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118TH CONGRESS
1ST SESSION

H. R. 4508

To amend the Employee Retirement Income Security Act of 1974 to clarify and strengthen the application of certain employer-sponsored health plan disclosure requirements.

IN THE HOUSE OF REPRESENTATIVES

JULY 10, 2023

Mr. COURTNEY (for himself and Mrs. HOUCHIN) introduced the following bill; which was referred to the Committee on Education and the Workforce

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A BILL

To amend the Employee Retirement Income Security Act of 1974 to clarify and strengthen the application of certain employer-sponsored health plan disclosure requirements.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Hidden Fee Disclosure Act''.

SEC. 2. CLARIFICATION OF THE APPLICATION OF FEE DISCLOSURE REQUIREMENTS TO COVERED SERVICE PROVIDERS.

(a) SERVICES.—Clause (ii)(I)(bb) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended—

(1) in subitem (AA) by striking ''Brokerage services,'' and inserting ''Services (including brokerage services),''; and

(2) in subitem (BB)—

(A) by striking ''Consulting,'' and inserting ''Other services,''; and

(B) by inserting ''any of the following:'' before ''plan design''.

(b) DISCLOSURES.—Clause (iii)(III) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended by striking '', either in the aggregate or by service,'' and inserting ''by service''.

SEC. 3. STRENGTHENING DISCLOSURE REQUIREMENTS WITH RESPECT TO PHARMACY BENEFIT MANAGERS AND THIRD PARTY ADMINISTRATORS FOR GROUP HEALTH PLANS.

(a) CERTAIN ARRANGEMENTS FOR PBM SERVICES CONSIDERED AS INDIRECT.—

(1) IN GENERAL.—Clause (i) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)(2)(B)) is amended—

(A) by striking ''requirements of this clause'' and inserting ''requirements of this subparagraph''; and

(B) by adding at the end the following: ''For purposes of applying section 406(a)(1)(C) with respect to a transaction described under this subparagraph, a contract or arrangement for services between a covered plan and a health insurance issuer providing health insurance coverage in connection with the covered plan in which the health insurance issuer contracts, in connection with such plan, with a service provider for pharmacy benefit management services shall be considered to constitute an indirect furnishing of goods, services, or facilities between the plan and the service provider acting as the party in interest.''.

(2) HEALTH INSURANCE ISSUER AND HEALTH INSURANCE COVERAGE DEFINED.—Clause (ii)(I)(aa) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 ((29 U.S.C.

1108(b)(2)(B)) is amended by inserting before the period at the end ''and the terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms in section 733(b)''.

(b) SPECIFIC DISCLOSURE REQUIREMENTS WITH RESPECT TO PHARMACY BENEFIT MANAGEMENT SERVICES.—

(1) IN GENERAL.—Clause (iii) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(VII) With respect to a contract or arrangement with the covered plan in connection with the provision of pharmacy benefit management services, as part of the description required under subclauses (III) and (IV)—

''(aa) all compensation described in clause (ii)(I)(dd)(AA), including fees, rebates, alternative discounts, co-payment offsets, and other remuneration expected to be received by the covered service provider, an affiliate, or a subcontractor from a pharmaceutical manufacturer, distributor, rebate aggregator, group purchasing organization, or any other third party; and

''(bb) the amount and form of any rebates, discounts, or price concessions, including the amount expected to be passed through to the plan sponsor or the participants and beneficiaries under the covered plan;

''(cc) all compensation expected to be received by the covered service provider as a result of paying a lower amount for the drug than the amount charged as a copayment, coinsurance amount, or deductible;

''(dd) all compensation expected to be received by the covered service provider as a result of paying pharmacies less than what is charged the health plan, plan sponsor, or participants and beneficiaries under the covered plan;

''(ee) all compensation expected to be received by the covered service provider from drug manufacturers and any other third party in exchange for—

''(AA) administering, invoicing, allocating, or collecting rebates related to the covered plan;

''(BB) providing business services and activities, including providing access to drug utilization data;

''(CC) keeping a percentage of the list price of a drug; or

''(DD) any other reason related to the role of a covered service provider as a conduit between the drug manufacturers or any other third party and the covered plan.''.

(2) ANNUAL DISCLOSURE.—

(A) Clause (v) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(III) A covered service provider, with respect to a contract or arrangement with the covered plan in connection with providing pharmacy benefit management services, shall disclose, on an annual basis not later than 60 days after the beginning of the current plan year, to a responsible plan fiduciary, in writing, the following with respect to the twelve months preceding the current plan year:

''(aa) All direct compensation described in subclause (III) of clause (iii)

and indirect compensation described in subclause (IV) of clause (iii) received by the covered service provider (including such compensation described in subclause (VII) of clause (iii)).

''(bb) For each drug covered under the covered plan, the amount by which the price for the drug paid by the plan exceeds the amount paid to pharmacies by the covered service provider.

''(cc) The total gross spending by the covered plan on drugs (excluding rebates, discounts, or other price concessions).

''(dd) The total net spending by the covered plan on drugs.

''(ee) The total gross spending at all pharmacies wholly or partially owned by the covered service provider, including mail-order, specialty and retail pharmacies, with a breakdown by individual pharmacy location.

''(ff) The aggregate amount of clawback from pharmacies, including mail-order, specialty, and retail pharmacies.

''(AA) categorical explanations (grouped by the reason for clawback, such as contractual true-up provisions, overpayments, or non-covered medication dispensed, and including information on the amount in each category that was passed through to the covered plan and to participants and beneficiaries of the covered plan); or

''(BB) individual explanations for such clawbacks.

''(gg) Total aggregate amounts of fees collected by the covered service provider in connection with the provision of pharmacy benefit management services to the covered plan.

''(hh) Any other information specified by the Secretary through regulations or guidance that may be necessary for a responsible plan fiduciary to consider the merits of the contract or arrangement with the covered service provider and any conflicts of interest that may exist.''.

(3) PHARMACY BENEFIT MANAGEMENT SERVICES DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)) is amended by adding at the end the following:

''(gg) The term 'pharmacy benefit management services' includes any services provided by a covered service provider to a covered plan with respect to the administration of prescription drug benefits under the covered plan, including—

''(AA) the processing and payment of claims;

''(BB) design of pharmacy networks;

''(CC) negotiation, aggregation, and distribution of rebates, discounts, and other price concessions;

''(DD) formulary design and maintenance;

''(EE) operation of pharmacies (whether retail, mail order, specialty drug, or otherwise); recordkeeping;

''(FF) utilization review;

''(GG) adjudication of claims; and

''(HH) any other services specified by the Secretary through guidance or rulemaking.''.

(4) CLAWBACK DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by paragraph (3), is amended by adding at the end the following:

''(hh) The term 'clawback' means amounts collected by a pharmacy benefit manager from a pharmacy for copayments collected from a participant or beneficiary in excess of the contracted rate.''.

(c) SPECIFIC DISCLOSURE REQUIREMENTS WITH RESPECT TO THIRD PARTY ADMINISTRATION SERVICES FOR GROUP HEALTH PLANS.—

(1) IN GENERAL.—Clause (iii) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by subsection (b)(1), is amended by adding at the end the following:

''(VIII) With respect to a contract or arrangement with the covered plan in connection with the provision of third party administration services for group health plans, as part of the description required under subclauses (III) and (IV)—

''(aa) the amount and form of any rebates, discounts, savings fees, refunds, or amounts received from providers and facilities, including the amounts that will be retained by the covered service provider as a fee;

''(bb) the amount and form of fees expected to be received from other service providers in relation to the covered plan, including the amounts that will be retained by the covered service provider as a fee; and

''(cc) the amount and form of expected recoveries by the covered service provider, including the amounts that will be retained by the covered service provider as a fee (disaggregated by category), as a result of—

''(AA) overpayments;

''(BB) erroneous payments;

''(CC) uncashed checks or incomplete payments;

''(DD) billing errors;

''(EE) subrogation;

''(FF) fraud; or

''(GG) any other reason on behalf of the covered plan, .''.

(2) ANNUAL DISCLOSURE.—Clause (v) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by subsection (b)(2), is amended by adding at the end the following:

''(IV) A covered service provider, with respect to a contract or arrangement with the covered plan in connection with providing third party administration services for group health plans, shall disclose, on an annual basis not later than 60 days after the beginning of the current plan year, to a responsible plan fiduciary, in writing, the following with respect to the twelve months preceding the current plan year:

''(aa) All direct compensation described in subclause (III) of clause (iii).

''(bb) All indirect compensation described in subclause (IV) of clause (iii) received by the covered service provider (including such compensation described in subclause (VIII) of clause (iii)).

''(cc) The aggregate amount for which the covered service provider received indi-

rect compensation and the estimated amount of cost-sharing incurred by plan participants and beneficiaries as a result.

''(dd) The total gross spending by the covered plan on all costs and fees arising under or paid under the administrative services agreement with the third-party administrator (not including any amounts described in items (aa) through (cc) of clause (iii)(VIII).

''(ee) The total net spending by the covered plan on all costs and fees arising under or paid under the administrative services agreement with the covered service provider.

''(ff) The aggregate fees collected by the covered service provider.

''(gg) Any other information specified by the Secretary through regulations or guidance that may be necessary for a responsible plan fiduciary to consider the merits of the contract or arrangement with the covered service provider and any conflicts of interest that may exist.''.

(3) THIRD PARTY ADMINISTRATION SERVICES FOR GROUP HEALTH PLANS DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by subsection (b)(3), is amended by adding at the end the following:

"(ii) The term 'third party administration services for group health plans' includes any services provided by a covered service provider to a covered plan with respect to the administration of health benefits under the covered plan, including—

"(AA) the processing, repricing, and payment of claims;

"(BB) design, creation, and maintenance of provider networks;

"(CC) negotiation of discounts off gross rates;

"(DD) benefit and plan design; negotiation of payment rates;

"(EE) recordkeeping;

"(FF) utilization review;

"(GG) adjudication of claims;

"(HH) regulatory compliance; and

''(II) any other services set forth in an administrative services agreement or similar agreement or specified by the Secretary through guidance or rulemaking.''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to imply that a practice in relation to which a covered service provider is required to provide information as a result of such amendments is permissible under Federal law.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2025.

SEC. 4. IMPLEMENTATION.

Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall issue notice and comment rulemaking as necessary to implement the provisions of this Act. The Secretary shall ensure that such rulemaking—

(1) accounts for the varied compensation practices of covered service providers (as defined under section 408(b)(2)(B); and

(2) establishes standards for the disclosure of expected compensation by such covered service providers.

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