

118TH CONGRESS  
1ST SESSION

# H. R. 4507

To amend the Employee Retirement Income Security Act of 1974 to promote transparency in health coverage and reform pharmacy benefit management services with respect to group health plans, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JULY 10, 2023

Mr. GOOD of Virginia (for himself and Mr. DESAULNIER) introduced the following bill; which was referred to the Committee on Education and the Workforce, and in addition to the Committees on Energy and Commerce, and Ways and Means, 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 amend the Employee Retirement Income Security Act of 1974 to promote transparency in health coverage and reform pharmacy benefit management services with respect to group health plans, 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 “Transparency in Cov-  
5 erage Act of 2023”.

1 **SEC. 2. PROMOTING GROUP HEALTH PLAN AND GROUP**  
2 **HEALTH INSURANCE COVERAGE PRICE**  
3 **TRANSPARENCY.**

4 (a) IN GENERAL.—

5 (1) ERISA.—

6 (A) IN GENERAL.—Section 719 of the Em-  
7 ployee Retirement Income Security Act of 1974  
8 (29 U.S.C. 1185h) is amended to read as fol-  
9 lows:

10 **“SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.**

11 “(a) IN GENERAL.—A group health plan, and a  
12 health insurance issuer offering group health insurance  
13 coverage, shall make available to the public accurate and  
14 timely disclosures of the following information:

15 “(1) Claims payment policies and practices.

16 “(2) Periodic financial disclosures.

17 “(3) Data on enrollment.

18 “(4) Data on disenrollment.

19 “(5) Data on the number of claims that are de-  
20 nied.

21 “(6) Data on rating practices.

22 “(7) Information on cost-sharing and payments  
23 with respect to any out-of-network coverage (or with  
24 respect to any item and service furnished under such  
25 a plan or such group health insurance coverage that  
26 does not use a network of providers).

1           “(8) Information on participant and beneficiary  
2           rights under this part.

3           “(9) Rate and payment information described  
4           in subsection (d).

5           “(10) Other information as determined appro-  
6           priate by the Secretary.

7   Rate and payment information described in paragraph (9)  
8   shall be made available to the public not later than Janu-  
9   ary 10, 2025, and not later than the tenth day of every  
10   month thereafter, in the manner described in subsection  
11   (d)(2)(A), and, beginning on January 1, 2027, in real-time  
12   through an application program interface (or successor  
13   technology) described in subsection (d)(2)(B).

14       “(b) USE OF PLAIN LANGUAGE.—The information  
15   required to be submitted under subsection (a) shall be pro-  
16   vided in plain language. The term ‘plain language’ means  
17   language that the intended audience, including individuals  
18   with limited English proficiency, can readily understand  
19   and use because that language is clear, concise, well-orga-  
20   nized, accurately describes the information, and follows  
21   other best practices of plain language writing. The Sec-  
22   retary, jointly with the Secretary of Health and Human  
23   Services and the Secretary of Labor, shall develop and  
24   issue standards for plain language writing for purposes  
25   of this section and shall develop a standardized reporting

1 template and standardized definitions of terms to allow  
2 for comparison across group health plans and health in-  
3 surance coverage.

4 “(c) COST SHARING TRANSPARENCY.—

5 “(1) IN GENERAL.—A group health plan, and a  
6 health insurance issuer offering group health insur-  
7 ance coverage, shall, upon request of a participant  
8 or beneficiary and in a timely manner, provide to the  
9 participant or beneficiary a statement of the amount  
10 of cost-sharing (including deductibles, copayments,  
11 and coinsurance) under the participant’s or bene-  
12 ficiary’s plan or coverage that the participant or  
13 beneficiary would be responsible for paying with re-  
14 spect to the furnishing of a specific item or service  
15 by a provider. At a minimum, such information shall  
16 include the information specified in paragraph (2)  
17 and shall be made available at no cost to the partici-  
18 pant or beneficiary through a self-service tool that  
19 meets the requirements of paragraph (3) or through  
20 a paper or phone disclosure, at the option of the  
21 participant or beneficiary, that meets such require-  
22 ments as the Secretary may specify.

23 “(2) SPECIFIED INFORMATION.—For purposes  
24 of paragraph (1), the information specified in this  
25 paragraph is, with respect to an item or service for

1       which benefits are available under a group health  
2       plan or group health insurance coverage (as applica-  
3       ble) furnished by a health care provider to a partici-  
4       pant or beneficiary of such plan or coverage, the fol-  
5       lowing:

6               “(A) If such provider is a participating  
7               provider with respect to such item or service,  
8               the in-network rate (as defined in subsection  
9               (f)) for such item or service and for any other  
10              item or service that is inherent in the fur-  
11              nishing of the item or service that is the subject  
12              of such request.

13             “(B) If such provider is not a participating  
14             provider, the allowed amount, percentage of  
15             billed charges, or other rate that such plan or  
16             coverage will recognize as payment for such  
17             item or service, along with a notice that such  
18             individual may be liable for additional charges  
19             billed by such provider.

20             “(C) The estimated amount of cost sharing  
21             (including deductibles, copayments, and coin-  
22             surance) that the participant or beneficiary will  
23             incur for such item or service (which, in the  
24             case such item or service is to be furnished by  
25             a provider described in subparagraph (B), shall

1 be calculated using the amount or rate de-  
2 scribed in such subparagraph (or, in the case  
3 such plan or issuer uses a percentage of billed  
4 charges to determined the amount of payment  
5 for such provider, using a reasonable estimate  
6 of such percentage of such charges)).

7 “(D) The amount the participant or bene-  
8 ficiary has already accumulated with respect to  
9 any deductible or out of pocket maximum under  
10 the plan or coverage (broken down, in the case  
11 separate deductibles or maximums apply to sep-  
12 arate participants and beneficiaries enrolled in  
13 the plan or coverage, by such separate  
14 deductibles or maximums, in addition to any  
15 cumulative deductible or maximum).

16 “(E) Any shared savings or other benefit  
17 available to the participant or beneficiary with  
18 respect to such item or service.

19 “(F) In the case such plan or coverage im-  
20 poses any frequency or volume limitations with  
21 respect to such item or service (excluding med-  
22 ical necessity determinations), the amount that  
23 such participant or beneficiary has accrued to-  
24 wards such limitation with respect to such item  
25 or service.

1           “(G) Any prior authorization, concurrent  
2           review, step therapy, fail first, or similar re-  
3           quirements applicable to coverage of such item  
4           or service under such plan or group health in-  
5           surance coverage.

6           “(3) SELF-SERVICE TOOL.—For purposes of  
7           paragraph (1), a self-service tool established by a  
8           group health plan or health insurance issuer offering  
9           group health insurance coverage meets the require-  
10          ments of this paragraph if such tool—

11           “(A) is based on an Internet website, mo-  
12           bile application, or other platform determined  
13           appropriate by the Secretary;

14           “(B) provides for real-time responses to re-  
15           quests described in paragraph (1);

16           “(C) is updated in a manner such that in-  
17           formation provided through such tool is accu-  
18           rate at the time such request is made;

19           “(D) allows such a request to be made  
20           with respect to an item or service furnished  
21           by—

22           “(i) a specific provider that is a par-  
23           ticipating provider with respect to such  
24           item or service;

1                   “(ii) all providers that are partici-  
2                   pating providers with respect to such plan  
3                   and such item or service for purposes of  
4                   facilitating price comparisons; or

5                   “(iii) a provider that is not described  
6                   in clause (ii); and

7                   “(E) provides that such a request may be  
8                   made with respect to an item or service through  
9                   use of the billing code for such item or service  
10                  or through use of a descriptive term for such  
11                  item or service.

12               The Secretary may require such tool, as a condition  
13               of complying with subparagraph (E), to link multiple  
14               billing codes to a single descriptive term if the Sec-  
15               retary determines that the billing codes to be so  
16               linked correspond to items and services.

17               “(4) PROVIDER TOOL.—A group health plan,  
18               and a health insurance issuer offering group health  
19               insurance coverage, shall permit providers to learn  
20               the amount of cost-sharing (including deductibles,  
21               copayments, and coinsurance) that would apply  
22               under an individual’s plan or coverage that the indi-  
23               vidual would be responsible for paying with respect  
24               to the furnishing of a specific item or service by an-  
25               other provider in a timely manner upon the request



1 of the provider and with the consent of such indi-  
2 vidual in the same manner and to the same extent  
3 as if such request has been made by such individual.  
4 As part of any tool used to facilitate such requests  
5 from a provider, such plan or issuer offering health  
6 insurance coverage may include functionality that—

7 “(A) allows providers to submit the notifi-  
8 cations to such plan or coverage required under  
9 section 2799B–6 of the Public Health Service  
10 Act; and

11 “(B) provides for notifications required  
12 under section 716(f) to such an individual.

13 “(d) RATE AND PAYMENT INFORMATION.—

14 “(1) IN GENERAL.—For purposes of subsection  
15 (a)(9), the rate and payment information described  
16 in this subsection is, with respect to a group health  
17 plan or group health insurance coverage (as applica-  
18 ble), the following:

19 “(A) With respect to each item or service  
20 (other than a drug) for which benefits are avail-  
21 able under such plan or coverage, the in-net-  
22 work rate (in a dollar amount) in effect as of  
23 the first day of the plan year during which such  
24 information is submitted with each provider  
25 (identified by national provider identifier) that

1 is a participating provider with respect to such  
2 item or service (or, in the case such rate is not  
3 available in a dollar amount, such formulae,  
4 pricing methodologies, or other information  
5 used to calculate such rate).

6 “(B) With respect to each dosage form and  
7 indication of each drug (identified by national  
8 drug code) for which benefits are available  
9 under such plan or coverage—

10 “(i) the in-network rate (in a dollar  
11 amount) in effect as of the first day of the  
12 plan year during which such information is  
13 submitted with each provider (identified by  
14 national provider identifier) that is a par-  
15 ticipating provider with respect to such  
16 drug (or, in the case such rate is not avail-  
17 able in a dollar amount, such formulae,  
18 pricing methodologies, or other information  
19 used to calculate such rate); and

20 “(ii) the average amount paid by such  
21 plan (net of rebates, discounts, and price  
22 concessions) for such drug dispensed or  
23 administered during the 90-day period be-  
24 ginning 180 days before such date of sub-  
25 mission to each provider that was a par-

1            participating provider with respect to such  
2            drug, broken down by each such provider  
3            (identified by national provider identifier),  
4            other than such an amount paid to a pro-  
5            vider that, during such period, submitted  
6            fewer than 20 claims for such drug to such  
7            plan or coverage.

8            “(C) With respect to each item or service  
9            for which benefits are available under such plan  
10           or coverage, the amount billed, and the amount  
11           allowed by the plan or coverage, for each such  
12           item or service furnished during the 90-day pe-  
13           riod specified in subparagraph (B) by a pro-  
14           vider that was not a participating provider with  
15           respect to such item or service, broken down by  
16           each such provider (identified by national pro-  
17           vider identifier), other than items and services  
18           with respect to which fewer than 20 claims for  
19           such item or service were submitted to such  
20           plan or coverage during such period.

21          Such rate and payment information shall be made  
22          available with respect to each individual item or  
23          service, regardless of whether such item or service is  
24          paid for as part of a bundled payment, episode of

1 care, value-based payment arrangement, or other-  
2 wise.

3 “(2) MANNER OF PUBLICATION.—

4 “(A) IN GENERAL.—Rate and payment in-  
5 formation required to be made available under  
6 subsection (a)(9) shall be so made available in  
7 dollar amounts through 3 separate machine-  
8 readable files corresponding to the information  
9 described in each of subparagraphs (A) through  
10 (C) of paragraph (1) that meet such require-  
11 ments as specified by the Secretary not later  
12 than 180 days after the date of the enactment  
13 of this paragraph through rulemaking. Such re-  
14 quirements shall ensure that such files are lim-  
15 ited to an appropriate size, do not include infor-  
16 mation that is duplicative of information con-  
17 tained in the same file or in other files made  
18 available under such subsection, are made avail-  
19 able in a widely-available format that allows for  
20 information contained in such files to be com-  
21 pared across group health plans and group  
22 health insurance coverage, and are accessible to  
23 individuals at no cost and without the need to  
24 establish a user account or provide other cre-  
25 dentials.

1                   “(B) REAL-TIME PROVISION OF INFORMA-  
2                   TION.—

3                   “(i) IN GENERAL.—Subject to clause  
4                   (ii), beginning January 1, 2026, rate and  
5                   payment information required to be made  
6                   available by a group health plan or health  
7                   insurance issuer under subsection (a)(9)  
8                   shall, in addition to being made available  
9                   in the manner described in subparagraph  
10                  (A), be made available through an applica-  
11                  tion program interface (or successor tech-  
12                  nology) that provides access to such infor-  
13                  mation in real time and that meets such  
14                  technical standards as may be specified by  
15                  the Secretary.

16                  “(ii) EXEMPTION FOR CERTAIN PLANS  
17                  OR COVERAGE.—Clause (i) shall not apply  
18                  with respect to information described in  
19                  such clause required to be made available  
20                  by a group health plan or health insurance  
21                  issuer offering health insurance coverage if  
22                  such plan or coverage, as applicable, pro-  
23                  vides benefits for fewer than 500 partici-  
24                  pants and beneficiaries.

1           “(3) USER GUIDE.—The Secretary, Secretary  
2           of Health and Human Services, and Secretary of the  
3           Treasury shall jointly make available to the public  
4           instructions written in plain language explaining how  
5           individuals may search for information described in  
6           paragraph (1) in files submitted in accordance with  
7           paragraph (2).

8           “(4) ANNUAL SUMMARY.—For each year (be-  
9           ginning with 2025), each group health plan and  
10          health insurance issuer offering group health insur-  
11          ance coverage shall make public a machine-readable  
12          file meeting such standards as established by the  
13          Secretary under paragraph (2) containing a sum-  
14          mary of all rate and payment information made pub-  
15          lic by such plan or issuer with respect to such plan  
16          or coverage during such year (such as averages of all  
17          such information so made public).

18          “(e) ATTESTATION.—Each group health plan and  
19          health insurance issuer offering group health insurance  
20          coverage shall annually submit to the Secretary an attesta-  
21          tion of such plan’s or such coverage’s compliance with the  
22          provisions of this section along with a link to disclosures  
23          made in accordance with subsection (a).

24          “(f) DEFINITIONS.—In this subsection:

1           “(1) PARTICIPATING PROVIDER.—The term  
2           ‘participating provider’ has the meaning given such  
3           term in section 716 and includes a participating fa-  
4           cility.

5           “(2) IN-NETWORK RATE.—The term ‘in-net-  
6           work rate’ means, with respect to a group health  
7           plan or group health insurance coverage and an item  
8           or service furnished by a provider that is a partici-  
9           pating provider with respect to such plan or cov-  
10          erage and item or service, the contracted rate (re-  
11          flected as a dollar amount) in effect between such  
12          plan or coverage and such provider for such item or  
13          service.”.

14                 (B) CLERICAL AMENDMENT.—The table of  
15                 contents in section 1 of such Act is amended by  
16                 striking the item relating to section 719 and in-  
17                 serting the following new item:

“Sec. 719. Price transparency requirements.”.

18                 (2) IRC.—

19                 (A) IN GENERAL.—Section 9819 of the In-  
20                 ternal Revenue Code of 1986 is amended to  
21                 read as follows:

22         **“SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.**

23                 “(a) IN GENERAL.—A group health plan shall make  
24                 available to the public accurate and timely disclosures of  
25                 the following information:

1 “(1) Claims payment policies and practices.

2 “(2) Periodic financial disclosures.

3 “(3) Data on enrollment.

4 “(4) Data on disenrollment.

5 “(5) Data on the number of claims that are de-  
6 nied.

7 “(6) Data on rating practices.

8 “(7) Information on cost-sharing and payments  
9 with respect to any out-of-network coverage (or with  
10 respect to any item and service furnished under such  
11 a plan that does not use a network of providers).

12 “(8) Information on participant and beneficiary  
13 rights under this part.

14 “(9) Rate and payment information described  
15 in subsection (d).

16 “(10) Other information as determined appro-  
17 priate by the Secretary.

18 Rate and payment information described in paragraph (9)  
19 shall be made available to the public not later than Janu-  
20 ary 10, 2025, and not later than the tenth day of every  
21 month thereafter, in the manner described in subsection  
22 (d)(2)(A), and, beginning on January 1, 2027, in real-time  
23 through an application program interface (or successor  
24 technology) described in subsection (d)(2)(B).



1       “(b) USE OF PLAIN LANGUAGE.—The information  
2 required to be submitted under subsection (a) shall be pro-  
3 vided in plain language. The term ‘plain language’ means  
4 language that the intended audience, including individuals  
5 with limited English proficiency, can readily understand  
6 and use because that language is clear, concise, well-orga-  
7 nized, accurately describes the information, and follows  
8 other best practices of plain language writing. The Sec-  
9 retary, jointly with the Secretary of Health and Human  
10 Services and the Secretary of Labor, shall develop and  
11 issue standards for plain language writing for purposes  
12 of this section and shall develop a standardized reporting  
13 template and standardized definitions of terms to allow  
14 for comparison across group health plans and health in-  
15 surance coverage.

16       “(c) COST SHARING TRANSPARENCY.—

17               “(1) IN GENERAL.—A group health plan shall,  
18 upon request of a participant or beneficiary and in  
19 a timely manner, provide to the participant or bene-  
20 ficiary a statement of the amount of cost-sharing  
21 (including deductibles, copayments, and coinsurance)  
22 under the participant’s or beneficiary’s plan that the  
23 participant or beneficiary would be responsible for  
24 paying with respect to the furnishing of a specific  
25 item or service by a provider. At a minimum, such

1 information shall include the information specified in  
2 paragraph (2) and shall be made available at no cost  
3 to the participant or beneficiary through a self-serv-  
4 ice tool that meets the requirements of paragraph  
5 (3) or through a paper or phone disclosure, at the  
6 option of the participant or beneficiary, that meets  
7 such requirements as the Secretary may specify.

8 “(2) SPECIFIED INFORMATION.—For purposes  
9 of paragraph (1), the information specified in this  
10 paragraph is, with respect to an item or service for  
11 which benefits are available under a group health  
12 plan furnished by a health care provider to a partici-  
13 pant or beneficiary of such plan, the following:

14 “(A) If such provider is a participating  
15 provider with respect to such item or service,  
16 the in-network rate (as defined in subsection  
17 (f)) for such item or service and for any other  
18 item or service that is inherent in the fur-  
19 nishing of the item or service that is the subject  
20 of such request.

21 “(B) If such provider is not a participating  
22 provider, the allowed amount, percentage of  
23 billed charges, or other rate that such plan will  
24 recognize as payment for such item or service,  
25 along with a notice that such individual may be

1           liable for additional charges billed by such pro-  
2           vider.

3           “(C) The estimated amount of cost sharing  
4           (including deductibles, copayments, and coin-  
5           surance) that the participant or beneficiary will  
6           incur for such item or service (which, in the  
7           case such item or service is to be furnished by  
8           a provider described in subparagraph (B), shall  
9           be calculated using the amount or rate de-  
10          scribed in such subparagraph (or, in the case  
11          such plan uses a percentage of billed charges to  
12          determined the amount of payment for such  
13          provider, using a reasonable estimate of such  
14          percentage of such charges)).

15          “(D) The amount the participant or bene-  
16          ficiary has already accumulated with respect to  
17          any deductible or out of pocket maximum under  
18          the plan (broken down, in the case separate  
19          deductibles or maximums apply to separate par-  
20          ticipants and beneficiaries enrolled in the plan,  
21          by such separate deductibles or maximums, in  
22          addition to any cumulative deductible or max-  
23          imum).

1           “(E) Any shared savings or other benefit  
2           available to the participant or beneficiary with  
3           respect to such item or service.

4           “(F) In the case such plan imposes any  
5           frequency or volume limitations with respect to  
6           such item or service (excluding medical neces-  
7           sity determinations), the amount that such par-  
8           ticipant or beneficiary has accrued towards such  
9           limitation with respect to such item or service.

10          “(G) Any prior authorization, concurrent  
11          review, step therapy, fail first, or similar re-  
12          quirements applicable to coverage of such item  
13          or service under such plan.

14          “(3) SELF-SERVICE TOOL.—For purposes of  
15          paragraph (1), a self-service tool established by a  
16          group health plan meets the requirements of this  
17          paragraph if such tool—

18               “(A) is based on an Internet website, mo-  
19               bile application, or other platform determined  
20               appropriate by the Secretary;

21               “(B) provides for real-time responses to re-  
22               quests described in paragraph (1);

23               “(C) is updated in a manner such that in-  
24               formation provided through such tool is accu-  
25               rate at the time such request is made;

1 “(D) allows such a request to be made  
2 with respect to an item or service furnished  
3 by—

4 “(i) a specific provider that is a par-  
5 ticipating provider with respect to such  
6 item or service;

7 “(ii) all providers that are partici-  
8 pating providers with respect to such item  
9 or service for purposes of facilitating price  
10 comparisons; or

11 “(iii) a provider that is not described  
12 in clause (ii); and

13 “(E) provides that such a request may be  
14 made with respect to an item or service through  
15 use of the billing code for such item or service  
16 or through use of a descriptive term for such  
17 item or service.

18 The Secretary may require such tool, as a condition  
19 of complying with subparagraph (E), to link multiple  
20 billing codes to a single descriptive term if the Sec-  
21 retary determines that the billing codes to be so  
22 linked correspond to items and services.

23 “(4) PROVIDER TOOL.—A group health plan  
24 shall permit providers to learn the amount of cost-  
25 sharing (including deductibles, copayments, and co-

1 insurance) that would apply under an individual's  
2 plan that the individual would be responsible for  
3 paying with respect to the furnishing of a specific  
4 item or service by another provider in a timely man-  
5 ner upon the request of the provider and with the  
6 consent of such individual in the same manner and  
7 to the same extent as if such request has been made  
8 by such individual. As part of any tool used to facili-  
9 tate such requests from a provider, such plan may  
10 include functionality that—

11 “(A) allows providers to submit the notifi-  
12 cations to such plan or coverage required under  
13 section 2799B–6 of the Public Health Services  
14 Act; and

15 “(B) provides for notifications required  
16 under section 9816(f) to such an individual.

17 “(d) RATE AND PAYMENT INFORMATION.—

18 “(1) IN GENERAL.—For purposes of subsection  
19 (a)(9), the rate and payment information described  
20 in this subsection is, with respect to a group health  
21 plan, the following:

22 “(A) With respect to each item or service  
23 (other than a drug) for which benefits are avail-  
24 able under such plan, the in-network rate (in a  
25 dollar amount) in effect as of the first day of

1 the plan year during which such information is  
2 submitted with each provider (identified by na-  
3 tional provider identifier) that is a participating  
4 provider with respect to such item or service  
5 (or, in the case such rate is not available in a  
6 dollar amount, such formulae, pricing meth-  
7 odologies, or other information used to calculate  
8 such rate).

9 “(B) With respect to each dosage form and  
10 indication of each drug (identified by national  
11 drug code) for which benefits are available  
12 under such plan—

13 “(i) the in-network rate (in a dollar  
14 amount) in effect as of the first day of the  
15 plan year during which such information is  
16 submitted with each provider (identified by  
17 national provider identifier) that is a par-  
18 ticipating provider with respect to such  
19 drug (or, in the case such rate is not avail-  
20 able in a dollar amount, such formulae,  
21 pricing methodologies, or other information  
22 used to calculate such rate); and

23 “(ii) the average amount paid by such  
24 plan (net of rebates, discounts, and price  
25 concessions) for such drug dispensed or

1           administered during the 90-day period be-  
2           ginning 180 days before such date of sub-  
3           mission to each provider that was a par-  
4           ticipating provider with respect to such  
5           drug, broken down by each such provider  
6           (identified by national provider identifier),  
7           other than such an amount paid to a pro-  
8           vider that, during such period, submitted  
9           fewer than 20 claims for such drug to such  
10          plan or coverage.

11          “(C) With respect to each item or service  
12          for which benefits are available under such  
13          plan, the amount billed, and the amount al-  
14          lowed by the plan, for each such item or service  
15          furnished during the 90-day period specified in  
16          subparagraph (B) by a provider that was not a  
17          participating provider with respect to such item  
18          or service, broken down by each such provider  
19          (identified by national provider identifier), other  
20          than items and services with respect to which  
21          fewer than 20 claims for such item or service  
22          were submitted to such plan or coverage during  
23          such period.

24          Such rate and payment information shall be made  
25          available with respect to each individual item or



1 service, regardless of whether such item or service is  
2 paid for as part of a bundled payment, episode of  
3 care, value-based payment arrangement, or other-  
4 wise.

5 “(2) MANNER OF PUBLICATION.—

6 “(A) IN GENERAL.—Rate and payment in-  
7 formation required to be made available under  
8 subsection (a)(9) shall be so made available in  
9 dollar amounts through 3 separate machine-  
10 readable files corresponding to the information  
11 described in each of subparagraphs (A) through  
12 (C) of paragraph (1) that meet such require-  
13 ments as specified by the Secretary not later  
14 than 180 days after the date of the enactment  
15 of this paragraph through rulemaking. Such re-  
16 quirements shall ensure that such files are lim-  
17 ited to an appropriate size, do not include infor-  
18 mation that is duplicative of information con-  
19 tained in other files made available under such  
20 subsection, are made available in a widely-avail-  
21 able format that allows for information con-  
22 tained in such files to be compared across  
23 group health plans, and are accessible to indi-  
24 viduals at no cost and without the need to es-

1           tablish a user account or provide other creden-  
2           tials.

3           “(B) REAL-TIME PROVISION OF INFORMA-  
4           TION.—

5                   “(i) IN GENERAL.—Subject to clause  
6                   (ii), beginning January 1, 2026, rate and  
7                   payment information required to be made  
8                   available by a group health plan under  
9                   subsection (a)(9) shall, in addition to being  
10                  made available in the manner described in  
11                  subparagraph (A), be made available  
12                  through an application program interface  
13                  (or successor technology) that provides ac-  
14                  cess to such information in real time and  
15                  that meets such technical standards as  
16                  may be specified by the Secretary.

17                  “(ii) EXEMPTION FOR CERTAIN PLANS  
18                  AND COVERAGE.—Clause (i) shall not  
19                  apply with respect to information described  
20                  in such clause required to be made avail-  
21                  able by a group health plan if such plan  
22                  provides benefits for fewer than 500 par-  
23                  ticipants and beneficiaries.

24                  “(3) USER GUIDE.—The Secretary, Secretary  
25                  of Health and Human Services, and Secretary of

1 Labor shall jointly make available to the public in-  
2 structions written in plain language explaining how  
3 individuals may search for information described in  
4 paragraph (1) in files submitted in accordance with  
5 paragraph (2).

6 “(4) ANNUAL SUMMARY.—For each year (be-  
7 ginning with 2025), each group health plan shall  
8 make public a machine-readable file meeting such  
9 standards as established by the Secretary under  
10 paragraph (2) containing a summary of all rate and  
11 payment information made public by such plan with  
12 respect to such plan or coverage during such year  
13 (such as averages of all such information so made  
14 public).

15 “(e) ATTESTATION.—Each group health plan shall  
16 annually submit to the Secretary an attestation of such  
17 plan’s compliance with the provisions of this section along  
18 with a link to disclosures made in accordance with sub-  
19 section (a).

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

21 “(1) PARTICIPATING PROVIDER.—The term  
22 ‘participating provider’ has the meaning given such  
23 term in section 9816 and includes a participating fa-  
24 cility.

1           “(2) IN-NETWORK RATE.—The term ‘in-net-  
 2       work rate’ means, with respect to a group health  
 3       plan and an item or service furnished by a provider  
 4       that is a participating provider with respect to such  
 5       plan and item or service, the contracted rate (re-  
 6       flected as a dollar amount) in effect between such  
 7       plan and such provider for such item or service.”.

8           (B) CLERICAL AMENDMENT.—The item re-  
 9       lating to section 9819 in the table of sections  
 10      for subchapter B of chapter 100 of the Internal  
 11      Revenue Code of 1986 is amended to read as  
 12      follows:

“Sec. 9819. Price transparency requirements.”.

13          (3) PHSA.—Section 2799A–4 of the Public  
 14      Health Service Act (42 U.S.C. 300gg–114) is  
 15      amended to read as follows:

16      **“SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.**

17          “(a) IN GENERAL.—A group health plan, and a  
 18      health insurance issuer offering group or individual health  
 19      insurance coverage, shall make available to the public ac-  
 20      curate and timely disclosures of the following information:

21              “(1) Claims payment policies and practices.

22              “(2) Periodic financial disclosures.

23              “(3) Data on enrollment.

24              “(4) Data on disenrollment.

1           “(5) Data on the number of claims that are de-  
2       nied.

3           “(6) Data on rating practices.

4           “(7) Information on cost-sharing and payments  
5       with respect to any out-of-network coverage (or with  
6       respect to any item and service furnished under such  
7       a plan or such group or individual health insurance  
8       coverage that does not use a network of providers).

9           “(8) Information on enrollee rights under this  
10      part.

11          “(9) Rate and payment information described  
12      in subsection (d).

13          “(10) Other information as determined appro-  
14      priate by the Secretary.

15      Rate and payment information described in paragraph (9)  
16      shall be made available to the public not later than Janu-  
17      ary 10, 2025, and not later than the tenth day of every  
18      month thereafter, in the manner described in subsection  
19      (d)(2)(A), and, beginning on January 1, 2027, in real-time  
20      through an application program interface (or successor  
21      technology) described in subsection (d)(2)(B).

22          “(b) USE OF PLAIN LANGUAGE.—The information  
23      required to be submitted under subsection (a) shall be pro-  
24      vided in plain language. The term ‘plain language’ means  
25      language that the intended audience, including individuals

1 with limited English proficiency, can readily understand  
2 and use because that language is clear, concise, well-orga-  
3 nized, accurately describes the information, and follows  
4 other best practices of plain language writing. The Sec-  
5 retary, jointly with the Secretary of Labor and the Sec-  
6 retary of the Treasury, shall develop and issue standards  
7 for plain language writing for purposes of this section and  
8 shall develop a standardized reporting template and stand-  
9 ardized definitions of terms to allow for comparison across  
10 group health plans and health insurance coverage.

11 “(c) COST SHARING TRANSPARENCY.—

12 “(1) IN GENERAL.—A group health plan, and a  
13 health insurance issuer offering group or individual  
14 health insurance coverage, shall, upon request of an  
15 enrollee and in a timely manner, provide to the en-  
16 rollee a statement of the amount of cost-sharing (in-  
17 cluding deductibles, copayments, and coinsurance)  
18 under the enrollee’s plan or coverage that the en-  
19 rollee would be responsible for paying with respect  
20 to the furnishing of a specific item or service by a  
21 provider. At a minimum, such information shall in-  
22 clude the information specified in paragraph (2) and  
23 shall be made available at no cost to the enrollee  
24 through a self-service tool that meets the require-  
25 ments of paragraph (3) or through a paper or phone

1 disclosure, at the option of the enrollee, that meets  
2 such requirements as the Secretary may specify.

3 “(2) SPECIFIED INFORMATION.—For purposes  
4 of paragraph (1), the information specified in this  
5 paragraph is, with respect to an item or service for  
6 which benefits are available under a group health  
7 plan or group or individual health insurance cov-  
8 erage (as applicable) furnished by a health care pro-  
9 vider to an enrollee of such plan or coverage, the fol-  
10 lowing:

11 “(A) If such provider is a participating  
12 provider with respect to such item or service,  
13 the in-network rate (as defined in subsection  
14 (f)) for such item or service and for any other  
15 item or service that is inherent in the fur-  
16 nishing of the item or service that is the subject  
17 of such request.

18 “(B) If such provider is not a participating  
19 provider, the allowed amount, percentage of  
20 billed charges, or other rate that such plan or  
21 coverage will recognize as payment for such  
22 item or service, along with a notice that such  
23 enrollee may be liable for additional charges  
24 billed by such provider.

1           “(C) The estimated amount of cost sharing  
2           (including deductibles, copayments, and coin-  
3           surance) that the enrollee will incur for such  
4           item or service (which, in the case such item or  
5           service is to be furnished by a provider de-  
6           scribed in subparagraph (B), shall be calculated  
7           using the amount or rate described in such sub-  
8           paragraph (or, in the case such plan or issuer  
9           uses a percentage of billed charges to deter-  
10          mined the amount of payment for such pro-  
11          vider, using a reasonable estimate of such per-  
12          centage of such charges)).

13          “(D) The amount the enrollee has already  
14          accumulated with respect to any deductible or  
15          out of pocket maximum under the plan or cov-  
16          erage (broken down, in the case separate  
17          deductibles or maximums apply to separate en-  
18          rollees in the plan or coverage, by such separate  
19          deductibles or maximums, in addition to any  
20          cumulative deductible or maximum).

21          “(E) Any shared savings or other benefit  
22          available to the enrollee with respect to such  
23          item or service.

24          “(F) In the case such plan or coverage im-  
25          poses any frequency or volume limitations with



1           respect to such item or service (excluding med-  
2           ical necessity determinations), the amount that  
3           such enrollee has accrued towards such limita-  
4           tion with respect to such item or service.

5           “(G) Any prior authorization, concurrent  
6           review, step therapy, fail first, or similar re-  
7           quirements applicable to coverage of such item  
8           or service under such plan or group or indi-  
9           vidual health insurance coverage.

10          “(3) SELF-SERVICE TOOL.—For purposes of  
11          paragraph (1), a self-service tool established by a  
12          group health plan or health insurance issuer offering  
13          group or individual health insurance coverage meets  
14          the requirements of this paragraph if such tool—

15               “(A) is based on an Internet website, mo-  
16               bile application, or other platform determined  
17               appropriate by the Secretary;

18               “(B) provides for real-time responses to re-  
19               quests described in paragraph (1);

20               “(C) is updated in a manner such that in-  
21               formation provided through such tool is accu-  
22               rate at the time such request is made;

23               “(D) allows such a request to be made  
24               with respect to an item or service furnished  
25               by—

1 “(i) a specific provider that is a par-  
2 ticipating provider with respect to such  
3 item or service;

4 “(ii) all providers that are partici-  
5 pating providers with respect to such plan  
6 and such item or service for purposes of  
7 facilitating price comparisons; or

8 “(iii) a provider that is not described  
9 in clause (ii); and

10 “(E) provides that such a request may be  
11 made with respect to an item or service through  
12 use of the billing code for such item or service  
13 or through use of a descriptive term for such  
14 item or service.

15 The Secretary may require such tool, as a condition  
16 of complying with subparagraph (E), to link multiple  
17 billing codes to a single descriptive term if the Sec-  
18 retary determines that the billing codes to be so  
19 linked correspond to items and services.

20 “(4) PROVIDER TOOL.—A group health plan,  
21 and a health insurance issuer offering group or indi-  
22 vidual health insurance coverage, shall permit pro-  
23 viders to learn the amount of cost-sharing (including  
24 deductibles, copayments, and coinsurance) that  
25 would apply under an individual’s plan or coverage

1       that the individual would be responsible for paying  
2       with respect to the furnishing of a specific item or  
3       service by another provider in a timely manner upon  
4       the request of the provider and with the consent of  
5       such individual in the same manner and to the same  
6       extent as if such request has been made by such in-  
7       dividual. As part of any tool used to facilitate such  
8       requests from a provider, such plan or issuer offer-  
9       ing health insurance coverage may include  
10      functionality that—

11               “(A) allows providers to submit the notifi-  
12               cations to such plan or coverage required under  
13               section 2799B–6; and

14               “(B) provides for notifications required  
15               under section 2799A–1(f) to such an individual.

16      “(d) RATE AND PAYMENT INFORMATION.—

17               “(1) IN GENERAL.—For purposes of subsection  
18               (a)(9), the rate and payment information described  
19               in this subsection is, with respect to a group health  
20               plan or group or individual health insurance cov-  
21               erage (as applicable), the following:

22               “(A) With respect to each item or service  
23               (other than a drug) for which benefits are avail-  
24               able under such plan or coverage, the in-net-  
25               work rate (in a dollar amount) in effect as of

1 the first day of the plan year during which such  
2 information is submitted with each provider  
3 (identified by national provider identifier) that  
4 is a participating provider with respect to such  
5 item or service (or, in the case such rate is not  
6 available in a dollar amount, such formulae,  
7 pricing methodologies, or other information  
8 used to calculate such rate).

9 “(B) With respect to each dosage form and  
10 indication of each drug (identified by national  
11 drug code) for which benefits are available  
12 under such plan or coverage—

13 “(i) the in-network rate (in a dollar  
14 amount) in effect as of the first day of the  
15 plan year during which such information is  
16 submitted with each provider (identified by  
17 national provider identifier) that is a par-  
18 ticipating provider with respect to such  
19 drug (or, in the case such rate is not avail-  
20 able in a dollar amount, such formulae,  
21 pricing methodologies, or other information  
22 used to calculate such rate); and

23 “(ii) the average amount paid by such  
24 plan (net of rebates, discounts, and price  
25 concessions) for such drug dispensed or

1 administered during the 90-day period be-  
2 ginning 180 days before such date of sub-  
3 mission to each provider that was a par-  
4 ticipating provider with respect to such  
5 drug, broken down by each such provider  
6 (identified by national provider identifier),  
7 other than such an amount paid to a pro-  
8 vider that, during such period, submitted  
9 fewer than 20 claims for such drug to such  
10 plan or coverage.

11 “(C) With respect to each item or service  
12 for which benefits are available under such plan  
13 or coverage, the amount billed, and the amount  
14 allowed by the plan or coverage, for each such  
15 item or service furnished during the 90-day pe-  
16 riod specified in subparagraph (B) by a pro-  
17 vider that was not a participating provider with  
18 respect to such item or service, broken down by  
19 each such provider (identified by national pro-  
20 vider identifier), other than items and services  
21 with respect to which fewer than 20 claims for  
22 such item or service were submitted to such  
23 plan or coverage during such period.

24 Such rate and payment information shall be made  
25 available with respect to each individual item or

1 service, regardless of whether such item or service is  
2 paid for as part of a bundled payment, episode of  
3 care, value-based payment arrangement, or other-  
4 wise.

5 “(2) MANNER OF PUBLICATION.—

6 “(A) IN GENERAL.—Rate and payment in-  
7 formation required to be made available under  
8 subsection (a)(9) shall be so made available in  
9 dollar amounts through 3 separate machine-  
10 readable files corresponding to the information  
11 described in each of subparagraphs (A) through  
12 (C) of paragraph (1) that meet such require-  
13 ments as specified by the Secretary not later  
14 than 180 days after the date of the enactment  
15 of this paragraph through rulemaking. Such re-  
16 quirements shall ensure that such files are lim-  
17 ited to an appropriate size, do not include infor-  
18 mation that is duplicative of information con-  
19 tained in other files made available under such  
20 subsection, are made available in a widely-avail-  
21 able format that allows for information con-  
22 tained in such files to be compared across  
23 group health plans and group or individual  
24 health insurance coverage, and are accessible to  
25 individuals at no cost and without the need to

1 establish a user account or provide other cre-  
2 dentials.

3 “(B) REAL-TIME PROVISION OF INFORMA-  
4 TION.—

5 “(i) IN GENERAL.—Subject to clause  
6 (ii), beginning January 1, 2026, rate and  
7 payment information required to be made  
8 available by a group health plan or health  
9 insurance issuer under subsection (a)(9)  
10 shall, in addition to being made available  
11 in the manner described in subparagraph  
12 (A), be made available through an applica-  
13 tion program interface (or successor tech-  
14 nology) that provides access to such infor-  
15 mation in real time and that meets such  
16 technical standards as may be specified by  
17 the Secretary.

18 “(ii) EXEMPTION FOR CERTAIN PLANS  
19 AND COVERAGE.—Clause (i) shall not  
20 apply with respect to information described  
21 in such clause required to be made avail-  
22 able by a group health plan or health in-  
23 surance issuer offering health insurance  
24 coverage if such plan or coverage, as appli-

1 cable, provides benefits for fewer than 500  
2 enrollees.

3 “(3) USER GUIDE.—The Secretary, Secretary  
4 of Labor, and Secretary of the Treasury shall jointly  
5 make available to the public instructions written in  
6 plain language explaining how individuals may  
7 search for information described in paragraph (1) in  
8 files submitted in accordance with paragraph (2).

9 “(4) ANNUAL SUMMARY.—For each year (be-  
10 ginning with 2025), each group health plan and  
11 health insurance issuer offering group or individual  
12 health insurance coverage shall make public a ma-  
13 chine-readable file meeting such standards as estab-  
14 lished by the Secretary under paragraph (2) con-  
15 taining a summary of all rate and payment informa-  
16 tion made public by such plan or issuer with respect  
17 to such plan or coverage during such year (such as  
18 averages of all such information so made public).

19 “(e) ATTESTATION.—Each group health plan and  
20 health insurance issuer offering group or individual health  
21 insurance coverage shall annually submit to the Secretary  
22 an attestation of such plan’s or such coverage’s compliance  
23 with the provisions of this section along with a link to dis-  
24 closures made in accordance with subsection (a).

25 “(f) DEFINITIONS.—In this subsection:



1           “(1) PARTICIPATING PROVIDER.—The term  
2           ‘participating provider’ has the meaning given such  
3           term in section 2799A–1 and includes a partici-  
4           pating facility.

5           “(2) IN-NETWORK RATE.—The term ‘in-net-  
6           work rate’ means, with respect to a group health  
7           plan or group or individual health insurance cov-  
8           erage and an item or service furnished by a provider  
9           that is a participating provider with respect to such  
10          plan or coverage and item or service, the contracted  
11          rate (reflected as a dollar amount) in effect between  
12          such plan or coverage and such provider for such  
13          item or service.”.

14          (b) REPORTS TO CONGRESS.—

15                 (1) QUALITY REPORT.—Not later than 1 year  
16                 after the date of enactment of this subsection, the  
17                 Secretary of Labor shall submit to Congress a report  
18                 on the feasibility of including data relating to the  
19                 quality of health care items and services with the  
20                 price transparency information required to be made  
21                 available under the amendments made by subsection  
22                 (a). Such report shall include recommendations for  
23                 legislative and regulatory actions to identify appro-  
24                 priate metrics for assessing and comparing quality  
25                 of care.

1           (2) TRANSPARENCY DATA ASSESSMENT.—Not  
 2       later than January 1, 2026, and biannually there-  
 3       after through 2032, the Secretary shall submit to  
 4       Congress, and make publicly available on a website  
 5       of the Department of Labor, a report with respect  
 6       to the information described in section 719 of the  
 7       Employee Retirement Income Security Act (29  
 8       U.S.C. 1185h) (as amended by the “Transparency  
 9       in Coverage Act of 2023”), assessing the differences  
 10      in commercial negotiated prices—

11                   (A) between rural and urban markets;

12                   (B) in the individual, small-employer, and  
 13      large-employer markets;

14                   (C) in consolidated and non-consolidated  
 15      provider markets;

16                   (D) between non-profit and for-profit hos-  
 17      pitals; and

18                   (E) between non-profit and for-profit in-  
 19      surers.

20      (c) EFFECTIVE DATE.—

21           (1) IN GENERAL.—The amendments made by  
 22      subsection (a) shall apply to plan years beginning on  
 23      or after January 1, 2025.

24           (2) CONTINUED APPLICABILITY OF RULES FOR  
 25      PREVIOUS YEARS.—Nothing in the amendments

1       made by subsection (a) may be construed as affect-  
 2       ing the applicability of the rule entitled “Trans-  
 3       parency in Coverage” published by the Department  
 4       of the Treasury, the Department of Labor, and the  
 5       Department of Health and Human Services on No-  
 6       vember 12, 2020 (85 Fed. Reg. 72158) for plan  
 7       years beginning before January 1, 2025.

8       **SEC. 3. PHARMACY BENEFIT MANAGER TRANSPARENCY.**

9       (a) ERISA.—

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

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

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

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

1 macy, subcontractor, rebate aggregator, or any associated  
2 third party that limits or delays the disclosure of informa-  
3 tion to plan administrators in such a manner that prevents  
4 the plan or issuer, or an entity or subsidiary providing  
5 pharmacy benefits management services on behalf of a  
6 plan or issuer, from making or substantiating the reports  
7 described in subsection (b).

8 “(b) REPORTS.—

9 “(1) IN GENERAL.—For plan years beginning  
10 on or after January 1, 2025, not less frequently  
11 than quarterly (and upon request by the plan admin-  
12 istrator), a group health plan or health insurance  
13 issuer offering group health insurance coverage, or  
14 an entity providing pharmacy benefits management  
15 services on behalf of a group health plan or an  
16 issuer providing group health insurance coverage,  
17 shall submit to the plan administrator (as defined in  
18 section 3(16)(A)) of such plan or coverage a report  
19 in accordance with this subsection, and make such  
20 report available to the plan administrator in a ma-  
21 chine-readable format (or as may be determined by  
22 the Secretary, other formats). Each such report  
23 shall include, with respect to the applicable group  
24 health plan or health insurance coverage—

1           “(A) information collected from a patient  
2           or copay assistance program administrator by  
3           such entity on the total amount of copayment  
4           assistance dollars paid, or copayment cards ap-  
5           plied, or other discounts that were funded by  
6           the drug manufacturer with respect to the par-  
7           ticipants and beneficiaries in such plan or cov-  
8           erage;

9           “(B) total gross spending on prescription  
10          drugs by the plan or coverage during the re-  
11          porting period;

12          “(C) total amount received, or expected to  
13          be received, by the plan or coverage from any  
14          entities, in rebates, fees, alternative discounts,  
15          and all other remuneration received from the  
16          entity or any third party (including group pur-  
17          chasing organizations) other than the plan ad-  
18          ministrator, related to utilization of drug or  
19          drug spending under such plan or coverage dur-  
20          ing the reporting period;

21          “(D) the total net spending on prescription  
22          drugs by the plan or coverage during such re-  
23          porting period;

24          “(E) amounts paid, directly or indirectly,  
25          in rebates, fees, or any other type of compensa-

tion (as defined in section 408(b)(2)(B)(ii)(dd)(AA)) to brokerage houses, brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's or health insurance issuer's business to the pharmacy benefits manager, identified by the recipient of such amounts;

“(F)(i) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives funded by an entity providing pharmacy benefit management services;

“(ii) the percentage of total prescriptions charged to the plan, issuer, or participants and beneficiaries in such plan or coverage, that were dispensed by mail order, specialty, or retail pharmacies that

1 are affiliated with or under common own-  
2 ership with the entity providing pharmacy  
3 benefit management services; and

4 “(iii) a list of all drugs dispensed by  
5 such affiliated pharmacy or pharmacy  
6 under common ownership and charged to  
7 the plan, issuer, or participants and bene-  
8 ficiaries of the plan, during the applicable  
9 period, and, with respect to each drug—

10 “(I)(aa) the amount charged, per  
11 dosage unit, per 30-day supply, and  
12 per 90-day supply, with respect to  
13 participants and beneficiaries in the  
14 plan or coverage, to the plan or  
15 issuer; and

16 “(bb) the amount charged,  
17 per dosage unit, per 30-day sup-  
18 ply, and per 90-day supply, to  
19 participants and beneficiaries;

20 “(II) the median amount charged  
21 to the plan or issuer, per dosage unit,  
22 per 30-day supply, and per 90-day  
23 supply, including amounts paid by the  
24 participants and beneficiaries, when  
25 the same drug is dispensed by other

1 pharmacies that are not affiliated with  
2 or under common ownership with the  
3 entity and that are included in the  
4 pharmacy network of such plan or  
5 coverage;

6 “(III) the interquartile range of  
7 the costs, per dosage unit, per 30-day  
8 supply, and per 90-day supply, includ-  
9 ing amounts paid by the participants  
10 and beneficiaries, when the same drug  
11 is dispensed by other pharmacies that  
12 are not affiliated with or under com-  
13 mon ownership with the entity and  
14 that are included in the pharmacy  
15 network of that plan or coverage;

16 “(IV) the lowest cost, per dosage  
17 unit, per 30-day supply, and per 90-  
18 day supply, for such drug, including  
19 amounts charged to the plan and par-  
20 ticipants and beneficiaries, that is  
21 available from any pharmacy included  
22 in the network of the plan or cov-  
23 erage;

24 “(V) the net acquisition cost per  
25 dosage unit, per 30-day supply, and



1 per 90-day supply, if the drug is sub-  
2 ject to a maximum price discount; and

3 “(VI) other information with re-  
4 spect to the cost of the drug, as deter-  
5 mined by the Secretary, such as aver-  
6 age sales price, wholesale acquisition  
7 cost, and national average drug acqui-  
8 sition cost per dosage unit or per 30-  
9 day supply, and per 90-day supply,  
10 for such drug, including amounts  
11 charged to the plan or issuer and par-  
12 ticipants and beneficiaries among all  
13 pharmacies included in the network of  
14 such plan or coverage; and

15 “(G) in the case of a large employer—

16 “(i) a list of each drug covered by  
17 such plan, issuer, or entity providing phar-  
18 macy benefits management services for  
19 which a claim was filed during the report-  
20 ing period, including, with respect to each  
21 such drug during the reporting period—

22 “(I) the brand name, generic or  
23 non-proprietary name, and the Na-  
24 tional Drug Code;

1 “(II)(aa) the number of partici-  
2 pants and beneficiaries for whom a  
3 claim for such drug was filed during  
4 the reporting period, the total number  
5 of prescription claims for such drug  
6 (including original prescriptions and  
7 refills), and the total number of dos-  
8 age units and total days supply of  
9 such drug for which a claim was filed  
10 during the reporting period; and

11 “(bb) with respect to each  
12 claim or dosage unit described in  
13 item (aa), the type of dispensing  
14 channel used, such as retail, mail  
15 order, or specialty pharmacy;

16 “(III) the wholesale acquisition  
17 cost, listed as cost per days supply  
18 and cost per dosage unit on date of  
19 dispensing;

20 “(IV) the total out-of-pocket  
21 spending by participants and bene-  
22 ficiaries on such drug after applica-  
23 tion of any benefits under such plan  
24 or coverage, including participant and  
25 beneficiary spending through copay-

1           ments, coinsurance, and deductibles  
2           (but not including any amounts spent  
3           by participants and beneficiaries on  
4           drugs not covered under such plan or  
5           coverage, or for which no claim was  
6           submitted to such plan or coverage);

7                   “(V) for any drug for which  
8           gross spending of the plan or coverage  
9           exceeded \$10,000 during the report-  
10          ing period—

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

19                   “(bb) the rationale for pre-  
20           ferred formulary placement of  
21           such drug in that therapeutic  
22           category or class, if applicable;  
23           and

24                   “(ii) a list of each therapeutic cat-  
25          egory or class of drugs for which a claim

1 was filed under the health plan or health  
2 insurance coverage during the reporting  
3 period, and, with respect to each such  
4 therapeutic category or class of drugs dur-  
5 ing the reporting period—

6 “(I) total gross spending by the  
7 plan;

8 “(II) the number of participants  
9 and beneficiaries who filled a prescrip-  
10 tion for a drug in that category or  
11 class;

12 “(III) if applicable to that cat-  
13 egory or class, a description of the  
14 formulary tiers and utilization mecha-  
15 nisms (such as prior authorization or  
16 step therapy) employed for drugs in  
17 that category or class;

18 “(IV) the total out-of-pocket  
19 spending by participants and bene-  
20 ficiaries, including participant and  
21 beneficiary spending through copay-  
22 ments, coinsurance, and deductibles;  
23 and

24 “(V) for each drug—

1 “(aa) the amount received,  
2 or expected to be received, from  
3 any entity in rebates, fees, alter-  
4 native discounts, or other remu-  
5 nation—

6 “(AA) for claims in-  
7 curred during the reporting  
8 period; or

9 “(BB) that is related to  
10 utilization of drugs or drug  
11 spending;

12 “(bb) the total net spending,  
13 after deducting rebates, price  
14 concessions, alternative discounts  
15 or other remuneration from drug  
16 manufacturers, by the health  
17 plan or health insurance coverage  
18 on that category or class of  
19 drugs; and

20 “(cc) the average net spend-  
21 ing per 30-day supply and per  
22 90-day supply, incurred by the  
23 health plan or health insurance  
24 coverage and its participants and  
25 beneficiaries, among all drugs

1 within the therapeutic class for  
2 which a claim was filed during  
3 the reporting period.

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

15 “(3) DISCLOSURE AND REDISCLOSURE.—

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

22 “(B) CLARIFICATION REGARDING PUBLIC  
23 DISCLOSURE OF INFORMATION.—Nothing in  
24 this section prevents a health insurance issuer  
25 offering group health insurance coverage or an

1           entity providing pharmacy benefits management  
2           services on behalf of a group health plan from  
3           placing reasonable restrictions on the public dis-  
4           closure of the information contained in a report  
5           described in paragraph (1), except that such en-  
6           tity may not restrict disclosure of such report  
7           to the Department of Health and Human Serv-  
8           ices, the Department of Labor, the Department  
9           of the Treasury, the Comptroller General of the  
10          United States, or applicable State agencies.

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

18           “(4) REPORT TO GAO.—A health insurance  
19          issuer offering group health insurance coverage or  
20          an entity providing pharmacy benefits management  
21          services on behalf of a group health plan shall sub-  
22          mit to the Comptroller General of the United States  
23          each of the first 4 reports submitted to a plan ad-  
24          ministrator under paragraph (1) with respect to  
25          such coverage or plan, and other such reports as re-

1 requested, in accordance with the privacy requirements  
2 under paragraph (2), the disclosure and redisclosure  
3 standards under paragraph (3), the standards speci-  
4 fied pursuant to paragraph (5).

5 “(5) STANDARD FORMAT.—Not later than 6  
6 months after the date of enactment of this section,  
7 the Secretary shall specify through rulemaking  
8 standards for health insurance issuers and entities  
9 required to submit reports under paragraph (4) to  
10 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) DEFINITIONS.—In this section:

19 “(1) LARGE EMPLOYER.—The term ‘large em-  
20 ployer’ means, in connection with a group health  
21 plan with respect to a calendar year and a plan year,  
22 an employer who employed an average of at least 50  
23 employees on business days during the preceding  
24 calendar year and who employs at least 1 employee  
25 on the first day of the plan year.



1           “(2) WHOLESALE ACQUISITION COST.—The  
 2           term ‘wholesale acquisition cost’ has the meaning  
 3           given such term in section 1847A(c)(6)(B) of the  
 4           Social Security Act.”; and

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

6                               (i) in subsection (a)—

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

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

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

14                                       (IV) by adding at the end the fol-  
 15                                       lowing new paragraph:

16                       “(12) by the Secretary, to enforce section  
 17           726.”;

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

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

23                       “(13) SECRETARIAL ENFORCEMENT AUTHORITY  
 24           RELATING TO OVERSIGHT OF PHARMACY BENEFITS  
 25           MANAGER SERVICES.—

1           “(A) FAILURE TO PROVIDE TIMELY INFOR-  
2           MATION.—The Secretary may impose a penalty  
3           against any health insurance issuer or entity  
4           providing pharmacy benefits management serv-  
5           ices that violates section 726(a) or fails to pro-  
6           vide information required under section 726(b)  
7           in the amount of \$10,000 for each day during  
8           which such violation continues or such informa-  
9           tion is not disclosed or reported.

10           “(B) FALSE INFORMATION.—The Sec-  
11           retary may impose a penalty against a health  
12           insurance issuer or entity providing pharmacy  
13           benefits management services that knowingly  
14           provides false information under section 726 in  
15           an amount not to exceed \$100,000 for each  
16           item of false information. Such penalty shall be  
17           in addition to other penalties as may be pre-  
18           scribed by law.

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

1           (2) CLERICAL AMENDMENT.—The table of con-  
 2           tents in section 1 of the Employee Retirement In-  
 3           come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
 4           is amended by inserting after the item relating to  
 5           section 725 the following new item:

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

6           (b) PHSA.—Part D of title XXVII of the Public  
 7           Health Service Act (42 U.S.C. 300gg–111 et seq.) is  
 8           amended by adding at the end the following new section:  
 9           **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-  
 10           AGER SERVICES.**

11          “(a) IN GENERAL.—For plan years beginning on or  
 12          after January 1, 2025, a group health plan (or health in-  
 13          surance issuer offering group health insurance coverage  
 14          in connection with such a plan) or an entity or subsidiary  
 15          providing pharmacy benefits management services on be-  
 16          half of such a plan or issuer may not enter into a contract  
 17          with a drug manufacturer, distributor, wholesaler, switch,  
 18          patient or copay assistance program administrator, phar-  
 19          macy, subcontractor, rebate aggregator, or any associated  
 20          third party that limits or delays the disclosure of informa-  
 21          tion to plan administrators in such a manner that prevents  
 22          the plan or issuer, or an entity or subsidiary providing  
 23          pharmacy benefits management services on behalf of a  
 24          plan or issuer, from making or substantiating the reports  
 25          described in subsection (b).

1 “(b) REPORTS.—

2 “(1) IN GENERAL.—For plan years beginning  
3 on or after January 1, 2025, not less frequently  
4 than quarterly (and upon request by the plan admin-  
5 istrator), a group health plan or health insurance  
6 issuer offering group health insurance coverage, or  
7 an entity providing pharmacy benefits management  
8 services on behalf of a group health plan or an  
9 issuer providing group health insurance coverage,  
10 shall submit to the plan administrator (as defined in  
11 section 3(16)(A) of the Employee Retirement In-  
12 come Security Act of 1974) of such plan or coverage  
13 a report in accordance with this subsection, and  
14 make such report available to the plan administrator  
15 in a machine-readable format (or as may be deter-  
16 mined by the Secretary, other formats). Each such  
17 report shall include, with respect to the applicable  
18 group health plan or health insurance coverage—

19 “(A) information collected from a patient  
20 or copay assistance program administrator by  
21 such entity on the total amount of copayment  
22 assistance dollars paid, or copayment cards ap-  
23 plied, or other discounts that were funded by  
24 the drug manufacturer with respect to the par-

1           participants and beneficiaries in such plan or cov-  
2           erage;

3           “(B) total gross spending on prescription  
4           drugs by the plan or coverage during the re-  
5           porting period;

6           “(C) total amount received, or expected to  
7           be received, by the plan or coverage from any  
8           entities, in rebates, fees, alternative discounts,  
9           and all other remuneration received from the  
10          entity or any third party (including group pur-  
11          chasing organizations) other than the plan ad-  
12          ministrator, related to utilization of drug or  
13          drug spending under such plan or coverage dur-  
14          ing the reporting period;

15          “(D) the total net spending on prescription  
16          drugs by the plan or coverage during such re-  
17          porting period;

18          “(E) amounts paid, directly or indirectly,  
19          in rebates, fees, or any other type of compensa-  
20          tion       (as       defined       in       section  
21          408(b)(2)(B)(ii)(dd)(AA) of the Employee Re-  
22          tirement Income Security Act of 1974) to bro-  
23          kerage houses, brokers, consultants, advisors, or  
24          any other individual or firm for the referral of  
25          the group health plan’s or health insurance

1 issuer's business to the pharmacy benefits man-  
2 ager, identified by the recipient of such  
3 amounts;

4 “(F)(i) an explanation of any benefit de-  
5 sign parameters that encourage or require par-  
6 ticipants and beneficiaries in the plan or cov-  
7 erage to fill prescriptions at mail order, spe-  
8 cialty, or retail pharmacies that are affiliated  
9 with or under common ownership with the enti-  
10 ty providing pharmacy benefit management  
11 services under such plan or coverage, including  
12 mandatory mail and specialty home delivery  
13 programs, retail and mail auto-refill programs,  
14 and cost-sharing assistance incentives funded  
15 by an entity providing pharmacy benefit man-  
16 agement services;

17 “(ii) the percentage of total prescrip-  
18 tions charged to the plan, issuer, or par-  
19 ticipants and beneficiaries in such plan or  
20 coverage, that were dispensed by mail  
21 order, specialty, or retail pharmacies that  
22 are affiliated with or under common own-  
23 ership with the entity providing pharmacy  
24 benefit management services; and

1 “(iii) a list of all drugs dispensed by  
2 such affiliated pharmacy or pharmacy  
3 under common ownership and charged to  
4 the plan, issuer, or participants and bene-  
5 ficiaries of the plan, during the applicable  
6 period, and, with respect to each drug—

7 “(I)(aa) the amount charged, per  
8 dosage unit, per 30-day supply, and  
9 per 90-day supply, with respect to  
10 participants and beneficiaries in the  
11 plan or coverage, to the plan or  
12 issuer; and

13 “(bb) the amount charged,  
14 per dosage unit, per 30-day sup-  
15 ply, and per 90-day supply, to  
16 participants and beneficiaries;

17 “(II) the median amount charged  
18 to the plan or issuer, per dosage unit,  
19 per 30-day supply, and per 90-day  
20 supply, including amounts paid by the  
21 participants and beneficiaries, when  
22 the same drug is dispensed by other  
23 pharmacies that are not affiliated with  
24 or under common ownership with the  
25 entity and that are included in the

1 pharmacy network of such plan or  
2 coverage;

3 “(III) the interquartile range of  
4 the costs, per dosage unit, per 30-day  
5 supply, and per 90-day supply, includ-  
6 ing amounts paid by the participants  
7 and beneficiaries, when the same drug  
8 is dispensed by other pharmacies that  
9 are not affiliated with or under com-  
10 mon ownership with the entity and  
11 that are included in the pharmacy  
12 network of that plan or coverage;

13 “(IV) the lowest cost, per dosage  
14 unit, per 30-day supply, and per 90-  
15 day supply, for such drug, including  
16 amounts charged to the plan and par-  
17 ticipants and beneficiaries, that is  
18 available from any pharmacy included  
19 in the network of the plan or cov-  
20 erage;

21 “(V) the net acquisition cost per  
22 dosage unit, per 30-day supply, and  
23 per 90-day supply, if the drug is sub-  
24 ject to a maximum price discount; and



1                   “(VI) other information with re-  
2                   spect to the cost of the drug, as deter-  
3                   mined by the Secretary, such as aver-  
4                   age sales price, wholesale acquisition  
5                   cost, and national average drug acqui-  
6                   sition cost per dosage unit or per 30-  
7                   day supply, and per 90-day supply,  
8                   for such drug, including amounts  
9                   charged to the plan or issuer and par-  
10                  ticipants and beneficiaries among all  
11                  pharmacies included in the network of  
12                  such plan or coverage; and

13               “(G) in the case of a large employer—

14                   “(i) a list of each drug covered by  
15                   such plan, issuer, or entity providing phar-  
16                   macy benefits management services for  
17                   which a claim was filed during the report-  
18                   ing period, including, with respect to each  
19                   such drug during the reporting period—

20                   “(I) the brand name, generic or  
21                   non-proprietary name, and the Na-  
22                   tional Drug Code;

23                   “(II)(aa) the number of partici-  
24                   pants and beneficiaries for whom a  
25                   claim for such drug was filed during

1 the reporting period, the total number  
2 of prescription claims for such drug  
3 (including original prescriptions and  
4 refills), and the total number of dos-  
5 age units and total days supply of  
6 such drug for which a claim was filed  
7 during the reporting period; and

8 “(bb) with respect to each  
9 claim or dosage unit described in  
10 item (aa), the type of dispensing  
11 channel used, such as retail, mail  
12 order, or specialty pharmacy;

13 “(III) the wholesale acquisition  
14 cost, listed as cost per days supply  
15 and cost per dosage unit on date of  
16 dispensing;

17 “(IV) the total out-of-pocket  
18 spending by participants and bene-  
19 ficiaries on such drug after applica-  
20 tion of any benefits under such plan  
21 or coverage, including participant and  
22 beneficiary spending through copay-  
23 ments, coinsurance, and deductibles  
24 (but not including any amounts spent  
25 by participants and beneficiaries on

1 drugs not covered under such plan or  
2 coverage, or for which no claim was  
3 submitted to such plan or coverage);

4 “(V) for any drug for which  
5 gross spending of the plan or coverage  
6 exceeded \$10,000 during the report-  
7 ing period—

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

16 “(bb) the rationale for pre-  
17 ferred formulary placement of  
18 such drug in that therapeutic  
19 category or class, if applicable;  
20 and

21 “(ii) a list of each therapeutic cat-  
22 egory or class of drugs for which a claim  
23 was filed under the health plan or health  
24 insurance coverage during the reporting  
25 period, and, with respect to each such

therapeutic category or class of drugs during the reporting period—

“(I) total gross spending by the plan;

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

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

“(IV) the total out-of-pocket spending by participants and beneficiaries, including participant and beneficiary spending through copayments, coinsurance, and deductibles; and

“(V) for each drug—

“(aa) the amount received, or expected to be received, from any entity in rebates, fees, alter-

1 native discounts, or other remuneration—  
2

3 “(AA) for claims incurred during the reporting  
4 period; or  
5

6 “(BB) that is related to  
7 utilization of drugs or drug  
8 spending;

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

17 “(cc) the average net spending per 30-day supply and per  
18 90-day supply, incurred by the  
19 health plan or health insurance  
20 coverage and its participants and  
21 beneficiaries, among all drugs  
22 within the therapeutic class for  
23 which a claim was filed during  
24 the reporting period.  
25

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 administrators who are drug  
13 manufacturers, drug wholesalers, or other direct  
14 participants in the drug supply chain, in order  
15 to 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 ad-  
22 ministrator under paragraph (1) with respect to  
23 such coverage or plan, and other such reports as re-  
24 quested, in accordance with the privacy requirements  
25 under paragraph (2), the disclosure and redisclosure

1 standards under paragraph (3), the standards speci-  
2 fied pursuant to paragraph (5).

3 “(5) STANDARD FORMAT.—Not later than 6  
4 months after the date of enactment of this section,  
5 the Secretary shall specify through rulemaking  
6 standards for health insurance issuers and entities  
7 required to submit reports under paragraph (4) to  
8 submit such reports in a standard format.

9 “(c) ENFORCEMENT.—

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

18 “(2) FALSE INFORMATION.—An entity pro-  
19 viding pharmacy benefits management services that  
20 knowingly provides false information under this sec-  
21 tion shall be subject to a civil money penalty in an  
22 amount not to exceed \$100,000 for each item of  
23 false information. Such civil money penalty shall be  
24 in addition to other penalties as may be prescribed  
25 by law.



1           “(3) PROCEDURE.—The provisions of section  
2       1128A of the Social Security Act, other than sub-  
3       section (a) and (b) and the first sentence of sub-  
4       section (c)(1) of such section shall apply to civil  
5       monetary penalties under this subsection in the  
6       same manner as such provisions apply to a penalty  
7       or proceeding under section 1128A of the Social Se-  
8       curity Act.

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

15      “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
16      tion shall be construed to permit a health insurance issuer,  
17      group health plan, or other entity to restrict disclosure to,  
18      or otherwise limit the access of, the Department of Health  
19      and Human Services to a report described in subsection  
20      (b)(1) or information related to compliance with sub-  
21      section (a) by such issuer, plan, or entity.

22      “(e) DEFINITIONS.—In this section:

23           “(1) LARGE EMPLOYER.—The term ‘large em-  
24      ployer’ means, in connection with a group health  
25      plan with respect to a calendar year and a plan year,

1 an employer who employed an average of at least 50  
2 employees on business days during the preceding  
3 calendar year and who employs at least 1 employee  
4 on the first day of the plan year.

5 “(2) WHOLESALE ACQUISITION COST.—The  
6 term ‘wholesale acquisition cost’ has the meaning  
7 given such term in section 1847A(c)(6)(B) of the  
8 Social Security Act.”.

9 (c) IRC.—

10 (1) IN GENERAL.—Subchapter B of chapter  
11 100 of the Internal Revenue Code of 1986 is amend-  
12 ed by adding at the end the following new section:

13 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-**  
14 **AGER SERVICES.**

15 “(a) IN GENERAL.—For plan years beginning on or  
16 after January 1, 2025, a group health plan or an entity  
17 or subsidiary providing pharmacy benefits management  
18 services on behalf of such a plan may not enter into a  
19 contract with a drug manufacturer, distributor, whole-  
20 saler, switch, patient or copay assistance program admin-  
21 istrator, pharmacy, subcontractor, rebate aggregator, or  
22 any associated third party that limits or delays the disclo-  
23 sure of information to plan administrators in such a man-  
24 ner that prevents the plan, or an entity or subsidiary pro-  
25 viding pharmacy benefits management services on behalf

1 of a plan, from making or substantiating the reports de-  
2 scribed in subsection (b).

3 “(b) REPORTS.—

4 “(1) IN GENERAL.—For plan years beginning  
5 on or after January 1, 2025, not less frequently  
6 than quarterly (and upon request by the plan admin-  
7 istrator), a group health plan, or an entity providing  
8 pharmacy benefits management services on behalf of  
9 a group health plan, shall submit to the plan admin-  
10 istrator (as defined in section 3(16)(A) of the Em-  
11 ployee Retirement Income Security Act of 1974) of  
12 such plan a report in accordance with this sub-  
13 section, and make such report available to the plan  
14 administrator in a machine-readable format (or as  
15 may be determined by the Secretary, other formats).  
16 Each such report shall include, with respect to the  
17 applicable group health plan—

18 “(A) information collected from a patient  
19 or copay assistance program administrator by  
20 such entity on the total amount of copayment  
21 assistance dollars paid, or copayment cards ap-  
22 plied, or other discounts that were funded by  
23 the drug manufacturer with respect to the par-  
24 ticipants and beneficiaries in such plan;

1           “(B) total gross spending on prescription  
2           drugs by the plan during the reporting period;

3           “(C) total amount received, or expected to  
4           be received, by the plan from any entities, in re-  
5           bates, fees, alternative discounts, and all other  
6           remuneration received from the entity or any  
7           third party (including group purchasing organi-  
8           zations) other than the plan administrator, re-  
9           lated to utilization of drug or drug spending  
10          under such plan during the reporting period;

11          “(D) the total net spending on prescription  
12          drugs by the plan during such reporting period;

13          “(E) amounts paid, directly or indirectly,  
14          in rebates, fees, or any other type of compensa-  
15          tion (as defined in section  
16          408(b)(2)(B)(ii)(dd)(AA) of the Employee Re-  
17          tirement Income Security Act of 1974) to bro-  
18          kerage houses, brokers, consultants, advisors, or  
19          any other individual or firm for the referral of  
20          the group health plan’s business to the phar-  
21          macy benefits manager, identified by the recipi-  
22          ent of such amounts;

23          “(F)(i) an explanation of any benefit de-  
24          sign parameters that encourage or require par-  
25          ticipants and beneficiaries in the plan to fill

1 prescriptions at mail order, specialty, or retail  
2 pharmacies that are affiliated with or under  
3 common ownership with the entity providing  
4 pharmacy benefit management services under  
5 such plan, including mandatory mail and spe-  
6 cialty home delivery programs, retail and mail  
7 auto-refill programs, and cost-sharing assist-  
8 ance incentives funded by an entity providing  
9 pharmacy benefit management services;

10 “(ii) the percentage of total prescrip-  
11 tions charged to the plan, or participants  
12 and beneficiaries in such plan, that were  
13 dispensed by mail order, specialty, or retail  
14 pharmacies that are affiliated with or  
15 under common ownership with the entity  
16 providing pharmacy benefit management  
17 services; and

18 “(iii) a list of all drugs dispensed by  
19 such affiliated pharmacy or pharmacy  
20 under common ownership and charged to  
21 the plan, or participants and beneficiaries  
22 of the plan, during the applicable period,  
23 and, with respect to each drug—

24 “(I)(aa) the amount charged, per  
25 dosage unit, per 30-day supply, and

1 per 90-day supply, with respect to  
2 participants and beneficiaries in the  
3 plan, to the plan; and

4 “(bb) the amount charged,  
5 per dosage unit, per 30-day sup-  
6 ply, and per 90-day supply, to  
7 participants and beneficiaries;

8 “(II) the median amount charged  
9 to the plan, per dosage unit, per 30-  
10 day supply, and per 90-day supply, in-  
11 cluding amounts paid by the partici-  
12 pants and beneficiaries, when the  
13 same drug is dispensed by other phar-  
14 macies that are not affiliated with or  
15 under common ownership with the en-  
16 tity and that are included in the phar-  
17 macy network of such plan;

18 “(III) the interquartile range of  
19 the costs, per dosage unit, per 30-day  
20 supply, and per 90-day supply, includ-  
21 ing amounts paid by the participants  
22 and beneficiaries, when the same drug  
23 is dispensed by other pharmacies that  
24 are not affiliated with or under com-  
25 mon ownership with the entity and

1 that are included in the pharmacy  
2 network of that plan;

3 “(IV) the lowest cost, per dosage  
4 unit, per 30-day supply, and per 90-  
5 day supply, for such drug, including  
6 amounts charged to the plan and par-  
7 ticipants and beneficiaries, that is  
8 available from any pharmacy included  
9 in the network of the plan;

10 “(V) the net acquisition cost per  
11 dosage unit, per 30-day supply, and  
12 per 90-day supply, if the drug is sub-  
13 ject to a maximum price discount; and

14 “(VI) other information with re-  
15 spect to the cost of the drug, as deter-  
16 mined by the Secretary, such as aver-  
17 age sales price, wholesale acquisition  
18 cost, and national average drug acqui-  
19 sition cost per dosage unit or per 30-  
20 day supply, and per-90 day supply,  
21 for such drug, including amounts  
22 charged to the plan and participants  
23 and beneficiaries among all phar-  
24 macies included in the network of  
25 such plan; and

1 “(G) in the case of a large employer—

2 “(i) a list of each drug covered by  
3 such plan or entity providing pharmacy  
4 benefits management services for which a  
5 claim was filed during the reporting period,  
6 including, with respect to each such drug  
7 during the reporting period—

8 “(I) the brand name, generic or  
9 non-proprietary name, and the Na-  
10 tional Drug Code;

11 “(II)(aa) the number of partici-  
12 pants and beneficiaries for whom a  
13 claim for such drug was filed during  
14 the reporting period, the total number  
15 of prescription claims for such drug  
16 (including original prescriptions and  
17 refills), and the total number of dos-  
18 age units and total days supply of  
19 such drug for which a claim was filed  
20 during the reporting period; and

21 “(bb) with respect to each  
22 claim or dosage unit described in  
23 item (aa), the type of dispensing  
24 channel used, such as retail, mail  
25 order, or specialty pharmacy;



1           “(III) the wholesale acquisition  
2 cost, listed as cost per days supply  
3 and cost per dosage unit on date of  
4 dispensing;

5           “(IV) the total out-of-pocket  
6 spending by participants and bene-  
7 ficiaries on such drug after applica-  
8 tion of any benefits under such plan,  
9 including participant and beneficiary  
10 spending through copayments, coin-  
11 surance, and deductibles (but not in-  
12 cluding any amounts spent by partici-  
13 pants and beneficiaries on drugs not  
14 covered under such plan, or for which  
15 no claim was submitted to such plan);

16           “(V) for any drug for which  
17 gross spending of the plan exceeded  
18 \$10,000 during the reporting period—

19           “(aa) a list of all other  
20 drugs in the same therapeutic  
21 category or class, including brand  
22 name drugs, biological products,  
23 generic drugs, or biosimilar bio-  
24 logical products that are in the

1 same therapeutic category or  
2 class as such drug; and

3 “(bb) the rationale for pre-  
4 ferred formulary placement of  
5 such drug in that therapeutic  
6 category or class, if applicable;  
7 and

8 “(ii) a list of each therapeutic cat-  
9 egory or class of drugs for which a claim  
10 was filed under the plan during the report-  
11 ing period, and, with respect to each such  
12 therapeutic category or class of drugs dur-  
13 ing the reporting period—

14 “(I) total gross spending by the  
15 plan;

16 “(II) the number of participants  
17 and beneficiaries who filled a prescrip-  
18 tion for a drug in that category or  
19 class;

20 “(III) if applicable to that cat-  
21 egory or class, a description of the  
22 formulary tiers and utilization mecha-  
23 nisms (such as prior authorization or  
24 step therapy) employed for drugs in  
25 that category or class;

1 “(IV) the total out-of-pocket  
2 spending by participants and bene-  
3 ficiaries, including participant and  
4 beneficiary spending through copay-  
5 ments, coinsurance, and deductibles;  
6 and

7 “(V) for each drug—

8 “(aa) the amount received,  
9 or expected to be received, from  
10 any entity in rebates, fees, alter-  
11 native discounts, or other remu-  
12 neration—

13 “(AA) for claims in-  
14 curred during the reporting  
15 period; or

16 “(BB) that is related to  
17 utilization of drugs or drug  
18 spending;

19 “(bb) the total net spending,  
20 after deducting rebates, price  
21 concessions, alternative discounts  
22 or other remuneration from drug  
23 manufacturers, by the plan on  
24 that category or class of drugs;  
25 and

1 “(cc) the average net spend-  
2 ing per 30-day supply and per  
3 90-day supply, incurred by the  
4 plan and its participants and  
5 beneficiaries, among all drugs  
6 within the therapeutic class for  
7 which a claim was filed during  
8 the reporting period.

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

19 “(3) DISCLOSURE AND REDISCLOSURE.—

20 “(A) LIMITATION TO BUSINESS ASSOCI-  
21 ATES.—A group health plan receiving a report  
22 under paragraph (1) may disclose such informa-  
23 tion only to business associates of such plan as  
24 defined in section 160.103 of title 45, Code of  
25 Federal Regulations (or successor regulations).

1           “(B) CLARIFICATION REGARDING PUBLIC  
2           DISCLOSURE OF INFORMATION.—Nothing in  
3           this section prevents an entity providing phar-  
4           macy benefits management services on behalf of  
5           a group health plan from placing reasonable re-  
6           strictions on the public disclosure of the infor-  
7           mation contained in a report described in para-  
8           graph (1), except that such entity may not re-  
9           strict disclosure of such report to the Depart-  
10          ment of Health and Human Services, the De-  
11          partment of Labor, the Department of the  
12          Treasury, the Comptroller General of the  
13          United States, or applicable State agencies.

14          “(C) LIMITED FORM OF REPORT.—The  
15          Secretary shall define through rulemaking a  
16          limited form of the report under paragraph (1)  
17          required of plan administrators who are drug  
18          manufacturers, drug wholesalers, or other direct  
19          participants in the drug supply chain, in order  
20          to prevent anti-competitive behavior.

21          “(4) REPORT TO GAO.—An entity providing  
22          pharmacy benefits management services on behalf of  
23          a group health plan shall submit to the Comptroller  
24          General of the United States each of the first 4 re-  
25          ports submitted to a plan administrator under para-

graph (1) with respect to such plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

“(5) STANDARD FORMAT.—Not later than 6 months after the date of enactment of this section, the Secretary shall specify through rulemaking standards for entities required to submit reports under paragraph (4) to submit such reports in a standard format.

“(c) ENFORCEMENT.—

“(1) FAILURE TO PROVIDE TIMELY INFORMATION.—An entity providing pharmacy benefits management services that violates subsection (a) or fails to provide information required under subsection (b) shall be subject to a civil monetary penalty in the amount of \$10,000 for each day during which such violation continues or such information is not disclosed or reported.

“(2) FALSE INFORMATION.—An entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an 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 “(3) 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 “(4) 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.

24 “(e) DEFINITIONS.—In this section:

1           “(1) LARGE EMPLOYER.—The term ‘large em-  
 2       ployer’ means, in connection with a group health  
 3       plan with respect to a calendar year and a plan year,  
 4       an employer who employed an average of at least 50  
 5       employees on business days during the preceding  
 6       calendar year and who employs at least 1 employee  
 7       on the first day of the plan year.

8           “(2) WHOLESALE ACQUISITION COST.—The  
 9       term ‘wholesale acquisition cost’ has the meaning  
 10      given such term in section 1847A(c)(6)(B) of the  
 11      Social Security Act.”.

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

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

16   **SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.**

17           (a) IN GENERAL.—Subpart B of part 7 of subtitle  
 18      B of title I of the Employee Retirement Income Security  
 19      Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sec-  
 20      tion 3, is further amended by adding at the end the fol-  
 21      lowing new section:

22   **“SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.**

23           “(a) IN GENERAL.—A group health plan or a health  
 24      insurance issuer offering group health insurance coverage  
 25      shall—



1           “(1) not restrict, directly or indirectly, any  
2           pharmacy that dispenses a prescription drug to a  
3           participant or beneficiary in the plan or coverage  
4           from informing (or penalize such pharmacy for in-  
5           forming) a participant or beneficiary of any differen-  
6           tial between the participant’s or beneficiary’s out-of-  
7           pocket cost under the plan or coverage with respect  
8           to acquisition of the drug and the amount an indi-  
9           vidual would pay for acquisition of the drug without  
10          using any health plan or health insurance coverage;  
11          and

12          “(2) ensure that any entity that provides phar-  
13          macy benefits management services under a contract  
14          with any such health plan or health insurance cov-  
15          erage does not, with respect to such plan or cov-  
16          erage, restrict, directly or indirectly, a pharmacy  
17          that dispenses a prescription drug from informing  
18          (or penalize such pharmacy for informing) a partici-  
19          pant or beneficiary of any differential between the  
20          participant’s or beneficiary’s out-of-pocket cost  
21          under the plan or coverage with respect to acquisi-  
22          tion of the drug and the amount an individual would  
23          pay for acquisition of the drug without using any  
24          health plan or health insurance coverage.

1 “(b) DEFINITION.—For purposes of this section, the  
 2 term ‘out-of-pocket cost’, with respect to acquisition of a  
 3 drug, means the amount to be paid by the participant or  
 4 beneficiary under the plan or coverage, including any cost-  
 5 sharing (including any deductible, copayment, or coinsur-  
 6 ance) and, as determined by the Secretary, any other ex-  
 7 penditure.”.

8 (b) CLERICAL AMENDMENT.—The table of contents  
 9 in section 1 of the Employee Retirement Income Security  
 10 Act of 1974 (29 U.S.C. 1001 et seq.), as amended by sec-  
 11 tion 3, is further amended by inserting after the item re-  
 12 lating to section 726 the following new item:

“Sec. 727. Information on prescription drugs.”.

13 **SEC. 5. ADVISORY COMMITTEE ON THE ACCESSIBILITY OF**  
 14 **CERTAIN INFORMATION.**

15 (a) IN GENERAL.—Not later than January 1, 2025,  
 16 the Secretary of Labor (in this section referred to as the  
 17 “Secretary”) shall convene an Advisory Committee (in this  
 18 section referred to as the “Committee”) consisting of 9  
 19 members to advise the Secretary on how to improve the  
 20 accessibility and usability of information made available  
 21 in accordance the amendments made by section 3 and by  
 22 section 204 of division BB of the Consolidated Appropria-  
 23 tion Act, 2021 (Public Law 116–260), streamline the re-  
 24 porting of such information, and ensure that such infor-

1 mation fully meets the needs of employers, patients, re-  
2 searchers, regulators, and purchasers.

3 (b) MEMBERSHIP.—The Secretary shall appoint  
4 members representing end-users of the information de-  
5 scribed in subsection (a). Vacancies on the Committee  
6 shall be filled by appointment consistent with this sub-  
7 section not later than 3 months after the vacancy arises.

8 (c) TERMINATION.—The Committee established  
9 under this section shall terminate on January 1, 2028.

○