



AMENDMENT NO. _____ Calendar No. _____

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—119th Cong., 2d Sess.

S. 2355

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

Referred to the Committee on _____ and
ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT IN THE NATURE OF A SUBSTITUTE intended
to be proposed by _____

Viz:

1 Strike all after the enacting clause and insert the fol-
2 lowing:

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Patients Deserve Price
5 Tags Act”.

6 **SEC. 2. STRENGTHENING HOSPITAL PRICE TRANS-**
7 **PARENCY.**

8 Title XXVII of the Public Health Service Act is
9 amended by inserting after section 2718 (42 U.S.C.
10 300gg–18) the following:

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

12 **“(a) DEFINITIONS.—In this section:**

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

14 “(2) APPLICABLE LABORATORY.—The term
15 ‘applicable laboratory’ means a ‘laboratory’ as such
16 term is defined in section 493.2, of title 42, Code of
17 Federal Regulations (or a successor regulation), ex-
18 cept that such term does not include a laboratory
19 with respect to which standard charges for specified
20 clinical diagnostic laboratory tests furnished by such
21 laboratory are made available by a hospital pursuant
22 to subsection (b) or specified ambulatory surgical
23 center pursuant to subsection (e).

24 “(3) DISCOUNTED CASH PRICE.—

1 “(A) IN GENERAL.—The term ‘discounted
2 cash price’ means the minimum charge ex-
3 pressed as a dollar amount, subject to subpara-
4 graph (B), that the applicable service provider
5 subject to this section accepts from an indi-
6 vidual who pays cash, or cash equivalent, for a
7 furnished item or service, without regard to
8 health insurance coverage, as payment in full.

9 “(B) EXCLUSIONS.—For purposes of sub-
10 paragraph (A), the minimum charge described
11 in such subparagraph, with respect to a fur-
12 nished item or service, as applicable, shall be
13 calculated without taking into account any fi-
14 nancial assistance, including assistance attrib-
15 utable to charity care (in the case of a hospital,
16 as such term is used for purposes of hospital
17 cost reporting under title XVIII of the Social
18 Security Act), or third-party assistance for such
19 item or service.

20 “(4) EXTRAORDINARY COLLECTION ACTIONS.—
21 The term ‘extraordinary collection action’ has the
22 meaning given such term for purposes of section
23 501(r) of the Internal Revenue Code of 1986.

24 “(5) GROSS CHARGE.—The term ‘gross charge’
25 means the charge for an individual item or service

1 that is reflected on a hospital's chargemaster or
2 similar list of prices facilitated by any other pro-
3 vider, as defined by the Secretary, absent any dis-
4 counts.

5 “(6) HOSPITAL.—The term ‘hospital’ means an
6 institution in any State in which State or applicable
7 local law provides for the licensing of hospitals, that
8 is licensed as a hospital pursuant to such law or is
9 approved, by the agency of such State or locality re-
10 sponsible for licensing hospitals, as meeting the
11 standards established for such licensing. For pur-
12 poses of this paragraph, the term ‘State’ includes
13 each of the several States, the District of Columbia,
14 Puerto Rico, the Virgin Islands, Guam, American
15 Samoa, and the Northern Mariana Islands.

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

20 “(8) SHOPPABLE SERVICE.—The term
21 ‘shoppable service’ means a service that can be
22 scheduled by a healthcare consumer in advance.
23 Such services are routinely provided in non-urgent
24 situations that do not require immediate action or
25 attention to the patient, thus allowing patients to

1 price shop and schedule a service at a time that is
2 convenient for them.

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

15 “(10) SPECIFIED CLINICAL DIAGNOSTIC LAB-
16 ORATORY TEST.—The term ‘specified clinical diag-
17 nostic laboratory test’ means any clinical diagnostic
18 laboratory test or service that is provided by the ap-
19 plicable laboratory, excluding advanced diagnostic
20 laboratory tests (as defined in section 1834A(d)(5)
21 of the Social Security Act).

22 “(11) SPECIFIED IMAGING SERVICE.—The term
23 ‘specified imaging service’ has the meaning given to
24 the term ‘radiology and certain other imaging serv-
25 ices’ for purposes of section 411.351 of title 42,

1 Code of Federal Regulations (or successor regula-
2 tions).

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

7 “(b) HOSPITAL PRICE TRANSPARENCY.—

8 “(1) IN GENERAL.—Beginning January 1 of
9 the year that begins on or after the date that is 1
10 year after the date of enactment of the Patients De-
11 serve Price Tags Act, each hospital shall, in accord-
12 ance with a method and format established by the
13 Secretary under paragraph (3), on a quarterly basis
14 (if there have been any changes to the standard
15 charges described in subparagraph (2) compile and
16 make publicly available on an internet website (with-
17 out subscription and free of charge)—

18 “(A) all of the hospital’s standard charges
19 for each item and service furnished by such
20 hospital in a machine-readable format (or a
21 successor technology specified by the Sec-
22 retary);

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

“(i) as many of the Centers for Medi-
care & Medicaid Services-specified
shoppable services that are furnished by
the hospital, and as many additional hos-
pital-selected shoppable services (or all
such additional services, if such hospital
furnishes fewer than 300 shoppable serv-
ices) 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

14 “(ii) with respect to each Centers for
15 Medicare & Medicaid Services-specified
16 shoppable service that is not furnished by
17 the hospital, an indication that such serv-
18 ice is not so furnished; and

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

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

24 “(ii) has a controlling interest

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

3 “(iv) is a significant equity investor.

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

7 “(A) A plain language description of each
8 item and service, accompanied by any applicable
9 billing codes, including modifiers, using com-
10 monly recognized billing code sets, including—

11 “(i) the Diagnosis Related Group;

12 “(ii) the Healthcare Common Proce-
13 dure Coding System code;

14 “(iii) the National Drug Code; and

15 “(iv) other applicable identifiers as de-
16 termined by the Secretary (or successor
17 code sets).

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

22 “(C) The discounted cash price.

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

1 ble third-party payer and name of each plan,
2 that apply to each such item or service when
3 provided in, as applicable, the inpatient setting
4 and outpatient department setting. If the
5 charges are based on an algorithm, percentage
6 of another amount, or other formula or criteria,
7 the hospital shall also disclose such algorithm,
8 percentage, formula, or criteria as set forth in
9 its contract and any other information nec-
10 essary to determine the negotiated charge as a
11 dollar amount.

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

15 “(F) The amount of any facility fee, as de-
16 fined by the Secretary, or add-on charges that
17 will be part of the final payment amount, in ad-
18 dition to any information that might help the
19 patient understand when a facility fee or add-
20 on charge may apply and how to avoid such
21 charges.

22 “(G) Any other additional information the
23 Secretary may require for the purpose of im-
24 proving the accuracy of, or enabling consumers
25 to easily understand and compare, standard

1 charges for an item or service, except informa-
2 tion that is duplicative of any other reporting
3 requirement under this subsection. In the case
4 of standard charges for an item or service in-
5 cluded as part of a bundled, per diem, episodic,
6 or other similar arrangement, the information
7 described in this subparagraph shall be made
8 available as determined appropriate by the Sec-
9 retary.

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

15 “(A) include a machine-readable format
16 (or successor technology specified by the Sec-
17 retary) containing the information described in
18 paragraph (2) for all items and services fur-
19 nished by each hospital;

20 “(B) meet such standards as determined
21 appropriate by the Secretary in order to ensure
22 the accessibility and usability of such charges;
23 and

1 “(C) be updated as determined appropriate
2 by the Secretary, in consultation with stake-
3 holders.

4 “(4) NO DEEMED COMPLIANCE.—Hospitals
5 may offer a price estimator tool, but the availability
6 of such a price estimator tool shall not be considered
7 to deem compliance with or otherwise vitiate the re-
8 quirements of paragraph (1)(B) or any other re-
9 quirements of this subsection.

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

17 “(6) ATTESTATION.—A senior official from
18 each hospital (the Chief Executive Officer, Chief Fi-
19 nancial Officer, or an official of equivalent seniority)
20 shall attest to the accuracy and completeness of the
21 disclosures, and any other attestations as required
22 by the Secretary, made in accordance with the hos-
23 pital price transparency requirements based on cri-
24 teria established by the Secretary.

25 “(7) ENFORCEMENT.—

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

9 “(B) CIVIL MONETARY PENALTY.—

10 “(i) IN GENERAL.—In addition to any
11 other enforcement actions or penalties that
12 may apply under another provision of law,
13 a hospital that has received a request for
14 a corrective action plan under subpara-
15 graph (A) and fails to comply with the re-
16 quirements of this subsection by the date
17 that is 90 days after such request is made
18 shall be subject to a civil monetary penalty
19 of an amount specified by the Secretary for
20 each day (beginning on the day the hos-
21 pital was first out of compliance, as deter-
22 mined by the Secretary) during which such
23 failure was ongoing. Such amount shall not
24 exceed—

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

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

18 “(III) in the case of a specified
19 hospital with more than 100 beds but
20 fewer than 201 beds, \$17.50 per bed
21 per day (or, in the case of such a hos-
22 pital that has been noncompliant with
23 such requirements for a 1-year period
24 or longer, beginning with the first day

1 following such 1-year period, \$20 per
2 bed per day);

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

12 “(V) in the case of a specified
13 hospital with more than 500 beds,
14 \$25 per bed per day (or, in the case
15 of such a hospital that has been non-
16 compliant with such requirements for
17 a 1-year period or longer, beginning
18 with the first day following such 1-
19 year period, \$35 per bed per day).

20 “(ii) INCREASE AUTHORITY.—In ap-
21 plying this subparagraph with respect to
22 hospitals that fail to comply in 2028 or a
23 subsequent year, the Secretary may
24 through notice and comment rulemaking
25 increase—

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

4 “(II) the limitations on the per
5 bed per day amount of any penalty
6 applicable under any of subclauses
7 (II) through (V) of clause (i); and

8 “(III) the limitation on the in-
9 crease of any penalty applied under
10 clause (iii) pursuant to the amounts
11 specified in subclause (II) of such
12 clause.

13 “(iii) PERSISTENT NONCOMPLI-
14 ANCE.—

15 “(I) IN GENERAL.—In the case
16 of a hospital that the Secretary has
17 determined to be noncompliant with
18 the provisions of this subsection two
19 or more times during a 1-year period
20 (as determined by the Secretary), the
21 Secretary may increase any penalty
22 otherwise applicable under this sub-
23 paragraph by the amount specified in
24 subclause (II) with respect to such
25 hospital and may require such hos-

1 pital to complete such additional cor-
2 rective actions plans as the Secretary
3 may specify.

4 “(II) SPECIFIED AMOUNT.—For
5 purposes of subclause (I), the amount
6 specified in this subclause is, with re-
7 spect to a hospital—

8 “(aa) with more than 30
9 beds but fewer than 101 beds, an
10 amount that is not less than
11 \$500,000 and not more than
12 \$1,000,000;

13 “(bb) with more than 100
14 beds but fewer than 301 beds, an
15 amount that is greater than
16 \$1,000,000 and not more than
17 \$2,000,000;

18 “(cc) with more than 300
19 beds but fewer than 501 beds, an
20 amount that is greater than
21 \$2,000,000 and not more than
22 \$4,000,000; and

23 “(dd) with more than 500
24 beds, and amount that is not less

1 than \$5,000,000 and not more
2 than \$10,000,000.

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

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

18 “(C) NO AUTHORITY TO WAIVE OR RE-
19 DUCE PENALTY.—The Secretary shall not grant
20 or extend any waiver, delay, tolling, or other
21 mitigation of a civil monetary penalty for failing
22 to comply with the requirements of this sub-
23 section except where the Secretary determines
24 that imposing the maximum civil monetary pen-
25 alty, including penalties for persistent non-

1 compliance, will disrupt hospital operations in a
2 manner that impacts patient care. The Sec-
3 retary may request documentation in such form
4 and manner as the Secretary may require in
5 order to evaluate impact on hospital operations.

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

18 “(i) not take any extraordinary collec-
19 tion actions against any patient or patient
20 guarantor for debt incurred by any patient
21 on the date or dates of service when the
22 hospital was not in compliance with the re-
23 quirements of this subsection;

24 “(ii) cease any extraordinary collec-
25 tion actions that have begun against any

1 patient or patient guarantor for debt in-
2 curred by any patient on the date or dates
3 of service when the hospital was not in
4 compliance with the requirements of this
5 subsection; and

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

15 “(8) RULEMAKING.—

16 “(A) IN GENERAL.—The Secretary shall
17 implement this subsection through notice and
18 comment rulemaking in accordance with section
19 553 of title 5, United States Code.

20 “(B) OWNERSHIP INFORMATION.—In pro-
21 mulgating regulations under this paragraph, the
22 Secretary shall define the individuals and orga-
23 nizations that must be disclosed under para-
24 graph (1)(C) in a manner that harmonizes dis-
25 closure requirements with requirements estab-

1 lished under section 1124 of the Social Security
2 Act and prioritizes the disclosure of individuals
3 and organizations who's ownership or manage-
4 ment relationship with a hospital impacts oper-
5 ational, financial, or clinical decision making for
6 such hospital.”.

7 **SEC. 3. CLINICAL DIAGNOSTIC LABORATORY PRICE TRANS-**
8 **PARENCY.**

9 Section 2718A of the Public Health Service Act, as
10 added by section 2, is amended by adding at the end the
11 following:

12 “(c) CLINICAL DIAGNOSTIC LABORATORY PRICE
13 TRANSPARENCY.—

14 “(1) IN GENERAL.—Beginning January 1 of
15 the year that begins on or after the date that is 1
16 year after the date of enactment of the Patients De-
17 serve Price Tags Act, an applicable laboratory shall,
18 on a quarterly basis (if there have been any changes
19 to the standard charges described in paragraph (2))
20 compile and make publicly available on an internet
21 website (without subscription and free of charge)—

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

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

4 “(i) has an ownership or investment
5 interest;

6 “(ii) has a controlling interest

7 “(iii) is a management services orga-
8 nization; or

9 “(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—

22 “(i) the Healthcare Common Proce-
23 dure Coding System code;

24 “(ii) the National Drug Code; or

1 “(iii) other applicable identifier as de-
2 termined by the Secretary (or successor
3 code sets).

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

6 “(C) The discounted cash price.

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

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

22 “(F) Any other additional information the
23 Secretary may require for the purpose of im-
24 proving the accuracy of, or enabling consumers
25 to easily understand and compare, standard

1 charges for an item or service, except informa-
2 tion that is duplicative of any other reporting
3 requirement under this section. In the case of
4 standard charges for an item or service in-
5 cluded as part of a bundled, per diem, episodic,
6 or other similar arrangement, the information
7 described in this subparagraph shall be made
8 available as determined appropriate by the Sec-
9 retary.

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

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

22 “(B) meet such standards as determined
23 appropriate by the Secretary in order to ensure
24 the accessibility and usability of such informa-
25 tion; and

1 “(C) be updated as determined appropriate
2 by the Secretary, in consultation with stake-
3 holders.

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

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

23 “(6) ATTESTATION.—A senior official from
24 each clinical diagnostic laboratory (the Chief Execu-
25 tive Officer, Chief Financial Officer, or an official of

1 equivalent seniority) shall attest to the accuracy and
2 completeness of the disclosures, and any other attes-
3 tations as required by the Secretary, made in ac-
4 cordance with the clinical laboratory price trans-
5 parency requirements based on criteria established
6 by the Secretary.

7 “(7) ENFORCEMENT.—

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

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

15 “(ii) upon request of the Secretary,
16 such laboratory shall submit to the Sec-
17 retary, not later than 45 days after the
18 date of such request, a corrective action
19 plan to comply with such requirements.

20 “(B) CIVIL MONETARY PENALTY.—

21 “(i) IN GENERAL.—An applicable lab-
22 oratory that has received a notification
23 under subparagraph (A)(i) and fails to
24 comply with the requirements of this sub-
25 section by the date that is 90 days after

1 such notification (or, in the case of an ap-
2 plicable laboratory that has submitted a
3 corrective action plan described in subpara-
4 graph (A)(ii) in response to a request so
5 described, by the date that is 90 days after
6 such submission) shall be subject to a civil
7 monetary penalty of an amount specified
8 by the Secretary for each day (beginning
9 with the day on which the Secretary first
10 determined that such laboratory was not
11 complying with such requirements) during
12 which such failure is ongoing (not to ex-
13 ceed \$300 per day).

14 “(ii) INCREASE AUTHORITY.—In ap-
15 plying this subparagraph with respect to
16 an applicable laboratory that fails to com-
17 ply with the requirements of this sub-
18 section in 2028 or a subsequent year, the
19 Secretary may through notice and com-
20 ment rulemaking increase the limitation on
21 the per day amount of any penalty applica-
22 ble to an applicable laboratory under
23 clause (i).

24 “(iii) APPLICATION OF CERTAIN PRO-
25 VISIONS.—The provisions of section 1128A

1 of the Social Security Act (other than sub-
2 sections (a) and (b) of such section) shall
3 apply to a civil monetary penalty imposed
4 under this subparagraph in the same man-
5 ner as such provisions apply to a civil mon-
6 etary penalty imposed under subsection (a)
7 of such section.

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

22 “(8) PROVISION OF TECHNICAL ASSISTANCE.—
23 The Secretary shall, to the extent practicable, pro-
24 vide technical assistance relating to compliance with

1 the provisions of this subsection to applicable labora-
2 tories requesting such assistance.

3 “(9) RULEMAKING.—

4 “(A) IN GENERAL.—The Secretary shall
5 implement this subsection through notice and
6 comment rulemaking in accordance with section
7 553 of title 5, United States Code.

8 “(B) OWNERSHIP INFORMATION.—In pro-
9 mulgating regulations under this paragraph, the
10 Secretary shall define the individuals and orga-
11 nizations that must be disclosed under para-
12 graph (1)(C) in a manner that harmonizes dis-
13 closure requirements with requirements estab-
14 lished under section 1124 of the Social Security
15 Act and prioritizes the disclosure of individuals
16 and organizations who’s ownership or manage-
17 ment relationship with a hospital impacts oper-
18 ational, financial, or clinical decision making for
19 such hospital.”.

20 **SEC. 4. IMAGING SERVICES PRICE TRANSPARENCY.**

21 Section 2718A of the Public Health Service Act, as
22 amended by section 3, is further amended by adding at
23 the end the following:

24 “(d) IMAGING SERVICES PRICE TRANSPARENCY.—

1 “(1) IN GENERAL.—Beginning January 1 of
2 the year that begins on or after the date that is 1
3 year after the date of enactment of the Patients De-
4 serve Price Tags Act, each applicable imaging serv-
5 ice provider shall, on a quarterly basis (if there have
6 been any changes to the standard charges described
7 in paragraph (2)) compile and make publicly avail-
8 able on an internet website (without subscription
9 and free of charge)—

10 “(A) the standard charges described in
11 paragraph (2) with respect to each such speci-
12 fied imaging service provided by such provider;
13 and

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

17 “(i) has an ownership or investment
18 interest;

19 “(ii) has a controlling interest

20 “(iii) is a management services orga-
21 nization; or

22 “(iv) is a significant equity investor.

23 “(2) STANDARD CHARGES DEFINED.—For pur-
24 poses of paragraph (1), the term ‘standard charges’,
25 with respect to an applicable imaging service pro-

1 vider and a specified imaging service, means the fol-
2 lowing:

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

10 “(i) the Healthcare Common Proce-
11 dure Coding System code;

12 “(ii) the National Drug Code; or

13 “(iii) other applicable identifier as de-
14 termined by the Secretary (or successor
15 code sets).

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

18 “(C) The discounted cash price.

19 “(D) The payer-specific negotiated
20 charges, expressed as a dollar amount and
21 clearly associated with the name of the applica-
22 ble third-party payer and name of each plan,
23 that apply to each such service. If the charges
24 are based on an algorithm, percentage of an-
25 other amount, or other formula or criteria, the

1 provider or supplier also shall disclose such al-
2 gorithm, percentage, formula, or criteria as set
3 forth in its contract and any other information
4 necessary to determine the negotiated charge as
5 a dollar amount.

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

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

22 “(3) UNIFORM METHOD AND FORMAT.—The
23 Secretary shall establish a standard, uniform method
24 and format for applicable imaging service providers

1 to use in making public information described in
2 paragraph (1). Any such method and format shall—

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

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

13 “(C) be updated as determined appropriate
14 by the Secretary, in consultation with stake-
15 holders.

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

21 “(5) ATTESTATION.—A senior official from
22 each specified imaging service provider (the Chief
23 Executive Officer, Chief Financial Officer, or an of-
24 ficial of equivalent seniority) shall attest to the accu-
25 racy and completeness of the disclosures, and any

1 other attestations as required by the Secretary,
2 made in accordance with the imaging service pro-
3 vider price transparency requirements based on cri-
4 teria established by the Secretary.

5 “(6) ENFORCEMENT.—

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

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

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

20 “(B) CIVIL MONETARY PENALTY.—

21 “(i) IN GENERAL.—A specified imag-
22 ing service provider that has received a no-
23 tification under subparagraph (A)(i) and
24 fails to comply with the requirements of
25 this subsection by the date that is 90 days

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

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

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

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

1 “(7) PROVISION OF TECHNICAL ASSISTANCE.—

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

6 “(8) RULEMAKING.—

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

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

1 **SEC. 5. AMBULATORY SURGICAL CENTER PRICE TRANS-**
2 **PARENCY.**

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

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

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

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

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

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

25 “(ii) has a controlling interest

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

3 “(iv) is a significant equity investor.

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

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

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

18 “(ii) the National Drug Code; or

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

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

24 “(C) The discounted cash price.

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

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

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

1 made available as determined appropriate by
2 the Secretary.

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

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

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

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

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

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

6 “(5) ATTESTATION.—A senior official from
7 each specified ambulatory surgical center (the Chief
8 Executive Officer, Chief Financial Officer, or an of-
9 ficial of equivalent seniority) shall attest to the accu-
10 racy and completeness of the disclosures, and any
11 other attestations as required by the Secretary,
12 made in accordance with the ambulatory center price
13 transparency requirements based on criteria estab-
14 lished by the Secretary.

15 “(6) ENFORCEMENT.—

16 “(A) IN GENERAL.—In the case of a speci-
17 fied ambulatory surgical center that fails to
18 comply with the requirements of this sub-
19 section—

20 “(i) the Secretary shall notify such
21 ambulatory surgical center of such failure
22 not later than 30 days after the date on
23 which the Secretary determines such fail-
24 ure exists; and

1 “(ii) upon request of the Secretary,
2 such ambulatory surgical center shall sub-
3 mit to the Secretary, not later than 45
4 days after the date of such request, a cor-
5 rective action plan to comply with such re-
6 quirements.

7 “(B) CIVIL MONETARY PENALTY.—

8 “(i) IN GENERAL.—A specified ambu-
9 latory surgical center that has received a
10 notification under subparagraph (A)(i) and
11 fails to comply with the requirements of
12 this subsection by the date that is 90 days
13 after such notification (or, in the case of a
14 specified ambulatory surgical center that
15 has submitted a corrective action plan de-
16 scribed in subparagraph (A)(ii) in response
17 to a request so described, by the date that
18 is 90 days after such submission) shall be
19 subject to a civil monetary penalty of an
20 amount specified by the Secretary for each
21 day (beginning with the day on which the
22 Secretary first determined that such ambu-
23 latory surgical center was not complying
24 with such requirements) during which such

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

3 “(ii) INCREASE AUTHORITY.—In ap-
4 plying this subparagraph with respect to a
5 specified ambulatory surgical center that
6 fails to comply with the requirements of
7 this subsection in 2028 or a subsequent
8 year, the Secretary may through notice
9 and comment rulemaking increase the limi-
10 tation on the per day amount of any pen-
11 alty applicable to a specified ambulatory
12 surgical center under clause (i).

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

22 “(iv) NO AUTHORITY TO WAIVE OR
23 REDUCE PENALTY.—The Secretary shall
24 not grant or extend any waiver, delay, toll-
25 ing, or other mitigation of a civil monetary

1 penalty for failing to comply with the re-
2 quirements of this subsection except where
3 the Secretary determines that imposing the
4 maximum civil monetary penalty will dis-
5 rupt specified ambulatory surgical center
6 operations in a manner that impacts pa-
7 tient care. The Secretary may request doc-
8 umentation in such form and manner as
9 the Secretary may require in order to
10 evaluate impact on specified ambulatory
11 surgical center operations.

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

17 “(8) RULEMAKING.—

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

22 “(B) OWNERSHIP INFORMATION.—In pro-
23 mulgating regulations under this paragraph, the
24 Secretary shall define the individuals and orga-
25 nizations that must be disclosed under para-

1 graph (1)(C) in a manner that harmonizes dis-
2 closure requirements with requirements estab-
3 lished under section 1124 of the Social Security
4 Act and prioritizes the disclosure of individuals
5 and organizations who's ownership or manage-
6 ment relationship with a hospital impacts oper-
7 ational, financial, or clinical decision making for
8 such hospital.

9 “(f) CONTINUED APPLICABILITY OF STATE LAW.—

10 The provisions of this section shall not supersede any pro-
11 vision of State law that establishes, implements, or con-
12 tinues in effect any requirement or prohibition related to
13 health care price transparency, except to the extent that
14 such requirement or prohibition prevents the application
15 of a requirement or prohibition of this section.”.

16 **SEC. 6. STRENGTHENING HEALTH COVERAGE TRANS-**
17 **PARENCY REQUIREMENTS.**

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

21 (1) by striking “A Group health” and inserting
22 the following:

23 “(a) IN GENERAL.—A group health”; and

24 (2) by ending at the end the following:

1 “(b) ADDITIONAL TRANSPARENCY REQUIRE-
2 MENTS.—

3 “(1) SPECIFIED INFORMATION REQUIRED.—

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

10 “(B) INFORMATION REQUIRED.—For pur-
11 poses of subparagraph (A), the information
12 specified in this subparagraph is, with respect
13 to benefits available under the plan or coverage
14 for an item or service furnished by a health
15 care provider, the following (or other informa-
16 tion as determined appropriate by the Sec-
17 retary):

18 “(i) If such provider is an in-network
19 provider with respect to such item or serv-
20 ice, the in-network rate (as defined in
21 paragraph (5)) for such item or service.

22 “(ii) If such provider is not described
23 in clause (i), the out-of-network allowed
24 amount (as such term is defined for pur-
25 poses of section 147.210(a)(2)(xvii) of title

1 45, Code of Federal Regulation) for such
2 item or service that the plan or coverage
3 will pay without regard to the amount in
4 clause (iii).

5 “(iii) The amount of cost-sharing li-
6 ability (including deductibles, copayments,
7 and coinsurance) that the individual will
8 incur for such item or service based on the
9 information available to the plan or cov-
10 erage at the time the request is made
11 (which, in the case such item or service is
12 to be furnished by a provider described in
13 clause (ii), shall be calculated using the
14 maximum amount described in such
15 clause).

16 “(iv) The accumulated amounts with
17 respect to any deductible or out-of-pocket
18 maximum under the plan or coverage re-
19 flected in the plan’s or coverage’s records
20 at the time the request is made (broken
21 down, in the case separate deductibles or
22 maximums apply to separate individuals
23 enrolled in the plan or coverage, by such
24 separate deductibles or maximums, in ad-

1 dition to any cumulative deductible or
2 maximum).

3 “(v) In the case such plan or coverage
4 imposes any frequency or volume limita-
5 tions with respect to such item or service
6 (excluding medical necessity determina-
7 tions), the amount that such individual has
8 accrued towards such limitation with re-
9 spect to such item or service reflected in
10 the plan’s or coverage’s records at the time
11 the request is made.

12 “(vi) Information about any utiliza-
13 tion management requirements, such as
14 prior authorization, concurrent review, step
15 therapy, fail first, or similar requirements
16 applicable to coverage of such item or serv-
17 ice under such plan or coverage, including
18 information regarding utilization manage-
19 ment practices and determinations, includ-
20 ing aggregate information related to ap-
21 proval and denial rates, associated
22 timelines, and appeals, as determined ap-
23 propriate by the Secretary.

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

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

3 “(i) is based on an internet website;

4 “(ii) provides for real-time responses
5 to requests described in such subpara-
6 graph;

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

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

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

17 “(II) all providers that are in-
18 network providers with respect to such
19 plan or coverage and such item or
20 service;

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

24 “(I) the billing code for such
25 item or service; or

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

3 “(vi) is made available in plain lan-
4 guage, without subscription or other fee.

5 “(D) NONDUPLICATION.—A group health
6 plan or health insurance issuers shall be
7 deemed to be in compliance with this paragraph
8 if such plan or issuer has a tool in place under
9 section 2799A-4.

10 “(2) RATE AND PAYMENT INFORMATION.—

11 “(A) IN GENERAL.—Beginning January 1
12 of the year that begins on or after the date that
13 is 1 year after the date of enactment of the Pa-
14 tients Deserve Price Tags Act, and every quar-
15 ter thereafter (if there have been any changes
16 to the rate and payment information described
17 in subparagraphs (B) and (C), each group
18 health plan or health insurance issuer offering
19 coverage in the group or individual market shall
20 make available to the public, the rate and pay-
21 ment information described in subparagraph
22 (B) in accordance with subparagraph (C).

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

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

3 “(i) With respect to each item or serv-
4 ice for which benefits are available under
5 such plan or coverage, excluding those in-
6 cluded in clause (ii), identified by CPT,
7 HCPCS, DRG, or other applicable nation-
8 ally recognized identifier, including any ap-
9 plicable code modifiers, and accompanied
10 by a plain language description of the item
11 or service, the in-network rate (expressed
12 as a dollar amount or percentage of
13 charges, unless otherwise specified by the
14 Secretary), including the individual and
15 total amounts for any bundled rates, in ef-
16 fect as of the date of the submission of
17 such information with each provider (iden-
18 tified by national provider identifier) that
19 is an in-network provider with respect to
20 such item or service, other than such a
21 rate in effect with a provider that an issuer
22 has determined based on factors deter-
23 mined by the Secretary (such as medical
24 specialty) that it is unlikely that the pro-

1 vider would be reimbursed for the item or
2 service.

3 “(ii) With respect to each drug and
4 biologic (identified by National Drug Code,
5 J-code, or other commonly recognized bill-
6 ing code used for drugs) for which benefits
7 are available under such plan or coverage,
8 the in-network rate (expressed as a dollar
9 amount or percentage of charges, unless
10 otherwise specified by the Secretary) in ef-
11 fect as of the first day of the quarter in
12 which such information is made public
13 with each pharmacy or other prescription
14 drug dispenser that is an in-network phar-
15 macy or other prescription drug dispenser
16 with respect to such drug.

17 “(iii) With respect to each item or
18 service for which benefits are available
19 under such plan or coverage (expressed as
20 a dollar amount), identified by CPT, DRG,
21 HCPCS, or other applicable nationally rec-
22 ognized identifier, including any applicable
23 code modifiers, and accompanied by a brief
24 description of the item or service, the
25 amount billed or charged by the provider,

1 and the amount allowed by the plan or cov-
2 erage, for each such item or service fur-
3 nished during a representative lookback
4 window established by the Secretary by
5 each provider that was an out-of-network
6 provider with respect to such item or serv-
7 ice, broken down by each such provider
8 (identified by national provider identifier),
9 other than items and services with respect
10 to which not fewer than 11 claims for such
11 item or service were submitted to such
12 plan during such period.

13 “(C) MANNER OF SUBMISSION.—Rate and
14 payment information required to be submitted
15 and made available under this paragraph shall
16 be so submitted and so made available as fol-
17 lows:

18 “(i) Information shall be contained in
19 at least 3 separate machine-readable files
20 corresponding to the information described
21 in each of clauses (i) through (iii) of sub-
22 paragraph (B) that meet such require-
23 ments as specified by the Secretary
24 through rulemaking, in consultation with
25 the Secretaries of Labor and the Treasury,

1 to apply comparable requirements to group
2 health plans and health insurance coverage
3 and to entities providing benefit manage-
4 ment or other third-party administration
5 services on a contractual basis with a
6 group health plan or coverage.

7 “(ii) Requirements specified by the
8 Secretary through rulemaking (or subregu-
9 latory guidance) shall ensure the following:

10 “(I) Such files are made available
11 in a widely available format that al-
12 lows for information contained in such
13 files to be compared across plans and
14 coverage and are freely accessible to
15 individuals at no cost and without the
16 need to establish a user account or
17 provide other credentials.

18 “(II) Each such file includes each
19 of the following data elements:

20 “(aa) A numerical identifier
21 for the group health plan or
22 health insurance issuer (such as
23 a Health Insurance Oversight
24 System identifier).

1 “(bb) A plain-language de-
2 scription of the item or service
3 (including, for drugs, the propri-
4 etary and nonproprietary name
5 assigned).

6 “(cc) The billing code, in-
7 cluding any applicable modifiers,
8 associated with such item or
9 service, including the Healthcare
10 Common Procedure Coding Sys-
11 tem code, diagnosis-related
12 group, national drug code, or
13 other commonly recognized code
14 set.

15 “(dd) The place of service
16 code.

17 “(ee) The National Provider
18 Identifier and provider Tax Iden-
19 tification Number.

20 “(iii) The rate and payment informa-
21 tion disclosed under clauses (i) through
22 (iii) of subparagraph (B) shall be sepa-
23 rately delineated for each item or service,
24 regardless of whether such item or service
25 is reimbursed as a part of a bundle, epi-

1 sode, or other grouping of items and serv-
2 ices.

3 “(iv) An officer or executive of com-
4 petent authority shall attest to the accu-
5 racy and completeness of information sub-
6 mitted and made available under this sub-
7 paragraph. In the case of a plan or cov-
8 erage that relies on a third-party adminis-
9 trator or other service provider to compile
10 the information submitted and made avail-
11 able under this subparagraph, such plan or
12 coverage may satisfy the requirement
13 under this clause by obtaining such an at-
14 testation from the third-party adminis-
15 trator or other service provider. Such at-
16 testation shall be subject to enforcement
17 under paragraph (6).

18 “(3) OWNERSHIP INFORMATION.—Beginning
19 January 1 of the year that begins on or after the
20 date that is 1 year after the date of enactment of
21 the Patients Deserve Price Tags Act, and every
22 quarter thereafter (if there have been any changes in
23 the required information), each group health plan or
24 health insurance issuer offering coverage in the indi-
25 vidual or group market shall submit to the Sec-

1 retary, the applicable State authority, and make
2 available to the public, the name and business ad-
3 dress of each person or entity that, with respect to
4 such plan or coverage—

5 “(A) has an ownership or investment inter-
6 est;

7 “(B) has a controlling interest;

8 “(C) is a management services organiza-
9 tion; or

10 “(D) is a significant equity investor.

11 “(4) ENFORCEMENT.—

12 “(A) IN GENERAL.—Each year, the Sec-
13 retary shall audit the machine-readable files re-
14 quired by paragraph (2)(B) posted by not fewer
15 than 50 group health plans or health insurance
16 issuers for compliance with format and accessi-
17 bility standards.

18 “(B) NOTIFICATION AND REQUEST FOR
19 CORRECTIVE ACTION.—In the case of a group
20 health plan or health insurance issuer that fails
21 to comply with the requirements of this para-
22 graph, not later than 30 days after the date on
23 which the Secretary determines such failure ex-
24 ists, the Secretary shall submit to such plan or
25 issuer a notification of such determination,

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

3 “(C) CIVIL MONETARY PENALTY.—A plan
4 or issuer that has received a request for a cor-
5 rective action plan under subparagraph (B) and
6 fails to comply with the requirements of this
7 paragraph by the date that is 30 days after
8 such request is made shall be subject to a civil
9 monetary penalty of an amount specified by the
10 Secretary for each day (beginning with the day
11 on which such health plan or health insurance
12 issuer was failing to comply with such para-
13 graph) during which such failure was ongoing.
14 Such amount shall not exceed \$300 per partici-
15 pant, beneficiary, or covered individual per day
16 or \$10,000,000, whichever is lesser.

17 “(5) DEFINITIONS.—In this subsection:

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

22 “(B) IN-NETWORK RATE.—The term ‘in-
23 network rate’ means, with respect to a health
24 plan and an item or service furnished by a pro-
25 vider that is a participating provider with re-

1 spect to such plan and item or service, the con-
2 tracted rate in effect between such plan and
3 such provider for such item or service. If the
4 rate is based on an algorithm, percentage of an-
5 other amount, or other formula or criteria, the
6 health plan also shall disclose such algorithm,
7 percentage, formula, or criteria as set forth in
8 its contract and any other terms, schedules, ex-
9 hibits, data, or other information referenced in
10 any such contract as shall be required to deter-
11 mine and disclose the negotiated rate.

12 “(6) RULEMAKING.—

“(A) IN GENERAL.—The Secretary shall implement this subsection through notice and comment rulemaking in accordance with section 553 of title 5, United States Code. The Secretary may implement the manner of submission of data described in paragraph (2)(C) through subregulatory guidance.

20 “(B) REGULATIONS.—Regulations promul-
21 gated pursuant to this subsection shall provide
22 the following:

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

1 than 50 group health plans or health in-
2 surance issuers for compliance with format
3 and accessibility standards.

4 “(ii) The Secretary of Labor shall an-
5 nually audit the machine-readable files re-
6 quired by paragraph (2)(B) posted by not
7 fewer than 250 group health plans or serv-
8 ice providers furnishing third-party admin-
9 istrator services to a group health plan for
10 compliance with format and accessibility
11 standards.

12 “(iii) The Secretary of Health and
13 Human Services, in conjunction with the
14 Secretary of Labor and the Secretary of
15 the Treasury, shall annually issue a report
16 to Congress that includes findings, conclu-
17 sions, and enforcement actions taken based
18 on audits of the machine-readable files.
19 Such report shall be provided no later than
20 July 1 following the calendar year during
21 which the audits were completed. The Sec-
22 retary of Health and Human Services shall
23 make such report to Congress accessible to
24 the public.”.

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 subsections (a) and (b) shall apply beginning Janu-
3 ary 1 of the year that begins on or after the date
4 that is 1 year after the date of enactment of the Pa-
5 tients Deserve Price Tags Act.

6 (2) CONTINUED APPLICABILITY OF RULES FOR
7 PREVIOUS YEARS.—Nothing in the amendments
8 made by this section may be construed as affecting
9 the applicability of the rule entitled “Transparency
10 in Coverage” published by the Department of the
11 Treasury, the Department of Labor, and the De-
12 partment of Health and Human Services on Novem-
13 ber 12, 2020 (85 Fed. Reg. 72158), or amendments
14 made to such rule that are applicable before the date
15 of enactment of the Patients Deserve Price Tags
16 Act.

17 **SEC. 7. INCREASING GROUP HEALTH PLAN ACCESS TO**
18 **HEALTH DATA.**

19 (a) GROUP HEALTH PLAN ACCESS TO INFORMA-
20 TION.—

21 (1) IN GENERAL.—Section 2799A-9 of the Pub-
22 lic Health Service Act (42 U.S.C. 300gg-119) is
23 amended by adding at the end the following:

24 “(1) GROUP HEALTH PLAN ACCESS TO INFOR-
25 MATION.—

1 “(A) IN GENERAL.—No contract or ar-
2 rangement for services, and no extension or re-
3 newal of such contract or arrangement, between
4 a group health plan that is offered by a speci-
5 fied large employer or that is a specified large
6 plan (as such terms are defined in subpara-
7 graph (F)) and a health care provider (which
8 for purposes of this subparagraph, includes a
9 health care facility), network or association of
10 providers, service provider offering access to a
11 network of providers, third-party administrator,
12 health insurance issuer offering group or indi-
13 vidual health insurance coverage, or pharmacy
14 benefit manager, or any entity acting as an
15 intermediary between the group health plan and
16 the health care provider, network association of
17 providers, service provider offering access to a
18 network or association of providers (including a
19 licensed health insurance issuer or third-party
20 administrator), or pharmacy benefit manager
21 (collectively referred to in this subsection as
22 ‘Covered Service Providers’), is reasonable with-
23 in the meaning of this subsection unless such
24 contract or arrangement—

1 “(i) allows the responsible plan fidu-
2 ciary (as that term is defined in section
3 408(b)(2)(B)(ii)(I)(ee)) access to all claims
4 and encounter information or data, and
5 any documentation supporting claim pay-
6 ments, including, but not limited to, med-
7 ical records and policy documents, or infor-
8 mation or data described in subsection
9 (a)(1)(B) to—

10 “(I) comply with applicable law;

11 and

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

14 “(ii) does not—

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

21 “(II) limit the volume of claims
22 and encounter information or data
23 that the group health plan, the plan
24 sponsor, the plan administrator, or a
25 business associate of such plan may

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1 access during an audit or pursuant to
2 any request for such information or
3 data;

4 “(III) limit the disclosure of pric-
5 ing terms for value-based payment ar-
6 rangements or capitated payment ar-
7 rangements, including—

8 “(aa) payment calculations
9 and formulas;

10 “(bb) quality measures;

11 “(cc) contract terms;

12 “(dd) payment amounts;

13 “(ee) measurement periods
14 for all incentives; and

15 “(ff) other payment meth-
16 odologies used by an entity, in-
17 cluding a health care provider
18 (including a health care facility),
19 network or association of pro-
20 viders, service provider offering
21 access to a network of providers,
22 third-party administrator, or
23 pharmacy benefit manager;

1 “(IV) limit the disclosure of over-
2 payments and overpayment recovery
3 terms;

4 “(V) limit the right of the group
5 health plan, the plan sponsor, or the
6 plan administrator of such plan to se-
7 lect an auditor or define audit scope
8 or frequency;

9 “(VI) otherwise limit or unduly
10 delay the group health plan, the plan
11 sponsor, the plan administrator, or a
12 business associate of such plan from
13 accessing claims and encounter infor-
14 mation or data;

15 “(VII) limit the disclosure of fees
16 charged to the group health plan re-
17 lated to plan administration and
18 claims processing, including renegoti-
19 ation fees, access fees, repricing fees,
20 or enhanced review fees;

21 “(VIII) limit the right of the
22 group health plan, the plan sponsor,
23 or the plan administrator to request
24 action on any suspect claim payments;

1 “(IX) limit public disclosure of
2 de-identified or aggregate information;

3 “(X) limit the disclosure of, with
4 respect to a provider that files claims
5 under such plan, whether a Covered
6 Service Provider—

7 “(aa) has an ownership or
8 investment interest;

9 “(bb) has a controlling in-
10 terest;

11 “(cc) is a management serv-
12 ices organization; or

13 “(dd) is a significant equity
14 investor; or

15 “(XI) limit the disclosure of the
16 name and address of each person or
17 entity that, with respect to the health
18 plan service provider—

19 “(aa) has an ownership or
20 investment interest;

21 “(bb) has a controlling in-
22 terest; or

23 “(cc) is a significant equity
24 investor.

1 “(B) MANNER OF PROVIDING INFORMA-
2 TION OR DATA.—

3 “(i) IN GENERAL.—A Covered Service
4 Provider shall provide information or data
5 under this subsection in a manner con-
6 sistent with the privacy regulations pro-
7 mulgated under section 13402(a) of the
8 Health Information Technology for Eco-
9 nomic and Clinical Health Act (42 U.S.C.
10 17932(a)) and consistent with the privacy
11 regulations promulgated under the Health
12 Insurance Portability and Accountability
13 Act of 1996 in part 160 and subparts A
14 and E of part 164 of title 45, Code of Fed-
15 eral Regulations (or successor regulations)
16 (referred to in this paragraph as the
17 ‘HIPAA privacy regulations’) and shall re-
18 strict the use and disclosure of such infor-
19 mation according to such privacy regula-
20 tions and such HIPAA privacy regulations.
21 A Covered Service Provider shall not be re-
22 quired to disclose information or data
23 under this subsection that could reasonably
24 identify a participant or beneficiary
25 through individually identifiable health in-

1 formation (as such term is defined under
2 HIPAA privacy regulations).

3 “(ii) ADDITIONAL REQUIREMENTS.—
4 In carrying out this subsection, a Covered
5 Service Provider shall comply with section
6 164.504(f) of title 45, Code of Federal
7 Regulations (or a successor regulation).

8 “(iii) RULE OF CONSTRUCTION.—

9 “(I) IN GENERAL.—Nothing in
10 this subsection shall be construed to
11 modify the requirements for the cre-
12 ation, receipt, maintenance, or trans-
13 mission of protected health informa-
14 tion under the HIPAA privacy regula-
15 tions.

16 “(II) CIVIL RIGHTS LAWS.—
17 Nothing in this subsection shall be
18 construed to affect the application of
19 any Federal or State privacy or civil
20 rights law, including the HIPAA pri-
21 vacy regulations, the Genetic Informa-
22 tion Nondiscrimination Act of 2008
23 (Public Law 110–233) (including the
24 amendments made by such Act), the
25 Americans with Disabilities Act of

1 1990 (42 U.S.C. 12101 et seq.), sec-
2 tion 504 of the Rehabilitation Act of
3 1973 (29 U.S.C. 794), section 1557
4 of the Patient Protection and Afford-
5 able Care Act (42 U.S.C. 18116), title
6 VI of the Civil Rights Act of 1964 (42
7 U.S.C. 2000d), and title VII of the
8 Civil Rights Act of 1964 (42 U.S.C.
9 2000e).

10 “(iv) WRITTEN NOTICE.—Each plan
11 year, a Covered Service Provider shall pro-
12 vide to each participant or beneficiary writ-
13 ten notice informing the participant or
14 beneficiary of the requirement that Cov-
15 ered Service Providers respond to requests
16 to submit information or data under para-
17 graph (1), as applicable, which may include
18 incorporating such notification in plan doc-
19 uments provided to the participant or ben-
20 eficiary, or providing individual notifica-
21 tion.

22 “(v) CLARIFICATION REGARDING PUB-
23 LIC DISCLOSURE OF INFORMATION.—Noth-
24 ing in this subsection shall prevent a Cov-
25 ered Service Provider from placing reason-

1 able restrictions on the public disclosure of
2 the information or data described in para-
3 graph (1), except that such Provider may
4 not restrict disclosure of such report to the
5 Department of Health and Human Serv-
6 ices, the Department of Labor, or the De-
7 partment of the Treasury.

8 “(vi) LIMITATION.—This paragraph
9 shall not be construed to abridge or limit
10 the disclosure requirements under this sub-
11 section or to impose additional privacy or
12 security requirements on Covered Service
13 Providers or plan sponsors.

14 “(C) LIMITATION ON DISCLOSURE.—A
15 group health plan receiving information or data
16 under this subsection may disclose such infor-
17 mation only in a manner that is consistent with
18 HIPAA and the privacy and security regula-
19 tions promulgated thereunder, regardless of
20 their direct or indirect applicability to the plan
21 or any entities that could be or are business as-
22 sociates. A group health plan (and any business
23 associate or other entity acting on behalf of
24 such plan) may use such information or data
25 only for purposes of plan administration and

1 may not sell, license, or otherwise commercially
2 exploit such information or data or provide such
3 information or data to any third party that may
4 take such action.

5 “(D) REQUIREMENTS OF INFORMATION.—
6 Information made available under this sub-
7 section shall conform to the following stand-
8 ards:

9 “(i) All claims from a healthcare pro-
10 vider shall be made to the group health
11 plan in accordance with transaction stand-
12 ards adopted by regulation under HIPAA,
13 as follows:

14 “(I) Institutional, professional,
15 and dental claims shall be in ASC
16 X12N 837D format or any subse-
17 quent standard as established by the
18 Secretary.

19 “(II) Pharmacy claims shall be in
20 the National Council for Prescription
21 Drug Programs (NCPDP) format or
22 any subsequent standard as estab-
23 lished by the Secretary.

24 “(III) The files shall be unmodi-
25 fied copies of the files sent from the

1 provider, or, upon request, delivered
2 in a machine readable format. In the
3 event that paper claims are sent by
4 the provider, they shall be converted
5 to the appropriate standard electronic
6 format. Files shall be accessible to the
7 plan at no cost to the group health
8 plan.

9 “(ii) All claim payment (or EFT, elec-
10 tronic funds transfer) and electronic remit-
11 tance advice (ERA) notices sent by a Cov-
12 ered Service Provider shall be made avail-
13 able to the group health plan as ASC
14 X12N 835 files (or any other format as
15 identified by the Secretary) in accordance
16 with standards adopted by regulation
17 under HIPAA. The files shall be unmodi-
18 fied copies of the files sent by the Covered
19 Service Provider to the healthcare pro-
20 vider. Files shall be accessible at no cost to
21 the group health plan.

22 “(iii) The contractual terms con-
23 taining payment calculations and formulas,
24 pricing methodologies, and other informa-
25 tion used to determine the dollar value of

1 reimbursement, in a format as specified by
2 the Secretary.

3 “(iv) All non-claim costs shall be
4 itemized and made available to the group
5 health plan as requested through a web-
6 based portal, through an application pro-
7 gram interface (API), through a
8 downloadable Comma-Separated Value
9 (CSV) file, and, as appropriate, through
10 other downloadable machine-readable file
11 types.

12 “(E) IMPLEMENTATION.—The Secretary
13 shall implement this subsection through notice
14 and comment rulemaking in accordance with
15 section 553 of title 5, United States Code.

16 “(F) DEFINITIONS.—

17 “(i) IN GENERAL.—The provisions of
18 sections 408 and 410 of the Employee Re-
19 tirement Income Security Act of 1974 shall
20 apply with respect to terms used under
21 this subsection.

22 “(ii) SPECIFIED LARGE EMPLOYER.—
23 In this subsection, the term ‘specified large
24 employer’ means, in connection with a
25 group health plan (including group health

1 insurance coverage offered in connection
2 with such a plan) established or main-
3 tained by a single employer, with respect
4 to a calendar year or a plan year, as appli-
5 cable, an employer who employed an aver-
6 age of at least 50 employees on business
7 days during the preceding calendar year or
8 plan year and who employs at least 1 em-
9 ployee on the first day of the calendar year
10 or plan year.

11 “(iii) SPECIFIED LARGE PLAN.—In
12 this subsection, the term ‘specified large
13 plan’ means a group health plan (including
14 group health insurance coverage offered in
15 connection with such a plan) established or
16 maintained by a plan sponsor described in
17 clause (ii) or (iii) of section 3(16)(B) of
18 the Employee Retirement Income Security
19 Act of 1974 that had an average of at
20 least 50 participants on business days dur-
21 ing the preceding calendar year or plan
22 year, as applicable.”.

23 (2) CIVIL ENFORCEMENT.—

24 (A) CIVIL ENFORCEMENT.—Subsection (c)
25 of section 502 of such Act (29 U.S.C. 1132) is

1 amended by adding at the end the following
2 new paragraph:

3 “(13)(A) In the case of an agreement between
4 a group health plan (as defined in section 733(a)),
5 the plan sponsor of such plan (as defined in section
6 3(16)(B)), or the plan administrator of such plan
7 (as defined in section 3(16)(A)) and a health care
8 provider (which, for purposes of this paragraph, in-
9 cludes a health care facility), network or association
10 of providers, service provider offering access to a
11 network or association of providers, third-party ad-
12 ministrator, or pharmacy benefit manager, that vio-
13 lates the provisions of section 724(b), the Secretary
14 may assess a civil penalty against such provider, net-
15 work or association, service provider offering access
16 to a network or association of providers, third-party
17 administrator, pharmacy benefit manager, or other
18 service provider in the amount of up to \$10,000 for
19 each day during which such violation continues.
20 Such penalty shall be in addition to other penalties
21 as may be prescribed by law.

22 “(B) Nothing in subparagraph (A) shall be con-
23 strued to permit the Secretary to regulate health
24 care providers acting in their capacity as medical or-

1 ganizations furnishing items and services to pa-
2 tients.”.

3 (B) EXISTING PROVISIONS VOID.—Section
4 410 of such Act (29 U.S.C. 1110) is amended
5 by adding at the end the following:

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

8 “(1) unduly delays or limits a group health plan
9 (as defined in section 733(a)), the plan sponsor of
10 such plan (as defined in section 3(16)(B)), or the
11 plan administrator of such plan (as defined in sec-
12 tion 3(16)(A)) from accessing the claims and en-
13 counter information or data described in section
14 724(b)(1)(B); or

15 “(2) violates the requirements of section
16 408(b)(2)(C).”.

17 (C) TECHNICAL AMENDMENTS.—Section
18 408(b)(2)(B) of such Act (29 U.S.C.
19 1108(b)(2)) is amended—

20 (i) in clause (i), by striking “this
21 clause” and inserting “this paragraph”;
22 and

23 (ii) by adding at the end the fol-
24 lowing:

1 “(xi) A contract or arrangement shall
2 not be reasonable under this subparagraph
3 if it fails to comply with section 724(b).”.

4 (b) UPDATED ATTESTATION FOR PRICE AND QUAL-
5 ITY INFORMATION.—Section 2799A-9(a)(4) of the Public
6 Health Service Act (42 U.S.C. 300gg-119(a)(4)) is
7 amended to read as follows:

8 “(4) ATTESTATION.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (C), a group health plan or health insur-
11 ance issuer offering group health insurance cov-
12 erage shall annually submit to the Secretary an
13 attestation that such plan or issuer of such cov-
14 erage is in compliance with the requirements of
15 this subsection. Such attestation shall also in-
16 clude a statement verifying that—

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

1 “(ii) there are no terms in the agree-
2 ment under such paragraph (1) that di-
3 rectly or indirectly restrict or unduly delay
4 a group health plan, the plan sponsor, the
5 plan administrator, a business associate of
6 such plan, or the issuer from auditing, re-
7 viewing, or otherwise accessing such infor-
8 mation.

9 “(B) LIMITATION ON SUBMISSION.—A
10 group health plan or issuer offering group
11 health insurance coverage may not enter into an
12 agreement with a third-party administrator or
13 other service provider to submit the attestation
14 required under subparagraph (A).

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

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

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

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

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

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

22 **SEC. 8. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
23 **VIDERS.**

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

1 seq.), as amended by section 6701(a) of the Consolidated
2 Appropriations Act, 2026, is amended by adding at the
3 end the following:

4 **“SEC. 2799A-12. OVERSIGHT OF ADMINISTRATIVE SERVICE**
5 **PROVIDERS.**

6 “(a) IN GENERAL.—For plan years beginning on or
7 after January 1 of the year that begins on or after the
8 date that is 1 year after the date of enactment of the Pa-
9 tients Deserve Price Tags Act, no agreement between a
10 group health plan that is offered by a specified large em-
11 ployer or that is a specified large plan (as such terms are
12 defined in section 2799A-11(f)) or a health insurance
13 issuer offering individual or group health coverage (that
14 makes an election subject to subsection (b)(5)) and a
15 health insurance issuer that is operating as a third-party
16 administrator, a health care provider, network or associa-
17 tion of providers, third-party administrator, service pro-
18 vider offering access to a network of providers, pharmacy
19 benefit managers, or any other third party (each referred
20 to in this section as a ‘health plan service provider’) is
21 permissible if such agreement limits (or delays beyond the
22 applicable reporting period described in subsection (b)(1))
23 the disclosure of information to such group health plans
24 and health insurance issuers in a manner that prevents

1 any health plan service provider from providing the infor-
2 mation described in subsection (b)).

3 “(b) REQUIRED DISCLOSURES.—

4 “(1) CONTENTS AND FREQUENCY.—With re-
5 spect to plan years beginning on or after the date
6 that is 1 year after the date of enactment of this
7 section, not less frequently than quarterly, a health
8 plan service provider shall provide to the group
9 health or the health insurance issuer offering indi-
10 vidual or group health insurance coverage the fol-
11 lowing information at no cost to the plan or issuer:

12 “(A) The information described in section
13 2799A-9(a)(1)(B) (42 U.S.C. 300gg-
14 119(a)(1)(B)).

15 “(B) Any contractual and subcontractual
16 calculation methodologies, pricing or fee sched-
17 ules, or other formulae used to determine reim-
18 bursement amounts to providers and sub-
19 contractors, including methodologies, schedules,
20 fee structures, and any applied adjustments or
21 modifiers, with such information provided in a
22 manner sufficiently detailed to enable the group
23 health plan or issuer to accurately assess,
24 verify, and ensure compliance with the terms of

1 any contractual and subcontractual agreement
2 governing the reimbursement amounts.

3 “(C) The total amount received or ex-
4 pected to be received by the health plan service
5 provider or its subcontractors in provider or
6 supplier rebates, fees, alternative discounts, and
7 all other remuneration including amounts held
8 in escrow or variance accounts that has been
9 paid or is to be paid for claims incurred and
10 administrative services including data sales or
11 network payments.

12 “(D) The total amount paid or expected to
13 be paid by the health plan service provider to
14 its subcontractors in rebates, fees, contractual
15 arrangements, and all other remuneration for
16 administrative and other services.

17 “(E) All payment data, calculation meth-
18 odologies, and reconciliation information related
19 to alternative compensation arrangements, in-
20 cluding accountable care organizations, value-
21 based programs, shared savings programs, in-
22 centive compensation, bundled payments, capi-
23 tation arrangements, performance payments,
24 and any other reimbursement or payment mod-
25 els, where the group health plan paid fees, in-

1 curred obligations, or made payments in con-
2 nection with the group health plan or issuer re-
3 lated to such arrangements.

4 “(F) Whether, with respect to a provider
5 that files claims under such plan or coverage,
6 the health plan service provider—

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

9 “(ii) has a controlling interest;

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

12 “(iv) is a significant equity investor.

13 “(G) The name and business address for
14 each person or entity that, with respect to the
15 health plan service provider—

16 “(i) has an ownership or investment
17 interest;

18 “(ii) has a controlling interest; or

19 “(iii) is a significant equity investor.

20 “(2) MANNER OF PROVIDING INFORMATION OR
21 DATA.—

22 “(A) IN GENERAL.—A health plan service
23 provider shall provide information or data
24 under paragraph (1) in a manner consistent
25 with the privacy regulations promulgated under

1 section 13402(a) of the Health Information
2 Technology for Economic and Clinical Health
3 Act (42 U.S.C. 17932(a)) and consistent with
4 the privacy regulations promulgated under the
5 Health Insurance Portability and Accountability
6 Act of 1996 in part 160 and subparts A and E
7 of part 164 of title 45, Code of Federal Regula-
8 tions (or successor regulations) (referred to in
9 this paragraph as the 'HIPAA privacy regula-
10 tions') and shall restrict the use and disclosure
11 of such information according to such privacy
12 regulations and such HIPAA privacy regula-
13 tions.

14 “(B) ADDITIONAL REQUIREMENTS.—In
15 carrying out this subsection, a health plan serv-
16 ice provider shall comply with section
17 164.504(f) of title 45, Code of Federal Regula-
18 tions (or a successor regulation).

19 “(C) RULE OF CONSTRUCTION.—

20 “(i) IN GENERAL.—Nothing in this
21 subsection shall be construed to modify the
22 requirements for the creation, receipt,
23 maintenance, or transmission of protected
24 health information under the HIPAA pri-
25 vacy regulations.

1 “(ii) CIVIL RIGHTS LAWS.—Nothing
2 in this subsection shall be construed to af-
3 fect the application of any Federal or State
4 privacy or civil rights law, including the
5 HIPAA privacy regulations, the Genetic
6 Information Nondiscrimination Act of
7 2008 (Public Law 110–233) (including the
8 amendments made by such Act), the Amer-
9 icans with Disabilities Act of 1990 (42
10 U.S.C. 12101 et seq.), section 504 of the
11 Rehabilitation Act of 1973 (29 U.S.C.
12 794), section 1557 of the Patient Protec-
13 tion and Affordable Care Act (42 U.S.C.
14 18116), title VI of the Civil Rights Act of
15 1964 (42 U.S.C. 2000d), and title VII of
16 the Civil Rights Act of 1964 (42 U.S.C.
17 2000e).

18 “(D) WRITTEN NOTICE.—Each plan year,
19 a health plan service provider shall provide to
20 each participant or beneficiary written notice
21 informing the participant or beneficiary of the
22 requirement for health plan service providers to
23 submit information or data under paragraph
24 (1), as applicable, which may include incor-
25 porating such notification in plan documents

1 provided to the participant or beneficiary, or
2 providing individual notification.

3 “(E) CLARIFICATION REGARDING PUBLIC
4 DISCLOSURE OF INFORMATION.—Nothing in
5 this subsection shall prevent a health plan serv-
6 ice provider from placing reasonable restrictions
7 on the public disclosure of the information or
8 data described in paragraph (1), except that
9 such provider may not restrict disclosures under
10 subsection (b)(1) to the Department of Health
11 and Human Services, the Department of Labor,
12 or the Department of the Treasury.

13 “(F) LIMITATION.—This paragraph shall
14 not be construed to abridge or limit the disclo-
15 sure requirements under this subsection or to
16 impose additional privacy or security require-
17 ments on health plan service providers or plan
18 sponsors.

19 “(3) DISCLOSURE AND REDISCLOSURE.—

20 “(A) IN GENERAL.—A group health plan
21 or health insurance issuer offering individual or
22 group coverage receiving information under
23 paragraph (1) may disclose such information
24 only—

1 “(i) to the entity from which the in-
2 formation was received or to that entity’s
3 business associates as defined in section
4 160.103 of title 45, Code of Federal Regu-
5 lations (or successor regulations); or

6 “(ii) as permitted by the HIPAA Pri-
7 vacy Rule (45 C.F.R. part 160 and sub-
8 parts A and E of part 164).

9 “(B) AVAILABILITY OF INFORMATION.—To
10 the extent the information required by this sub-
11 section is made available to the health insur-
12 ance issuer offering group health insurance cov-
13 erage, the health insurance issuer shall make
14 such information available, at the same time, in
15 the same format, and at no cost, to the group
16 health plan.

17 “(C) LIMITATION ON USE OF INFORMA-
18 TION.—A group health plan or health insurance
19 issuer (and any business associate or other enti-
20 ty acting on behalf of such plan) may use infor-
21 mation or data under this paragraph only for
22 purposes of plan administration and may not
23 sell, license, or otherwise commercially exploit
24 such information or data or provide such infor-

1 mation or data to any third party that may
2 take such action.

3 “(D) RULE OF CONSTRUCTION.—Nothing
4 in this section shall be construed to prevent a
5 group health plan, a health insurance issuer, or
6 a health plan service provider providing services
7 with respect to such a plan, from placing rea-
8 sonable restrictions on the public disclosure of
9 the information described in paragraph (1), ex-
10 cept that such plan or entity may not restrict
11 disclosure of such information to the Depart-
12 ment of Health and Human Services, the De-
13 partment of Labor, the Department of the
14 Treasury, or the Comptroller General of the
15 United States.

16 “(E) FAILURE TO PROVIDE.—The obliga-
17 tion to provide information pursuant to this
18 subsection shall exist notwithstanding the pres-
19 ence of any formal data-sharing agreement be-
20 tween the parties. Failure to provide the re-
21 quired information as specified shall constitute
22 a violation of this Act and the Secretary shall
23 initiate enforcement action under section
24 2723(b) (42 U.S.C. 300gg-22(b)) within 90
25 days of becoming aware of a violation of this

1 section, except that nothing in this section shall
2 be construed to limit the Secretary's existing
3 authority under this Act.

4 “(4) DATA FORMAT STANDARDS.—All data and
5 information provided pursuant to this subsection
6 shall comply with the following standards:

7 “(A) All claims from a healthcare provider
8 shall be made to the group health plan in ac-
9 cordance with standards adopted under HIPAA
10 as described in subpart K of part 162 of title
11 45, Code of Federal Regulations, as follows:

12 “(i) Institutional, professional, and
13 dental claims and adjustments to these
14 claims shall be provided to the group
15 health plan or health insurance issuer in
16 the ASC X12N 837 format.

17 “(ii) Prescription drug claims shall be
18 in the National Council for Prescription
19 Drug Programs (NCPDP) format.

20 “(iii) The files shall be unmodified
21 copies of the files sent from the provider.
22 In the event that paper claims are sent by
23 the provider, they shall be converted to the
24 appropriate standard electronic format.

1 Such data shall be provided at no cost to
2 the group health plan.

3 “(B) All claim payment (or EFT, elec-
4 tronic funds transfer) and electronic remittance
5 advice (ERA) information sent by a health plan
6 service provider shall be provided to the group
7 health plan or health insurance issuer in the
8 ASC X12N 835 format, in accordance with
9 standards and operating rules adopted under
10 HIPAA at subpart P of part 162 of title 45,
11 Code of Federal Regulations, unmodified from
12 the form in which it was transmitted to the
13 healthcare provider. Such information shall be
14 provided at no cost to the group health plan.

15 “(C) The Secretary may modify the stand-
16 ards set forth in this paragraph as necessary to
17 align with any changes adopted by the Sec-
18 retary pursuant to the authority provided under
19 section 1173 of the Social Security Act (42
20 U.S.C. 1320d-2).

21 “(5) OPT-IN FOR HEALTH INSURANCE COV-
22 ERAGE.—In the case of a health insurance issuer of-
23 fering coverage in the individual or group market,
24 such issuer may, on an annual basis, for plan years
25 beginning on or after the effective date of this sec-

1 tion, elect to require a health plan service provider
2 to submit to such issuer a report that includes all
3 of the information described in paragraph (1).

4 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
5 provision in an agreement that unduly delays or limits a
6 group health plan or issuer’s access to information de-
7 scribed in this section or that restricts the format or tim-
8 ing of the provision of such information in a manner that
9 is inconsistent with the requirements of this section shall
10 be prohibited and, if a group health plan or issuer enters
11 into such agreement, shall be deemed void as against pub-
12 lic policy.

13 “(d) REGULATIONS.—The Secretary shall implement
14 this section through notice and comment rulemaking in
15 accordance with section 553 of title 5, United States
16 Code.”.

17 (b) PENALTY.—Section 2723(b) of the Public Health
18 Service Act (42 U.S.C. 300gg–22(b)) is amended by add-
19 ing at the end the following:

20 “(4) ENFORCEMENT AUTHORITY RELATING TO
21 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
22 standing any provisions to the contrary, the Sec-
23 retary may assess a penalty against a health plan
24 service provider, as defined in section 2799A–12(a)
25 (42 U.S.C. 300gg–121(a)), of \$100,000 per day for

1 each violation of such section, pursuant to substan-
2 tially similar processes and procedures as those set
3 forth in section 2723(b)(2)(D) through (G) (42
4 U.S.C. 300gg-121(b)(2)(D) through (G)).”.

5 (c) ERISA AMENDMENTS.—

6 (1) IN GENERAL.—Section 502(c) of the Em-
7 ployee Retirement Income Security Act of 1974 (29
8 U.S.C. 1132(c)) is amended by adding at the end
9 the following new paragraph:

10 “(14) The Secretary may assess a civil penalty
11 against any person of \$100,000 per day for each vio-
12 lation by any person of section 727.”.

13 (2) TECHNICAL AMENDMENT.—Paragraph (6)
14 of section 502(a) of the Employee Retirement In-
15 come Security Act of 1974 (29 U.S.C. 1132(a)) is
16 amended by striking “or (9)” and inserting “(9),
17 (13), or (14)”.

18 **SEC. 9. STATE PREEMPTION ONLY IN EVENT OF CONFLICT.**

19 The provisions of section 2718A of the Public Health
20 Service Act (as added and amended by this Act) shall not
21 be construed to supersede any provision of State law which
22 establishes, implements, or continues in effect any require-
23 ment or prohibition related to health care price trans-
24 parency, including for hospitals, clinical diagnostic labora-
25 tories, provider of specified imaging services, and ambula-

1 tory surgical centers (as such terms are defined in section
2 2718A(a) of the Public Health Service Act), except to the
3 extent that such requirement or prohibition prevents the
4 application of a requirement or prohibition of such sec-
5 tions (or such amendments). Nothing in this section shall
6 be construed to affect group health plans established
7 under the Employee Retirement Income Security Act of
8 1974, or alter the application of section 514 of such Act
9 (29 U.S.C. 1144).

10 **SEC. 10. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

11 (a) **ADVANCED EXPLANATION OF BENEFITS.**—Sec-
12 tion 2799A–1(f) of the Public Health Service Act (42
13 U.S.C. 300gg–111(f)) is amended—

14 (1) in paragraph (1)—

15 (A) by striking subparagraph (C) and in-
16 serting the following:

17 “(C) A good faith estimate of the amount
18 the plan or coverage is responsible for paying
19 for items and services included in the estimate
20 described in subparagraph (B), including a
21 plain language description of each item or serv-
22 ice and all applicable billing codes for each item
23 or service, including modifiers, using standard
24 and commonly recognized billing code sets that
25 are clearly identified.”; and

1 (B) by adding at the end the following

2 “(I) A notification that the recipient may
3 be held harmless, in certain circumstances, if
4 the information in the advanced explanation of
5 benefits does not match the amount the recipi-
6 ent is billed.”; and

7 (2) by adding at the end the following

8 “(3) HOLD HARMLESS.—

9 “(A) IN GENERAL.—For plan years begin-
10 ning on or after the date that is 1 year after
11 the date on which the Secretary implements
12 this section, a participant, beneficiary, or en-
13 rollee shall be held harmless for any amount
14 that is substantially in excess (as defined by the
15 Secretary in a manner consistent with the proc-
16 ess described in section 2799B-7) of the esti-
17 mate generated by the advanced explanation of
18 benefits.

19 “(B) NO PATIENT RESPONSIBILITY FOR
20 EXCESS CHARGES.—A group health plan or a
21 health insurance issuer in the group or indi-
22 vidual market shall not hold a participant, ben-
23 eficiary, or enrollee responsible for excess
24 charges described in this paragraph if such ex-
25 cess is the result of coverage or payment deter-

1 minations that differ from projections made in
2 the advanced explanation of benefits at the time
3 such explanation was generated.

4 “(C) SUBSTANTIAL EXCESS.—A partici-
5 pant, beneficiary, or enrollee shall not be held
6 harmless for excess amounts if such amounts
7 reflect the cost of medically necessary items or
8 services furnished based on unforeseen cir-
9 cumstances that could not have reasonably been
10 anticipated by the provider or facility at the
11 time the good faith estimate was generated or
12 by the plan or issuer at the time the advanced
13 explanation of benefits was generated.”.

14 (b) GOOD FAITH ESTIMATES.—Section 2799B-6 of
15 the Public Health Service Act (42 U.S.C. 300gg-136) is
16 amended—

17 (1) by striking “Each health care” and insert-
18 ing the following:

19 “(a) IN GENERAL.—Each health care”; and

20 (2) by adding at the end the following:

21 “(b) HOLD HARMLESS.—

22 “(1) IN GENERAL.—For plan years beginning
23 on or after the date that is 1 year after the date on
24 which the Secretary implements section 2799A-1(f),
25 if an individual enrolled in a group health plan or

1 health insurance coverage (and seeks to have a claim
2 for an item or service submitted to such plan or cov-
3 erage) is responsible for any amount that is substan-
4 tially in excess (as defined by the Secretary in a
5 manner consistent the process described in section
6 2799B-7) of the estimate generated in the advanced
7 explanation of benefits described in section 2799A-
8 1(f) because the final charges for items and services
9 were substantially in excess of the good faith esti-
10 mate provided to the plan or coverage under this
11 section, a provider shall not bill the patient for
12 amounts substantially in excess of the advanced ex-
13 planation of benefits.

14 “(2) SUBSTANTIAL EXCESS.—An individual
15 seeking to have a claim for an item or service cov-
16 ered by a group health plan or health insurance cov-
17 erage shall not be held harmless for excess amounts
18 if such amounts reflect the cost of medically nec-
19 essary items or services furnished based on unfore-
20 seen circumstances that could not have reasonably
21 been anticipated by the provider or facility at the
22 time the good faith estimate was generated or by the
23 plan or issuer at the time the advanced explanation
24 of benefits was generated.”.

1 (c) EXPLANATION OF BENEFITS.—Section 2799A-1
2 of the Public Health Service Act (42 U.S.C. 300gg-111)
3 is amended by adding at the end the following:

4 “(g) EXPLANATION OF BENEFITS.—

5 “(1) IN GENERAL.—For plan years beginning
6 on January 1 of the year that begins on or after the
7 date that is 1 year after the date of enactment of
8 the Patients Deserve Price Tags Act, each group
9 health plan, or a health insurance issuer offering
10 group or individual health insurance coverage shall,
11 within 45 days of receiving the information nec-
12 essary to decide a claim for payment (as defined by
13 the Secretary) for an item or service under the plan
14 or coverage for which liability under the plan or cov-
15 erage has been determined, provide to the partici-
16 pant, beneficiary, or enrollee (through mail or elec-
17 tronic means, as requested by the participant, bene-
18 ficiary, or enrollee) a notification (in clear and un-
19 derstandable language and utilizing substantially the
20 same format as the advanced explanation of benefits
21 required by subsection (f) to enable comparison
22 when an advanced explanation of benefits is pro-
23 vided) including the following:

24 “(A) Whether or not the provider or facil-
25 ity is a participating provider or a participating

1 facility with respect to the plan or coverage
2 with respect to the furnishing of such item or
3 service.

4 “(B) An itemized explanation of benefits
5 that includes the following:

6 “(i) A plain language description of
7 each item or service.

8 “(ii) All applicable billing codes for
9 each item or service, including modifiers,
10 using standard and commonly recognized
11 billing code sets that are clearly identified.

12 “(iii) The amount the plan or cov-
13 erage is responsible for paying for each
14 item or service.

15 “(iv) The amount of any cost-sharing
16 for which the participant, beneficiary, or
17 enrollee is responsible for each item or
18 service (as of the date of such notification).

19 “(v) The amount that the participant,
20 beneficiary, or enrollee has incurred toward
21 meeting the limit of the financial responsi-
22 bility (including with respect to deductibles
23 and out-of-pocket maximums) under the
24 plan or coverage (as of the date of such
25 notification).

1 “(vi) The type of site of each item or
2 service, including office, facility, or emer-
3 gency room.

4 “(vii) If applicable, a description of
5 any discrepancies that exist between the
6 services outlined in a patient’s advanced
7 explanation of benefits and the explanation
8 of benefits.

9 “(viii) The amount of any facility fee
10 or other patient charges that were added
11 to the final payment amount, together with
12 a plain language explanation of the fee, if
13 applicable.

14 “(C) If the provider or facility is a partici-
15 pating provider or facility with respect to the
16 plan or coverage with respect to the furnishing
17 of such item or service, the contracted rate
18 under such plan or coverage for such item or
19 service.

20 “(D) The charges submitted by the pro-
21 vider or facility for each item or service.

22 “(E) Information pertaining to plan type,
23 as defined the Secretary.

24 “(2) FORMAT.—If applicable, the notification
25 described in paragraph (1) may be provided in con-

1 junction with, or as part of, a notice of a claim de-
2 termination or other communication required by sec-
3 tion 2719(a) (42 U.S.C. 300gg-19(a)), or regula-
4 tions thereunder.

5 “(h) REGULATIONS.—The Secretary shall implement
6 this section through notice and comment rulemaking in
7 accordance with section 553 of title 5, United States
8 Code.”.

9 **SEC. 11. TRANSPARENCY IN BILLING.**

10 (a) IN GENERAL.—Part E of title XXVII of the Pub-
11 lic Health Service Act (42 U.S.C. 300gg-131 et seq.) is
12 amended by adding at the end the following:

13 **“SEC. 2799B-10. PATIENT ACCESS TO COMPLETE BILLING**
14 **INFORMATION.**

15 “(a) REQUIREMENTS.—

16 “(1) NOTICE OF RIGHT OF ACCESS TO
17 ITEMIZED BILLS; IN GENERAL.—A health care pro-
18 vider or health care facility that requests payment
19 from an individual for providing a health care item
20 or service to the patient shall include with such re-
21 quest a written notice of the individual’s right to re-
22 quest an itemized bill as part of the individual’s des-
23 ignated record set under section 164,524 of title 45,
24 Code of Federal Regulations (or a successor regula-
25 tion).

1 “(2) REQUIRED INFORMATION.—A notice under
2 paragraph (1) shall provide—

3 “(A) a phone number and internet website
4 where an individual can make a request for ac-
5 cess to their itemized bill;

6 “(B) information about the availability of
7 language-assistance services for individuals with
8 limited English proficiency (LEP); and

9 “(C) information about the health care
10 provider’s or health care facility’s charity care
11 policies and instructions on how to apply for
12 charity care.

13 “(3) COLLECTIONS ACTIONS.—

14 “(A) IN GENERAL.—A health care provider
15 or health care facility shall not bill or take any
16 collections actions against an individual—

17 “(i) for any provided health care item
18 or service unless the health care provider
19 or health care facility has complied with
20 paragraph (1) or section 13405(e)(4) of
21 the HITECH Act; or

22 “(ii) with respect to any items or serv-
23 ices for which the amount appearing on an
24 itemized bill described above in paragraph
25 (1) exceeds the amount disclosed pursuant

1 to Federal health care price transparency
2 regulations, including part 180 of title 45,
3 Code of Federal Regulations, or provided
4 in a good faith estimate that complies with
5 section 2799B-6 of this Act and section
6 149.610 of title 45, Code of Federal Regu-
7 lations, or another good faith estimate pro-
8 vided by a health care entity covered under
9 this section but not otherwise covered
10 under such section 2799B-6, unless the
11 provider or facility documents that the ad-
12 ditional items or services were medically
13 necessary due to unforeseen complications
14 or a patient-initiated change, and could not
15 reasonably have been anticipated.

16 “(B) PROVIDER REQUIREMENT.—If a pro-
17 vider fails to provide a documentation as re-
18 quired under subparagraph (A)(ii) in the case
19 of items or services, the good faith estimate de-
20 scribed in such subparagraph with respect to
21 such items or services shall be binding.

22 “(b) FAILURE TO COMPLY.—

23 “(1) PENALTIES.—The Secretary shall impose
24 penalties on any health care provider or health care
25 facility that fails to comply with the requirements of

1 this section in an amount not to exceed \$10,000 for
2 each instance of failure to comply.

3 “(2) PRESUMPTION IN FAVOR OF INDI-
4 VIDUAL.—If a health care provider or health care fa-
5 cility fails to comply with the requirements of this
6 section, the presumption shall be that charges were
7 substantially in excess of the good faith estimate, as
8 set forth in section 2799B–6, for the purpose of any
9 patient-provider dispute, including in accordance
10 with section 2799B–7 and regulations promulgated
11 thereunder.

12 “(c) REGULATIONS.—The Secretary shall implement
13 this section through notice and comment rulemaking in
14 accordance with section 553 of title 5, United States
15 Code.”.

16 (b) STANDARDS FOR ACCESSING ITEMIZED BILLS.—
17 Section 13405(e) of the HITECH Act (42 U.S.C.
18 17935(e)) is amended—

19 (1) in paragraph (2), by striking “and” at the
20 end;

21 (2) in paragraph (3), by striking the period and
22 inserting “; and”; and

23 (3) by adding at the end, the following:

1 “(4) if the individual makes a request only for
2 an itemized copy of a bill for services provided, the
3 covered entity or business associate shall—

4 “(A) make such protected health informa-
5 tion available within 30 days of such request;

6 “(B) not impose any fee for providing such
7 individual a copy of their information; and

8 “(C) include in such itemized bill, a plain
9 language description of each distinct health
10 care item or service, all applicable billing codes
11 for each distinct item or service, including
12 modifiers, using standard and commonly recog-
13 nized billing code sets, the price and billed
14 amount, if different, of each distinct item or
15 service.”.

16 **SEC. 12. TECHNICAL AMENDMENTS.**

17 (a) ERISA.—Section 715(a)(1) of the Employee Re-
18 tirement Income Security Act of 1974 (29 U.S.C.
19 1185d(a)(1)) is amended by inserting “and parts D and
20 E of the Public Health Service Act (as amended by the
21 Patients Deserve Price Tags Act)” after “Affordable Care
22 Act)”.

23 (b) INTERNAL REVENUE CODE.—Section 9815(a)(1)
24 of the Internal Revenue Code of 1986 is amended by in-
25 serting “and parts D and E of the Public Health Service

1 Act (as amended by the Patients Deserve Price Tags
2 Act)” after “Affordable Care Act)”.

3 **SEC. 13. IMPLEMENTATION AND ENFORCEMENT FUNDING.**

4 (a) APPROPRIATION FOR SECRETARY OF LABOR.—

5 There are authorized to be appropriated, such sums as
6 may be necessary for fiscal year 2026, and each subse-
7 quent fiscal year, to enable the Secretary of Labor to carry
8 out this Act and the amendments made by this Act, in-
9 cluding enforcement activities.

10 (b) APPROPRIATION FOR THE SECRETARY OF

11 HEALTH AND HUMAN SERVICES.—There are authorized
12 to be appropriated, such sums as may be necessary for
13 fiscal year 2026, and each subsequent fiscal year, to en-
14 able the Secretary of Health and Human Services to carry
15 out the amendments made by this Act, including imple-
16 mentation and enforcement activities.