such failure not later than 30 days after the date on which the Secretary determines such failure exists; and

''(ii) upon request of the Secretary, such imaging service provider shall submit to the Secretary, not later than 45 days after the date of such request, a corrective action plan to comply with such requirements.

''(B) CIVIL MONETARY PENALTY.—

''(i) IN GENERAL.—A specified imaging service provider that has received a no-

tification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of a specified imaging service provider that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such imaging service provider was not complying with such requirements) during which such failure is ongoing (not to exceed $300 per day).

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to a specified imaging service provider that fails to comply with the requirements of this subsection in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applica-

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

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

''(iv) NO AUTHORITY TO WAIVE OR REDUCE PENALTY.—The Secretary shall not grant or extend any waiver, delay, tolling, or other mitigation of a civil monetary penalty for failing to comply with the requirements of this subsection except where the Secretary determines that imposing the maximum civil monetary penalty will disrupt specified imaging service provider operations in a manner that impacts patient care. The Secretary may request documentation in such form and manner as the Secretary may require in order to evaluate

impact on specified imaging service provider operations.

''(7) PROVISION OF TECHNICAL ASSISTANCE.—The Secretary shall, to the extent practicable, provide technical assistance relating to compliance with the provisions of this subsection to providers of services and suppliers requesting such assistance.

''(8) 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.

''(B) OWNERSHIP INFORMATION.—In promulgating regulations under this paragraph, the Secretary shall define the individuals and organizations that must be disclosed under paragraph (1)(B) in a manner that harmonizes disclosure requirements with requirements established under section 1124 of the Social Security Act and prioritizes the disclosure of individuals and organizations whose ownership or management relationship with an imaging service provider impacts operational, financial, or clinical decision making for such imaging service provider.''.

SEC. 604. AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.

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

''(e) AMBULATORY SURGICAL CENTER PRICE TRANSPARENCY.—

''(1) IN GENERAL.—Beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, each specified ambulatory surgical center shall, on a quarterly basis (if there have been any changes to the standard charges described in paragraph (2)), compile and make publicly available on an internet website (without subscription and free of charge)—

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

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

''(i) has an ownership or investment interest;

''(ii) has a controlling interest;

"(iii) is a management services organization; or

"(iv) is a significant equity investor.

"(2) STANDARD CHARGES DEFINED.—For purposes of paragraph (1), the term 'standard charges' with respect to standard charges and prices made public by a specified ambulatory surgical center means the following:

"(A) A plain language description of each item or service, accompanied by any applicable billing codes (including modifiers that materially change the price for insurers or providers, and that materially change out-of-pocket costs for consumers) using commonly recognized billing code sets, including—

"(i) the Healthcare Common Procedure Coding System code;

"(ii) the National Drug Code; or

"(iii) other applicable identifier as determined by the Secretary (or successor code sets).

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

"(C) The discounted cash price.

"(D) The payer-specific negotiated charges, expressed as a dollar amount and clearly associated with the name of the applicable third party payer and name of each plan, that apply to each such item or service. If the charges are based on an algorithm, percentage of another amount, or other formula or criteria, the ambulatory surgical center also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other information necessary to determine the negotiated charge as a dollar amount.

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

"(F) Any other additional information the Secretary may require for the purpose of improving the accuracy of, or enabling consumers to easily understand and compare, standard charges and prices for an item or service. In the case of standard charges for an item or service included as part of a bundled, per diem, episodic, or other similar arrangement, the information described in this subparagraph shall be

made available as determined appropriate by the Secretary.

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

''(A) include a machine-readable format (or a successor technology specified by the Secretary) containing the information described in paragraph (2) for all specified services furnished by each ambulatory surgical center and for the ownership information described in paragraph (1)(B);

''(B) meet such standards as determined appropriate by the Secretary in order to ensure the accessibility and usability of such charges; and

''(C) be updated as determined appropriate by the Secretary, in consultation with stakeholders.

''(4) MONITORING COMPLIANCE.—The Secretary shall, in consultation with the Inspector General of the Department of Health and Human Serv-

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

"(5) ATTESTATION.—A senior official from each specified ambulatory surgical center (the Chief Executive Officer, Chief Financial Officer, or an official of equivalent seniority) shall attest to the accuracy and completeness of the disclosures, and any other attestations as required by the Secretary, made in accordance with the ambulatory center price transparency requirements based on criteria established by the Secretary.

"(6) ENFORCEMENT.—

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

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

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

"(B) CIVIL MONETARY PENALTY.—

"(i) IN GENERAL.—A specified ambulatory surgical center that has received a notification under subparagraph (A)(i) and fails to comply with the requirements of this subsection by the date that is 90 days after such notification (or, in the case of a specified ambulatory surgical center that has submitted a corrective action plan described in subparagraph (A)(ii) in response to a request so described, by the date that is 90 days after such submission) shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which the Secretary first determined that such ambulatory surgical center was not complying with such requirements) during which such

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

''(ii) INCREASE AUTHORITY.—In applying this subparagraph with respect to a specified ambulatory surgical center that fails to comply with the requirements of this subsection in 2028 or a subsequent year, the Secretary may through notice and comment rulemaking increase the limitation on the per day amount of any penalty applicable to a specified ambulatory surgical center under clause (i).

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

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

penalty for failing to comply with the requirements of this subsection except where the Secretary determines that imposing the maximum civil monetary penalty will disrupt specified ambulatory surgical center operations in a manner that impacts patient care. The Secretary may request documentation in such form and manner as the Secretary may require in order to evaluate impact on specified ambulatory surgical center operations.

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

''(8) 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.

''(B) OWNERSHIP INFORMATION.—In promulgating regulations under this paragraph, the Secretary shall define the individuals and organizations that must be disclosed under para-

graph (1)(B) in a manner that harmonizes disclosure requirements with requirements established under section 1124 of the Social Security Act and prioritizes the disclosure of individuals and organizations whose ownership or management relationship with an ambulatory surgical center impacts operational, financial, or clinical decision making for such ambulatory surgical center.

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

SEC. 605. STRENGTHENING HEALTH COVERAGE TRANSPARENCY REQUIREMENTS.

(a) TRANSPARENCY IN COVERAGE.—Section 2715A of the Public Health Service Act (42 U.S.C. 300gg–15a) is amended—

(1) by striking ''A Group health'' and inserting the following:

''(a) IN GENERAL.—A group health''; and

(2) by ending at the end the following:

"(b) ADDITIONAL TRANSPARENCY REQUIREMENTS.—

"(1) SPECIFIED INFORMATION REQUIRED.—

"(A) IN GENERAL.—A group health plan or health insurance issuer offering coverage in the individual or group market shall provide to each participant, beneficiary, or enrollee, at the time of enrollment in the plan or coverage, the information described in subparagraph (B).

"(B) INFORMATION REQUIRED.—For purposes of subparagraph (A), the information specified in this subparagraph is, with respect to benefits available under the plan or coverage for an item or service furnished by a health care provider, the following (or other information as determined appropriate by the Secretary):

"(i) If such provider is an in-network provider with respect to such item or service, the in-network rate (as defined in paragraph (5)) for such item or service.

"(ii) If such provider is not described in clause (i), the out-of-network allowed amount (as such term is defined for purposes of section 147.210(a)(2)(xvii) of title

45, Code of Federal Regulation) for such item or service that the plan or coverage will pay without regard to the amount in clause (iii).

''(iii) The amount of cost-sharing liability (including deductibles, copayments, and coinsurance) that the individual will incur for such item or service based on the information available to the plan or coverage at the time the request is made (which, in the case such item or service is to be furnished by a provider described in clause (ii), shall be calculated using the maximum amount described in such clause).

''(iv) The accumulated amounts with respect to any deductible or out-of-pocket maximum under the plan or coverage reflected in the plan's or coverage's records at the time the request is made (broken down, in the case separate deductibles or maximums apply to separate individuals enrolled in the plan or coverage, by such separate deductibles or maximums, in ad-

dition to any cumulative deductible or maximum).

''(v) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such individual has accrued towards such limitation with respect to such item or service reflected in the plan's or coverage's records at the time the request is made.

''(vi) Information about any utilization management requirements, such as prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or coverage, including information regarding utilization management practices and determinations, including aggregate information related to approval and denial rates, associated timelines, and appeals, as determined appropriate by the Secretary.

''(C) SELF-SERVICE TOOL .—For purposes of subparagraph (A), a self-service tool estab-

lished by a health plan meets the requirements of this subparagraph if such tool—

"(i) is based on an internet website;

"(ii) provides for real-time responses to requests described in such subparagraph;

"(iii) is updated in a manner such that the information is accurate based on the information available to the plan or coverage at the time the request is made;

"(iv) allows such a request to be made for information with respect to an item or service furnished by—

"(I) a specific provider that is an in-network provider with respect to such item or service; or

"(II) all providers that are in-network providers with respect to such plan or coverage and such item or service;

"(v) provides that such a request may be made for information with respect to an item or service through use of—

"(I) the billing code for such item or service; or

"(II) through use of a descriptive term for such item or service; and

"(vi) is made available in plain language, without subscription or other fee.

"(D) NONDUPLICATION.—A group health plan or health insurance issuers shall be deemed to be in compliance with this paragraph if such plan or issuer has a tool in place under section 2799A–4.

"(2) RATE AND PAYMENT INFORMATION.—

"(A) IN GENERAL.—Beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, and every quarter thereafter (if there have been any changes to the rate and payment information described in subparagraphs (B) and (C), each group health plan or health insurance issuer offering coverage in the group or individual market shall make available to the public, the rate and payment information described in subparagraph (B) in accordance with subparagraph (C).

"(B) RATE AND PAYMENT INFORMATION DESCRIBED.—For purposes of subparagraph (A), the rate and payment information de-

scribed in this subparagraph is, with respect to a plan or coverage, the following:

"(i) With respect to each item or service for which benefits are available under such plan or coverage, excluding those included in clause (ii), identified by CPT, HCPCS, DRG, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a plain language description of the item or service, the in-network rate (expressed as a dollar amount or percentage of charges, unless otherwise specified by the Secretary), including the individual and total amounts for any bundled rates, in effect as of the date of the submission of such information with each provider (identified by national provider identifier) that is an in-network provider with respect to such item or service, other than such a rate in effect with a provider that an issuer has determined based on factors determined by the Secretary (such as medical specialty) that it is unlikely that the pro-

vider would be reimbursed for the item or service.

''(ii) With respect to each drug and biologic (identified by National Drug Code, J-code, or other commonly recognized billing code used for drugs) for which benefits are available under such plan or coverage, the in-network rate (expressed as a dollar amount or percentage of charges, unless otherwise specified by the Secretary) in effect as of the first day of the quarter in which such information is made public with each pharmacy or other prescription drug dispenser that is an in-network pharmacy or other prescription drug dispenser with respect to such drug.

''(iii) With respect to each item or service for which benefits are available under such plan or coverage (expressed as a dollar amount), identified by CPT, DRG, HCPCS, or other applicable nationally recognized identifier, including any applicable code modifiers, and accompanied by a brief description of the item or service, the amount billed or charged by the provider,

and the amount allowed by the plan or coverage, for each such item or service furnished during a representative lookback window established by the Secretary by each provider that was an out-of-network provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which not fewer than 11 claims for such item or service were submitted to such plan during such period.

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

''(i) Information shall be contained in at least 3 separate machine-readable files corresponding to the information described in each of clauses (i) through (iii) of subparagraph (B) that meet such requirements as specified by the Secretary through rulemaking, in consultation with the Secretaries of Labor and the Treasury,

to apply comparable requirements to group health plans and health insurance coverage and to entities providing benefit management or other third-party administration services on a contractual basis with a group health plan or coverage.

''(ii) Requirements specified by the Secretary through rulemaking (or subregulatory guidance) shall ensure the following:

''(I) Such files are made available in a widely available format that allows for information contained in such files to be compared across plans and coverage and are freely accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

''(II) Each such file includes each of the following data elements:

''(aa) A numerical identifier for the group health plan or health insurance issuer (such as a Health Insurance Oversight System identifier).

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

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

"(dd) The place of service code.

"(ee) The National Provider Identifier and provider Tax Identification Number.

"(iii) The rate and payment information disclosed under clauses (i) through (iii) of subparagraph (B) shall be separately delineated for each item or service, regardless of whether such item or service is reimbursed as a part of a bundle, epi-

sode, or other grouping of items and services.

''(iv) An officer or executive of competent authority shall attest to the accuracy and completeness of information submitted and made available under this subparagraph. In the case of a plan or coverage that relies on a third-party administrator or other service provider to compile the information submitted and made available under this subparagraph, such plan or coverage may satisfy the requirement under this clause by obtaining such an attestation from the third-party administrator or other service provider. Such attestation shall be subject to enforcement under paragraph (6).

''(3) OWNERSHIP INFORMATION.—Beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, and every quarter thereafter (if there have been any changes in the required information), each group health plan or health insurance issuer offering coverage in the individual or group market shall submit to the Sec-

retary, the applicable State authority, and make available to the public, the name and business address of each person or entity that, with respect to such plan or coverage—

"(A) has an ownership or investment interest;

"(B) has a controlling interest;

"(C) is a management services organization; or

"(D) is a significant equity investor.

"(4) ENFORCEMENT.—

"(A) IN GENERAL.—Each year, the Secretary shall audit the machine-readable files required by paragraph (2)(B) posted by not fewer than 50 group health plans or health insurance issuers for compliance with format and accessibility standards.

"(B) NOTIFICATION AND REQUEST FOR CORRECTIVE ACTION.—In the case of a group health plan or health insurance issuer that fails to comply with the requirements of this paragraph, not later than 30 days after the date on which the Secretary determines such failure exists, the Secretary shall submit to such plan or issuer a notification of such determination,

which shall include a request for a corrective action plan to comply with such requirements.

''(C) CIVIL MONETARY PENALTY.—A plan or issuer that has received a request for a corrective action plan under subparagraph (B) and fails to comply with the requirements of this paragraph by the date that is 30 days after such request is made shall be subject to a civil monetary penalty of an amount specified by the Secretary for each day (beginning with the day on which such health plan or health insurance issuer was failing to comply with such paragraph) during which such failure was ongoing. Such amount shall not exceed $300 per participant, beneficiary, or covered individual per day or $10,000,000, whichever is lesser.

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

''(A) IN-NETWORK PROVIDER.—The term 'in-network provider' has the meaning given such term in section 54.9815-2715A1(a)(2)(xii) of title 26, Code of Federal Regulations.

''(B) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a health plan and an item or service furnished by a provider that is a participating provider with re-

spect to such plan and item or service, the contracted rate in effect between such plan and such provider for such item or service. If the rate is based on an algorithm, percentage of another amount, or other formula or criteria, the health plan also shall disclose such algorithm, percentage, formula, or criteria as set forth in its contract and any other terms, schedules, exhibits, data, or other information referenced in any such contract as shall be required to determine and disclose the negotiated rate.

''(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.

''(B) REGULATIONS.—Regulations promulgated pursuant to this subsection shall provide the following:

''(i) The Secretary shall annually audit the machine-readable files required by paragraph (2)(B) posted by not fewer

than 50 group health plans or health insurance issuers for compliance with format and accessibility standards.

''(ii) The Secretary of Labor shall annually audit the machine-readable files required by paragraph (2)(B) posted by not fewer than 250 group health plans or service providers furnishing third-party administrator services to a group health plan for compliance with format and accessibility standards.

''(iii) The Secretary of Health and Human Services, in conjunction with the Secretary of Labor and the Secretary of the Treasury, shall annually issue a report to Congress that includes findings, conclusions, and enforcement actions taken based on audits of the machine-readable files. Such report shall be provided no later than July 1 following the calendar year during which the audits were completed. The Secretary of Health and Human Services shall make such report to Congress accessible to the public.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply beginning January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026.

(2) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by this section may be construed as affecting the applicability of the rule entitled ''Transparency in Coverage'' published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158), or amendments made to such rule that are applicable before the date of enactment of the Health CARE Act of 2026.

SEC. 606. INCREASING GROUP HEALTH PLAN ACCESS TO HEALTH DATA.

(a) GROUP HEALTH PLAN ACCESS TO INFORMATION.—

(1) IN GENERAL.—Section 2799A–9 of the Public Health Service Act (42 U.S.C. 300gg–119) is amended by adding at the end the following:

''(1) GROUP HEALTH PLAN ACCESS TO INFORMATION.—

"(A) IN GENERAL.—No contract or arrangement for services, and no extension or renewal of such contract or arrangement, between a group health plan that is offered by a specified large employer or that is a specified large plan (as such terms are defined in subparagraph (F)) and a health care provider (which for purposes of this subparagraph, includes a health care facility), network or association of providers, service provider offering access to a network of providers, third-party administrator, health insurance issuer offering group or individual health insurance coverage, or pharmacy benefit manager, or any entity acting as an intermediary between the group health plan and the health care provider, network association of providers, service provider offering access to a network or association of providers (including a licensed health insurance issuer or third-party administrator), or pharmacy benefit manager (collectively referred to in this subsection as 'Covered Service Providers'), is reasonable within the meaning of this subsection unless such contract or arrangement—

''(i) allows the responsible plan fiduciary (as that term is defined in section 408(b)(2)(B)(ii)(I)(ee)) access to all claims and encounter information or data, and any documentation supporting claim payments, including, but not limited to, medical records and policy documents, or information or data described in subsection (a)(1)(B) to—

''(I) comply with applicable law; and

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

''(ii) does not—

''(I) unreasonably limit or delay access, as determined by the Secretary but in any event not longer than 15 days, after a request for access by a plan fiduciary to such information or data;

''(II) limit the volume of claims and encounter information or data that the group health plan, the plan sponsor, the plan administrator, or a business associate of such plan may

access during an audit or pursuant to any request for such information or data;

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

"(aa) payment calculations and formulas;

"(bb) quality measures;

"(cc) contract terms;

"(dd) payment amounts;

"(ee) measurement periods for all incentives; and

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

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

''(V) limit the right of the group health plan, the plan sponsor, or the plan administrator of such plan to select an auditor or define audit scope or frequency;

''(VI) otherwise limit or unduly delay the group health plan, the plan sponsor, the plan administrator, or a business associate of such plan from accessing claims and encounter information or data;

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

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

"(IX) limit public disclosure of de-identified or aggregate information;

"(X) limit the disclosure of, with respect to a provider that files claims under such plan, whether a Covered Service Provider—

"(aa) has an ownership or investment interest;

"(bb) has a controlling interest;

"(cc) is a management services organization; or

"(dd) is a significant equity investor; or

"(XI) limit the disclosure of the name and address of each person or entity that, with respect to the health plan service provider—

"(aa) has an ownership or investment interest;

"(bb) has a controlling interest; or

"(cc) is a significant equity investor.

"(B) MANNER OF PROVIDING INFORMATION OR DATA.—

"(i) IN GENERAL.—A Covered Service Provider shall provide information or data under this subsection in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations. A Covered Service Provider shall not be required to disclose information or data under this subsection that could reasonably identify a participant or beneficiary through individually identifiable health in-

formation (as such term is defined under HIPAA privacy regulations).

"(ii) ADDITIONAL REQUIREMENTS.—In carrying out this subsection, a Covered Service Provider shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation).

"(iii) RULE OF CONSTRUCTION.—

"(I) IN GENERAL.—Nothing in this subsection shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

"(II) CIVIL RIGHTS LAWS.—Nothing in this subsection shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of

1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

''(iv) WRITTEN NOTICE.—Each plan year, a Covered Service Provider shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement that Covered Service Providers respond to requests to submit information or data under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

''(v) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this subsection shall prevent a Covered Service Provider from placing reason-

able restrictions on the public disclosure of the information or data described in paragraph (1), except that such Provider may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury.

''(vi) LIMITATION.—This paragraph shall not be construed to abridge or limit the disclosure requirements under this subsection or to impose additional privacy or security requirements on Covered Service Providers or plan sponsors.

''(C) LIMITATION ON DISCLOSURE.—A group health plan receiving information or data under this subsection may disclose such information only in a manner that is consistent with HIPAA and the privacy and security regulations promulgated thereunder, regardless of their direct or indirect applicability to the plan or any entities that could be or are business associates. A group health plan (and any business associate or other entity acting on behalf of such plan) may use such information or data only for purposes of plan administration and

may not sell, license, or otherwise commercially exploit such information or data or provide such information or data to any third party that may take such action.

''(D) REQUIREMENTS OF INFORMATION.—Information made available under this subsection shall conform to the following standards:

''(i) All claims from a healthcare provider shall be made to the group health plan in accordance with transaction standards adopted by regulation under HIPAA, as follows:

''(I) Institutional, professional, and dental claims shall be in ASC X12N 837D format or any subsequent standard as established by the Secretary.

''(II) Pharmacy claims shall be in the National Council for Prescription Drug Programs (NCPDP) format or any subsequent standard as established by the Secretary.

''(III) The files shall be unmodified copies of the files sent from the

provider, or, upon request, delivered in a machine readable format. In the event that paper claims are sent by the provider, they shall be converted to the appropriate standard electronic format. Files shall be accessible to the plan at no cost to the group health plan.

''(ii) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) notices sent by a Covered Service Provider shall be made available to the group health plan as ASC X12N 835 files (or any other format as identified by the Secretary) in accordance with standards adopted by regulation under HIPAA. The files shall be unmodified copies of the files sent by the Covered Service Provider to the healthcare provider. Files shall be accessible at no cost to the group health plan.

''(iii) The contractual terms containing payment calculations and formulas, pricing methodologies, and other information used to determine the dollar value of

reimbursement, in a format as specified by the Secretary.

"(iv) All non-claim costs shall be itemized and made available to the group health plan as requested through a web-based portal, through an application program interface (API), through a downloadable Comma-Separated Value (CSV) file, and, as appropriate, through other downloadable machine-readable file types.

"(E) IMPLEMENTATION.—The Secretary shall implement this subsection through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.

"(F) DEFINITIONS.—

"(i) IN GENERAL.—The provisions of sections 408 and 410 of the Employee Retirement Income Security Act of 1974 shall apply with respect to terms used under this subsection.

"(ii) SPECIFIED LARGE EMPLOYER.—In this subsection, the term 'specified large employer' means, in connection with a group health plan (including group health

insurance coverage offered in connection with such a plan) established or maintained by a single employer, with respect to a calendar year or a plan year, as applicable, an employer who employed an average of at least 50 employees on business days during the preceding calendar year or plan year and who employs at least 1 employee on the first day of the calendar year or plan year.

''(iii) SPECIFIED LARGE PLAN.—In this subsection, the term 'specified large plan' means a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a plan sponsor described in clause (ii) or (iii) of section 3(16)(B) of the Employee Retirement Income Security Act of 1974 that had an average of at least 50 participants on business days during the preceding calendar year or plan year, as applicable.''.

(2) CIVIL ENFORCEMENT.—

(A) CIVIL ENFORCEMENT.—Subsection (c) of section 502 of such Act (29 U.S.C. 1132) is

amended by adding at the end the following new paragraph:

''(13)(A) In the case of an agreement between a group health plan (as defined in section 733(a)), the plan sponsor of such plan (as defined in section 3(16)(B)), or the plan administrator of such plan (as defined in section 3(16)(A)) and a health care provider (which, for purposes of this paragraph, includes a health care facility), network or association of providers, service provider offering access to a network or association of providers, third-party administrator, or pharmacy benefit manager, that violates the provisions of section 724(b), the Secretary may assess a civil penalty against such provider, network or association, service provider offering access to a network or association of providers, third-party administrator, pharmacy benefit manager, or other service provider in the amount of up to $10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.

''(B) Nothing in subparagraph (A) shall be construed to permit the Secretary to regulate health care providers acting in their capacity as medical or-

ganizations furnishing items and services to patients.''.

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

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

''(1) unduly delays or limits a group health plan (as defined in section 733(a)), the plan sponsor of such plan (as defined in section 3(16)(B)), or the plan administrator of such plan (as defined in section 3(16)(A)) from accessing the claims and encounter information or data described in section 724(b)(1)(B); or

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

(C) TECHNICAL AMENDMENTS.—Section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)) is amended—

(i) in clause (i), by striking ''this clause'' and inserting ''this paragraph''; and

(ii) by adding at the end the following:

"(xi) A contract or arrangement shall not be reasonable under this subparagraph if it fails to comply with section 724(b).".

(b) UPDATED ATTESTATION FOR PRICE AND QUALITY INFORMATION.—Section 2799A–9(a)(4) of the Public Health Service Act (42 U.S.C. 300gg–119(a)(4)) is amended to read as follows:

"(4) ATTESTATION.—

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

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

"(ii) there are no terms in the agreement under such paragraph (1) that directly or indirectly restrict or unduly delay a group health plan, the plan sponsor, the plan administrator, a business associate of such plan, or the issuer from auditing, reviewing, or otherwise accessing such information.

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

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

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

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

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

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

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

SEC. 607. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

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

seq.), as amended by section 404, is amended by adding at the end the following:

"SEC. 2799A–15. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

"(a) IN GENERAL.—For plan years beginning on or after January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, no agreement between a group health plan that is offered by a specified large employer or that is a specified large plan (as such terms are defined in section 2799A–11(f)) or a health insurance issuer offering individual or group health coverage (that makes an election subject to subsection (b)(5)) and a health insurance issuer that is operating as a third-party administrator, a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to in this section as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to such group health plans and health insurance issuers in a manner that prevents any health plan service provider from providing the information described in subsection (b)).

"(b) REQUIRED DISCLOSURES.—

"(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 1 year after the date of enactment of this section, not less frequently than quarterly, a health plan service provider shall provide to the group health or the health insurance issuer offering individual or group health insurance coverage the following information at no cost to the plan or issuer:

"(A) The information described in section 2799A–9(a)(1)(B) (42 U.S.C. 300gg–119(a)(1)(B)).

"(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan or issuer to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

"(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

"(D) The total amount paid or expected to be paid by the health plan service provider to its subcontractors in rebates, fees, contractual arrangements, and all other remuneration for administrative and other services.

"(E) All payment data, calculation methodologies, and reconciliation information related to alternative compensation arrangements, including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan paid fees, incurred obligations, or made payments in con-

nection with the group health plan or issuer related to such arrangements.

"(F) Whether, with respect to a provider that files claims under such plan or coverage, the health plan service provider—

"(i) has an ownership or investment interest;

"(ii) has a controlling interest;

"(iii) is a management services organization; or

"(iv) is a significant equity investor.

"(G) The name and business address for each person or entity that, with respect to the health plan service provider—

"(i) has an ownership or investment interest;

"(ii) has a controlling interest; or

"(iii) is a significant equity investor.

"(2) MANNER OF PROVIDING INFORMATION OR DATA.—

"(A) IN GENERAL.—A health plan service provider shall provide information or data under paragraph (1) in a manner consistent with the privacy regulations promulgated under section 13402(a) of the Health Information

Technology for Economic and Clinical Health Act (42 U.S.C. 17932(a)) and consistent with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 in part 160 and subparts A and E of part 164 of title 45, Code of Federal Regulations (or successor regulations) (referred to in this paragraph as the 'HIPAA privacy regulations') and shall restrict the use and disclosure of such information according to such privacy regulations and such HIPAA privacy regulations.

''(B) ADDITIONAL REQUIREMENTS.—In carrying out this subsection, a health plan service provider shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation).

''(C) RULE OF CONSTRUCTION.—

''(i) IN GENERAL.—Nothing in this subsection shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

"(ii) CIVIL RIGHTS LAWS.—Nothing in this subsection shall be construed to affect the application of any Federal or State privacy or civil rights law, including the HIPAA privacy regulations, the Genetic Information Nondiscrimination Act of 2008 (Public Law 110–233) (including the amendments made by such Act), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e).

"(D) WRITTEN NOTICE.—Each plan year, a health plan service provider shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for health plan service providers to submit information or data under paragraph (1), as applicable, which may include incorporating such notification in plan documents

provided to the participant or beneficiary, or providing individual notification.

''(E) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this subsection shall prevent a health plan service provider from placing reasonable restrictions on the public disclosure of the information or data described in paragraph (1), except that such provider may not restrict disclosures under subsection (b)(1) to the Department of Health and Human Services, the Department of Labor, or the Department of the Treasury.

''(F) LIMITATION.—This paragraph shall not be construed to abridge or limit the disclosure requirements under this subsection or to impose additional privacy or security requirements on health plan service providers or plan sponsors.

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) IN GENERAL.—A group health plan or health insurance issuer offering individual or group coverage receiving information under paragraph (1) may disclose such information only—

"(i) to the entity from which the information was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

"(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. part 160 and subparts A and E of part 164).

"(B) AVAILABILITY OF INFORMATION.—To the extent the information required by this subsection is made available to the health insurance issuer offering group health insurance coverage, the health insurance issuer shall make such information available, at the same time, in the same format, and at no cost, to the group health plan.

"(C) LIMITATION ON USE OF INFORMATION.—A group health plan or health insurance issuer (and any business associate or other entity acting on behalf of such plan) may use information or data under this paragraph only for purposes of plan administration and may not sell, license, or otherwise commercially exploit such information or data or provide such infor-

mation or data to any third party that may take such action.

''(D) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan, a health insurance issuer, or a health plan service provider providing services with respect to such a plan, from placing reasonable restrictions on the public disclosure of the information described in paragraph (1), except that such plan or entity may not restrict disclosure of such information to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or the Comptroller General of the United States.

''(E) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 2723(b) (42 U.S.C. 300gg–22(b)) within 90 days of becoming aware of a violation of this

section, except that nothing in this section shall be construed to limit the Secretary's existing authority under this Act.

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

"(A) All claims from a healthcare provider shall be made to the group health plan in accordance with standards adopted under HIPAA as described in subpart K of part 162 of title 45, Code of Federal Regulations, as follows:

"(i) Institutional, professional, and dental claims and adjustments to these claims shall be provided to the group health plan or health insurance issuer in the ASC X12N 837 format.

"(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format.

"(iii) The files shall be unmodified copies of the files sent from the provider. In the event that paper claims are sent by the provider, they shall be converted to the appropriate standard electronic format.

Such data shall be provided at no cost to the group health plan.

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group health plan or health insurance issuer in the ASC X12N 835 format, in accordance with standards and operating rules adopted under HIPAA at subpart P of part 162 of title 45, Code of Federal Regulations, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan.

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary pursuant to the authority provided under section 1173 of the Social Security Act (42 U.S.C. 1320d–2).

''(5) OPT-IN FOR HEALTH INSURANCE COVERAGE.—In the case of a health insurance issuer offering coverage in the individual or group market, such issuer may, on an annual basis, for plan years beginning on or after the effective date of this sec-

tion, elect to require a health plan service provider to submit to such issuer a report that includes all of the information described in paragraph (1).

''(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement that unduly delays or limits a group health plan or issuer's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a group health plan or issuer enters into such agreement, shall be deemed void as against public policy.

''(d) REGULATIONS.—The Secretary shall implement this section through notice and comment rulemaking in accordance with section 553 of title 5, United States Code.''.

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

''(4) ENFORCEMENT AUTHORITY RELATING TO HEALTH PLAN SERVICE PROVIDERS.—Notwithstanding any provisions to the contrary, the Secretary may assess a penalty against a health plan service provider, as defined in section 2799A–15(a), of $100,000 per day for each violation of such sec-

tion, pursuant to substantially similar processes and procedures as those set forth in section 2723(b)(2)(D) through (G).''.

(c) ERISA AMENDMENTS.—

(1) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by adding at the end the following new paragraph:

''(14) The Secretary may assess a civil penalty against any person of $100,000 per day for each violation by any person of section 2799A–15 of the Public Health Service Act.''.

(2) TECHNICAL AMENDMENT.—Paragraph (6) of section 502(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended by striking ''or (9)'' and inserting ''(9), (13), or (14)''.

SEC. 608. STATE PREEMPTION ONLY IN EVENT OF CONFLICT.

The provisions of section 2718A of the Public Health Service Act (as added and amended by this Act) shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition related to health care price transparency, including for hospitals, clinical diagnostic labora-

tories, provider of specified imaging services, and ambulatory surgical centers (as such terms are defined in section 2718A(a) of the Public Health Service Act), except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition of such sections (or such amendments). Nothing in this section shall be construed to affect group health plans established under the Employee Retirement Income Security Act of 1974, or alter the application of section 514 of such Act (29 U.S.C. 1144).

SEC. 609. REQUIREMENT FOR EXPLANATION OF BENEFITS.

(a) ADVANCED EXPLANATION OF BENEFITS.—Section 2799A–1(f) of the Public Health Service Act (42 U.S.C. 300gg–111(f)) is amended—

(1) in paragraph (1)—

(A) by striking subparagraph (C) and inserting the following:

''(C) A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate described in subparagraph (B), including a plain language description of each item or service and all applicable billing codes for each item or service, including modifiers, using standard

and commonly recognized billing code sets that are clearly identified.''; and

(B) by adding at the end the following

''(I) A notification that the recipient may be held harmless, in certain circumstances, if the information in the advanced explanation of benefits does not match the amount the recipient is billed.''; and

(2) by adding at the end the following

''(3) HOLD HARMLESS.—

''(A) IN GENERAL.—For plan years beginning on or after the date that is 1 year after the date on which the Secretary implements this section, a participant, beneficiary, or enrollee shall be held harmless for any amount that is substantially in excess (as defined by the Secretary in a manner consistent with the process described in section 2799B–7) of the estimate generated by the advanced explanation of benefits.

''(B) NO PATIENT RESPONSIBILITY FOR EXCESS CHARGES.—A group health plan or a health insurance issuer in the group or individual market shall not hold a participant, beneficiary, or enrollee responsible for excess

charges described in this paragraph if such excess is the result of coverage or payment determinations that differ from projections made in the advanced explanation of benefits at the time such explanation was generated.

''(C) SUBSTANTIAL EXCESS.—A participant, beneficiary, or enrollee shall not be held harmless for excess amounts if such amounts reflect the cost of medically necessary items or services furnished based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility at the time the good faith estimate was generated or by the plan or issuer at the time the advanced explanation of benefits was generated.''.

(b) GOOD FAITH ESTIMATES.—Section 2799B–6 of the Public Health Service Act (42 U.S.C. 300gg–136) is amended—

(1) by striking ''Each health care'' and inserting the following:

''(a) IN GENERAL.—Each health care''; and

(2) by adding at the end the following:

''(b) HOLD HARMLESS.—

''(1) IN GENERAL.—For plan years beginning on or after the date that is 1 year after the date on

which the Secretary implements section 2799A–1(f), if an individual enrolled in a group health plan or health insurance coverage (and seeks to have a claim for an item or service submitted to such plan or coverage) is responsible for any amount that is substantially in excess (as defined by the Secretary in a manner consistent the process described in section 2799B–7) of the estimate generated in the advanced explanation of benefits described in section 2799A–1(f) because the final charges for items and services were substantially in excess of the good faith estimate provided to the plan or coverage under this section, a provider shall not bill the patient for amounts substantially in excess of the advanced explanation of benefits.

''(2) SUBSTANTIAL EXCESS.—An individual seeking to have a claim for an item or service covered by a group health plan or health insurance coverage shall not be held harmless for excess amounts if such amounts reflect the cost of medically necessary items or services furnished based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility at the time the good faith estimate was generated or by the

plan or issuer at the time the advanced explanation of benefits was generated.''.

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

''(g) EXPLANATION OF BENEFITS.—

''(1) IN GENERAL.—For plan years beginning on January 1 of the year that begins on or after the date that is 1 year after the date of enactment of the Health CARE Act of 2026, each group health plan, or a health insurance issuer offering group or individual health insurance coverage shall, within 45 days of receiving the information necessary to decide a claim for payment (as defined by the Secretary) for an item or service under the plan or coverage for which liability under the plan or coverage has been determined, provide to the participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) a notification (in clear and understandable language and utilizing substantially the same format as the advanced explanation of benefits required by subsection (f) to enable comparison when an advanced explanation of benefits is provided) including the following:

''(A) Whether or not the provider or facility is a participating provider or a participating facility with respect to the plan or coverage with respect to the furnishing of such item or service.

''(B) An itemized explanation of benefits that includes the following:

''(i) A plain language description of each item or service.

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

''(iii) The amount the plan or coverage is responsible for paying for each item or service.

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

''(v) The amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the

plan or coverage (as of the date of such notification).

''(vi) The type of site of each item or service, including office, facility, or emergency room.

''(vii) If applicable, a description of any discrepancies that exist between the services outlined in a patient's advanced explanation of benefits and the explanation of benefits.

''(viii) The amount of any facility fee or other patient charges that were added to the final payment amount, together with a plain language explanation of the fee, if applicable.

''(C) If the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan or coverage for such item or service.

''(D) The charges submitted by the provider or facility for each item or service.

''(E) Information pertaining to plan type, as defined the Secretary.

''(2) FORMAT.—If applicable, the notification described in paragraph (1) may be provided in conjunction with, or as part of, a notice of a claim determination or other communication required by section 2719(a) (42 U.S.C. 300gg–19(a)), or regulations thereunder.

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

SEC. 610. TRANSPARENCY IN BILLING.

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

''SEC. 2799B–10. PATIENT ACCESS TO COMPLETE BILLING INFORMATION.

''(a) REQUIREMENTS.—

''(1) NOTICE OF RIGHT OF ACCESS TO ITEMIZED BILLS; IN GENERAL.—A health care provider or health care facility that requests payment from an individual for providing a health care item or service to the patient shall include with such request a written notice of the individual's right to request an itemized bill as part of the individual's designated record set under section 164.524 of title 45,

Code of Federal Regulations (or a successor regulation).

''(2) REQUIRED INFORMATION.—A notice under paragraph (1) shall provide—

''(A) a phone number and internet website where an individual can make a request for access to their itemized bill;

''(B) information about the availability of language-assistance services for individuals with limited English proficiency (LEP); and

''(C) information about the health care provider's or health care facility's charity care policies and instructions on how to apply for charity care.

''(3) COLLECTIONS ACTIONS.—

''(A) IN GENERAL.—A health care provider or health care facility shall not bill or take any collections actions against an individual—

''(i) for any provided health care item or service unless the health care provider or health care facility has complied with paragraph (1) or section 13405(e)(4) of the HITECH Act; or

''(ii) with respect to any items or services for which the amount appearing on an

itemized bill described above in paragraph (1) exceeds the amount disclosed pursuant to Federal health care price transparency regulations, including part 180 of title 45, Code of Federal Regulations, or provided in a good faith estimate that complies with section 2799B-6 of this Act and section 149.610 of title 45, Code of Federal Regulations, or another good faith estimate provided by a health care entity covered under this section but not otherwise covered under such section 2799B–6, unless the provider or facility documents that the additional items or services were medically necessary due to unforeseen complications or a patient-initiated change, and could not reasonably have been anticipated.

''(B) PROVIDER REQUIREMENT.—If a provider fails to provide a documentation as required under subparagraph (A)(ii) in the case of items or services, the good faith estimate described in such subparagraph with respect to such items or services shall be binding.

''(b) FAILURE TO COMPLY.—

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

''(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—If a health care provider or health care facility fails to comply with the requirements of this section, the presumption shall be that charges were substantially in excess of the good faith estimate, as set forth in section 2799B–6, for the purpose of any patient-provider dispute, including in accordance with section 2799B–7 and regulations promulgated thereunder.

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

(b) STANDARDS FOR ACCESSING ITEMIZED BILLS.—Section 13405(e) of the HITECH Act (42 U.S.C. 17935(e)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period and inserting ''; and''; and

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

''(4) if the individual makes a request only for an itemized copy of a bill for services provided, the covered entity or business associate shall—

''(A) make such protected health information available within 30 days of such request;

''(B) not impose any fee for providing such individual a copy of their information; and

''(C) include in such itemized bill, a plain language description of each distinct health care item or service, all applicable billing codes for each distinct item or service, including modifiers, using standard and commonly recognized billing code sets, the price and billed amount, if different, of each distinct item or service.''.

SEC. 611. TECHNICAL AMENDMENTS.

(a) ERISA.—Section 715(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185d(a)(1)) is amended by inserting ''and parts D and E of title XXVII of the Public Health Service Act (as amended by title VI the Health CARE Act of 2026)'' after ''Affordable Care Act)''.

(b) INTERNAL REVENUE CODE.—Section 9815(a)(1) of the Internal Revenue Code of 1986 is amended by in-

serting ''and parts D and E of title XXVII of the Public Health Service Act (as amended by title VI of the Health CARE Act of 2026)'' after ''Affordable Care Act)''.

SEC. 612. IMPLEMENTATION AND ENFORCEMENT FUNDING.

(a) APPROPRIATION FOR SECRETARY OF LABOR.—There are authorized to be appropriated, such sums as may be necessary for fiscal year 2027, and each subsequent fiscal year, to enable the Secretary of Labor to carry out this Act and the amendments made by this Act, including enforcement activities.

(b) APPROPRIATION FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES.—There are authorized to be appropriated, such sums as may be necessary for fiscal year 2027, and each subsequent fiscal year, to enable the Secretary of Health and Human Services to carry out the amendments made by this Act, including implementation and enforcement activities.

TITLE VII—REFORMING PBMS AND PROTECTING PHARMACIES

SEC. 701. ENSURING ACCURATE PAYMENTS TO PHARMACIES UNDER MEDICAID.

(a) IN GENERAL.—Section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) is amended—

(1) in paragraph (1)(A)—

(A) by redesignating clause (ii) as clause (iii); and

(B) by striking ''and'' after the semicolon at the end of clause (i) and all that precedes it through ''(1)'' and inserting the following:

''(1) DETERMINING PHARMACY ACTUAL ACQUISITION COSTS.—The Secretary shall conduct a survey of retail community pharmacy drug prices and applicable non-retail pharmacy drug prices to determine national average drug acquisition cost benchmarks (as such term is defined by the Secretary) as follows:

''(A) USE OF VENDOR.—The Secretary may contract services for—

''(i) with respect to retail community pharmacies, the determination of retail survey prices of the national average drug acquisition cost for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts, rebates, and other price concessions (to the extent any information with respect to such discounts, rebates, and other price concessions is

available) based on a monthly survey of such pharmacies;

''(ii) with respect to applicable non-retail pharmacies—

''(I) the determination of survey prices, separate from the survey prices described in clause (i), of the non-retail national average drug acquisition cost for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts, rebates, and other price concessions (to the extent any information with respect to such discounts, rebates, and other price concessions is available) based on a monthly survey of such pharmacies; and

''(II) at the discretion of the Secretary, for each type of applicable non-retail pharmacy, the determination of survey prices, separate from the survey prices described in clause (i) or subclause (I) of this clause, of the national average drug acquisition

cost for such type of pharmacy for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts, rebates, and other price concessions (to the extent any information with respect to such discounts, rebates, and other price concessions is available) based on a monthly survey of such pharmacies; and'';

(2) in subparagraph (B) of paragraph (1), by striking ''subparagraph (A)(ii)'' and inserting ''subparagraph (A)(iii)'';

(3) in subparagraph (D) of paragraph (1), by striking clauses (ii) and (iii) and inserting the following:

''(ii) The vendor must update the Secretary no less often than monthly on the survey prices for covered outpatient drugs.

''(iii) The vendor must differentiate, in collecting and reporting survey data, for all cost information collected, whether a pharmacy is a retail community pharmacy or an applicable non-retail pharmacy, in-

cluding whether such pharmacy is an affiliate (as defined in subsection (k)(13)), and, in the case of an applicable non-retail pharmacy, which type of applicable non-retail pharmacy it is using the relevant pharmacy type indicators included in the guidance required by subsection (d)(2) of section 701 of the Health CARE Act of 2026.'';

(4) by adding at the end of paragraph (1) the following:

''(F) SURVEY REPORTING.—In order to meet the requirement of section 1902(a)(54), a State shall require that any retail community pharmacy or applicable non-retail pharmacy in the State that receives any payment, reimbursement, administrative fee, discount, rebate, or other price concession related to the dispensing of covered outpatient drugs to individuals receiving benefits under this title, regardless of whether such payment, reimbursement, administrative fee, discount, rebate, or other price concession is received from the State or a managed care entity or other specified entity (as such terms are defined in section

1903(m)(9)(D)) directly or from a pharmacy benefit manager or another entity that has a contract with the State or a managed care entity or other specified entity (as so defined), shall respond to surveys conducted under this paragraph.

''(G) SURVEY INFORMATION.—Information on national drug acquisition prices obtained under this paragraph shall be made publicly available in a form and manner to be determined by the Secretary and shall include at least the following:

''(i) The monthly response rate to the survey including a list of pharmacies not in compliance with subparagraph (F).

''(ii) The sampling methodology and number of pharmacies sampled monthly.

''(iii) Information on price concessions to pharmacies, including discounts, rebates, and other price concessions, to the extent that such information may be publicly released and has been collected by the Secretary as part of the survey.

''(H) PENALTIES.—

"(i) IN GENERAL.—Subject to clauses (ii), (iii), and (iv), the Secretary shall enforce the provisions of this paragraph with respect to a pharmacy through the establishment of civil money penalties applicable to a retail community pharmacy or an applicable non-retail pharmacy.

"(ii) BASIS FOR PENALTIES.—The Secretary shall impose a civil money penalty established under this subparagraph on a retail community pharmacy or applicable non-retail pharmacy if—

"(I) the retail pharmacy or applicable non-retail pharmacy refuses or otherwise fails to respond to a request for information about prices in connection with a survey under this subsection;

"(II) knowingly provides false information in response to such a survey; or

"(III) otherwise fails to comply with the requirements established under this paragraph.

"(iii) PARAMETERS FOR PENALTIES.—

"(I) IN GENERAL.—A civil money penalty established under this subparagraph may be assessed with respect to each violation, and with respect to each non-compliant retail community pharmacy (including a pharmacy that is part of a chain) or non-compliant applicable non-retail pharmacy (including a pharmacy that is part of a chain), in an amount not to exceed $100,000 for each such violation.

"(II) CONSIDERATIONS.—In determining the amount of a civil money penalty imposed under this subparagraph, the Secretary may consider the size, business structure, and type of pharmacy involved, as well as the type of violation and other relevant factors, as determined appropriate by the Secretary.

"(iv) RULE OF APPLICATION.—The provisions of section 1128A (other than

subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).

''(I) LIMITATION ON USE OF APPLICABLE NON-RETAIL PHARMACY PRICING INFORMATION.—No State shall use pricing information reported by applicable non-retail pharmacies under subparagraph (A)(ii) to develop or inform payment methodologies for retail community pharmacies.'';

(5) in paragraph (2)—

(A) in subparagraph (A), by inserting '', including payment rates and methodologies for determining ingredient cost reimbursement under managed care entities or other specified entities (as such terms are defined in section 1903(m)(9)(D)),'' after ''under this title''; and

(B) in subparagraph (B), by inserting ''and the basis for such dispensing fees'' before the semicolon;

(6) by redesignating paragraph (4) as paragraph (5);

(7) by inserting after paragraph (3) the following new paragraph:

''(4) OVERSIGHT.—

''(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct periodic studies of the survey data reported under this subsection, as appropriate, including with respect to substantial variations in acquisition costs or other applicable costs, as well as with respect to how internal transfer prices and related party transactions may influence the costs reported by pharmacies that are affiliates (as defined in subsection (k)(13)) or are owned by, controlled by, or related under a common ownership structure with a wholesaler, distributor, or other entity that acquires covered outpatient drugs relative to costs reported by pharmacies not affiliated with such entities. The Inspector General shall provide periodic updates to Congress on the results of such studies, as appropriate, in a manner that does not disclose trade secrets or other proprietary information.

''(B) APPROPRIATION.—There is appropriated to the Inspector General of the Depart-

ment of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $5,000,000 for fiscal year 2027, to remain available until expended, to carry out this paragraph.''; and

(8) in paragraph (5), as so redesignated—

(A) by inserting '', and $9,000,000 for fiscal year 2027 and each fiscal year thereafter,'' after ''2010''; and

(B) by inserting ''Funds appropriated under this paragraph for fiscal year 2027 and any subsequent fiscal year shall remain available until expended.'' after the period.

(b) DEFINITIONS.—Section 1927(k) of the Social Security Act (42 U.S.C. 1396r–8(k)) is amended—

(1) in the matter preceding paragraph (1), by striking ''In the section'' and inserting ''In this section''; and

(2) by adding at the end the following new paragraphs:

''(12) APPLICABLE NON-RETAIL PHARMACY.—The term 'applicable non-retail pharmacy' means a pharmacy that is licensed as a pharmacy by the State and that is not a retail community pharmacy, including a pharmacy that dispenses prescription

medications to patients primarily through mail and specialty pharmacies. Such term does not include nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or low dispensing pharmacies (as defined by the Secretary).

''(13) AFFILIATE.—The term 'affiliate' means any entity that is owned by, controlled by, or related under a common ownership structure with a pharmacy benefit manager or a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D)).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall take effect on the first day of the first quarter that begins on or after the date that is 6 months after the date of enactment of this Act.

(2) DELAYED APPLICATION TO APPLICABLE NON-RETAIL PHARMACIES.—The pharmacy survey requirements established by the amendments to section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)) made by this section shall apply to retail community pharmacies beginning on the effec-

tive date described in paragraph (1), but shall not apply to applicable non-retail pharmacies until the first day of the first quarter that begins on or after the date that is 18 months after the date of enactment of this Act.

(d) IDENTIFICATION OF APPLICABLE NON-RETAIL PHARMACIES.—

(1) IN GENERAL.—Not later than January 1, 2028, the Secretary of Health and Human Services shall, in consultation with stakeholders as appropriate, publish guidance specifying pharmacies that meet the definition of applicable non-retail pharmacies (as such term is defined in subsection (k)(12) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8), as added by subsection (b)), and that will be subject to the survey requirements under subsection (f)(1) of such section, as amended by subsection (a).

(2) INCLUSION OF PHARMACY TYPE INDICATORS.—The guidance published under paragraph (1) shall include pharmacy type indicators to distinguish between different types of applicable non-retail pharmacies, such as pharmacies that dispense prescriptions primarily through the mail and pharmacies that dispense prescriptions that require special han-

dling or distribution. An applicable non-retail pharmacy may be identified through multiple pharmacy type indicators.

(e) IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

(2) NONAPPLICATION OF ADMINISTRATIVE PROCEDURE ACT.—Implementation of the amendments made by this section shall be exempt from the requirements of section 553 of title 5, United States Code.

(f) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to any data collection undertaken by the Secretary of Health and Human Services under section 1927(f) of the Social Security Act (42 U.S.C. 1396r–8(f)), as amended by this section.

SEC. 702. PREVENTING THE USE OF ABUSIVE SPREAD PRICING IN MEDICAID.

(a) IN GENERAL.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (e), by adding at the end the following new paragraph:

''(6) TRANSPARENT PRESCRIPTION DRUG PASS-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—

''(i) any payment made by the entity or the PBM (as applicable) for such a drug—

''(I) is limited to—

''(aa) ingredient cost; and

''(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State would pay if the State were making the payment directly in accordance with the State plan;

''(II) is passed through in its entirety (except as reduced under Federal or State laws and regulations in response to instances of waste, fraud, or abuse) by the entity or PBM to the pharmacy or provider that dispenses the drug; and

''(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations (or any successor regulation) as if such requirements applied directly to the entity or the PBM, except that any payment by the entity or the PBM for the ingredient cost of such drug purchased by a covered entity (as defined in subsection (a)(5)(B))

may exceed the actual acquisition cost (as defined in 447.502 of title 42, Code of Federal Regulations, or any successor regulation) for such drug if—

"(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act;

"(bb) such payment for the ingredient cost of such drug does not exceed the maximum payment that would have been made by the entity or the PBM for the ingredient cost of such drug if such drug had not been purchased by such covered entity; and

"(cc) such covered entity reports to the Secretary (in a form and manner specified by the Secretary), on an annual basis and with respect to payments for the ingredient costs of such drugs so purchased by such covered entity

that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess;

''(ii) payment to the entity or the PBM (as applicable) for administrative services performed by the entity or PBM is limited to an administrative fee that reflects the fair market value (as defined by the Secretary) of such services;

''(iii) the entity or the PBM (as applicable) makes available to the State, and the Secretary upon request in a form and manner specified by the Secretary, all costs and payments related to covered outpatient drugs and accompanying administrative services (as described in clause (ii)) incurred, received, or made by the entity or the PBM, broken down (as specified by the Secretary), to the extent such costs and payments are attributable to an individual covered outpatient drug, by each such drug, including any ingredient costs, professional dispensing fees, administrative fees (as described in clause (ii)), post-sale

and post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees, and any and all other remuneration, as defined by the Secretary; and

"(iv) any form of spread pricing whereby any amount charged or claimed by the entity or the PBM (as applicable) that exceeds the amount paid to the pharmacies or providers on behalf of the State or entity, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments, as defined by the Secretary, (after allowing for an administrative fee as described in clause (ii)) is not allowable for purposes of claiming Federal matching payments under this title.

"(B) PUBLICATION OF INFORMATION.—The Secretary shall publish, not less frequently than on an annual basis and in a manner that does not disclose the identity of a particular covered entity or organization, information received by the Secretary pursuant to subparagraph (A)(iii)(III) that is broken out by State

and by each of the following categories of covered entity within each such State:

''(i) Covered entities described in subparagraph (A) of section 340B(a)(4) of the Public Health Service Act.

''(ii) Covered entities described in subparagraphs (B) through (K) of such section.

''(iii) Covered entities described in subparagraph (L) of such section.

''(iv) Covered entities described in subparagraph (M) of such section.

''(v) Covered entities described in subparagraph (N) of such section.

''(vi) Covered entities described in subparagraph (O) of such section.''; and

(2) in subsection (k), as amended by section 701(b), by adding at the end the following new paragraph:

''(14) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a State, managed care entity (as defined in section 1903(m)(9)(D)), or other specified

entity (as so defined), or manages the prescription drug benefits provided by a State, managed care entity, or other specified entity, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the managing of appeals or grievances related to the prescription drug benefits, contracting with pharmacies, controlling the cost of covered outpatient drugs, or the provision of services related thereto. Such term includes any person or entity that acts as a price negotiator (with regard to payment amounts to pharmacies and providers for a covered outpatient drug or the net cost of the drug) or group purchaser on behalf of a State, managed care entity, or other specified entity or that carries out 1 or more of the other activities described in the preceding sentence, irrespective of whether such person or entity calls itself a pharmacy benefit manager.''.

(b) CONFORMING AMENDMENTS.—Section 1903(m) of such Act (42 U.S.C. 1396b(m)) is amended—

(1) in paragraph (2)(A)(xiii)—

(A) by striking ''and (III)'' and inserting ''(III)'';

(B) by inserting before the period at the end the following: ‘‘, and (IV) if the contract includes provisions making the entity responsible for coverage of covered outpatient drugs, the entity shall comply with the requirements of section 1927(e)(6)’’; and

(C) by moving the margin 2 ems to the left; and

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

‘‘(10) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by an other specified entity (as defined in paragraph (9)(D)(iii)) unless such services are provided in accordance with a contract between the State and such entity which satisfies the requirements of paragraph (2)(A)(xiii).’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts between States and managed care entities, other specified entities, or pharmacy benefit managers that have an effective date beginning on or after the date that is 18 months after the date of enactment of this Act.

(d) IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

(2) NONAPPLICATION OF ADMINISTRATIVE PROCEDURE ACT.—Implementation of the amendments made by this section shall be exempt from the requirements of section 553 of title 5, United States Code.

(e) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to any data collection undertaken by the Secretary of Health and Human Services under section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)), as amended by this section.