

118TH CONGRESS  
1ST SESSION

# H. R. 3561

To promote hospital and insurer price transparency, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 22, 2023

Mrs. RODGERS of Washington (for herself and Mr. PALLONE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To promote hospital and insurer price transparency, and  
for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Promoting Access to  
5 Treatments and Increasing Extremely Needed Trans-  
6 parency Act of 2023” or the “PATIENT Act of 2023”.

1 **TITLE I—INCREASING PRICE**  
2 **TRANSPARENCY TO LOWER**  
3 **COSTS**

4 **SEC. 101. PRICE TRANSPARENCY REQUIREMENTS.**

5 (a) IN GENERAL.—Section 2718(e) of the Public  
6 Health Service Act (42 U.S.C. 300gg–18(e)) is amend-  
7 ed—

8 (1) by striking “Each hospital” and inserting  
9 the following:

10 “(1) IN GENERAL.—Each hospital”;

11 (2) by inserting “, without subscription and  
12 free of charge, in a single machine-readable file,”  
13 after “a list”;

14 (3) by inserting “and a list, in plain language  
15 and without subscription and free of charge, in a  
16 consumer-friendly format, of the hospital’s standard  
17 charges for as many of the 70 Centers for Medicare  
18 & Medicaid Services-specified shoppable services that  
19 are provided by the hospital, and as many additional  
20 hospital-selected shoppable services (or all such addi-  
21 tional services, if such hospital provides fewer than  
22 300 shoppable services) as may be necessary for a  
23 combined total of at least 300 shoppable services”  
24 after “Social Security Act”; and

1           (4) by adding at the end the following: “Such  
2 lists shall be updated not less frequently than annu-  
3 ally. Beginning January 1, 2024, each hospital shall  
4 include in its lists of standard charges, along with  
5 such additional information as the Secretary may re-  
6 quire with respect to such charges for purposes of  
7 promoting public awareness of hospital pricing in  
8 advance of receiving a hospital item or service, the  
9 following:

10                   “(A) A plain language description of each  
11 item or service included on such list, including,  
12 as applicable, the Healthcare Common Proce-  
13 dure Coding System (HCPCS) code, the Diag-  
14 nosis Related Group (DRG), the National Drug  
15 Code (NDC), or other payer identifier used or  
16 approved by the Centers for Medicare & Med-  
17 icaid Services for such item or service.

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 hospital inpatient  
21 setting and outpatient department setting.

22                   “(C) Any current payer-specific negotiated  
23 charges, clearly associated with the name of the  
24 third party payer and plan and expressed as a  
25 dollar amount, that applies to each such item or

1 service when provided in, as applicable, the hos-  
2 pital inpatient setting and outpatient depart-  
3 ment setting.

4 “(D) The de-identified maximum and min-  
5 imum negotiated charges for each such item or  
6 service.

7 “(E) The discounted cash price, expressed  
8 as a dollar amount, for each such item or serv-  
9 ice when provided in, as applicable, the hospital  
10 inpatient setting and outpatient department  
11 setting. If the discounted cash price is a per-  
12 centage of another value provided, the cal-  
13 culated value must be entered as a dollar  
14 amount. If the discounted cash price equates to  
15 the gross charge, the gross charge shall be re-  
16 entered to indicate that no cash discount is  
17 available.

18 “(2) DEEMED COMPLIANCE WITH SHOPPABLE  
19 SERVICES REQUIREMENT FOR CERTAIN YEARS.—  
20 With respect to a year before 2025, a hospital shall  
21 be deemed to meet the requirement of paragraph (1)  
22 that such hospital make available a list of standard  
23 charges for shoppable services if the hospital main-  
24 tains an internet-based price estimator tool that  
25 meets the following requirements:

1           “(A) The tool provides estimates for as  
2 many of the 70 Centers for Medicare & Med-  
3 icaid Services specified shoppable services that  
4 are provided by the hospital, and as many addi-  
5 tional hospital-selected shoppable services (or  
6 all such additional services, if such hospital pro-  
7 vides fewer than 300 shoppable services) as  
8 may be necessary for a combined total of at  
9 least 300 shoppable services.

10           “(B) The tool allows health care con-  
11 sumers to, at the time they use the tool, obtain  
12 an estimate of the amount they will be obligated  
13 to pay the hospital for the shoppable service.

14           “(C) The tool is prominently displayed on  
15 the hospital’s website and easily accessible to  
16 the public, without subscription, fee, or having  
17 to submit personal identifying information, and  
18 searchable by service description, billing code,  
19 and payer.

20           The Secretary may not deem the establishment of an  
21 internet-based price estimator tool that meets the re-  
22 quirements of this paragraph to constitute compli-  
23 ance with the requirement of paragraph (1) that  
24 such hospital make available a list of standard

1 charges for shoppable services for 2025 or a subse-  
2 quent year.

3 “(3) UNIFORM METHOD AND FORMAT.—Not  
4 later than January 1, 2025, the Secretary shall im-  
5 plement a standard, uniform method and format for  
6 hospitals to use in order to satisfy the requirements  
7 of this subsection for disclosing directly to the public  
8 charge and price information. Such method and for-  
9 mat may be similar to any template established by  
10 the Centers for Medicare & Medicaid Services as of  
11 the date of the enactment of this paragraph for re-  
12 porting such information under this subsection and  
13 shall meet such standards as determined appropriate  
14 by the Secretary.

15 “(4) MONITORING OF PRICING INFORMATION.—  
16 The Secretary, in consultation with the Inspector  
17 General of the Department of Health and Human  
18 Services, shall, through notice and comment rule-  
19 making, establish a process to regularly monitor the  
20 accuracy and validity of pricing information dis-  
21 played by each hospital pursuant to paragraph (1).

22 “(5) DEFINITIONS.—Notwithstanding any other  
23 provision of law, for the purpose of paragraphs (1)  
24 and (2):

1           “(A) DE-IDENTIFIED MAXIMUM NEGO-  
2           TIATED CHARGE.—The term ‘de-identified max-  
3           imum negotiated charge’ means the highest  
4           charge that a hospital has negotiated with all  
5           third party payers for an item or service.

6           “(B) DE-IDENTIFIED MINIMUM NEGO-  
7           TIATED CHARGE.—The term ‘de-identified min-  
8           imum negotiated charge’ means the lowest  
9           charge that a hospital has negotiated with all  
10          third party payers for an item or service.

11          “(C) DISCOUNTED CASH PRICE.—The  
12          term ‘discounted cash price’ means the charge  
13          that applies to an individual who pays cash, or  
14          cash equivalent, for a hospital item or service.  
15          Hospitals that do not offer self-pay discounts  
16          may display the hospital’s undiscounted gross  
17          charges as found in the hospital chargemaster.

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

22          “(E) PAYER-SPECIFIC NEGOTIATED  
23          CHARGE.—The term ‘payer-specific negotiated  
24          charge’ means the charge that a hospital has

1 negotiated with a third party payer for an item  
2 or service.

3 “(F) SHOPPABLE SERVICE.—The term  
4 ‘shoppable service’ means a service that can be  
5 scheduled by a health care consumer in ad-  
6 vance.

7 “(G) THIRD PARTY PAYER.—The term  
8 ‘third party payer’ means an entity that is, by  
9 statute, contract, or agreement, legally respon-  
10 sible for payment of a claim for a health care  
11 item or service.

12 “(6) ENFORCEMENT.—

13 “(A) IN GENERAL.—In the case of a hos-  
14 pital that fails to comply with this subsection—

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

19 “(ii) not later than 45 days after the  
20 date of such notification, the hospital shall  
21 complete a corrective action plan to comply  
22 with such requirements.

23 “(B) CIVIL MONETARY PENALTY.—

24 “(i) IN GENERAL.—In addition to any  
25 other enforcement actions or penalties that



1 may apply under subsection (b)(3) or an-  
2 other provision of law, a hospital that has  
3 received a notification under subparagraph  
4 (A)(i) and fails to satisfy the requirement  
5 under subparagraph (A)(ii) or otherwise  
6 comply with the requirements of this sub-  
7 section by the date that is 90 days after  
8 such notification shall be subject to a civil  
9 monetary penalty of an amount—

10 “(I) in the case the hospital pro-  
11 vides not more than 30 beds (as de-  
12 termined under section  
13 180.90(c)(2)(ii)(D) of title 45, Code  
14 of Federal Regulations, as in effect on  
15 the date of the enactment of this  
16 paragraph), not to exceed \$300 per  
17 day that the violation is ongoing as  
18 determined by the Secretary; and

19 “(II) in the case the hospital pro-  
20 vides more than 30 beds (as so deter-  
21 mined), equal to—

22 “(aa) subject to item (bb),  
23 \$10 per bed per day that the vio-  
24 lation is ongoing as determined  
25 by the Secretary, but for viola-

1 tions occurring before January 1,  
2 2024, not to exceed \$5,500 per  
3 each such day; or

4 “(bb) in the case such hos-  
5 pital has failed to satisfy the re-  
6 quirement under subparagraph  
7 (A)(ii) or otherwise comply with  
8 the requirements of this sub-  
9 section for any continuous 1-year  
10 period beginning on or after Jan-  
11 uary 1, 2024, and the amount  
12 otherwise imposed under item  
13 (aa) for such failure for such pe-  
14 riod would be less than  
15 \$5,000,000, an amount not less  
16 than \$5,000,000.

17 “(ii) INCREASE AUTHORITY.—In ap-  
18 plying this subparagraph with respect to  
19 violations occurring in 2025 or a subse-  
20 quent year, the Secretary may through no-  
21 tice and comment rulemaking increase any  
22 dollar amount applied under this subpara-  
23 graph by an amount specified by the Sec-  
24 retary.

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 clause (i) in the same manner as  
7           such provisions apply to a civil monetary  
8           penalty imposed under subsection (a) of  
9           such section.”.

10       (b) PUBLICATION OF LIST OF HOSPITALS.—

11           (1) LIST OF HOSPITALS.—Beginning not later  
12       than 90 days after the date of enactment of this  
13       Act, the Secretary of Health and Human Services  
14       (referred to in this section as the “Secretary”) shall  
15       establish and maintain a publicly available list on  
16       the website of the Centers for Medicare & Medicaid  
17       Services of each hospital with respect to which the  
18       Secretary has conducted a review of such hospital’s  
19       compliance with the provisions of section 2718(e) of  
20       the Public Health Service Act (42 U.S.C. 300gg–  
21       18(e)). Such list shall include, with respect to each  
22       such hospital that was noncompliant with such pro-  
23       visions, a specification as to whether such hospital—

24                   (A) has been issued a civil monetary pen-  
25                   alty;

1 (B) has received a warning notice; or

2 (C) has submitted a corrective action plan.

3 (2) ADDITIONS AND UPDATES.—In the case of  
4 a hospital not included on the list described in para-  
5 graph (1) as of the date of the establishment of such  
6 list and that is subject to a review of such hospital’s  
7 compliance with the provisions described in such  
8 paragraph after such date, the Secretary shall add  
9 such hospital to such list, along with the specifica-  
10 tions described in such paragraph, not later than 1  
11 business day after such review occurs. The Secretary  
12 shall update such specifications with respect to any  
13 hospital included on such list—

14 (A) not later than 1 business day after any  
15 subsequent review of such hospital’s compliance  
16 with such provisions; and

17 (B) not later than 1 business day after any  
18 penalty, notice, or request described in para-  
19 graph (1) is made with respect to such hospital.

20 (3) FOIA REQUESTS.—Any penalty, notice, or  
21 request described in paragraph (1) shall be subject  
22 to public disclosure, in full and without redaction,  
23 under section 552 of title 21, United States Code,  
24 notwithstanding any exemptions or exclusions other-  
25 wise available under such section 552.

1           (4) REPORTS TO CONGRESS.—Not later than 1  
2 year after the date of enactment of this Act and  
3 each year thereafter, the Secretary of Health and  
4 Human Services shall submit to Congress, and make  
5 publicly available, a report that contains information  
6 regarding complaints of alleged violations of law and  
7 enforcement activities by the Secretary under the  
8 hospital price transparency rule implementing sec-  
9 tion 2718(e) of the Public Health Service Act (42  
10 U.S.C. 300gg–18(e)). Such report shall be made  
11 available to the public on the website of the Centers  
12 for Medicare & Medicaid Services. Each such report  
13 shall include, with respect to the year involved—

14                   (A) the number of compliance and enforce-  
15                   ment inquiries opened by the Secretary pursu-  
16                   ant to such section;

17                   (B) the number of notices of noncompli-  
18                   ance issued by the Secretary based on such in-  
19                   quiries;

20                   (C) the identity of each hospital entity that  
21                   received a notice of noncompliance and the na-  
22                   ture of the failure giving rise to the Secretary’s  
23                   determination of noncompliance;

24                   (D) the amount of civil monetary penalty  
25                   assessed against the hospital entity;

1 (E) whether the hospital entity subse-  
2 quently corrected the noncompliance; and

3 (F) an analysis of factors contributing to  
4 increasing health care costs.

5 (5) GAO REPORT.—Not later than 1 year after  
6 the date of enactment of this Act, the Comptroller  
7 General of the United States shall submit to the  
8 Committee on Energy and Commerce of the House  
9 of Representatives and the Committee on Health,  
10 Education, Labor, and Pensions of the Senate a re-  
11 port on the compliance and enforcement with the  
12 hospital price transparency rule implementing sec-  
13 tion 2718(e) of the Public Health Service Act (42  
14 U.S.C. 300gg–18(e)). The report shall include rec-  
15 ommendations related to—

16 (A) improving price transparency to pa-  
17 tients, employers, and the public; and

18 (B) increased civil monetary penalty  
19 amounts to ensure compliance.

20 (6) REQUEST FOR INFORMATION.—Not later  
21 than January 1, 2025, the Secretary of Health and  
22 Human Services shall issue a public request for in-  
23 formation as to the best method through which hos-  
24 pitals may be required to publish quality data (such  
25 as data required to be reported under the Medicare

1 Hospital Compare program) alongside data required  
2 to be reported under section 2718(e) of the Public  
3 Health Service Act (42 U.S.C. 300gg-18(e)).

4 (c) ENSURING ACCESSIBILITY THROUGH IMPLEMEN-  
5 TATION.—In implementing the amendments made by this  
6 section, the Secretary of Health and Human Services shall  
7 through rulemaking ensure that a hospital submitting  
8 charges and information pursuant to such amendments  
9 takes reasonable steps (as specified by the Secretary) to  
10 ensure the accessibility of such charges and information  
11 to individuals with limited English proficiency. Such steps  
12 may include the hospital’s provision of interpretation serv-  
13 ices or the hospital’s provision of translations of charges  
14 and information.

15 **SEC. 102. STRENGTHENING HEALTH INSURER TRANS-**  
16 **PARENCY REQUIREMENTS.**

17 (a) TRANSPARENCY IN COVERAGE.—Section  
18 1311(e)(3)(C) of the Patient Protection and Affordable  
19 Care Act (42 U.S.C. 18031(e)(3)(C)) is amended—

20 (1) by striking “The Exchange” and inserting  
21 the following:

22 “(i) IN GENERAL.—The Exchange”;

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

24 (A) by striking “participating provider”  
25 and inserting “provider”;

1 (B) by inserting “shall include the infor-  
2 mation specified in clause (ii) and” after “such  
3 information”;

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

7 (D) by striking “and such other” and all  
8 that follows through the period and inserting  
9 “or, at the option such individual, through a  
10 paper or phone disclosure (as selected by such  
11 individual and provided at no cost to such indi-  
12 vidual) that meets such requirements as the  
13 Secretary may specify.”;

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

16 “(ii) SPECIFIED INFORMATION.—For  
17 purposes of clause (i), the information  
18 specified in this clause is, with respect to  
19 an item or service for which benefits are  
20 available under a health plan furnished by  
21 a health care provider, the following:

22 “(I) If such provider is a partici-  
23 pating provider with respect to such  
24 item or service, the in-network rate



1 (as defined in subparagraph (F)) for  
2 such item or service.

3 “(II) If such provider is not de-  
4 scribed in subclause (I), the maximum  
5 allowed amount for such item or serv-  
6 ice.

7 “(III) The amount of cost shar-  
8 ing (including deductibles, copay-  
9 ments, and coinsurance) that the indi-  
10 vidual will incur for such item or serv-  
11 ice (which, in the case such item or  
12 service is to be furnished by a pro-  
13 vider described in subclause (II), shall  
14 be calculated using the maximum  
15 amount described in such subclause).

16 “(IV) The amount the individual  
17 has already accumulated with respect  
18 to any deductible or out of pocket  
19 maximum under the plan (broken  
20 down, in the case separate deductibles  
21 or maximums apply to separate indi-  
22 viduals enrolled in the plan, by such  
23 separate deductibles or maximums, in  
24 addition to any cumulative deductible  
25 or maximum).

1           “(V) In the case such plan im-  
2 poses any frequency or volume limita-  
3 tions with respect to such item or  
4 service (excluding medical necessity  
5 determinations), the amount that such  
6 individual has accrued towards such  
7 limitation with respect to such item or  
8 service.

9           “(VI) Any prior authorization,  
10 concurrent review, step therapy, fail  
11 first, or similar requirements applica-  
12 ble to coverage of such item or service  
13 under such plan.

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

18           “(I) is based on an internet  
19 website;

20           “(II) provides for real-time re-  
21 sponses to requests described in such  
22 clause;

23           “(III) is updated in a manner  
24 such that information provided

1 through such tool is timely and accu-  
2 rate;

3 “(IV) allows such a request to be  
4 made with respect to an item or serv-  
5 ice furnished by—

6 “(aa) a specific provider  
7 that is a participating provider  
8 with respect to such item or serv-  
9 ice;

10 “(bb) all providers that are  
11 participating providers with re-  
12 spect to such plan and such item  
13 or service; or

14 “(cc) a provider that is not  
15 described in item (bb); and

16 “(V) provides that such a request  
17 may be made with respect to an item  
18 or service through use of the billing  
19 code for such item or service or  
20 through use of a descriptive term for  
21 such item or service.

22 The Secretary may require such tool, as a  
23 condition of complying with subclause (V),  
24 to link multiple billing codes to a single de-  
25 scriptive term if the Secretary determines

1                   that the billing codes to be so linked cor-  
2                   respond to items and services.”.

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

7                   “(E) RATE AND PAYMENT INFORMA-  
8                   TION.—

9                   “(i) IN GENERAL.—Not later than  
10                   January 1, 2025, and every 3 months  
11                   thereafter, each health plan shall submit to  
12                   the Exchange, the Secretary, the State in-  
13                   surance commissioner, and make available  
14                   to the public, the rate and payment infor-  
15                   mation described in clause (ii) in accord-  
16                   ance with clause (iii).

17                   “(ii) RATE AND PAYMENT INFORMA-  
18                   TION DESCRIBED.—For purposes of clause  
19                   (i), the rate and payment information de-  
20                   scribed in this clause is, with respect to a  
21                   health plan, the following:

22                   “(I) With respect to each item or  
23                   service for which benefits are available  
24                   under such plan, the in-network rate  
25                   in effect as of the date of the submis-

1 sion of such information with each  
2 provider (identified by national pro-  
3 vider identifier) that is a participating  
4 provider with respect to such item or  
5 service, other than such a rate in ef-  
6 fect with a provider that, during the  
7 1-year period ending on such date,  
8 submitted fewer than 10 claims for  
9 such item or service to such plan.

10 “(II) With respect to each drug  
11 (identified by national drug code) for  
12 which benefits are available under  
13 such plan, the average amount paid  
14 by such plan (net of rebates, dis-  
15 counts, and price concessions) for  
16 such drug dispensed or administered  
17 during the 90-day period beginning  
18 180 days before such date of submis-  
19 sion to each provider that was a par-  
20 ticipating provider with respect to  
21 such drug, broken down by each such  
22 provider (identified by national pro-  
23 vider identifier), other than such an  
24 amount paid to a provider that, dur-

1 ing such period, submitted fewer than  
2 20 claims for such drug to such plan.

3 “(III) With respect to each item  
4 or service for which benefits are avail-  
5 able under such plan, the amount  
6 billed, and the amount allowed by the  
7 plan, for each such item or service  
8 furnished during the 90-day period  
9 specified in subclause (II) by a pro-  
10 vider that was not a participating pro-  
11 vider with respect to such item or  
12 service, broken down by each such  
13 provider (identified by national pro-  
14 vider identifier), other than items and  
15 services with respect to which fewer  
16 than 20 claims for such item or serv-  
17 ice were submitted to such plan dur-  
18 ing such period.

19 “(iii) MANNER OF SUBMISSION.—Rate  
20 and payment information required to be  
21 submitted and made available under this  
22 subparagraph shall be so submitted and so  
23 made available in 3 separate machine-read-  
24 able files corresponding to the information  
25 described in each of subclauses (I) through

1 (III) of clause (ii) that meet such require-  
2 ments as specified by the Secretary  
3 through rulemaking. Such requirements  
4 shall ensure that such files are limited to  
5 an appropriate size, are made available in  
6 a widely-available format that allows for  
7 information contained in such files to be  
8 compared across health plans, and are ac-  
9 cessible to individuals at no cost and with-  
10 out the need to establish a user account or  
11 provider other credentials.

12 “(iv) USER GUIDE.—Each health plan  
13 shall make available to the public instruc-  
14 tions written in plain language explaining  
15 how individuals may search for information  
16 described in clause (ii) in files submitted in  
17 accordance with clause (iii).

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

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

23 “(ii) IN-NETWORK RATE.—The term  
24 ‘in-network rate’ means, with respect to a  
25 health plan and an item or service fur-

1 nished by a provider that is a participating  
2 provider with respect to such plan and  
3 item or service, the contracted rate in ef-  
4 fect between such plan and such provider  
5 for such item or service.”.

6 (c) REPORTS.—

7 (1) COMPLIANCE.—Not later than January 1,  
8 2025, the Comptroller General of the United States  
9 shall submit to Congress a report containing—

10 (A) an analysis of health plan compliance  
11 with the amendments made by this section;

12 (B) an analysis of enforcement of such  
13 amendments by the Secretaries of Health and  
14 Human Services, Labor, and the Treasury;

15 (C) recommendations relating to improving  
16 such enforcement; and

17 (D) recommendations relating to improving  
18 public disclosure, and public awareness, of in-  
19 formation required to be made available by such  
20 plans pursuant to such amendments.

21 (2) PRICES.—Not later than January 1, 2028,  
22 the Comptroller General of the United States shall  
23 submit to Congress a report containing an assess-  
24 ment of differences in negotiated prices (and any



1 trends in such prices) in the private market be-  
2 tween—

3 (A) rural and urban areas;

4 (B) the individual, small group, and large  
5 group markets;

6 (C) consolidated and nonconsolidated  
7 health care provider areas (as specified by the  
8 Secretary);

9 (D) nonprofit and for-profit hospitals;

10 (E) nonprofit and for-profit insurers; and

11 (F) insurers serving local or regional areas  
12 and insurers serving multistate or national  
13 areas.

14 (d) ENSURING ACCESSIBILITY THROUGH IMPLEMEN-  
15 TATION.—In implementing the amendments made by this  
16 section, the Secretary shall through rulemaking ensure  
17 that any entity making available information pursuant to  
18 such amendments takes reasonable steps (as specified by  
19 the Secretary) to ensure the accessibility of such to indi-  
20 viduals with limited English proficiency. Such steps may  
21 include the entity's provision of interpretation services or  
22 of translations of such information.

23 (e) EFFECTIVE DATE.—

1           (1) IN GENERAL.—The amendments made by  
2 subsection (a) shall apply beginning January 1,  
3 2025.

4           (2) CONTINUED APPLICABILITY OF RULES FOR  
5 PREVIOUS YEARS.—Nothing in the amendments  
6 made by this section may be construed as affecting  
7 the applicability of the rule entitled “Transparency  
8 in Coverage” published by the Department of the  
9 Treasury, the Department of Labor, and the De-  
10 partment of Health and Human Services on Novem-  
11 ber 12, 2020 (85 Fed. Reg. 72158) before January  
12 1, 2025.

13 **SEC. 103. REQUIRING A SEPARATE IDENTIFICATION NUM-**  
14 **BER AND AN ATTESTATION FOR EACH OFF-**  
15 **CAMPUS OUTPATIENT DEPARTMENT OF A**  
16 **PROVIDER.**

17           Section 1833(t) of the Social Security Act (42 U.S.C.  
18 1395l(t)) is amended by adding at the end the following  
19 new paragraph:

20           “(23) USE OF UNIQUE HEALTH IDENTIFIERS;  
21 ATTESTATION.—

22           “(A) IN GENERAL.—No payment may be  
23 made under this subsection (or under an appli-  
24 cable payment system pursuant to paragraph  
25 (21)) for items and services furnished on or

1 after January 1, 2026, by an off-campus out-  
2 patient department of a provider (as defined in  
3 subparagraph (C)) unless—

4 “(i) such department has obtained,  
5 and such items and services are billed  
6 under, a standard unique health identifier  
7 for health care providers (as described in  
8 section 1173(b)) that is separate from  
9 such identifier for such provider; and

10 “(ii) such provider has submitted to  
11 the Secretary, during the 2-year period  
12 ending on the date such items and services  
13 are so furnished, an attestation that such  
14 department is compliant with the require-  
15 ments described in section 413.65 of title  
16 42, Code of Federal Regulations (or a suc-  
17 cessor regulation).

18 “(B) PROCESS FOR SUBMISSION AND RE-  
19 VIEW.—Not later than 1 year after the date of  
20 enactment of this paragraph, the Secretary  
21 shall, through notice and comment rulemaking,  
22 establish a process for each provider with an  
23 off-campus outpatient department of a provider  
24 to submit an attestation pursuant to subpara-  
25 graph (A)(ii), and for the Secretary to review

1 each such attestation and determine, through  
2 site visits or through remote audits (as deter-  
3 mined appropriate by the Secretary), whether  
4 such department is compliant with the require-  
5 ments described in such subparagraph.

6 “(C) OFF-CAMPUS OUTPATIENT DEPART-  
7 MENT OF A PROVIDER DEFINED.—For purposes  
8 of this paragraph, the term ‘off-campus out-  
9 patient department of a provider’ means a de-  
10 partment of a provider (as defined in section  
11 413.65 of title 42, Code of Federal Regulations,  
12 or any successor regulation) that is not lo-  
13 cated—

14 “(i) on the campus (as defined in such  
15 section) of such provider; or

16 “(ii) within the distance (described in  
17 such definition of campus) from a remote  
18 location of a hospital facility (as defined in  
19 such section).”.

20 **SEC. 104. MANDATORY REPORTING WITH RESPECT TO CER-**  
21 **TAIN HEALTH-RELATED OWNERSHIP INFOR-**  
22 **MATION.**

23 Part A of title XI of the Social Security Act (42  
24 U.S.C. 1301 et seq.) is amended by adding at the end  
25 the following new section:

1 **“SEC. 1150D. MANDATORY REPORTING WITH RESPECT TO**  
2 **CERTAIN HEALTH-RELATED OWNERSHIP IN-**  
3 **FORMATION.**

4 “(a) MANDATORY REPORTING WITH RESPECT CER-  
5 TAIN HEALTH-RELATED OWNERSHIP INFORMATION.—

6 “(1) INITIAL REPORT.—Not later than January  
7 1, 2025 (or in the case of a specified entity formed  
8 after January 1, 2025, within 60 days of becoming  
9 a specified entity), each specified entity (as defined  
10 in subsection (f)(5)) shall submit to the Secretary,  
11 in a form and manner specified by the Secretary, a  
12 report containing the following information:

13 “(A) Data on mergers, acquisitions, and  
14 changes in ownership with respect to such spec-  
15 ified entity for the previous 1-year period.

16 “(B) In the case that a specified entity is,  
17 or includes, a hospital, the additional informa-  
18 tion described in subsection (b).

19 “(C) As applicable, the name, address, and  
20 business structure of the parent company of  
21 such specified entity (including the tax status of  
22 such parent company), as of the date of the  
23 submission of this report.

24 “(D) Any other information with respect to  
25 ownership of a specified entity, as determined  
26 by the Secretary.

1           “(2) SUBSEQUENT REPORTS.—Not later than 1  
2           year after submitting the report under paragraph  
3           (1), and annually thereafter, each specified entity  
4           shall submit to the Secretary an updated report, in-  
5           cluding—

6                   “(A)(i) data on mergers, acquisitions, and  
7                   changes in ownership with respect to such enti-  
8                   ties for the previous 1-year period; and

9                           “(ii) any other information with re-  
10                           spect to ownership of a specified entity, as  
11                           determined by the Secretary; and

12                           “(B) in the case that a specified entity is,  
13                           or includes, a hospital, the additional informa-  
14                           tion described in subsection (b).

15           “(b) ADDITIONAL INFORMATION SUBMITTED BY  
16           CERTAIN SPECIFIED ENTITIES.—For purposes of para-  
17           graphs (1)(B) and (2)(B) of subsection (a), with respect  
18           to a specified entity that is, or includes, a hospital, the  
19           information described in this subsection is the following  
20           information with respect to the previous 1-year period:

21                   “(1) The business structure of the specified en-  
22                   tity, including the business type and the tax status  
23                   of such entity.

24                   “(2) The average debt-to-earnings ratio of the  
25                   specified entity.

1           “(3) The average amount of debt incurred—

2                   “(A) by the hospital; and

3                   “(B) by the entire specified entity.

4           “(4) Information with respect to real estate  
5 leases and purchases for property used, or intended  
6 to be used, to furnish or otherwise support the provi-  
7 sion of health care services.

8           “(5) In the case of a non-profit hospital, a sub-  
9 sidiary of a non-profit hospital, or a 501(c)(3) entity  
10 that shares common ownership with a non-profit  
11 hospital, capital gains investments (disaggregated by  
12 the type of investment) and any taxes paid on such  
13 gains from such investments.

14           “(6) As applicable, information with respect to  
15 the parent company of such specified entity.

16           “(c) PUBLIC REPORTING.—Not later than January  
17 1, 2027, and annually thereafter, the Secretary shall post  
18 on a publicly available website of the Department of  
19 Health and Human Services a report with respect to the  
20 previous 1-year period, including—

21                   “(1) the number of specified entities reporting  
22 for such year, disaggregated by the business struc-  
23 ture of each specified entity;

24                   “(2) the number of owners of each specified en-  
25 tity;

1           “(3) any change in ownership for each specified  
2           entity;

3           “(4) any change in the tax status of a specified  
4           entity;

5           “(5) an analysis of trends in horizontal and  
6           vertical consolidation, disaggregated by business  
7           structure and provider type; and

8           “(6) as applicable, the name, address, and busi-  
9           ness structure of the parent company of such speci-  
10          fied entity (including the business type and the tax  
11          status of such parent company).

12          “(d) AUDITS.—The Secretary shall conduct an an-  
13          nual audit consisting of a random sample of specified enti-  
14          ties to verify compliance with the requirements of this sec-  
15          tion and the accuracy of information submitted pursuant  
16          to this section.

17          “(e) PENALTY FOR FAILURE TO REPORT.—If a spec-  
18          ified entity fails to provide a complete report under sub-  
19          section (a), or submits a report containing false informa-  
20          tion, such entity shall be subject to a civil monetary pen-  
21          alty of not more than \$5,000,000 for each such report  
22          not provided or containing false information. Such penalty  
23          shall be imposed and collected in the same manner as civil  
24          money penalties under subsection (a) of section 1128A are  
25          imposed and collected under that section.



1 “(f) INAPPLICABILITY OF PAPERWORK REDUCTION  
2 ACT.—Chapter 35 of title 44, United States Code, shall  
3 not apply to collections of information made under this  
4 section.

5 “(g) DEFINITIONS.—In this section:

6 “(1) HEALTH PLAN.—The term ‘health plan’  
7 has the meaning given such term in section  
8 1128C(c).

9 “(2) HOSPITAL.—The term ‘hospital’ has the  
10 meaning given such term in section 1861(e).

11 “(3) INDEPENDENT FREESTANDING EMER-  
12 GENCY DEPARTMENT.—The term ‘independent free-  
13 standing emergency department’ has the meaning  
14 given such term in section 2799A–1(a)(3)(D) of the  
15 Public Health Service Act.

16 “(4) PRIVATE EQUITY COMPANY.—The term  
17 ‘private equity company’ means a publicly-traded or  
18 non-publicly traded company that collects capital in-  
19 vestments from individuals or entities and purchases  
20 an ownership share of a provider of services (as de-  
21 fined in section 1861(u)).

22 “(5) SPECIFIED ENTITY.—The term ‘specified  
23 entity’ means—

24 “(A) a hospital;

1           “(B) a physician-owned physician practice  
2 with more than 25 physicians for a year;

3           “(C) a physician practice owned by a hos-  
4 pital, a health plan, a private equity company,  
5 or a venture capital firm;

6           “(D) an ambulatory surgical center meet-  
7 ing the standards specified under section  
8 1832(a)(2)(F)(i); or

9           “(E) an independent freestanding emer-  
10 gency department.

11           “(6) VENTURE CAPITAL FUND.—The term ‘ven-  
12 ture capital fund’ has the meaning given such term  
13 in section 275.203(l)–1 of title 17, Code of Federal  
14 Regulations.”.

15 **SEC. 105. INCREASING PRICE TRANSPARENCY OF CLINICAL**  
16 **DIAGNOSTIC LABORATORY TESTS UNDER**  
17 **THE MEDICARE PROGRAM.**

18           Section 1846 of the Social Security Act (42 U.S.C.  
19 1395w–2) is amended—

20           (1) in the header, by inserting “**AND ADDI-**  
21 **TIONAL REQUIREMENTS**” after “**SANCTIONS**”;

22 and

23           (2) by adding at the end the following new sub-  
24 section:

25           “(c) PRICE TRANSPARENCY REQUIREMENT.—

1           “(1) IN GENERAL.—Beginning January 1,  
2           2025, each provider of services or supplier that is  
3           available to furnish any specified clinical diagnostic  
4           laboratory test under this title shall—

5                   “(A) make publicly available on an internet  
6           website the information described in paragraph  
7           (2) with respect to each such specified clinical  
8           diagnostic laboratory test that such provider or  
9           supplier is so available to furnish; and

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

12           “(2) INFORMATION DESCRIBED.—For purposes  
13           of paragraph (1), the information described in this  
14           paragraph is, with respect to a provider of services  
15           or supplier and a specified clinical diagnostic labora-  
16           tory test, the following:

17                   “(A) The discounted cash price for such  
18           test (or, if no such price exists, the gross  
19           charge for such test).

20                   “(B) The deidentified minimum negotiated  
21           rate in effect between such provider or supplier  
22           and any group health plan or group or indi-  
23           vidual health insurance coverage for such test.

1           “(C) The deidentified maximum negotiated  
2           rate in effect between such provider or supplier  
3           and any such plan or coverage for such test.

4           “(3) INCLUSION OF ANCILLARY SERVICES.—  
5           Any price or rate for a specified clinical diagnostic  
6           laboratory test available to be furnished by a pro-  
7           vider of services or supplier made publicly available  
8           in accordance with paragraph (1) shall include the  
9           price or rate (as applicable) for any ancillary item  
10          or service (such as specimen collection services) that  
11          would normally be furnished by such provider or  
12          supplier as part of such test, as specified by the Sec-  
13          retary.

14          “(4) ENFORCEMENT.—

15                 “(A) IN GENERAL.—In the case that the  
16                 Secretary determines that a provider of services  
17                 or supplier is not in compliance with paragraph  
18                 (1)—

19                         “(i) not later than 30 days after such  
20                         determination, the Secretary shall notify  
21                         such provider or supplier of such deter-  
22                         mination;

23                         “(ii) not later than 90 days after such  
24                         notification is sent, such provider or sup-  
25                         plier shall complete a corrective action plan

1 to comply with such paragraph and submit  
2 such plan to the Secretary; and

3 “(iii) if such provider or supplier con-  
4 tinues to fail to comply with such para-  
5 graph after the date that is 90 days after  
6 such notification is sent, the Secretary may  
7 impose a civil monetary penalty in an  
8 amount not to exceed \$300 for each day  
9 (beginning with the date that is 91 days  
10 after such notification was sent) during  
11 which such failure is ongoing.

12 “(B) APPLICATION OF CERTAIN PROVI-  
13 SIONS.—The provisions of section 1128A (other  
14 than subsections (a) and (b) of such section)  
15 shall apply to a civil monetary penalty imposed  
16 under this paragraph in the same manner as  
17 such provisions apply to a civil monetary pen-  
18 alty imposed under subsection (a) of such sec-  
19 tion.

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

21 “(A) GROUP HEALTH PLAN; GROUP  
22 HEALTH INSURANCE COVERAGE; INDIVIDUAL  
23 HEALTH INSURANCE COVERAGE.—The terms  
24 ‘group health plan’, ‘group health insurance  
25 coverage’, and ‘individual health insurance cov-

1 erage’ have the meaning given such terms in  
2 section 2791 of the Public Health Service Act.

3 “(B) SPECIFIED CLINICAL DIAGNOSTIC  
4 LABORATORY TEST.—the term ‘specified clinical  
5 diagnostic laboratory test’ means a clinical di-  
6 agnostic laboratory test that is included on the  
7 list of shoppable services specified by the Cen-  
8 ters for Medicare & Medicaid Services (as de-  
9 scribed in section 180.60 of title 42, Code of  
10 Federal Regulations (or a successor regula-  
11 tion)).”.

12 **SEC. 106. PROMOTING TRANSPARENCY OF COMMON OWN-**  
13 **ERSHIP INTERESTS UNDER PARTS C AND D**  
14 **OF THE MEDICARE PROGRAM.**

15 (a) MEDICARE ADVANTAGE.—Section 1857(e) of the  
16 Social Security Act (42 U.S.C. 1395w–27(e)) is amended  
17 by adding at the end the following new paragraph:

18 “(6) REQUIRED DISCLOSURE OF CERTAIN IN-  
19 FORMATION RELATING TO HEALTH CARE PROVIDER  
20 OWNERSHIP.—

21 “(A) IN GENERAL.—For plan years begin-  
22 ning on or after January 1, 2025, a contract  
23 under this section with an MA organization  
24 shall require the organization to report to the  
25 Secretary, not later than 1 year after the last

1 day of such plan year, the information de-  
2 scribed in subparagraph (B) with respect to  
3 such plan year.

4 “(B) INFORMATION DESCRIBED.—For pur-  
5 poses of subparagraph (A), the information de-  
6 scribed in this subparagraph is, with respect to  
7 an MA organization and a plan year, the fol-  
8 lowing:

9 “(i) The number of items and services  
10 furnished during such plan year by each  
11 specified provider (as defined in subpara-  
12 graph (C)) for which payment was made  
13 by such organization.

14 “(ii) The number of items and serv-  
15 ices furnished during such plan year by  
16 providers of services or suppliers not de-  
17 scribed in clause (i) for which payment was  
18 made by such organization.

19 “(iii) The average per-enrollee number  
20 of qualifying diagnoses (as defined in sub-  
21 paragraph (C)) made during such plan  
22 year by specified providers (including  
23 through chart reviews and health risk as-  
24 sements) with respect to individuals en-  
25 rolled under an MA plan offered by such

1 organization, broken down by site of serv-  
2 ice of such providers, as specified by the  
3 Secretary.

4 “(iv) The average per-enrollee number  
5 of qualifying diagnoses made during such  
6 plan year by providers of services and sup-  
7 pliers not described in clause (iii) (includ-  
8 ing through such reviews and assessments)  
9 with respect to such individuals, broken  
10 down by site of service of such providers.

11 “(v) The average risk score (as cal-  
12 culated under the methodology described in  
13 subparagraph (C)(i)) for such an indi-  
14 vidual for such plan year who received  
15 items and services from a specified pro-  
16 vider during such plan year.

17 “(vi) The average risk score for such  
18 an individual for such plan year who did  
19 not receive items and services from a speci-  
20 fied provider during such plan year.

21 “(vii) The average risk score for such  
22 an individual for such plan year who re-  
23 ceived a health risk assessment from an  
24 assessment entity that was a specified as-  
25 sessment entity during such plan year.



1           “(viii) The average risk score for such  
2           an individual for such plan year who re-  
3           ceived a health risk assessment from an  
4           assessment entity that was not a specified  
5           assessment entity during such plan year.

6           “(ix) The number of prior authoriza-  
7           tion requests for an item or service sub-  
8           mitted to such organization during such  
9           plan year, the number of such requests  
10          that were approved, the number of such re-  
11          quests that were denied, and the number  
12          of such denied requests that were subse-  
13          quently appealed and then approved, bro-  
14          ken down by whether the entity proposing  
15          to furnish such item or service was a speci-  
16          fied provider or not a specified provider.

17          “(x) The total amount of incentive-  
18          based payments made to, and the total  
19          amount of shared losses recoupments col-  
20          lected from, specified providers during  
21          such plan year.

22          “(xi) The total amount of incentive-  
23          based payments made to, and the total  
24          amount of shared losses recoupments col-  
25          lected from, providers of services and sup-

1 pliers not described in clause (x) during  
2 such plan year.

3 “(xii) The allowed amount, and the  
4 amount of cost sharing imposed, with re-  
5 spect to each item and service furnished  
6 during such plan year by specified pro-  
7 viders paid by such organization.

8 “(xiii) The allowed amount, and the  
9 amount of cost sharing imposed, with re-  
10 spect to each item and service furnished  
11 during such plan year by providers of serv-  
12 ices and suppliers not described in clause  
13 (xii) paid by such organization.

14 “(xiv) For each MA plan offered by  
15 such organization during such plan year—

16 “(I) the total amount of pay-  
17 ments made under section 1853(a)(1)  
18 to such organization for coverage of  
19 individuals under such plan, and the  
20 total amount of payments made by  
21 such individuals to such organization  
22 for coverage under such plan;

23 “(II) the total amount expended  
24 under such plan as payment for items

1 and services furnished by each speci-  
2 fied provider during such year;

3 “(III) the total amount expended  
4 under such plan as payment for items  
5 and services furnished by providers of  
6 services or suppliers not described in  
7 subclause (II) during such year;

8 “(IV) the medical loss ratio  
9 under such plan with respect to indi-  
10 viduals furnished an item or service  
11 from a specified provider during such  
12 year; and

13 “(V) the medical loss ratio under  
14 such plan with respect to individuals  
15 not described in subclause (IV).

16 “(C) DEFINITIONS.—In this paragraph:

17 “(i) ASSESSMENT ENTITY.—The term  
18 ‘assessment entity’ means an entity with a  
19 focus on furnishing in-home medical as-  
20 sessments, as specified by the Secretary.

21 “(ii) QUALIFYING DIAGNOSIS.—The  
22 term ‘qualifying diagnosis’ means, with re-  
23 spect to an individual, a diagnosis that is  
24 taken into account in calculating a risk  
25 score for such individual under the risk ad-

1           justment methodology established by the  
2           Secretary pursuant to section 1853(a)(3).

3           “(iii) SPECIFIED ASSESSMENT ENTI-  
4           TY.—The term ‘specified assessment enti-  
5           ty’ means, with respect to an MA organiza-  
6           tion and a plan year, an assessment entity  
7           with respect to which such organization (or  
8           any person with an ownership or control  
9           interest (as defined in section 1124(a)(3))  
10          in such organization) is a person with an  
11          ownership or control interest (as so de-  
12          fined).

13          “(iv) SPECIFIED PROVIDER.—The  
14          term ‘specified provider’ means, with re-  
15          spect to an MA organization and a plan  
16          year, a provider of services or supplier with  
17          respect to which such organization (or any  
18          person with an ownership or control inter-  
19          est (as defined in section 1124(a)(3)) in  
20          such organization) is a person with an  
21          ownership or control interest (as so de-  
22          fined).

23          “(D) NONAPPLICATION OF PAPERWORK  
24          REDUCTION ACT.—Chapter 35 of title 44,

1 United States Code, shall not apply to informa-  
2 tion collected under this paragraph.”.

3 (b) PHARMACY BENEFIT MANAGER AND PHARMACY  
4 INFORMATION.—Section 1860D–12(b) of the Social Secu-  
5 rity Act (42 U.S.C. 1395w–112(b)) is amended by adding  
6 at the end the following new paragraphs:

7 “(9) PROVISION OF INFORMATION RELATING TO  
8 PHARMACY OWNERSHIP.—

9 “(A) IN GENERAL.—For plan years begin-  
10 ning on or after January 1, 2025, a contract  
11 entered into under this part with a PDP spon-  
12 sor shall require the sponsor to report to the  
13 Secretary, not later than 1 year after the last  
14 day of such plan year, the information de-  
15 scribed in subparagraph (B) with respect to  
16 such plan year.

17 “(B) INFORMATION DESCRIBED.—For pur-  
18 poses of subparagraph (A), the information de-  
19 scribed in this subparagraph is, for each pre-  
20 scription drug plan offered by a PDP sponsor  
21 for a plan year, the following:

22 “(i) The negotiated price for each cov-  
23 ered part D drug for which benefits are  
24 available under such plan for each network  
25 pharmacy (including an identification of

1 whether each such pharmacy is a specified  
2 pharmacy).

3 “(ii) The average per-drug amount of  
4 direct and indirect remuneration paid by  
5 specified pharmacies for such covered part  
6 D drugs dispensed during such plan year  
7 under such plan.

8 “(iii) The average per-drug amount of  
9 direct and indirect remuneration paid by  
10 pharmacies not described in clause (ii) for  
11 such covered part D drugs dispensed dur-  
12 ing such plan year under such plan.

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

14 “(i) DIRECT AND INDIRECT REMU-  
15 NERATION.—The term ‘direct and indirect  
16 remuneration’ has the meaning given such  
17 term in section 423.308 of title 42, Code  
18 of Federal Regulations (or any successor  
19 regulation).

20 “(ii) NETWORK PHARMACY.—The  
21 term ‘network pharmacy’ has the meaning  
22 given such term in section 423.100 of title  
23 42, Code of Federal Regulations (or any  
24 successor regulation).

1           “(iii) NEGOTIATED PRICE.—The ‘ne-  
2           gotiated price’ for a covered part D drug  
3           shall take into account all negotiated price  
4           concessions, such as discounts, direct or in-  
5           direct subsidies, rebates, and direct or indi-  
6           rect remunerations, for such drug, and in-  
7           clude any dispensing fee for such drug.

8           “(iv) SPECIFIED PHARMACY.—The  
9           term ‘specified pharmacy’ means, with re-  
10          spect to an PDP sponsor and a plan year,  
11          a pharmacy with respect to which such  
12          sponsor (or any person with an ownership  
13          or control interest (as defined in section  
14          1124(a)(3)) in such sponsor) is a person  
15          with an ownership or control interest (as  
16          so defined).

17          “(D) NONAPPLICATION OF PAPERWORK  
18          REDUCTION ACT.—Chapter 35 of title 44,  
19          United States Code, shall not apply to informa-  
20          tion collected under this paragraph.

21          “(10) PROVISION OF INFORMATION BY PHAR-  
22          MACY BENEFIT MANAGERS.—

23                 “(A) IN GENERAL.—For plan years begin-  
24                 ning on or after January 1, 2025, a contract  
25                 entered into under this part with a PDP spon-

1           sor shall prohibit such sponsor from entering  
2           into a contract with a specified pharmacy ben-  
3           efit manager for purposes of performing any  
4           service with respect to covered part D drugs  
5           dispensed under any prescription drug plan of-  
6           fered by such sponsor for such plan year unless  
7           such manager agrees to report to the Secretary,  
8           not later than 1 year after the last day of such  
9           plan year, the information described in subpara-  
10          graph (B) with respect to each prescription  
11          drug plan for which such manager is providing  
12          any such service during such plan year, regard-  
13          less of the sponsor of such plan.

14                 “(B) INFORMATION DESCRIBED.—For pur-  
15                 poses of subparagraph (A), the information de-  
16                 scribed in this subparagraph is, with respect to  
17                 a pharmacy benefit manager performing serv-  
18                 ices under a prescription drug plan for a plan  
19                 year, the following:

20                         “(i) With respect to the total amount  
21                         of pharmacy and manufacturer rebates col-  
22                         lected by such manager (or collected on be-  
23                         half of such plan by any other entity with  
24                         a contract in effect with such manager for  
25                         such collection) for all covered part D



1 drugs dispensed under such plan during  
2 such plan year—

3 “(I) the total amount of such re-  
4 bates passed through to the PDP  
5 sponsor of such plan; and

6 “(II) the total amount of such re-  
7 bates retained by such manager or  
8 such other entities.

9 “(ii) The total amount paid by such  
10 manager to pharmacies for drugs furnished  
11 under such plan during such plan year.

12 “(iii) The total amount of payments  
13 made by such sponsor to such manager as  
14 reimbursement for such manager’s pay-  
15 ments described in clause (ii).

16 “(iv) The total amount of payments  
17 made by such sponsor to such manager as  
18 fees for services furnished by such man-  
19 ager with respect to such plan for such  
20 plan year (not including payments de-  
21 scribed in clause (iii)).

22 “(v) The total amount of administra-  
23 tive costs incurred by such manager for  
24 furnishing such services under such plan  
25 for such plan year.

1                   “(vi) A specification as to whether  
2                   such manager is a specified pharmacy ben-  
3                   efit manager with respect to the PDP  
4                   sponsor of such plan.

5                   “(C) DEFINITION.—In this paragraph, the  
6                   term ‘specified pharmacy benefit manager’  
7                   means, with respect to an PDP sponsor and a  
8                   plan year, a pharmacy benefit manager with re-  
9                   spect to which such sponsor (or any person with  
10                  an ownership or control interest (as defined in  
11                  section 1124(a)(3)) in such sponsor) is a person  
12                  with an ownership or control interest (as so de-  
13                  fined).”.

14                  (c) ENCOUNTER DATA.—Section 1859 of the Social  
15                  Security Act (42 U.S.C. 1395w–28) is amended by adding  
16                  at the end the following new subsection:

17                  “(j) INCLUSION OF CERTAIN INFORMATION IN EN-  
18                  COUNTER DATA.—

19                  “(1) IN GENERAL.—In the case of any encoun-  
20                  ter data submitted by a Medicare Advantage plan  
21                  with respect to an item or service furnished to an in-  
22                  dividual under such plan during a plan year begin-  
23                  ning on or after January 1, 2025, the Secretary  
24                  shall require that such data include—

1           “(A) the allowed amount for such item or  
2           service;

3           “(B) the amount of cost sharing (including  
4           deductibles, copayments, and coinsurance) im-  
5           posed for such item or service;

6           “(C) in the case such individual was fur-  
7           nished, during such plan year before such item  
8           or service was so furnished, an at-home health  
9           risk assessment from a specified assessment en-  
10          tity, an indicator that such individual was so  
11          furnished such an assessment by such an entity;  
12          and

13          “(D) in the case such individual was fur-  
14          nished, during such plan year before such item  
15          or service was so furnished, an at-home health  
16          risk assessment from an assessment entity not  
17          described in subparagraph (C), an indicator  
18          (distinct from the indicator described in such  
19          subparagraph) that such individual was so fur-  
20          nished such an assessment by such an entity.

21          “(2) DEFINITIONS.—For purposes of this sub-  
22          section, the terms ‘assessment entity’ and ‘specified  
23          assessment entity’ have the meaning given such  
24          terms in section 1857(e)(6).”.

1 (d) MEDPAC REPORT.—Not later than December  
2 31, 2027, and every 2 years thereafter, the Medicare Pay-  
3 ment Advisory Commission shall submit to Congress a re-  
4 port on the effects of vertical integration in the health care  
5 sector on the Medicare program. Such report shall include  
6 an analysis of the effects of entities such as health care  
7 providers, pharmacies, PDP sponsors, Medicare Advan-  
8 tage organizations, and pharmacy benefit managers that  
9 were previously under separate ownership from one an-  
10 other coming under common ownership.

11 (e) PUBLICATION.—Not later than January 1, 2027,  
12 the Secretary of Health and Human Services shall estab-  
13 lish a process under which information submitted to the  
14 Secretary pursuant to the amendments made by sub-  
15 sections (a) and (b) is publicly disclosed. Such process  
16 shall ensure that any information so disclosed does not  
17 identify a specific drug manufacturer, provider of services  
18 or supplier, pharmacy, pharmacy benefit manager, or any  
19 price charged with respect to a particular drug.

20 **SEC. 107. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
21 **SERVICES.**

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

24 (1) in part D (42 U.S.C. 300gg–111 et seq.),  
25 by adding at the end the following new section:

1 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-**  
2 **AGER SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or  
4 after January 1, 2025, a group health plan or health in-  
5 surance issuer offering group health insurance coverage  
6 or an entity or subsidiary providing pharmacy benefits  
7 management services on behalf of such a plan or issuer  
8 shall not enter into a contract with a drug manufacturer,  
9 distributor, wholesaler, subcontractor, rebate aggregator,  
10 or any associated third party that limits the disclosure of  
11 information to plan sponsors in such a manner that pre-  
12 vents the plan or issuer, or an entity or subsidiary pro-  
13 viding pharmacy benefits management services on behalf  
14 of a plan or issuer, from making the reports described in  
15 subsection (b).

16 “(b) REPORTS.—

17 “(1) IN GENERAL.—For plan years beginning  
18 on or after January 1, 2025, not less frequently  
19 than annually, a health insurance issuer offering  
20 group health insurance coverage or an entity pro-  
21 viding pharmacy benefits management services on  
22 behalf of a group health plan or an issuer providing  
23 group health insurance coverage shall submit to the  
24 plan sponsor (as defined in section 3(16)(B) of the  
25 Employee Retirement Income Security Act of 1974)  
26 of such group health plan or health insurance cov-

1 erage a report in accordance with this subsection  
2 and make such report available to the plan sponsor  
3 in a machine-readable format. Each such report  
4 shall include, with respect to the applicable group  
5 health plan or health insurance coverage—

6 “(A) as applicable, information collected  
7 from drug manufacturers by such issuer or en-  
8 tity on the total amount of copayment assist-  
9 ance dollars paid, or copayment cards applied,  
10 that were funded by the drug manufacturer  
11 with respect to the participants and bene-  
12 ficiaries in such plan or coverage;

13 “(B) a list of each drug covered by such  
14 plan, issuer, or entity providing pharmacy bene-  
15 fits management services that was dispensed  
16 during the reporting period, including, with re-  
17 spect to each such drug during the reporting  
18 period—

19 “(i) the brand name, chemical entity,  
20 and National Drug Code;

21 “(ii) the number of participants and  
22 beneficiaries for whom the drug was filled  
23 during the plan year, the total number of  
24 prescription fills for the drug (including  
25 original prescriptions and refills), and the

1 total number of dosage units of the drug  
2 dispensed across the plan year, including  
3 whether the dispensing channel was by re-  
4 tail, mail order, or specialty pharmacy;

5 “(iii) the wholesale acquisition cost,  
6 listed as cost per days supply and cost per  
7 pill, or in the case of a drug in another  
8 form, per dose;

9 “(iv) the total out-of-pocket spending  
10 by participants and beneficiaries on such  
11 drug, including participant and beneficiary  
12 spending through copayments, coinsurance,  
13 and deductibles; and

14 “(v) for any drug for which gross  
15 spending of the group health plan or  
16 health insurance coverage exceeded  
17 \$10,000 during the reporting period—

18 “(I) a list of all other drugs in  
19 the same therapeutic category or  
20 class, including brand name drugs  
21 and biological products and generic  
22 drugs or biosimilar biological products  
23 that are in the same therapeutic cat-  
24 egory or class as such drug; and

1                   “(II) the rationale for preferred  
2                   formulary placement of such drug in  
3                   that therapeutic category or class, if  
4                   applicable;

5                   “(C) a list of each therapeutic category or  
6                   class of drugs that were dispensed under the  
7                   health plan or health insurance coverage during  
8                   the reporting period, and, with respect to each  
9                   such therapeutic category or class of drugs,  
10                  during the reporting period—

11                  “(i) total gross spending by the plan,  
12                  before manufacturer rebates, fees, or other  
13                  manufacturer remuneration;

14                  “(ii) the number of participants and  
15                  beneficiaries who filled a prescription for a  
16                  drug in that category or class;

17                  “(iii) if applicable to that category or  
18                  class, a description of the formulary tiers  
19                  and utilization mechanisms (such as prior  
20                  authorization or step therapy) employed  
21                  for drugs in that category or class;

22                  “(iv) the total out-of-pocket spending  
23                  by participants and beneficiaries, including  
24                  participant and beneficiary spending



1 through copayments, coinsurance, and  
2 deductibles; and

3 “(v) for each therapeutic category or  
4 class under which 3 or more drugs are in-  
5 cluded on the formulary of such plan or  
6 coverage—

7 “(I) the amount received, or ex-  
8 pected to be received, from drug man-  
9 ufacturers in rebates, fees, alternative  
10 discounts, or other remuneration—

11 “(aa) that has been paid, or  
12 is to be paid, by drug manufac-  
13 turers for claims incurred during  
14 the reporting period; or

15 “(bb) that is related to utili-  
16 zation of drugs, in such thera-  
17 peutic category or class;

18 “(II) the total net spending, after  
19 deducting rebates, price concessions,  
20 alternative discounts or other remu-  
21 nation from drug manufacturers, by  
22 the health plan or health insurance  
23 coverage on that category or class of  
24 drugs; and

1                   “(III) the net price per course of  
2                   treatment or single fill, such as a 30-  
3                   day supply or 90-day supply, incurred  
4                   by the health plan or health insurance  
5                   coverage and its participants and  
6                   beneficiaries, after manufacturer re-  
7                   bates, fees, and other remuneration  
8                   for drugs dispensed within such thera-  
9                   peutic category or class during the re-  
10                  porting period;

11                  “(D) total gross spending on prescription  
12                  drugs by the plan or coverage during the re-  
13                  porting period, before rebates and other manu-  
14                  facturer fees or remuneration;

15                  “(E) total amount received, or expected to  
16                  be received, by the health plan or health insur-  
17                  ance coverage in drug manufacturer rebates,  
18                  fees, alternative discounts, and all other remu-  
19                  neration received from the manufacturer or any  
20                  third party, other than the plan sponsor, re-  
21                  lated to utilization of drug or drug spending  
22                  under that health plan or health insurance cov-  
23                  erage during the reporting period;

1           “(F) the total net spending on prescription  
2           drugs by the health plan or health insurance  
3           coverage during the reporting period; and

4           “(G) amounts paid directly or indirectly in  
5           rebates, fees, or any other type of remuneration  
6           to brokers, consultants, advisors, or any other  
7           individual or firm who referred the group health  
8           plan’s or health insurance issuer’s business to  
9           the pharmacy benefits manager.

10          “(2) PRIVACY REQUIREMENTS.—Health insur-  
11          ance issuers offering group health insurance cov-  
12          erage and entities providing pharmacy benefits man-  
13          agement services on behalf of a group health plan  
14          shall provide information under paragraph (1) in a  
15          manner consistent with the privacy, security, and  
16          breach notification regulations promulgated under  
17          section 264(c) of the Health Insurance Portability  
18          and Accountability Act of 1996, and shall restrict  
19          the use and disclosure of such information according  
20          to such privacy regulations.

21          “(3) DISCLOSURE AND REDISCLOSURE.—

22          “(A) LIMITATION TO BUSINESS ASSOCI-  
23          ATES.—A group health plan receiving a report  
24          under paragraph (1) may disclose such informa-  
25          tion only to business associates of such plan as

1 defined in section 160.103 of title 45, Code of  
2 Federal Regulations (or successor regulations).

3 “(B) CLARIFICATION REGARDING PUBLIC  
4 DISCLOSURE OF INFORMATION.—Nothing in  
5 this section prevents a health insurance issuer  
6 offering group health insurance coverage or an  
7 entity providing pharmacy benefits management  
8 services on behalf of a group health plan from  
9 placing reasonable restrictions on the public dis-  
10 closure of the information contained in a report  
11 described in paragraph (1), except that such  
12 issuer or entity may not restrict disclosure of  
13 such report to the Department of Health and  
14 Human Services, the Department of Labor, the  
15 Department of the Treasury, the Comptroller  
16 General of the United States, or applicable  
17 State agencies.

18 “(C) LIMITED FORM OF REPORT.—The  
19 Secretary shall define through rulemaking a  
20 limited form of the report under paragraph (1)  
21 required of plan sponsors who are drug manu-  
22 facturers, drug wholesalers, or other direct par-  
23 ticipants in the drug supply chain, in order to  
24 prevent anti-competitive behavior.

1           “(4) REPORT TO GAO.—A health insurance  
2 issuer offering group health insurance coverage or  
3 an entity providing pharmacy benefits management  
4 services on behalf of a group health plan shall sub-  
5 mit to the Comptroller General of the United States  
6 each of the first 4 reports submitted to a plan spon-  
7 sor under paragraph (1) with respect to such cov-  
8 erage or plan, and other such reports as requested,  
9 in accordance with the privacy requirements under  
10 paragraph (2), the disclosure and redisclosure stand-  
11 ards under paragraph (3), the standards specified  
12 pursuant to paragraph (5), and such other informa-  
13 tion that the Comptroller General determines nec-  
14 essary to carry out the study under section 2(d) of  
15 the Pharmacy Benefits Manager Accountability Act.

16           “(5) STANDARD FORMAT.—Not later than June  
17 1, 2023, the Secretary shall specify through rule-  
18 making standards for health insurance issuers and  
19 entities required to submit reports under paragraph  
20 (4) to submit such reports in a standard format.

21           “(c) ENFORCEMENT.—

22           “(1) IN GENERAL.—The Secretary, in consulta-  
23 tion with the Secretary of Labor and the Secretary  
24 of the Treasury, shall enforce this section.

1           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
2           TION.—A health insurance issuer or an entity pro-  
3           viding pharmacy benefits management services that  
4           violates subsection (a) or fails to provide information  
5           required under subsection (b) shall be subject to a  
6           civil monetary penalty in the amount of \$10,000 for  
7           each day during which such violation continues or  
8           such information is not disclosed or reported.

9           “(3) FALSE INFORMATION.—A health insurance  
10          issuer or entity providing pharmacy benefits man-  
11          agement services that knowingly provides false infor-  
12          mation under this section shall be subject to a civil  
13          money penalty in an amount not to exceed \$100,000  
14          for each item of false information. Such civil money  
15          penalty shall be in addition to other penalties as  
16          may be prescribed by law.

17          “(4) PROCEDURE.—The provisions of section  
18          1128A of the Social Security Act, other than sub-  
19          section (a) and (b) and the first sentence of sub-  
20          section (c)(1) of such section shall apply to civil  
21          monetary penalties under this subsection in the  
22          same manner as such provisions apply to a penalty  
23          or proceeding under section 1128A of the Social Se-  
24          curity Act.

1           “(5) WAIVERS.—The Secretary may waive pen-  
2           alties under paragraph (2), or extend the period of  
3           time for compliance with a requirement of this sec-  
4           tion, for an entity in violation of this section that  
5           has made a good-faith effort to comply with this sec-  
6           tion.

7           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
8           tion shall be construed to permit a health insurance issuer,  
9           group health plan, or other entity to restrict disclosure to,  
10          or otherwise limit the access of, the Department of Health  
11          and Human Services to a report described in subsection  
12          (b)(1) or information related to compliance with sub-  
13          section (a) by such issuer, plan, or entity.

14          “(e) DEFINITION.—In this section, the term ‘whole-  
15          sale acquisition cost’ has the meaning given such term in  
16          section 1847A(c)(6)(B) of the Social Security Act.”; and

17                       (2) in section 2723 (42 U.S.C. 300gg–22)—

18                               (A) in subsection (a)—

19                                       (i) in paragraph (1), by inserting  
20                                       “(other than subsections (a) and (b) of  
21                                       section 2799A–11)” after “part D”; and

22                                       (ii) in paragraph (2), by inserting  
23                                       “(other than subsections (a) and (b) of  
24                                       section 2799A–11)” after “part D”; and

25                               (B) in subsection (b)—

1 (i) in paragraph (1), by inserting  
2 “(other than subsections (a) and (b) of  
3 section 2799A–11)” after “part D”;

4 (ii) in paragraph (2)(A), by inserting  
5 “(other than subsections (a) and (b) of  
6 section 2799A–11)” after “part D”; and

7 (iii) in paragraph (2)(C)(ii), by insert-  
8 ing “(other than subsections (a) and (b) of  
9 section 2799A–11)” after “part D”.

10 (b) ERISA.—

11 (1) IN GENERAL.—Subtitle B of title I of the  
12 Employee Retirement Income Security Act of 1974  
13 (29 U.S.C. 1021 et seq.) is amended—

14 (A) in subpart B of part 7 (29 U.S.C.  
15 1185 et seq.), by adding at the end the fol-  
16 lowing:

17 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**  
18 **SERVICES.**

19 “(a) IN GENERAL.—For plan years beginning on or  
20 after January 1, 2025, a group health plan (or health in-  
21 surance issuer offering group health insurance coverage  
22 in connection with such a plan) or an entity or subsidiary  
23 providing pharmacy benefits management services on be-  
24 half of such a plan or issuer shall not enter into a contract  
25 with a drug manufacturer, distributor, wholesaler, subcon-



1 tractor, rebate aggregator, or any associated third party  
2 that limits the disclosure of information to plan sponsors  
3 in such a manner that prevents the plan or issuer, or an  
4 entity or subsidiary providing pharmacy benefits manage-  
5 ment services on behalf of a plan or issuer, from making  
6 the reports described in subsection (b).

7 “(b) REPORTS.—

8 “(1) IN GENERAL.—For plan years beginning  
9 on or after January 1, 2025, not less frequently  
10 than annually, a health insurance issuer offering  
11 group health insurance coverage or an entity pro-  
12 viding pharmacy benefits management services on  
13 behalf of a group health plan or an issuer providing  
14 group health insurance coverage shall submit to the  
15 plan sponsor (as defined in section 3(16)(B)) of  
16 such group health plan or group health insurance  
17 coverage a report in accordance with this subsection  
18 and make such report available to the plan sponsor  
19 in a machine-readable format. Each such report  
20 shall include, with respect to the applicable group  
21 health plan or health insurance coverage—

22 “(A) as applicable, information collected  
23 from drug manufacturers by such issuer or en-  
24 tity on the total amount of copayment assist-  
25 ance dollars paid, or copayment cards applied,

1 that were funded by the drug manufacturer  
2 with respect to the participants and bene-  
3 ficiaries in such plan or coverage;

4 “(B) a list of each drug covered by such  
5 plan, issuer, or entity providing pharmacy bene-  
6 fits management services that was dispensed  
7 during the reporting period, including, with re-  
8 spect to each such drug during the reporting  
9 period—

10 “(i) the brand name, chemical entity,  
11 and National Drug Code;

12 “(ii) the number of participants and  
13 beneficiaries for whom the drug was filled  
14 during the plan year, the total number of  
15 prescription fills for the drug (including  
16 original prescriptions and refills), and the  
17 total number of dosage units of the drug  
18 dispensed across the plan year, including  
19 whether the dispensing channel was by re-  
20 tail, mail order, or specialty pharmacy;

21 “(iii) the wholesale acquisition cost,  
22 listed as cost per days supply and cost per  
23 pill, or in the case of a drug in another  
24 form, per dose;

1           “(iv) the total out-of-pocket spending  
2           by participants and beneficiaries on such  
3           drug, including participant and beneficiary  
4           spending through copayments, coinsurance,  
5           and deductibles; and

6           “(v) for any drug for which gross  
7           spending of the group health plan or  
8           health insurance coverage exceeded  
9           \$10,000 during the reporting period—

10           “(I) a list of all other drugs in  
11           the same therapeutic category or  
12           class, including brand name drugs  
13           and biological products and generic  
14           drugs or biosimilar biological products  
15           that are in the same therapeutic cat-  
16           egory or class as such drug; and

17           “(II) the rationale for preferred  
18           formulary placement of such drug in  
19           that therapeutic category or class, if  
20           applicable;

21           “(C) a list of each therapeutic category or  
22           class of drugs that were dispensed under the  
23           health plan or health insurance coverage during  
24           the reporting period, and, with respect to each

1 such therapeutic category or class of drugs,  
2 during the reporting period—

3 “(i) total gross spending by the plan,  
4 before manufacturer rebates, fees, or other  
5 manufacturer remuneration;

6 “(ii) the number of participants and  
7 beneficiaries who filled a prescription for a  
8 drug in that category or class;

9 “(iii) if applicable to that category or  
10 class, a description of the formulary tiers  
11 and utilization mechanisms (such as prior  
12 authorization or step therapy) employed  
13 for drugs in that category or class;

14 “(iv) the total out-of-pocket spending  
15 by participants and beneficiaries, including  
16 participant and beneficiary spending  
17 through copayments, coinsurance, and  
18 deductibles; and

19 “(v) for each therapeutic category or  
20 class under which 3 or more drugs are in-  
21 cluded on the formulary of such plan or  
22 coverage—

23 “(I) the amount received, or ex-  
24 pected to be received, from drug man-

1 manufacturers in rebates, fees, alternative  
2 discounts, or other remuneration—

3 “(aa) that has been paid, or  
4 is to be paid, by drug manufac-  
5 turers for claims incurred during  
6 the reporting period; or

7 “(bb) that is related to utili-  
8 zation of drugs, in such thera-  
9 peutic category or class;

10 “(II) the total net spending, after  
11 deducting rebates, price concessions,  
12 alternative discounts or other remu-  
13 nation from drug manufacturers, by  
14 the health plan or health insurance  
15 coverage on that category or class of  
16 drugs; and

17 “(III) the net price per course of  
18 treatment or single fill, such as a 30-  
19 day supply or 90-day supply, incurred  
20 by the health plan or health insurance  
21 coverage and its participants and  
22 beneficiaries, after manufacturer re-  
23 bates, fees, and other remuneration  
24 for drugs dispensed within such thera-

1                   peutic category or class during the re-  
2                   porting period;

3                   “(D) total gross spending on prescription  
4                   drugs by the plan or coverage during the re-  
5                   porting period, before rebates and other manu-  
6                   facturer fees or remuneration;

7                   “(E) total amount received, or expected to  
8                   be received, by the health plan or health insur-  
9                   ance coverage in drug manufacturer rebates,  
10                  fees, alternative discounts, and all other remu-  
11                  neration received from the manufacturer or any  
12                  third party, other than the plan sponsor, re-  
13                  lated to utilization of drug or drug spending  
14                  under that health plan or health insurance cov-  
15                  erage during the reporting period;

16                  “(F) the total net spending on prescription  
17                  drugs by the health plan or health insurance  
18                  coverage during the reporting period; and

19                  “(G) amounts paid directly or indirectly in  
20                  rebates, fees, or any other type of remuneration  
21                  to brokers, consultants, advisors, or any other  
22                  individual or firm who referred the group health  
23                  plan’s or health insurance issuer’s business to  
24                  the pharmacy benefits manager.

1           “(2) PRIVACY REQUIREMENTS.—Health insur-  
2           ance issuers offering group health insurance cov-  
3           erage and entities providing pharmacy benefits man-  
4           agement services on behalf of a group health plan  
5           shall provide information under paragraph (1) in a  
6           manner consistent with the privacy, security, and  
7           breach notification regulations promulgated under  
8           section 264(c) of the Health Insurance Portability  
9           and Accountability Act of 1996, and shall restrict  
10          the use and disclosure of such information according  
11          to such privacy regulations.

12           “(3) DISCLOSURE AND REDISCLOSURE.—

13           “(A) LIMITATION TO BUSINESS ASSOCI-  
14           ATES.—A group health plan receiving a report  
15           under paragraph (1) may disclose such informa-  
16           tion only to business associates of such plan as  
17           defined in section 160.103 of title 45, Code of  
18           Federal Regulations (or successor regulations).

19           “(B) CLARIFICATION REGARDING PUBLIC  
20           DISCLOSURE OF INFORMATION.—Nothing in  
21           this section prevents a health insurance issuer  
22           offering group health insurance coverage or an  
23           entity providing pharmacy benefits management  
24           services on behalf of a group health plan from  
25           placing reasonable restrictions on the public dis-

1 closure of the information contained in a report  
2 described in paragraph (1), except that such  
3 issuer or entity may not restrict disclosure of  
4 such report to the Department of Health and  
5 Human Services, the Department of Labor, the  
6 Department of the Treasury, the Comptroller  
7 General of the United States, or applicable  
8 State agencies.

9 “(C) LIMITED FORM OF REPORT.—The  
10 Secretary shall define through rulemaking a  
11 limited form of the report under paragraph (1)  
12 required of plan sponsors who are drug manu-  
13 facturers, drug wholesalers, or other direct par-  
14 ticipants in the drug supply chain, in order to  
15 prevent anti-competitive behavior.

16 “(4) REPORT TO GAO.—A health insurance  
17 issuer offering group health insurance coverage or  
18 an entity providing pharmacy benefits management  
19 services on behalf of a group health plan shall sub-  
20 mit to the Comptroller General of the United States  
21 each of the first 4 reports submitted to a plan spon-  
22 sor under paragraph (1) with respect to such cov-  
23 erage or plan, and other such reports as requested,  
24 in accordance with the privacy requirements under  
25 paragraph (2), the disclosure and redisclosure stand-



1 ards under paragraph (3), the standards specified  
2 pursuant to paragraph (5), and such other informa-  
3 tion that the Comptroller General determines nec-  
4 essary to carry out the study under section 2(d) of  
5 the Pharmacy Benefits Manager Accountability Act.

6 “(5) STANDARD FORMAT.—Not later than June  
7 1, 2023, the Secretary shall specify through rule-  
8 making standards for health insurance issuers and  
9 entities required to submit reports under paragraph  
10 (4) to submit such reports in a standard format.

11 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-  
12 tion shall be construed to permit a health insurance issuer,  
13 group health plan, or other entity to restrict disclosure to,  
14 or otherwise limit the access of, the Department of Labor  
15 to a report described in subsection (b)(1) or information  
16 related to compliance with subsection (a) by such issuer,  
17 plan, or entity.

18 “(d) DEFINITION.—In this section, the term ‘whole-  
19 sale acquisition cost’ has the meaning given such term in  
20 section 1847A(c)(6)(B) of the Social Security Act.”; and

21 (B) in section 502 (29 U.S.C. 1132)—

22 (i) in subsection (a)—

23 (I) in paragraph (6), by striking  
24 “or (9)” and inserting “(9), or (13)”;

1 (II) in paragraph (10), by strik-  
2 ing at the end “or”;

3 (III) in paragraph (11), at the  
4 end by striking the period and insert-  
5 ing “; or”; and

6 (IV) by adding at the end the fol-  
7 lowing new paragraph:

8 “(12) by the Secretary, in consultation with the  
9 Secretary of Health and Human Services, and the  
10 Secretary of the Treasury, to enforce section 726.”;

11 (ii) in subsection (b)(3), by inserting  
12 “and subsections (a)(12) and (c)(13)” be-  
13 fore “, the Secretary is not”; and

14 (iii) in subsection (c), by adding at  
15 the end the following new paragraph:

16 “(13) SECRETARIAL ENFORCEMENT AUTHORITY  
17 RELATING TO OVERSIGHT OF PHARMACY BENEFITS  
18 MANAGER SERVICES.—

19 “(A) FAILURE TO PROVIDE TIMELY INFOR-  
20 MATION.—The Secretary, in consultation with  
21 the Secretary of Health and Human Services  
22 and the Secretary of the Treasury, may impose  
23 a penalty against any health insurance issuer or  
24 entity providing pharmacy benefits management  
25 services that violates section 726(a) or fails to

1 provide information required under section  
2 726(b) in the amount of \$10,000 for each day  
3 during which such violation continues or such  
4 information is not disclosed or reported.

5 “(B) FALSE INFORMATION.—The Sec-  
6 retary, in consultation with the Secretary of  
7 Health and Human Services and the Secretary  
8 of the Treasury, may impose a penalty against  
9 a health insurance issuer or entity providing  
10 pharmacy benefits management services that  
11 knowingly provides false information under sec-  
12 tion 726 in an amount not to exceed \$100,000  
13 for each item of false information. Such penalty  
14 shall be in addition to other penalties as may  
15 be prescribed by law.

16 “(C) WAIVERS.—The Secretary may waive  
17 penalties under subparagraph (A), or extend  
18 the period of time for compliance with a re-  
19 quirement of section 726, for an entity in viola-  
20 tion of such section that has made a good-faith  
21 effort to comply with such section.”.

22 (2) CLERICAL AMENDMENT.—The table of con-  
23 tents in section 1 of the Employee Retirement In-  
24 come Security Act of 1974 (29 U.S.C. 1001 et seq.)

1 is amended by inserting after the item relating to  
2 section 725 the following new item:

“Sec. 726. Oversight of pharmacy benefits manager services.”.

3 (c) IRC.—

4 (1) IN GENERAL.—Subchapter B of chapter  
5 100 of the Internal Revenue Code of 1986 is amend-  
6 ed by adding at the end the following:

7 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-  
8 AGER SERVICES.**

9 “(a) IN GENERAL.—For plan years beginning on or  
10 after January 1, 2025, a group health plan or an entity  
11 or subsidiary providing pharmacy benefits management  
12 services on behalf of such a plan shall not enter into a  
13 contract with a drug manufacturer, distributor, whole-  
14 saler, subcontractor, rebate aggregator, or any associated  
15 third party that limits the disclosure of information to  
16 plan sponsors in such a manner that prevents the plan,  
17 or an entity or subsidiary providing pharmacy benefits  
18 management services on behalf of a plan, from making  
19 the reports described in subsection (b).

20 “(b) REPORTS.—

21 “(1) IN GENERAL.—For plan years beginning  
22 on or after January 1, 2025, not less frequently  
23 than annually, an entity providing pharmacy benefits  
24 management services on behalf of a group health  
25 plan shall submit to the plan sponsor (as defined in

1 section 3(16)(B) of the Employee Retirement In-  
2 come Security Act of 1974) of such group health  
3 plan a report in accordance with this subsection and  
4 make such report available to the plan sponsor in a  
5 machine-readable format. Each such report shall in-  
6 clude, with respect to the applicable group health  
7 plan—

8 “(A) as applicable, information collected  
9 from drug manufacturers by such entity on the  
10 total amount of copayment assistance dollars  
11 paid, or copayment cards applied, that were  
12 funded by the drug manufacturer with respect  
13 to the participants and beneficiaries in such  
14 plan;

15 “(B) a list of each drug covered by such  
16 plan or entity providing pharmacy benefits  
17 management services that was dispensed during  
18 the reporting period, including, with respect to  
19 each such drug during the reporting period—

20 “(i) the brand name, chemical entity,  
21 and National Drug Code;

22 “(ii) the number of participants and  
23 beneficiaries for whom the drug was filled  
24 during the plan year, the total number of  
25 prescription fills for the drug (including

1 original prescriptions and refills), and the  
2 total number of dosage units of the drug  
3 dispensed across the plan year, including  
4 whether the dispensing channel was by re-  
5 tail, mail order, or specialty pharmacy;

6 “(iii) the wholesale acquisition cost,  
7 listed as cost per days supply and cost per  
8 pill, or in the case of a drug in another  
9 form, per dose;

10 “(iv) the total out-of-pocket spending  
11 by participants and beneficiaries on such  
12 drug, including participant and beneficiary  
13 spending through copayments, coinsurance,  
14 and deductibles; and

15 “(v) for any drug for which gross  
16 spending of the group health plan exceeded  
17 \$10,000 during the reporting period—

18 “(I) a list of all other drugs in  
19 the same therapeutic category or  
20 class, including brand name drugs  
21 and biological products and generic  
22 drugs or biosimilar biological products  
23 that are in the same therapeutic cat-  
24 egory or class as such drug; and

1                   “(II) the rationale for preferred  
2                   formulary placement of such drug in  
3                   that therapeutic category or class, if  
4                   applicable;

5                   “(C) a list of each therapeutic category or  
6                   class of drugs that were dispensed under the  
7                   health plan during the reporting period, and,  
8                   with respect to each such therapeutic category  
9                   or class of drugs, during the reporting period—

10                   “(i) total gross spending by the plan,  
11                   before manufacturer rebates, fees, or other  
12                   manufacturer remuneration;

13                   “(ii) the number of participants and  
14                   beneficiaries who filled a prescription for a  
15                   drug in that category or class;

16                   “(iii) if applicable to that category or  
17                   class, a description of the formulary tiers  
18                   and utilization mechanisms (such as prior  
19                   authorization or step therapy) employed  
20                   for drugs in that category or class;

21                   “(iv) the total out-of-pocket spending  
22                   by participants and beneficiaries, including  
23                   participant and beneficiary spending  
24                   through copayments, coinsurance, and  
25                   deductibles; and

1 “(v) for each therapeutic category or  
2 class under which 3 or more drugs are in-  
3 cluded on the formulary of such plan—

4 “(I) the amount received, or ex-  
5 pected to be received, from drug man-  
6 ufacturers in rebates, fees, alternative  
7 discounts, or other remuneration—

8 “(aa) that has been paid, or  
9 is to be paid, by drug manufac-  
10 turers for claims incurred during  
11 the reporting period; or

12 “(bb) that is related to utili-  
13 zation of drugs, in such thera-  
14 peutic category or class;

15 “(II) the total net spending, after  
16 deducting rebates, price concessions,  
17 alternative discounts or other remu-  
18 neration from drug manufacturers, by  
19 the health plan on that category or  
20 class of drugs; and

21 “(III) the net price per course of  
22 treatment or single fill, such as a 30-  
23 day supply or 90-day supply, incurred  
24 by the health plan and its participants  
25 and beneficiaries, after manufacturer



1 rebates, fees, and other remuneration  
2 for drugs dispensed within such thera-  
3 peutic category or class during the re-  
4 porting period;

5 “(D) total gross spending on prescription  
6 drugs by the plan during the reporting period,  
7 before rebates and other manufacturer fees or  
8 remuneration;

9 “(E) total amount received, or expected to  
10 be received, by the health plan in drug manu-  
11 facturer rebates, fees, alternative discounts, and  
12 all other remuneration received from the manu-  
13 facturer or any third party, other than the plan  
14 sponsor, related to utilization of drug or drug  
15 spending under that health plan during the re-  
16 porting period;

17 “(F) the total net spending on prescription  
18 drugs by the health plan during the reporting  
19 period; and

20 “(G) amounts paid directly or indirectly in  
21 rebates, fees, or any other type of remuneration  
22 to brokers, consultants, advisors, or any other  
23 individual or firm who referred the group health  
24 plan’s business to the pharmacy benefits man-  
25 ager.

1           “(2) PRIVACY REQUIREMENTS.—Entities pro-  
2           viding pharmacy benefits management services on  
3           behalf of a group health plan shall provide informa-  
4           tion under paragraph (1) in a manner consistent  
5           with the privacy, security, and breach notification  
6           regulations promulgated under section 264(c) of the  
7           Health Insurance Portability and Accountability Act  
8           of 1996, and shall restrict the use and disclosure of  
9           such information according to such privacy regula-  
10          tions.

11           “(3) DISCLOSURE AND REDISCLOSURE.—

12           “(A) LIMITATION TO BUSINESS ASSOCI-  
13           ATES.—A group health plan receiving a report  
14           under paragraph (1) may disclose such informa-  
15           tion only to business associates of such plan as  
16           defined in section 160.103 of title 45, Code of  
17           Federal Regulations (or successor regulations).

18           “(B) CLARIFICATION REGARDING PUBLIC  
19           DISCLOSURE OF INFORMATION.—Nothing in  
20           this section prevents an entity providing phar-  
21           macy benefits management services on behalf of  
22           a group health plan from placing reasonable re-  
23           strictions on the public disclosure of the infor-  
24           mation contained in a report described in para-  
25           graph (1), except that such entity may not re-

1 strict disclosure of such report to the Depart-  
2 ment of Health and Human Services, the De-  
3 partment of Labor, the Department of the  
4 Treasury, the Comptroller General of the  
5 United States, or applicable State agencies.

6 “(C) LIMITED FORM OF REPORT.—The  
7 Secretary shall define through rulemaking a  
8 limited form of the report under paragraph (1)  
9 required of plan sponsors who are drug manu-  
10 facturers, drug wholesalers, or other direct par-  
11 ticipants in the drug supply chain, in order to  
12 prevent anti-competitive behavior.

13 “(4) REPORT TO GAO.—An entity providing  
14 pharmacy benefits management services on behalf of  
15 a group health plan shall submit to the Comptroller  
16 General of the United States each of the first 4 re-  
17 ports submitted to a plan sponsor under paragraph  
18 (1) with respect to such plan, and other such reports  
19 as requested, in accordance with the privacy require-  
20 ments under paragraph (2), the disclosure and re-  
21 disclosure standards under paragraph (3), the stand-  
22 ards specified pursuant to paragraph (5), and such  
23 other information that the Comptroller General de-  
24 termines necessary to carry out the study under sec-

1 tion 2(d) of the Pharmacy Benefits Manager Ac-  
2 countability Act.

3 “(5) STANDARD FORMAT.—Not later than June  
4 1, 2023, the Secretary shall specify through rule-  
5 making standards for entities required to submit re-  
6 ports under paragraph (4) to submit such reports in  
7 a standard format.

8 “(c) ENFORCEMENT.—

9 “(1) IN GENERAL.—The Secretary, in consulta-  
10 tion with the Secretary of Labor and the Secretary  
11 of Health and Human Services, shall enforce this  
12 section.

13 “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
14 TION.—An entity providing pharmacy benefits man-  
15 agement services that violates subsection (a) or fails  
16 to provide information required under subsection (b)  
17 shall be subject to a civil monetary penalty in the  
18 amount of \$10,000 for each day during which such  
19 violation continues or such information is not dis-  
20 closed or reported.

21 “(3) FALSE INFORMATION.—An entity pro-  
22 viding pharmacy benefits management services that  
23 knowingly provides false information under this sec-  
24 tion shall be subject to a civil money penalty in an  
25 amount not to exceed \$100,000 for each item of

1 false information. Such civil money penalty shall be  
2 in addition to other penalties as may be prescribed  
3 by law.

4 “(4) PROCEDURE.—The provisions of section  
5 1128A of the Social Security Act, other than sub-  
6 section (a) and (b) and the first sentence of sub-  
7 section (c)(1) of such section shall apply to civil  
8 monetary penalties under this subsection in the  
9 same manner as such provisions apply to a penalty  
10 or proceeding under section 1128A of the Social Se-  
11 curity Act.

12 “(5) WAIVERS.—The Secretary may waive pen-  
13 alties under paragraph (2), or extend the period of  
14 time for compliance with a requirement of this sec-  
15 tion, for an entity in violation of this section that  
16 has made a good-faith effort to comply with this sec-  
17 tion.

18 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
19 tion shall be construed to permit a group health plan or  
20 other entity to restrict disclosure to, or otherwise limit the  
21 access of, the Department of the Treasury to a report de-  
22 scribed in subsection (b)(1) or information related to com-  
23 pliance with subsection (a) by such plan or entity.

1       “(e) DEFINITION.—In this section, the term ‘whole-  
2 sale acquisition cost’ has the meaning given such term in  
3 section 1847A(c)(6)(B) of the Social Security Act.”.

4           (2) CLERICAL AMENDMENT.—The table of sec-  
5 tions for subchapter B of chapter 100 of the Inter-  
6 nal Revenue Code of 1986 is amended by adding at  
7 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

8       (d) GAO STUDY.—

9           (1) IN GENERAL.—Not later than 3 years after  
10 the date of enactment of this Act, the Comptroller  
11 General of the United States shall submit to Con-  
12 gress a report on—

13           (A) pharmacy networks of group health  
14 plans, health insurance issuers, and entities  
15 providing pharmacy benefits management serv-  
16 ices under such group health plan or group or  
17 individual health insurance coverage, including  
18 networks that have pharmacies that are under  
19 common ownership (in whole or part) with  
20 group health plans, health insurance issuers, or  
21 entities providing pharmacy benefits manage-  
22 ment services or pharmacy benefits administra-  
23 tive services under group health plan or group  
24 or individual health insurance coverage;

1 (B) as it relates to pharmacy networks  
2 that include pharmacies under common owner-  
3 ship described in subparagraph (A)—

4 (i) whether such networks are de-  
5 signed to encourage enrollees of a plan or  
6 coverage to use such pharmacies over other  
7 network pharmacies for specific services or  
8 drugs, and if so, the reasons the networks  
9 give for encouraging use of such phar-  
10 macies; and

11 (ii) whether such pharmacies are used  
12 by enrollees disproportionately more in the  
13 aggregate or for specific services or drugs  
14 compared to other network pharmacies;

15 (C) whether group health plans and health  
16 insurance issuers offering group or individual  
17 health insurance coverage have options to elect  
18 different network pricing arrangements in the  
19 marketplace with entities that provide phar-  
20 macy benefits management services, the preva-  
21 lence of electing such different network pricing  
22 arrangements;

23 (D) pharmacy network design parameters  
24 that encourage enrollees in the plan or coverage  
25 to fill prescriptions at mail order, specialty, or

1 retail pharmacies that are wholly or partially-  
2 owned by that issuer or entity; and

3 (E) the degree to which mail order, spe-  
4 cialty, or retail pharmacies that dispense pre-  
5 scription drugs to an enrollee in a group health  
6 plan or health insurance coverage that are  
7 under common ownership (in whole or part)  
8 with group health plans, health insurance  
9 issuers, or entities providing pharmacy benefits  
10 management services or pharmacy benefits ad-  
11 ministrative services under group health plan or  
12 group or individual health insurance coverage  
13 receive reimbursement that is greater than the  
14 median price charged to the group health plan  
15 or health insurance issuer when the same drug  
16 is dispensed to enrollees in the plan or coverage  
17 by other pharmacies included in the pharmacy  
18 network of that plan, issuer, or entity that are  
19 not wholly or partially owned by the health in-  
20 surance issuer or entity providing pharmacy  
21 benefits management services.

22 (2) REQUIREMENT.—The Comptroller General  
23 of the United States shall ensure that the report  
24 under paragraph (1) does not contain information  
25 that would allow a reader to identify a specific plan



1 or entity providing pharmacy benefits management  
2 services or otherwise contain commercial or financial  
3 information that is privileged or confidential.

4 (3) DEFINITIONS.—In this subsection, the  
5 terms “group health plan”, “health insurance cov-  
6 erage”, and “health insurance issuer” have the  
7 meanings given such terms in section 2791 of the  
8 Public Health Service Act (42 U.S.C. 300gg–91).

9 **TITLE II—SUPPORTING PA-**  
10 **TIENTS, HEALTH CARE WORK-**  
11 **ERS, COMMUNITY HEALTH**  
12 **CENTERS, AND HOSPITALS**

13 **SEC. 201. EXTENSION FOR COMMUNITY HEALTH CENTERS,**  
14 **THE NATIONAL HEALTH SERVICE CORPS,**  
15 **AND TEACHING HEALTH CENTERS THAT OP-**  
16 **ERATE GME PROGRAMS.**

17 (a) TEACHING HEALTH CENTERS THAT OPERATE  
18 GRADUATE MEDICAL EDUCATION PROGRAMS.—Section  
19 340H(g) of the Public Health Service Act (42 U.S.C.  
20 256h(g)) is amended—

21 (1) by amending paragraph (1) to read as fol-  
22 lows:

23 “(1) IN GENERAL.—To carry out this section,  
24 there are appropriated such sums as may be nec-  
25 essary, not to exceed—

1           “(A) \$230,000,000, for the period of fiscal  
2           years 2011 through 2015;

3           “(B) \$60,000,000 for each of fiscal years  
4           2016 and 2017;

5           “(C) \$126,500,000 for each of fiscal years  
6           2018 through 2023;

7           “(D) \$175,000,000 for each of fiscal years  
8           2024 and 2025;

9           “(E) \$225,000,000 for each of fiscal years  
10          2026 and 2027; and

11          “(F) \$275,000,000 for each of fiscal years  
12          2028 and 2029.”; and

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

14          “(3) AVAILABILITY.—The amounts made avail-  
15          able under paragraph (1) shall remain available until  
16          expended.”.

17          (b) EXTENSION FOR COMMUNITY HEALTH CEN-  
18          TERS.—Section 10503(b)(1)(F) of the Patient Protection  
19          and Affordable Care Act (42 U.S.C. 254b–2(b)(1)(F)) is  
20          amended—

21                 (1) by striking “and” before “\$4,000,000,000”  
22                 and inserting a comma; and

23                 (2) by inserting “, and \$4,200,000,000 for each  
24                 of fiscal years 2024 and 2025” before the semicolon.

1 (c) EXTENSION FOR THE NATIONAL HEALTH SERV-  
2 ICE CORPS.—Section 10503(b)(2) of the Patient Protec-  
3 tion and Affordable Care Act (42 U.S.C. 254b–2(b)(2))  
4 is amended—

5 (1) in subparagraph (G), by striking “and” at  
6 the end;

7 (2) in subparagraph (H), by striking the period  
8 at the end and inserting “; and”; and

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

10 “(I) \$350,000,000 for each of fiscal years  
11 2024 and 2025.”

12 (d) APPLICATION OF PROVISIONS.—Amounts appro-  
13 priated pursuant to the amendments made by this section  
14 shall be subject to the requirements contained in Public  
15 Law 117–328 for funds for programs authorized under  
16 sections 330 through 340 of the Public Health Service  
17 Act.

18 (e) CONFORMING AMENDMENT.—Paragraph (4) of  
19 section 3014(h) of title 18, United States Code, is amend-  
20 ed by striking “and section 301(d) of division BB of the  
21 Consolidated Appropriations Act, 2021.” and inserting  
22 “section 301(d) of division BB of the Consolidated Appro-  
23 priations Act, 2021, and section 201(d) of the PATIENT  
24 Act of 2023”.

1 **SEC. 202. EXTENSION OF SPECIAL DIABETES PROGRAMS.**

2 (a) EXTENSION OF SPECIAL DIABETES PROGRAMS  
3 FOR TYPE I DIABETES.—Section 330B(b)(2) of the Pub-  
4 lic Health Service Act (42 U.S.C. 254e–2(b)(2)) is amend-  
5 ed—

6 (1) in subparagraph (C), by striking “and” at  
7 the end;

8 (2) in subparagraph (D), by striking the period  
9 and inserting “; and”; and

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

12 “(E) \$170,000,000 for each of fiscal years  
13 2024 and 2025.”.

14 (b) EXTENDING FUNDING FOR SPECIAL DIABETES  
15 PROGRAMS FOR INDIANS.—Section 330C(c)(2) of the  
16 Public Health Service Act (42 U.S.C. 254e–3(c)(2)) is  
17 amended—

18 (1) in subparagraph (C), by striking “and” at  
19 the end;

20 (2) in subparagraph (D), by striking the period  
21 and inserting “; and”; and

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

24 “(E) \$170,000,000 for each of fiscal years  
25 2024 and 2025.”.

1 **SEC. 203. DELAYING CERTAIN DISPROPORTIONATE SHARE**  
2 **HOSPITAL PAYMENT REDUCTIONS UNDER**  
3 **THE MEDICAID PROGRAM.**

4 Section 1923(f)(7)(A) of the Social Security Act (42  
5 U.S.C.1396r-4(f)(7)(A)) is amended—

6 (1) in clause (i), in the matter preceding sub-  
7 clause (I), by striking “2024” and inserting “2026”;  
8 and

9 (2) in clause (ii), by striking “2024” and in-  
10 sserting “2026”.

11 **SEC. 204. MEDICAID IMPROVEMENT FUND.**

12 Section 1941(b)(3)(A) of the Social Security Act (42  
13 U.S.C. 1396w-1(b)(3)(A)) is amended by striking  
14 “\$7,000,000,000” and inserting “\$0”.

15 **TITLE III—REDUCING HEALTH**  
16 **CARE COSTS**

17 **SEC. 301. INCREASING TRANSPARENCY IN GENERIC DRUG**  
18 **APPLICATIONS.**

19 (a) IN GENERAL.—Section 505(j)(3) of the Federal  
20 Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(3)) is  
21 amended by adding at the end the following:

22 “(H)(i) Upon request (in controlled correspondence  
23 or an analogous process) by a person that has submitted  
24 or intends to submit an abbreviated application under this  
25 subsection for a drug that is required by regulation to con-  
26 tain one or more of the same inactive ingredients in the

1 same concentrations as the listed drug referred to, or for  
2 which the Secretary determines there is a scientific jus-  
3 tification for an approach that is in vitro in whole or in  
4 part to be used to demonstrate bioequivalence for a drug  
5 if such a drug contains one or more of the same inactive  
6 ingredients in the same concentrations as the listed drug,  
7 the Secretary shall inform the person whether such drug  
8 is qualitatively and quantitatively the same as the listed  
9 drug. The Secretary may also provide such information  
10 to such a person on the Secretary's own initiative during  
11 the review of an abbreviated application under this sub-  
12 section for such drug.

13       “(ii) Notwithstanding section 301(j), if the Secretary  
14 determines that such drug is not qualitatively or quan-  
15 titatively the same as the listed drug, the Secretary shall  
16 identify and disclose to the person—

17               “(I) the ingredient or ingredients that cause  
18 such drug not to be qualitatively or quantitatively  
19 the same as the listed drug; and

20               “(II) for any ingredient for which there is an  
21 identified quantitative deviation, whether the quan-  
22 tity or proportion of any ingredient in such drug is  
23 greater than or less than the quantity or proportion  
24 of such ingredient in the listed drug.

1       “(iii) If the Secretary determines that such drug is  
2 qualitatively and quantitatively the same as the listed  
3 drug, the Secretary shall not change or rescind such deter-  
4 mination after the submission of an abbreviated applica-  
5 tion for such drug under this subsection unless—

6               “(I) the formulation of the listed drug has been  
7 changed and the Secretary has determined that the  
8 prior listed drug formulation was withdrawn for rea-  
9 sons of safety or effectiveness; or

10              “(II) the Secretary makes a written determina-  
11 tion that the prior determination must be changed  
12 because an error has been identified.

13       “(iv) If the Secretary makes a written determination  
14 described in clause (iii)(II), the Secretary shall provide no-  
15 tice and a copy of the written determination to the person  
16 making the request under clause (i).

17       “(v) The disclosures required by this subparagraph  
18 are disclosures authorized by law, including for purposes  
19 of section 1905 of title 18, United States Code.”.

20       (b) GUIDANCE.—

21              (1) IN GENERAL.—Not later than one year  
22 after the date of enactment of this Act, the Sec-  
23 retary of Health and Human Services shall issue  
24 draft guidance, or update guidance, describing how  
25 the Secretary will determine whether a drug is quali-

1 tatively and quantitatively the same as the listed  
2 drug (as such terms are used in section  
3 505(j)(3)(H) of the Federal Food, Drug, and Cos-  
4 metic Act, as added by subsection (a)), including  
5 with respect to assessing pH adjusters.

6 (2) PROCESS.—In issuing guidance under this  
7 subsection, the Secretary of Health and Human  
8 Services shall—

9 (A) publish draft guidance;

10 (B) provide a period of at least 60 days for  
11 comment on the draft guidance; and

12 (C) after considering any comments re-  
13 ceived and not later than one year after the  
14 close of the comment period on the draft guid-  
15 ance, publish final guidance.

16 (c) APPLICABILITY.—Section 505(j)(3)(H) of the  
17 Federal Food, Drug, and Cosmetic Act, as added by sub-  
18 section (a), applies beginning on the date of enactment  
19 of this Act, irrespective of the date on which the guidance  
20 required by subsection (b) is finalized.



1 **SEC. 302. PARITY IN MEDICARE PAYMENTS FOR HOSPITAL**  
2 **OUTPATIENT DEPARTMENT SERVICES FUR-**  
3 **NISHED OFF-CAMPUS.**

4 (a) IN GENERAL.—Section 1833(t)(16) of the Social  
5 Security Act (42 U.S.C. 1395l(t)(16)) is amended by add-  
6 ing at the end the following new subparagraph:

7 “(H) PARITY IN FEE SCHEDULE AMOUNT  
8 FOR CERTAIN SERVICES FURNISHED BY AN  
9 OFF-CAMPUS OUTPATIENT DEPARTMENT OF A  
10 PROVIDER.—

11 “(i) IN GENERAL.—Subject to clause  
12 (iii), in the case of specified OPD services  
13 (as defined in clause (iv)) that are fur-  
14 nished during 2025 or a subsequent year  
15 by an off-campus outpatient department of  
16 a provider (as defined in clause (iv)), there  
17 shall be substituted for the amount other-  
18 wise determined under this subsection for  
19 such service and year an amount equal to  
20 the payment amount that would have been  
21 payable under the applicable payment sys-  
22 tem under this part (other than under this  
23 subsection) had such services been fur-  
24 nished by such a department subject to  
25 such payment system pursuant to para-  
26 graph (21)(C).

1           “(ii) NOT BUDGET NEUTRAL IMPLE-  
2           MENTATION.—In making any budget neu-  
3           trality adjustments under this subsection  
4           for 2025 or a subsequent year, the Sec-  
5           retary shall not take into account the re-  
6           duced expenditures that result from the  
7           application of this subparagraph.

8           “(iii) TRANSITION.—The Secretary  
9           shall provide for a 4-year phase-in of the  
10          application of clause (i), with clause (i)  
11          being fully applicable for specified OPD  
12          services beginning with 2028.

13          “(iv) DEFINITIONS.—For purposes of  
14          this subparagraph:

15                 “(I) DESIGNATED AMBULATORY  
16                 PAYMENT CLASSIFICATION GROUP.—  
17                 The term ‘designated ambulatory pay-  
18                 ment classification group’ means an  
19                 ambulatory payment classification  
20                 group for drug administration serv-  
21                 ices.

22                 “(II) SPECIFIED OPD SERVICES  
23                 DEFINED.—The term ‘specified OPD  
24                 services’ means covered OPD services

1 included in a designated ambulatory  
2 payment classification group.

3 “(III) OFF-CAMPUS OUTPATIENT  
4 DEPARTMENT OF A PROVIDER DE-  
5 FINED.—The term ‘off-campus out-  
6 patient department of a provider’  
7 means a department of a provider (as  
8 defined in section 413.65(a)(2) of title  
9 42, Code of Federal Regulations) that  
10 is not located—

11 “(aa) on the campus (as  
12 such term is defined in such sec-  
13 tion 413.65(a)(2)) of such pro-  
14 vider; or

15 “(bb) within the distance  
16 (described in such definition of  
17 campus) from a remote location  
18 of a hospital facility (as defined  
19 in such section 413.65(a)(2)).”.

20 (b) IMPLEMENTATION.—Section 1833(t)(12) of the  
21 Social Security Act (42 U.S.C. 1395l(t)(12)) is amend-  
22 ed—

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

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

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

5                     “(F) the determination of any payment  
6                     amount under paragraph (16)(H), including the  
7                     transition under clause (iii) of such para-  
8                     graph.”.

9   **SEC. 303. IMPROVING TRANSPARENCY AND PREVENTING**  
10                   **THE USE OF ABUSIVE SPREAD PRICING AND**  
11                   **RELATED PRACTICES IN MEDICAID.**

12           (a) PHARMACY PRICE REIMBURSEMENT REQUIRE-  
13           MENTS.—

14                   (1) IN GENERAL.—Section 1927(e) of the So-  
15                   cial Security Act (42 U.S.C. 1396r–8(e)) is amended  
16                   by adding at the end the following:

17                             “(6) PHARMACY PRICE REIMBURSEMENT RE-  
18                             QUIRED.—A contract between the State and a man-  
19                             aged care entity (or subcontractor of a managed  
20                             care entity that manages the pharmacy benefit for  
21                             such entity (in this section referred to as a ‘PBM’),  
22                             or other specified entity (as such terms are defined  
23                             in section 1903(m)(9)(D)) that includes provisions  
24                             making the managed care entity responsible for cov-  
25                             erage of covered outpatient drugs dispensed to indi-

1       viduals enrolled with the entity, shall require that  
2       payment for such drugs and related administrative  
3       services (as applicable), including payments made by  
4       a PBM on behalf of the State or entity, is based on  
5       a pass-through pricing model under which—

6               “(A) any payment made by the entity or  
7       the PBM (as applicable) for such a drug—

8                       “(i) is limited to—

9                               “(I) ingredient cost; and

10                               “(II) a professional dispensing

11       fee that is not less than the profes-  
12       sional dispensing fee that the State  
13       plan or waiver would pay if the plan  
14       or waiver was making the payment di-  
15       rectly;

16                       “(ii) is passed through in its entirety  
17       by the entity or PBM to the pharmacy or  
18       provider that dispenses the drug; and

19                       “(iii) is made in a manner that is con-  
20       sistent with sections 447.502, 447.512,  
21       447.514, and 447.518 of title 42, Code of  
22       Federal Regulations (or any successor reg-  
23       ulation) as if such requirements applied di-  
24       rectly to the entity or the PBM;

1           “(B) payment to the entity or the PBM  
2           (as applicable) for administrative services per-  
3           formed by the entity or PBM is limited to an  
4           administrative fee that covers the reasonable  
5           cost of providing such services;

6           “(C) the entity or the PBM (as applicable)  
7           shall make available to the State, and the Sec-  
8           retary upon request, all costs and payments re-  
9           lated to covered outpatient drugs and accom-  
10          panying administrative services incurred, re-  
11          ceived, or made by the entity or the PBM, in-  
12          cluding ingredient costs, professional dispensing  
13          fees, administrative fees, post-sale and post-in-  
14          voice fees, discounts, or related adjustments  
15          such as direct and indirect remuneration fees,  
16          and any and all other remuneration; and

17          “(D) any form of spread pricing whereby  
18          any amount charged or claimed by the entity or  
19          the PBM (as applicable) is in excess of the  
20          amount paid to the pharmacies on behalf of the  
21          entity, including any post-sale or post-invoice  
22          fees, discounts, or related adjustments such as  
23          direct and indirect remuneration fees or assess-  
24          ments (after allowing for a reasonable adminis-  
25          trative fee as described in subparagraph (B)) is

1 not allowable for purposes of claiming Federal  
2 matching payments under this title.”.

3 (2) CONFORMING AMENDMENTS.—Section  
4 1903(m)(2)(A)(xiii) of such Act (42 U.S.C.  
5 1396b(m)(2)(A)(xiii)) is amended—

6 (A) by striking “and (III)” and inserting  
7 “(III)”;

8 (B) by inserting before the period at the  
9 end the following: “, and (IV) the pharmacy  
10 benefit provided by the entity (or pharmacy  
11 benefit manager on behalf of the entity under  
12 a contract), the other specified entity (as de-  
13 fined in paragraph (9)(D)), or by another ar-  
14 rangement between the entity and the phar-  
15 macy benefit manager, shall comply with the re-  
16 quirements of section 1927(e)(6)”;

17 (C) by moving the left margin 2 ems to the  
18 left.

19 (3) EFFECTIVE DATE.—The amendments made  
20 by this subsection apply to contracts between States  
21 and managed care entities, or other specified enti-  
22 ties, that have an initial effective date or are re-  
23 newed on or after the date that is 18 months after  
24 the date of enactment of this Act.

1 (b) ENSURING ACCURATE PAYMENTS TO PHAR-  
2 MACIES UNDER MEDICAID.—

3 (1) IN GENERAL.—Section 1927(f) of the Social  
4 Security Act (42 U.S.C. 1396r–8(f)) is amended—

5 (A) by striking “and” after the semicolon  
6 at the end of paragraph (1)(A)(i) and all that  
7 precedes it through “(1)” and inserting the fol-  
8 lowing:

9 “(1) DETERMINING PHARMACY ACTUAL ACQUI-  
10 SITION COSTS.—The Secretary shall conduct a sur-  
11 vey of retail community pharmacy drug prices to de-  
12 termine the national average drug acquisition cost as  
13 follows:

14 “(A) USE OF VENDOR.—The Secretary  
15 may contract services for—

16 “(i) with respect to retail community  
17 pharmacies, the determination of retail  
18 survey prices of the national average drug  
19 acquisition cost for covered outpatient  
20 drugs based on a monthly survey of such  
21 pharmacies; and”;

22 (B) by adding at the end of paragraph (1)  
23 the following:

24 “(F) SURVEY REPORTING.—A State shall  
25 require that any retail community pharmacy in



1 the State that receives any payment, reimburse-  
2 ment, administrative fee, discount, or rebate re-  
3 lated to the dispensing of covered outpatient  
4 drugs to individuals receiving benefits under  
5 this title, regardless of whether such payment,  
6 reimbursement, administrative fee, discount, or  
7 rebate is received from the State or a managed  
8 care entity directly or from a pharmacy benefit  
9 manager or other specified entity (as defined in  
10 section 1903(m)(9)(D)) that has a contract  
11 with the State or a managed care entity, shall  
12 respond to surveys of retail prices conducted  
13 under this subsection.

14 “(G) SURVEY INFORMATION.—Information  
15 on national drug acquisition prices obtained  
16 under this paragraph shall be made publicly  
17 available in a timely manner following the col-  
18 lection of such information and shall include at  
19 least the following:

20 “(i) The monthly response rate to the  
21 survey including a list of pharmacies not in  
22 compliance with subparagraph (F).

23 “(ii) The sampling frame and number  
24 of pharmacies sampled monthly.

1           “(iii) Information on price concessions  
2           to the pharmacy, including discounts, re-  
3           bates, and other price concessions, to the  
4           extent that such information is available  
5           during the survey period.

6           “(H) REPORT ON SPECIALTY PHAR-  
7           MACIES.—Not later than 1 year after the date  
8           that this subparagraph takes effect, the Sec-  
9           retary shall submit to Congress a report exam-  
10          ining specialty drug coverage and reimburse-  
11          ment under this title, including—

12                   “(i) a description of how State Med-  
13                   icaid programs define specialty drugs and  
14                   specialty pharmacies;

15                   “(ii) the amount State Medicaid pro-  
16                   grams pay for specialty drugs;

17                   “(iii) how States and managed care  
18                   entities determine payment for specialty  
19                   drugs;

20                   “(iv) the settings in which specialty  
21                   drugs are dispensed to individuals receiv-  
22                   ing benefits under this title (such as retail  
23                   community pharmacies or specialty phar-  
24                   macies);

1           “(v) the extent to which speciality  
2           drugs (as defined by the respective States)  
3           are captured in the national average drug  
4           acquisition cost survey (or through another  
5           process);

6           “(vi) examples of specialty drug dis-  
7           pensing fees to support the services associ-  
8           ated with dispensing such specialty drugs;  
9           and

10           “(vii) recommendations as to whether  
11           specialty pharmacies should be included in  
12           the survey of retail prices to ensure na-  
13           tional average drug acquisition costs cap-  
14           ture drugs sold at specialty pharmacies,  
15           and how such specialty pharmacies should  
16           be defined.

17           “(I) ENFORCEMENT.—At the discretion of  
18           the Secretary, the Secretary may enforce non-  
19           compliance with this paragraph by a pharmacy  
20           through the establishment of penalties or the  
21           suspension of payments under this title, in full  
22           or in part, until compliance with this paragraph  
23           has been completed.”; and

24           (C) in paragraph (2)—

1 (i) in subparagraph (A), by inserting  
2 “(including payment rates under Medicaid  
3 managed care plans)” after “under this  
4 title”; and

5 (ii) in subparagraph (B), by inserting  
6 “, and the basis for such dispensing fees”  
7 before the semicolon at the end.

8 (2) EFFECTIVE DATE.—The amendments made  
9 by this subsection take effect on the first day of the  
10 first quarter that begins on or after the date that is  
11 18 months after the date of enactment of this Act.

○