

Union Calendar No. 767

118TH CONGRESS
2D SESSION

H. R. 4507

[Report No. 118–742, Part I]

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.

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

NOVEMBER 18, 2024

Reported from the Committee on Education and the Workforce with an amendment

[Strike out all after the enacting clause and insert the part printed in italic]

NOVEMBER 18, 2024

Referral to the Committees on Energy and Commerce and Ways and Means extended for a period ending not later than December 19, 2024

DECEMBER 19, 2024

Additional sponsor: Mr. NORMAN

DECEMBER 19, 2024

Committees on Energy and Commerce and Ways and Means discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

[For text of introduced bill, see copy of bill as introduced on July 10, 2023]

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”.*

6 **SEC. 2. PROMOTING GROUP HEALTH PLAN AND GROUP**
 7 **HEALTH INSURANCE COVERAGE PRICE**
 8 **TRANSPARENCY.**

9 *(a) IN GENERAL.—*

10 *(1) ERISA.—*

11 *(A) IN GENERAL.—Section 719 of the Em-*
 12 *ployee Retirement Income Security Act of 1974*
 13 *(29 U.S.C. 1185h) is amended to read as follows:*

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

15 *“(a) IN GENERAL.—A group health plan, and a health*
 16 *insurance issuer offering group health insurance coverage,*
 17 *shall make available to the public accurate and timely dis-*
 18 *closures of the following information:*

19 *“(1) Claims payment policies and practices.*

20 *“(2) Periodic financial disclosures.*

21 *“(3) Data on enrollment.*

22 *“(4) Data on disenrollment.*

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

25 *“(6) Data on rating practices.*

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

6 “(8) *Information on participant and beneficiary*
 7 *rights under this part.*

8 “(9) *Rate and payment information described in*
 9 *subsection (d).*

10 “(10) *Other information as determined appro-*
 11 *priate by the Secretary.*

12 *Rate and payment information described in paragraph (9)*
 13 *shall be made available to the public not later than January*
 14 *10, 2025, and not later than the tenth day of every month*
 15 *thereafter, in the manner described in subsection (d)(2)(A),*
 16 *and, beginning on January 1, 2027, in real-time through*
 17 *an application program interface (or successor technology)*
 18 *described in subsection (d)(2)(B).*

19 “(b) *USE OF PLAIN LANGUAGE.—The information re-*
 20 *quired to be submitted under subsection (a) shall be pro-*
 21 *vided in plain language. The term ‘plain language’ means*
 22 *language that the intended audience, including individuals*
 23 *with limited English proficiency, can readily understand*
 24 *and use because that language is clear, concise, well-orga-*
 25 *nized, accurately describes the information, and follows*

1 *other best practices of plain language writing. The Sec-*
2 *retary, jointly with the Secretary of Health and Human*
3 *Services and the Secretary of Labor, shall develop and issue*
4 *standards for plain language writing for purposes of this*
5 *section and shall develop a standardized reporting template*
6 *and standardized definitions of terms to allow for compari-*
7 *son across group health plans and health insurance cov-*
8 *erage.*

9 “(c) *COST SHARING TRANSPARENCY.*—

10 “(1) *IN GENERAL.*—A group health plan, and a
11 *health insurance issuer offering group health insur-*
12 *ance coverage, shall, upon request of a participant or*
13 *beneficiary and in a timely manner, provide to the*
14 *participant or beneficiary a statement of the amount*
15 *of cost-sharing (including deductibles, copayments,*
16 *and coinsurance) under the participant’s or bene-*
17 *ficiary’s plan or coverage that the participant or ben-*
18 *eficiary would be responsible for paying with respect*
19 *to the furnishing of a specific item or service by a*
20 *provider. At a minimum, such information shall in-*
21 *clude the information specified in paragraph (2) and*
22 *shall be made available at no cost to the participant*
23 *or beneficiary through a self-service tool that meets*
24 *the requirements of paragraph (3) or through a paper*
25 *or phone disclosure, at the option of the participant*

1 or beneficiary, that meets such requirements as the
2 Secretary may specify.

3 “(2) *SPECIFIED INFORMATION.*—For purposes of
4 paragraph (1), the information specified in this para-
5 graph is, with respect to an item or service for which
6 benefits are available under a group health plan or
7 group health insurance coverage (as applicable) fur-
8 nished by a health care provider to a participant or
9 beneficiary of such plan or coverage, the following:

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

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

23 “(C) The estimated amount of cost sharing
24 (including deductibles, copayments, and coinsur-
25 ance) that the participant or beneficiary will

1 incur for such item or service (which, in the case
2 such item or service is to be furnished by a pro-
3 vider described in subparagraph (B), shall be
4 calculated using the amount or rate described in
5 such subparagraph (or, in the case such plan or
6 issuer uses a percentage of billed charges to de-
7 termined the amount of payment for such pro-
8 vider, using a reasonable estimate of such per-
9 centage of such charges)).

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

19 “(E) Any shared savings or other benefit
20 available to the participant or beneficiary with
21 respect to such item or service.

22 “(F) In the case such plan or coverage im-
23 poses any frequency or volume limitations with
24 respect to such item or service (excluding medical
25 necessity determinations), the amount that such

1 *participant or beneficiary has accrued towards*
2 *such limitation with respect to such item or serv-*
3 *ice.*

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

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

14 *“(A) is based on an Internet website, mobile*
15 *application, or other platform determined appro-*
16 *priate by the Secretary;*

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

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

22 *“(D) allows such a request to be made with*
23 *respect to an item or service furnished 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 fa-
 7 cilitating 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 or
 13 through use of a descriptive term for such item
 14 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 linked*
 19 *correspond to items and services.*

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

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

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

14 *“(B) provides for notifications required*
15 *under section 716(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 in*
19 *this subsection is, with respect to a group health plan*
20 *or group health insurance coverage (as applicable),*
21 *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-network*
25 *rate (in a dollar amount) in effect as of the first*

1 *day of the plan year during which such informa-*
2 *tion is submitted with each provider (identified*
3 *by national provider identifier) that is a partici-*
4 *pating provider with respect to such item or*
5 *service (or, in the case such rate is not available*
6 *in a dollar amount, such formulae, pricing*
7 *methodologies, or other information used to cal-*
8 *culate 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 under*
12 *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 ad-*

1 *ministered during the 90-day period begin-*
2 *ning 180 days before such date of submis-*
3 *sion to each provider that was a partici-*
4 *pating provider with respect to such drug,*
5 *broken down by each such provider (identi-*
6 *fied by national provider identifier), other*
7 *than such an amount paid to a provider*
8 *that, during such period, submitted fewer*
9 *than 20 claims for such drug to such plan*
10 *or coverage.*

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

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

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

4 “(2) *MANNER OF PUBLICATION.—*

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

1 *establish 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 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 *OR COVERAGE.—Clause (i) shall not apply*
20 *with respect to information described in*
21 *such clause required to be made available by*
22 *a group health plan or health insurance*
23 *issuer offering health insurance coverage if*
24 *such plan or coverage, as applicable, pro-*

1 vides benefits for fewer than 500 partici-
2 pants and beneficiaries.

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

10 “(4) *ANNUAL SUMMARY.*—*For each year (begin-*
11 *ning with 2025), each group health plan and health*
12 *insurance issuer offering group health insurance cov-*
13 *erage shall make public a machine-readable file meet-*
14 *ing such standards as established by the Secretary*
15 *under paragraph (2) containing a summary of all*
16 *rate and payment information made public by such*
17 *plan or issuer with respect to such plan or coverage*
18 *during such year (such as averages of all such infor-*
19 *mation so made public).*

20 “(e) *ATTESTATION.*—*Each group health plan and*
21 *health insurance issuer offering group health insurance cov-*
22 *erage shall annually submit to the Secretary an attestation*
23 *of such plan’s or such coverage’s compliance with the provi-*
24 *sions of this section along with a link to disclosures made*
25 *in accordance with subsection (a).*

1 “(f) *DEFINITIONS.*—*In this subsection:*

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

4 “(2) *IN-NETWORK RATE.*—*The term ‘in-network*
5 *rate’ means, with respect to a group health plan or*
6 *group health insurance coverage and an item or serv-*
7 *ice furnished by a provider that is a participating*
8 *provider with respect to such plan or coverage and*
9 *item or service, the contracted rate (reflected as a dol-*
10 *lar amount) in effect between such plan or coverage*
11 *and such provider for such item or service.’.*

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

16 “*Sec. 719. Price transparency requirements.*”.

17 (2) *IRC.*—

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

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

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

25 “(1) *Claims payment policies and practices.*

1 “(2) *Periodic financial disclosures.*

2 “(3) *Data on enrollment.*

3 “(4) *Data on disenrollment.*

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

6 “(6) *Data on rating practices.*

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

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

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

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

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

24 “(b) *USE OF PLAIN LANGUAGE.—The information re-*
25 *quired to be submitted under subsection (a) shall be pro-*

1 *vided in plain language. The term ‘plain language’ means*
 2 *language that the intended audience, including individuals*
 3 *with limited English proficiency, can readily understand*
 4 *and use because that language is clear, concise, well-orga-*
 5 *nized, accurately describes the information, and follows*
 6 *other best practices of plain language writing. The Sec-*
 7 *retary, jointly with the Secretary of Health and Human*
 8 *Services and the Secretary of Labor, shall develop and issue*
 9 *standards for plain language writing for purposes of this*
 10 *section and shall develop a standardized reporting template*
 11 *and standardized definitions of terms to allow for compari-*
 12 *son across group health plans and health insurance cov-*
 13 *erage.*

14 “(c) *COST SHARING TRANSPARENCY.—*

15 “(1) *IN GENERAL.—A group health plan shall,*
 16 *upon request of a participant or beneficiary and in*
 17 *a timely manner, provide to the participant or bene-*
 18 *ficiary a statement of the amount of cost-sharing (in-*
 19 *cluding deductibles, copayments, and coinsurance)*
 20 *under the participant’s or beneficiary’s plan that the*
 21 *participant or beneficiary would be responsible for*
 22 *paying with respect to the furnishing of a specific*
 23 *item or service by a provider. At a minimum, such*
 24 *information shall include the information specified in*
 25 *paragraph (2) and shall be made available at no cost*

1 to the participant or beneficiary through a self-service
2 tool that meets the requirements of paragraph (3) or
3 through a paper or phone disclosure, at the option of
4 the participant or beneficiary, that meets such re-
5 quirements as the Secretary may specify.

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

12 “(A) If such provider is a participating
13 provider with respect to such item or service, the
14 in-network rate (as defined in subsection (f)) for
15 such item or service and for any other item or
16 service that is inherent in the furnishing of the
17 item or service that is the subject 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 will
21 recognize as payment for such item or service,
22 along with a notice that such individual may be
23 liable for additional charges billed by such pro-
24 vider.

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

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

22 “(E) *Any shared savings or other benefit*
23 *available to the participant or beneficiary with*
24 *respect to such item or service.*

1 “(F) *In the case such plan imposes any fre-*
2 *quency or volume limitations with respect to*
3 *such item or service (excluding medical necessity*
4 *determinations), the amount that such partici-*
5 *pant or beneficiary has accrued towards such*
6 *limitation with respect to such item or service.*

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

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

15 “(A) *is based on an Internet website, mobile*
16 *application, or other platform determined appro-*
17 *priate 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 accurate*
22 *at the time such request is made;*

23 “(D) *allows such a request to be made with*
24 *respect to an item or service furnished 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 item
6 or service for purposes of facilitating price
7 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 or
13 through use of a descriptive term for such item
14 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 linked*
19 *correspond to items and services.*

20 “(4) *PROVIDER TOOL.*—A group health plan
21 shall permit providers to learn the amount of cost-
22 sharing (including deductibles, copayments, and coin-
23 surance) that would apply under an individual’s
24 plan that the individual would be responsible for pay-
25 ing with respect to the furnishing of a specific item

1 or service by another provider in a timely manner
 2 upon the request of the provider and with the consent
 3 of such individual in the same manner and to the
 4 same extent as if such request has been made by such
 5 individual. As part of any tool used to facilitate such
 6 requests from a provider, such plan may include
 7 functionality that—

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

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

14 “(d) *RATE AND PAYMENT INFORMATION.*—

15 “(1) *IN GENERAL.*—For purposes of subsection
 16 (a)(9), the rate and payment information described in
 17 this subsection is, with respect to a group health plan,
 18 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, the in-network rate (in a
 22 dollar amount) in effect as of the first day of the
 23 plan year during which such information is sub-
 24 mitted with each provider (identified by national
 25 provider identifier) that is a participating pro-

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

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

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

19 *“(ii) the average amount paid by such*
20 *plan (net of rebates, discounts, and price*
21 *concessions) for such drug dispensed or ad-*
22 *ministered during the 90-day period begin-*
23 *ning 180 days before such date of submis-*
24 *sion to each provider that was a partici-*
25 *pating provider with respect to such drug,*

1 *broken down by each such provider (identi-*
2 *fied by national provider identifier), other*
3 *than such an amount paid to a provider*
4 *that, during such period, submitted fewer*
5 *than 20 claims for such drug to such plan*
6 *or coverage.*

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

19 *Such rate and payment information shall be made*
20 *available with respect to each individual item or serv-*
21 *ice, regardless of whether such item or service is paid*
22 *for as part of a bundled payment, episode of care,*
23 *value-based payment arrangement, or otherwise.*

24 “(2) *MANNER OF PUBLICATION.—*

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

21 “(B) *REAL-TIME PROVISION OF INFORMA-*
22 *TION.*—

23 “(i) *IN GENERAL.*—Subject to clause
24 (ii), beginning January 1, 2026, rate and
25 payment information required to be made

1 *available by a group health plan under sub-*
2 *section (a)(9) shall, in addition to being*
3 *made available in the manner described in*
4 *subparagraph (A), be made available*
5 *through an application program interface*
6 *(or successor technology) that provides ac-*
7 *cess to such information in real time and*
8 *that meets such technical standards as may*
9 *be specified by the Secretary.*

10 “(i) *EXEMPTION FOR CERTAIN PLANS*
11 *AND COVERAGE.—Clause (i) shall not apply*
12 *with respect to information described in*
13 *such clause required to be made available by*
14 *a group health plan if such plan provides*
15 *benefits for fewer than 500 participants and*
16 *beneficiaries.*

17 “(3) *USER GUIDE.—The Secretary, Secretary of*
18 *Health and Human Services, and Secretary of Labor*
19 *shall jointly make available to the public instructions*
20 *written in plain language explaining how individuals*
21 *may search for information described in paragraph*
22 *(1) in files submitted in accordance with paragraph*
23 *(2).*

24 “(4) *ANNUAL SUMMARY.—For each year (begin-*
25 *ning with 2025), each group health plan shall make*

1 *public a machine-readable file meeting such standards*
 2 *as established by the Secretary under paragraph (2)*
 3 *containing a summary of all rate and payment infor-*
 4 *mation made public by such plan with respect to such*
 5 *plan or coverage during such year (such as averages*
 6 *of all such information so made public).*

7 “(e) *ATTESTATION.*—*Each group health plan shall an-*
 8 *nually submit to the Secretary an attestation of such plan’s*
 9 *compliance with the provisions of this section along with*
 10 *a link to disclosures made in accordance with subsection*
 11 *(a).*

12 “(f) *DEFINITIONS.*—*In this subsection:*

13 “(1) *PARTICIPATING PROVIDER.*—*The term ‘par-*
 14 *ticipating provider’ has the meaning given such term*
 15 *in section 9816 and includes a participating facility.*

16 “(2) *IN-NETWORK RATE.*—*The term ‘in-network*
 17 *rate’ means, with respect to a group health plan and*
 18 *an item or service furnished by a provider that is a*
 19 *participating provider with respect to such plan and*
 20 *item or service, the contracted rate (reflected as a dol-*
 21 *lar amount) in effect between such plan and such pro-*
 22 *vider for such item or service.’.*

23 “(B) *CLERICAL AMENDMENT.*—*The item re-*
 24 *lating to section 9819 in the table of sections for*

1 subchapter B of chapter 100 of the Internal Rev-
2 enue Code of 1986 is amended to read as follows:

“Sec. 9819. Price transparency requirements.”.

3 (3) PHSA.—Section 2799A–4 of the Public
4 Health Service Act (42 U.S.C. 300gg–114) is amend-
5 ed to read as follows:

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

7 “(a) IN GENERAL.—A group health plan, and a health
8 insurance issuer offering group or individual health insur-
9 ance coverage, shall make available to the public accurate
10 and timely disclosures of the following information:

11 “(1) Claims payment policies and practices.

12 “(2) Periodic financial disclosures.

13 “(3) Data on enrollment.

14 “(4) Data on disenrollment.

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

17 “(6) Data on rating practices.

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

23 “(8) Information on enrollee rights under this
24 part.

1 “(9) *Rate and payment information described in*
2 *subsection (d).*

3 “(10) *Other information as determined appro-*
4 *priate by the Secretary.*

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

12 “(b) *USE OF PLAIN LANGUAGE.—The information re-*
13 *quired to be submitted under subsection (a) shall be pro-*
14 *vided in plain language. The term ‘plain language’ means*
15 *language that the intended audience, including individuals*
16 *with limited English proficiency, can readily understand*
17 *and use because that language is clear, concise, well-orga-*
18 *nized, accurately describes the information, and follows*
19 *other best practices of plain language writing. The Sec-*
20 *retary, jointly with the Secretary of Labor and the Sec-*
21 *retary of the Treasury, shall develop and issue standards*
22 *for plain language writing for purposes of this section and*
23 *shall develop a standardized reporting template and stand-*
24 *ardized definitions of terms to allow for comparison across*
25 *group health plans and health insurance coverage.*

1 “(c) *COST SHARING TRANSPARENCY.*—

2 “(1) *IN GENERAL.*—A group health plan, and a
3 health insurance issuer offering group or individual
4 health insurance coverage, shall, upon request of an
5 enrollee and in a timely manner, provide to the en-
6 rollee a statement of the amount of cost-sharing (in-
7 cluding deductibles, copayments, and coinsurance)
8 under the enrollee’s plan or coverage that the enrollee
9 would be responsible for paying with respect to the
10 furnishing of a specific item or service by a provider.
11 At a minimum, such information shall include the
12 information specified in paragraph (2) and shall be
13 made available at no cost to the enrollee through a
14 self-service tool that meets the requirements of para-
15 graph (3) or through a paper or phone disclosure, at
16 the option of the enrollee, that meets such require-
17 ments as the Secretary may specify.

18 “(2) *SPECIFIED INFORMATION.*—For purposes of
19 paragraph (1), the information specified in this para-
20 graph is, with respect to an item or service for which
21 benefits are available under a group health plan or
22 group or individual health insurance coverage (as ap-
23 plicable) furnished by a health care provider to an en-
24 rollee of such plan or coverage, the following:

1 “(A) If such provider is a participating
2 provider with respect to such item or service, the
3 in-network rate (as defined in subsection (f)) for
4 such item or service and for any other item or
5 service that is inherent in the furnishing of the
6 item or service that is the subject of such request.

7 “(B) If such provider is not a participating
8 provider, the allowed amount, percentage of
9 billed charges, or other rate that such plan or
10 coverage will recognize as payment for such item
11 or service, along with a notice that such enrollee
12 may be liable for additional charges billed by
13 such provider.

14 “(C) The estimated amount of cost sharing
15 (including deductibles, copayments, and coinsur-
16 ance) that the enrollee will incur for such item
17 or service (which, in the case such item or service
18 is to be furnished by a provider described in sub-
19 paragraph (B), shall be calculated using the
20 amount or rate described in such subparagraph
21 (or, in the case such plan or issuer uses a per-
22 centage of billed charges to determined the
23 amount of payment for such provider, using a
24 reasonable estimate of such percentage of such
25 charges)).

1 “(D) *The amount the enrollee has already*
2 *accumulated with respect to any deductible or*
3 *out of pocket maximum under the plan or cov-*
4 *erage (broken down, in the case separate*
5 *deductibles or maximums apply to separate en-*
6 *rollees in the plan or coverage, by such separate*
7 *deductibles or maximums, in addition to any cu-*
8 *mulative deductible or maximum).*

9 “(E) *Any shared savings or other benefit*
10 *available to the enrollee with respect to such item*
11 *or service.*

12 “(F) *In the case such plan or coverage im-*
13 *poses any frequency or volume limitations with*
14 *respect to such item or service (excluding medical*
15 *necessity determinations), the amount that such*
16 *enrollee has accrued towards such limitation*
17 *with respect to such item or service.*

18 “(G) *Any prior authorization, concurrent*
19 *review, step therapy, fail first, or similar re-*
20 *quirements applicable to coverage of such item or*
21 *service under such plan or group or individual*
22 *health insurance coverage.*

23 “(3) *SELF-SERVICE TOOL.—For purposes of*
24 *paragraph (1), a self-service tool established by a*
25 *group health plan or health insurance issuer offering*

1 *group or individual health insurance coverage meets*
2 *the requirements of this paragraph if such tool—*

3 “(A) *is based on an Internet website, mobile*
4 *application, or other platform determined appro-*
5 *priate by the Secretary;*

6 “(B) *provides for real-time responses to re-*
7 *quests described in paragraph (1);*

8 “(C) *is updated in a manner such that in-*
9 *formation provided through such tool is accurate*
10 *at the time such request is made;*

11 “(D) *allows such a request to be made with*
12 *respect to an item or service furnished by—*

13 “(i) *a specific provider that is a par-*
14 *ticipating provider with respect to such*
15 *item or service;*

16 “(ii) *all providers that are partici-*
17 *pating providers with respect to such plan*
18 *and such item or service for purposes of fa-*
19 *cilitating price comparisons; or*

20 “(iii) *a provider that is not described*
21 *in clause (ii); and*

22 “(E) *provides that such a request may be*
23 *made with respect to an item or service through*
24 *use of the billing code for such item or service or*

1 *through use of a descriptive term for such item*
2 *or service.*

3 *The Secretary may require such tool, as a condition*
4 *of complying with subparagraph (E), to link multiple*
5 *billing codes to a single descriptive term if the Sec-*
6 *retary determines that the billing codes to be so linked*
7 *correspond to items and services.*

8 “(4) *PROVIDER TOOL.*—*A group health plan,*
9 *and a health insurance issuer offering group or indi-*
10 *vidual health insurance coverage, shall permit pro-*
11 *viders to learn the amount of cost-sharing (including*
12 *deductibles, copayments, and coinsurance) that would*
13 *apply under an individual’s plan or coverage that the*
14 *individual would be responsible for paying with re-*
15 *spect to the furnishing of a specific item or service by*
16 *another provider in a timely manner upon the request*
17 *of the provider and with the consent of such indi-*
18 *vidual in the same manner and to the same extent as*
19 *if such request has been made by such individual. As*
20 *part of any tool used to facilitate such requests from*
21 *a provider, such plan or issuer offering health insur-*
22 *ance coverage may include functionality that—*

23 “(A) *allows providers to submit the notifi-*
24 *cations to such plan or coverage required under*
25 *section 2799B–6; and*

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

3 “(d) *RATE AND PAYMENT INFORMATION.*—

4 “(1) *IN GENERAL.*—For purposes of subsection
5 (a)(9), the rate and payment information described in
6 this subsection is, with respect to a group health plan
7 or group or individual health insurance coverage (as
8 applicable), the following:

9 “(A) With respect to each item or service
10 (other than a drug) for which benefits are avail-
11 able under such plan or coverage, the in-network
12 rate (in a dollar amount) in effect as of the first
13 day of the plan year during which such informa-
14 tion is submitted with each provider (identified
15 by national provider identifier) that is a partici-
16 pating provider with respect to such item or
17 service (or, in the case such rate is not available
18 in a dollar amount, such formulae, pricing
19 methodologies, or other information used to cal-
20 culate such rate).

21 “(B) With respect to each dosage form and
22 indication of each drug (identified by national
23 drug code) for which benefits are available under
24 such plan or coverage—

1 “(i) the in-network rate (in a dollar
2 amount) in effect as of the first day of the
3 plan year during which such information is
4 submitted with each provider (identified by
5 national provider identifier) that is a par-
6 ticipating provider with respect to such
7 drug (or, in the case such rate is not avail-
8 able in a dollar amount, such formulae,
9 pricing methodologies, or other information
10 used to calculate such rate); and

11 “(ii) the average amount paid by such
12 plan (net of rebates, discounts, and price
13 concessions) for such drug dispensed or ad-
14 ministered during the 90-day period begin-
15 ning 180 days before such date of submis-
16 sion to each provider that was a partici-
17 pating provider with respect to such drug,
18 broken down by each such provider (identi-
19 fied by national provider identifier), other
20 than such an amount paid to a provider
21 that, during such period, submitted fewer
22 than 20 claims for such drug to such plan
23 or coverage.

24 “(C) With respect to each item or service for
25 which benefits are available under such plan or

1 *coverage, the amount billed, and the amount al-*
2 *lowed by the plan or coverage, for each such item*
3 *or service furnished during the 90-day period*
4 *specified in subparagraph (B) by a provider that*
5 *was not a participating provider with respect to*
6 *such item or service, broken down by each such*
7 *provider (identified by national provider identi-*
8 *fier), other than items and services with respect*
9 *to which fewer than 20 claims for such item or*
10 *service were submitted to such plan or coverage*
11 *during such period.*

12 *Such rate and payment information shall be made*
13 *available with respect to each individual item or serv-*
14 *ice, regardless of whether such item or service is paid*
15 *for as part of a bundled payment, episode of care,*
16 *value-based payment arrangement, or otherwise.*

17 “(2) *MANNER OF PUBLICATION.—*

18 “(A) *IN GENERAL.—Rate and payment in-*
19 *formation required to be made available under*
20 *subsection (a)(9) shall be so made available in*
21 *dollar amounts through 3 separate machine-*
22 *readable files corresponding to the information*
23 *described in each of subparagraphs (A) through*
24 *(C) of paragraph (1) that meet such require-*
25 *ments as specified by the Secretary not later*

1 *than 180 days after the date of the enactment of*
2 *this paragraph through rulemaking. Such re-*
3 *quirements shall ensure that such files are lim-*
4 *ited to an appropriate size, do not include infor-*
5 *mation that is duplicative of information con-*
6 *tained in other files made available under such*
7 *subsection, are made available in a widely-avail-*
8 *able format that allows for information con-*
9 *tained in such files to be compared across group*
10 *health plans and group or individual health in-*
11 *surance coverage, and are accessible to individ-*
12 *uals at no cost and without the need to establish*
13 *a user account or provide other credentials.*

14 *“(B) REAL-TIME PROVISION OF INFORMA-*
15 *TION.—*

16 *“(i) IN GENERAL.—Subject to clause*
17 *(ii), beginning January 1, 2026, rate and*
18 *payment information required to be made*
19 *available by a group health plan or health*
20 *insurance issuer under subsection (a)(9)*
21 *shall, in addition to being made available*
22 *in the manner described in subparagraph*
23 *(A), be made available through an applica-*
24 *tion program interface (or successor tech-*
25 *nology) that provides access to such infor-*

1 *mation in real time and that meets such*
2 *technical standards as may be specified by*
3 *the Secretary.*

4 “(ii) *EXEMPTION FOR CERTAIN PLANS*
5 *AND COVERAGE.*—*Clause (i) shall not apply*
6 *with respect to information described in*
7 *such clause required to be made available by*
8 *a group health plan or health insurance*
9 *issuer offering health insurance coverage if*
10 *such plan or coverage, as applicable, pro-*
11 *vides benefits for fewer than 500 enrollees.*

12 “(3) *USER GUIDE.*—*The Secretary, Secretary of*
13 *Labor, and Secretary of the Treasury shall jointly*
14 *make available to the public instructions written in*
15 *plain language explaining how individuals may*
16 *search for information described in paragraph (1) in*
17 *files submitted in accordance with paragraph (2).*

18 “(4) *ANNUAL SUMMARY.*—*For each year (begin-*
19 *ning with 2025), each group health plan and health*
20 *insurance issuer offering group or individual health*
21 *insurance coverage shall make public a machine-read-*
22 *able file meeting such standards as established by the*
23 *Secretary under paragraph (2) containing a sum-*
24 *mary of all rate and payment information made pub-*
25 *lic by such plan or issuer with respect to such plan*

1 or coverage during such year (such as averages of all
2 such information so made public).

3 “(e) *ATTESTATION.*—Each group health plan and
4 health insurance issuer offering group or individual health
5 insurance coverage shall annually submit to the Secretary
6 an attestation of such plan’s or such coverage’s compliance
7 with the provisions of this section along with a link to dis-
8 closures made in accordance with subsection (a).

9 “(f) *DEFINITIONS.*—In this subsection:

10 “(1) *PARTICIPATING PROVIDER.*—The term ‘par-
11 ticipating provider’ has the meaning given such term
12 in section 2799A–1 and includes a participating fa-
13 cility.

14 “(2) *IN-NETWORK RATE.*—The term ‘in-network
15 rate’ means, with respect to a group health plan or
16 group or individual health insurance coverage and an
17 item or service furnished by a provider that is a par-
18 ticipating provider with respect to such plan or cov-
19 erage and item or service, the contracted rate (re-
20 flected as a dollar amount) in effect between such
21 plan or coverage and such provider for such item or
22 service.”.

23 (b) *REPORTS TO CONGRESS.*—

24 “(1) *QUALITY REPORT.*—Not later than 1 year
25 after the date of enactment of this subsection, the Sec-

retary of Labor shall submit to Congress a report on the feasibility of including data relating to the quality of health care items and services with the price transparency information required to be made available under the amendments made by subsection (a). Such report shall include recommendations for legislative and regulatory actions to identify appropriate metrics for assessing and comparing quality of care.

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

(A) between rural and urban markets;

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

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

(D) between non-profit and for-profit hospitals; and

1 (E) between non-profit and for-profit insur-
 2 ers.

3 (c) *EFFECTIVE DATE.*—

4 (1) *IN GENERAL.*—The amendments made by
 5 subsection (a) shall apply to plan years beginning on
 6 or after January 1, 2025.

7 (2) *CONTINUED APPLICABILITY OF RULES FOR*
 8 *PREVIOUS YEARS.*—Nothing in the amendments made
 9 by subsection (a) may be construed as affecting the
 10 applicability of the rule entitled “Transparency in
 11 Coverage” published by the Department of the Treas-
 12 ury, the Department of Labor, and the Department of
 13 Health and Human Services on November 12, 2020
 14 (85 Fed. Reg. 72158) for plan years beginning before
 15 January 1, 2025.

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

17 (a) *ERISA.*—

18 (1) *IN GENERAL.*—Subtitle B of title I of the
 19 Employee Retirement Income Security Act of 1974
 20 (29 U.S.C. 1021 *et seq.*) is amended—

21 (A) in subpart B of part 7 (29 U.S.C. 1185
 22 *et seq.*), by adding at the end the following:

1 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
2 **SERVICES.**

3 “(a) *IN GENERAL.*—For plan years beginning on or
4 *after January 1, 2025, a group health plan (or health in-*
5 *surance issuer offering group health insurance coverage in*
6 *connection with such a plan) or an entity or subsidiary*
7 *providing pharmacy benefits management services on behalf*
8 *of such a plan or issuer may not enter into a contract with*
9 *a drug manufacturer, distributor, wholesaler, switch, pa-*
10 *tient or copay assistance program administrator, phar-*
11 *macy, subcontractor, rebate aggregator, or any associated*
12 *third party that limits or delays the disclosure of informa-*
13 *tion to plan administrators in such a manner that prevents*
14 *the plan or issuer, or an entity or subsidiary providing*
15 *pharmacy benefits management services on behalf of a plan*
16 *or issuer, from making or substantiating the reports de-*
17 *scribed in subsection (b).*

18 “(b) *REPORTS.*—

19 “(1) *IN GENERAL.*—For plan years beginning on
20 *or after January 1, 2025, not less frequently than*
21 *quarterly (and upon request by the plan adminis-*
22 *trator), a group health plan or health insurance*
23 *issuer offering group health insurance coverage, or an*
24 *entity providing pharmacy benefits management serv-*
25 *ices on behalf of a group health plan or an issuer pro-*
26 *viding group health insurance coverage, shall submit*

1 to the plan administrator (as defined in section
2 3(16)(A)) of such plan or coverage a report in accord-
3 ance with this subsection, and make such report
4 available to the plan administrator in a machine-
5 readable format (or as may be determined by the Sec-
6 retary, other formats). Each such report shall include,
7 with respect to the applicable group health plan or
8 health insurance coverage—

9 “(A) information collected from a patient or
10 copay assistance program administrator by such
11 entity on the total amount of copayment assist-
12 ance dollars paid, or copayment cards applied,
13 or other discounts that were funded by the drug
14 manufacturer with respect to the participants
15 and beneficiaries in such plan or coverage;

16 “(B) total gross spending on prescription
17 drugs by the plan or coverage during the report-
18 ing period;

19 “(C) total amount received, or expected to
20 be received, by the plan or coverage from any en-
21 tities, in rebates, fees, alternative discounts, and
22 all other remuneration received from the entity
23 or any third party (including group purchasing
24 organizations) other than the plan adminis-
25 trator, related to utilization of drug or drug

1 *spending under such plan or coverage during the*
2 *reporting period;*

3 *“(D) the total net spending on prescription*
4 *drugs by the plan or coverage during such re-*
5 *porting period;*

6 *“(E) amounts paid, directly or indirectly,*
7 *in rebates, fees, or any other type of compensa-*
8 *tion (as defined in section*
9 *408(b)(2)(B)(ii)(dd)(AA)) to brokerage houses,*
10 *brokers, consultants, advisors, or any other indi-*
11 *vidual or firm for the referral of the group health*
12 *plan’s or health insurance issuer’s business to the*
13 *pharmacy benefits manager, identified by the re-*
14 *cipient of such amounts;*

15 *“(F)(i) an explanation of any benefit design*
16 *parameters that encourage or require partici-*
17 *pants and beneficiaries in the plan or coverage*
18 *to fill prescriptions at mail order, specialty, or*
19 *retail pharmacies that are affiliated with or*
20 *under common ownership with the entity pro-*
21 *viding pharmacy benefit management services*
22 *under such plan or coverage, including manda-*
23 *tory mail and specialty home delivery programs,*
24 *retail and mail auto-refill programs, and cost-*
25 *sharing assistance incentives funded by an entity*

1 *providing pharmacy benefit management serv-*
2 *ices;*

3 *“(ii) the percentage of total prescrip-*
4 *tions charged to the plan, issuer, or partici-*
5 *pants and beneficiaries in such plan or cov-*
6 *erage, that were dispensed by mail order,*
7 *specialty, or retail pharmacies that are af-*
8 *filiated with or under common ownership*
9 *with the entity providing pharmacy benefit*
10 *management services; and*

11 *“(iii) a list of all drugs dispensed by*
12 *such affiliated pharmacy or pharmacy*
13 *under common ownership and charged to*
14 *the plan, issuer, or participants and bene-*
15 *ficiaries of the plan, during the applicable*
16 *period, and, with respect to each drug—*

17 *“(I)(aa) the amount charged, per*
18 *dosage unit, per 30-day supply, and*
19 *per 90-day supply, with respect to par-*
20 *ticipants and beneficiaries in the plan*
21 *or coverage, to the plan or issuer; and*

22 *“(bb) the amount charged,*
23 *per dosage unit, per 30-day sup-*
24 *ply, and per 90-day supply, to*
25 *participants and beneficiaries;*

1 “(II) the median amount charged
2 to the plan or issuer, per dosage unit,
3 per 30-day supply, and per 90-day
4 supply, including amounts paid by the
5 participants and beneficiaries, when
6 the same drug is dispensed by other
7 pharmacies that are not affiliated with
8 or under common ownership with the
9 entity and that are included in the
10 pharmacy network of such plan or cov-
11 erage;

12 “(III) the interquartile range of
13 the costs, per dosage unit, per 30-day
14 supply, and per 90-day supply, includ-
15 ing amounts paid by the participants
16 and beneficiaries, when the same drug
17 is dispensed by other pharmacies that
18 are not affiliated with or under com-
19 mon ownership with the entity and
20 that are included in the pharmacy net-
21 work of that plan or coverage;

22 “(IV) the lowest cost, per dosage
23 unit, per 30-day supply, and per 90-
24 day supply, for such drug, including
25 amounts charged to the plan and par-

1 *ticipants and beneficiaries, that is*
2 *available from any pharmacy included*
3 *in the network of the plan or coverage;*

4 *“(V) the net acquisition cost per*
5 *dosage unit, per 30-day supply, and*
6 *per 90-day supply, if the drug is sub-*
7 *ject to a maximum price discount; and*

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

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

21 *“(i) a list of each drug covered by such*
22 *plan, issuer, or entity providing pharmacy*
23 *benefits management services for which a*
24 *claim was filed during the reporting period,*

1 *including, with respect to each such drug*
2 *during the reporting period—*

3 “(I) *the brand name, generic or*
4 *non-proprietary name, and the Na-*
5 *tional Drug Code;*

6 “(II)(aa) *the number of partici-*
7 *pants and beneficiaries for whom a*
8 *claim for such drug was filed during*
9 *the reporting period, the total number*
10 *of prescription claims for such drug*
11 *(including original prescriptions and*
12 *refills), and the total number of dosage*
13 *units and total days supply of such*
14 *drug for which a claim was filed dur-*
15 *ing the reporting period; and*

16 “(bb) *with respect to each*
17 *claim or dosage unit described in*
18 *item (aa), the type of dispensing*
19 *channel used, such as retail, mail*
20 *order, or specialty pharmacy;*

21 “(III) *the wholesale acquisition*
22 *cost, listed as cost per days supply and*
23 *cost per dosage unit on date of dis-*
24 *persing;*

1 “(IV) the total out-of-pocket
2 spending by participants and bene-
3 ficiaries on such drug after application
4 of any benefits under such plan or cov-
5 erage, including participant and bene-
6 ficiary spending through copayments,
7 coinsurance, and deductibles (but not
8 including any amounts spent by par-
9 ticipants and beneficiaries on drugs
10 not covered under such plan or cov-
11 erage, or for which no claim was sub-
12 mitted to such plan or coverage);

13 “(V) for any drug for which gross
14 spending of the plan or coverage ex-
15 ceeded \$10,000 during the reporting
16 period—

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

1 “(bb) the rationale for pre-
2 ferred formulary placement of
3 such drug in that therapeutic cat-
4 egory or class, if applicable; and

5 “(ii) a list of each therapeutic category
6 or class of drugs for which a claim was filed
7 under the health plan or health insurance
8 coverage during the reporting period, and,
9 with respect to each such therapeutic cat-
10 egory or class of drugs during the reporting
11 period—

12 “(I) total gross spending by the
13 plan;

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

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

24 “(IV) the total out-of-pocket
25 spending by participants and bene-

1 *ficiaries, including participant and*
2 *beneficiary spending through copay-*
3 *ments, coinsurance, and deductibles;*
4 *and*

5 *“(V) for each drug—*

6 *“(aa) the amount received, or*
7 *expected to be received, from any*
8 *entity in rebates, fees, alternative*
9 *discounts, or other remunera-*
10 *tion—*

11 *“(AA) for claims in-*
12 *curred during the reporting*
13 *period; or*

14 *“(BB) that is related to*
15 *utilization of drugs or drug*
16 *spending;*

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

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

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

21 “(3) *DISCLOSURE AND REDISCLOSURE.*—

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

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

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

17 “(C) *LIMITED FORM OF REPORT.—The Sec-*
18 *retary shall define through rulemaking a limited*
19 *form of the report under paragraph (1) required*
20 *of plan administrators who are drug manufac-*
21 *turers, drug wholesalers, or other direct partici-*
22 *pants in the drug supply chain, in order to pre-*
23 *vent anti-competitive behavior.*

24 “(4) *REPORT TO GAO.—A health insurance*
25 *issuer offering group health insurance coverage or an*

1 *entity providing pharmacy benefits management serv-*
2 *ices on behalf of a group health plan shall submit to*
3 *the Comptroller General of the United States each of*
4 *the first 4 reports submitted to a plan administrator*
5 *under paragraph (1) with respect to such coverage or*
6 *plan, and other such reports as requested, in accord-*
7 *ance with the privacy requirements under paragraph*
8 *(2), the disclosure and redisclosure standards under*
9 *paragraph (3), the standards specified pursuant to*
10 *paragraph (5).*

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

17 *“(c) RULE OF CONSTRUCTION.—Nothing in this sec-*
18 *tion shall be construed to permit a health insurance issuer,*
19 *group health plan, or other entity to restrict disclosure to,*
20 *or otherwise limit the access of, the Department of Labor*
21 *to a report described in subsection (b)(1) or information*
22 *related to compliance with subsection (a) by such issuer,*
23 *plan, or entity.*

24 *“(d) 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 cal-*
 6 *endar year and who employs at least 1 employee on*
 7 *the first day of the plan year.*

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

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

13 *(i) in subsection (a)—*

14 *(I) in paragraph (6), by striking*
 15 *“or (9)” and inserting “(9), or (13)”;*

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

18 *(III) in paragraph (11), at the*
 19 *end by striking the period and insert-*
 20 *ing “; or”;* and

21 *(IV) by adding at the end the fol-*
 22 *lowing new paragraph:*

23 *“(12) by the Secretary, to enforce section 726.”;*

1 (ii) in subsection (b)(3), by inserting
 2 “and subsections (a)(12) and (c)(13)” before
 3 “, the Secretary is not”; and
 4 (iii) in subsection (c), by adding at the
 5 end the following new paragraph:

6 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
 7 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
 8 MANAGER SERVICES.—

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

18 “(B) FALSE INFORMATION.—The Secretary
 19 may impose a penalty against a health insur-
 20 ance issuer or entity providing pharmacy bene-
 21 fits management services that knowingly pro-
 22 vides false information under section 726 in an
 23 amount not to exceed \$100,000 for each item of
 24 false information. Such penalty shall be in addi-

1 tion to other penalties as may be prescribed by
2 law.

3 “(C) **WAIVERS.**—*The Secretary may waive*
4 *penalties under subparagraph (A), or extend the*
5 *period of time for compliance with a requirement*
6 *of section 726, for an entity in violation of such*
7 *section that has made a good-faith effort to com-*
8 *ply with such section.”.*

9 (2) **CLERICAL AMENDMENT.**—*The table of con-*
10 *tents in section 1 of the Employee Retirement Income*
11 *Security Act of 1974 (29 U.S.C. 1001 et seq.) is*
12 *amended by inserting after the item relating to sec-*
13 *tion 725 the following new item:*

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

14 (b) **PHSA.**—*Part D of title XXVII of the Public*
15 *Health Service Act (42 U.S.C. 300gg–111 et seq.) is amend-*
16 *ed by adding at the end the following new section:*

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

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

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

9 “(b) *REPORTS.*—

10 “(1) *IN GENERAL.*—For plan years beginning on
 11 *or after January 1, 2025, not less frequently than*
 12 *quarterly (and upon request by the plan adminis-*
 13 *trator), a group health plan or health insurance*
 14 *issuer offering group health insurance coverage, or an*
 15 *entity providing pharmacy benefits management serv-*
 16 *ices on behalf of a group health plan or an issuer pro-*
 17 *viding group health insurance coverage, shall submit*
 18 *to the plan administrator (as defined in section*
 19 *3(16)(A) of the Employee Retirement Income Security*
 20 *Act of 1974) of such plan or coverage a report in ac-*
 21 *cordance with this subsection, and make such report*
 22 *available to the plan administrator in a machine-*
 23 *readable format (or as may be determined by the Sec-*
 24 *retary, other formats). Each such report shall include,*

1 *with respect to the applicable group health plan or*
2 *health insurance coverage—*

3 “(A) *information collected from a patient or*
4 *copay assistance program administrator by such*
5 *entity on the total amount of copayment assist-*
6 *ance dollars paid, or copayment cards applied,*
7 *or other discounts that were funded by the drug*
8 *manufacturer with respect to the participants*
9 *and beneficiaries in such plan or coverage;*

10 “(B) *total gross spending on prescription*
11 *drugs by the plan or coverage during the report-*
12 *ing period;*

13 “(C) *total amount received, or expected to*
14 *be received, by the plan or coverage from any en-*
15 *tities, in rebates, fees, alternative discounts, and*
16 *all other remuneration received from the entity*
17 *or any third party (including group purchasing*
18 *organizations) other than the plan adminis-*
19 *trator, related to utilization of drug or drug*
20 *spending under such plan or coverage during the*
21 *reporting period;*

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

1 “(E) amounts paid, directly or indirectly,
2 in rebates, fees, or any other type of compensa-
3 tion (as defined in section
4 408(b)(2)(B)(ii)(dd)(AA) of the *Employee Retire-*
5 *ment Income Security Act of 1974*) to brokerage
6 houses, brokers, consultants, advisors, or any
7 other individual or firm for the referral of the
8 group health plan’s or health insurance issuer’s
9 business to the pharmacy benefits manager, iden-
10 tified by the recipient of such amounts;

11 “(F)(i) an explanation of any benefit design
12 parameters that encourage or require partici-
13 pants and beneficiaries in the plan or coverage
14 to fill prescriptions at mail order, specialty, or
15 retail pharmacies that are affiliated with or
16 under common ownership with the entity pro-
17 viding pharmacy benefit management services
18 under such plan or coverage, including manda-
19 tory mail and specialty home delivery programs,
20 retail and mail auto-refill programs, and cost-
21 sharing assistance incentives funded by an entity
22 providing pharmacy benefit management serv-
23 ices;

24 “(ii) the percentage of total prescrip-
25 tions charged to the plan, issuer, or partici-

1 *pants and beneficiaries in such plan or cov-*
2 *erage, that were dispensed by mail order,*
3 *specialty, or retail pharmacies that are af-*
4 *filiated with or under common ownership*
5 *with the entity providing pharmacy benefit*
6 *management services; and*

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

13 *“(I)(aa) the amount charged, per*
14 *dosage unit, per 30-day supply, and*
15 *per 90-day supply, with respect to par-*
16 *ticipants and beneficiaries in the plan*
17 *or coverage, to the plan or issuer; and*

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

22 *“(II) the median amount charged*
23 *to the plan or issuer, per dosage unit,*
24 *per 30-day supply, and per 90-day*
25 *supply, including amounts paid by the*

1 *participants and beneficiaries, when*
2 *the same drug is dispensed by other*
3 *pharmacies that are not affiliated with*
4 *or under common ownership with the*
5 *entity and that are included in the*
6 *pharmacy network of such plan or cov-*
7 *erage;*

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

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

1 “(V) *the net acquisition cost per*
2 *dosage unit, per 30-day supply, and*
3 *per 90-day supply, if the drug is sub-*
4 *ject to a maximum price discount; and*

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

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

18 “(i) *a list of each drug covered by such*
19 *plan, issuer, or entity providing pharmacy*
20 *benefits management services for which a*
21 *claim was filed during the reporting period,*
22 *including, with respect to each such drug*
23 *during the reporting period—*

1 “(I) the brand name, generic or
2 non-proprietary name, and the Na-
3 tional Drug Code;

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

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

19 “(III) the wholesale acquisition
20 cost, listed as cost per days supply and
21 cost per dosage unit on date of dis-
22 pensing;

23 “(IV) the total out-of-pocket
24 spending by participants and bene-
25 ficiaries on such drug after application

1 *of any benefits under such plan or cov-*
2 *erage, including participant and bene-*
3 *ficiary spending through copayments,*
4 *coinsurance, and deductibles (but not*
5 *including any amounts spent by par-*
6 *ticipants and beneficiaries on drugs*
7 *not covered under such plan or cov-*
8 *erage, or for which no claim was sub-*
9 *mitted to such plan or coverage);*

10 *“(V) for any drug for which gross*
11 *spending of the plan or coverage ex-*
12 *ceeded \$10,000 during the reporting*
13 *period—*

14 *“(aa) a list of all other drugs*
15 *in the same therapeutic category*
16 *or class, including brand name*
17 *drugs, biological products, generic*
18 *drugs, or biosimilar biological*
19 *products that are in the same*
20 *therapeutic category or class as*
21 *such drug; and*

22 *“(bb) the rationale for pre-*
23 *ferred formulary placement of*
24 *such drug in that therapeutic cat-*
25 *egory or class, if applicable; and*

1 “(ii) a list of each therapeutic category
2 or class of drugs for which a claim was filed
3 under the health plan or health insurance
4 coverage during the reporting period, and,
5 with respect to each such therapeutic cat-
6 egory or class of drugs during the reporting
7 period—

8 “(I) total gross spending by the
9 plan;

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

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

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

1 “(V) for each drug—

2 “(aa) the amount received, or
3 expected to be received, from any
4 entity in rebates, fees, alternative
5 discounts, or other remunera-
6 tion—

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

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

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

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

1 beneficiaries, among all drugs
2 within the therapeutic class for
3 which a claim was filed during
4 the reporting period.

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

16 “(3) *DISCLOSURE AND REDISCLOSURE.*—

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

23 “(B) *CLARIFICATION REGARDING PUBLIC*
24 *DISCLOSURE OF INFORMATION.*—Nothing in this
25 section prevents a health insurance issuer offer-

1 *ing group health insurance coverage or an entity*
2 *providing pharmacy benefits management serv-*
3 *ices on behalf of a group health plan from plac-*
4 *ing reasonable restrictions on the public disclo-*
5 *sure of the information contained in a report de-*
6 *scribed in paragraph (1), except that such issuer*
7 *or entity may not restrict disclosure of such re-*
8 *port to the Department of Health and Human*
9 *Services, the Department of Labor, the Depart-*
10 *ment of the Treasury, the Comptroller General of*
11 *the United States, or applicable State agencies.*

12 “(C) *LIMITED FORM OF REPORT.*—*The Sec-*
13 *retary shall define through rulemaking a limited*
14 *form of the report under paragraph (1) required*
15 *of plan administrators who are drug manufac-*
16 *turers, drug wholesalers, or other direct partici-*
17 *pants in the drug supply chain, in order to pre-*
18 *vent anti-competitive behavior.*

19 “(4) *REPORT TO GAO.*—*A health insurance*
20 *issuer offering group health insurance coverage or an*
21 *entity providing pharmacy benefits management serv-*
22 *ices on behalf of a group health plan shall submit to*
23 *the Comptroller General of the United States each of*
24 *the first 4 reports submitted to a plan administrator*
25 *under paragraph (1) with respect to such coverage or*

1 *plan, and other such reports as requested, in accord-*
2 *ance with the privacy requirements under paragraph*
3 *(2), the disclosure and redisclosure standards under*
4 *paragraph (3), the standards specified pursuant to*
5 *paragraph (5).*

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

12 “(c) *ENFORCEMENT.*—

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

21 “(2) *FALSE INFORMATION.*—*An entity providing*
22 *pharmacy benefits management services that know-*
23 *ingly provides false information under this section*
24 *shall be subject to a civil money penalty in an*
25 *amount not to exceed \$100,000 for each item of false*

1 *information. Such civil money penalty shall be in ad-*
 2 *dition to other penalties as may be prescribed by law.*

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

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

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 subsection*
 21 *(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 cal-*
 3 *endar year and who employs at least 1 employee on*
 4 *the first day of the plan year.*

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

9 *(c) IRC.—*

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

13 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
 14 **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 con-*
 19 *tract with a drug manufacturer, distributor, wholesaler,*
 20 *switch, patient or copay assistance program administrator,*
 21 *pharmacy, subcontractor, rebate aggregator, or any associ-*
 22 *ated third party that limits or delays the disclosure of infor-*
 23 *mation to plan administrators in such a manner that pre-*
 24 *vents the plan, or an entity or subsidiary providing phar-*
 25 *macy benefits management services on behalf of a plan,*

1 *from making or substantiating the reports described in sub-*
2 *section (b).*

3 “(b) *REPORTS.*—

4 “(1) *IN GENERAL.*—For plan years beginning on
5 *or after January 1, 2025, not less frequently than*
6 *quarterly (and upon request by the plan adminis-*
7 *trator), 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 subsection,*
13 *and make such report available to the plan adminis-*
14 *trator in a machine-readable format (or as may be*
15 *determined by the Secretary, other formats). Each*
16 *such report shall include, with respect to the applica-*
17 *ble group health plan—*

18 “(A) *information collected from a patient or*
19 *copay assistance program administrator by such*
20 *entity on the total amount of copayment assist-*
21 *ance dollars paid, or copayment cards applied,*
22 *or other discounts that were funded by the drug*
23 *manufacturer with respect to the participants*
24 *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 Retire-*
17 *ment Income Security Act of 1974*) to brokerage
18 houses, brokers, consultants, advisors, or any
19 other individual or firm for the referral of the
20 group health plan’s business to the pharmacy
21 benefits manager, identified by the recipient of
22 such amounts;

23 “(F)(i) an explanation of any benefit design
24 parameters that encourage or require partici-
25 pants and beneficiaries in the plan to fill pre-

1 *scriptions 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 assistance*
8 *incentives funded by an entity providing phar-*
9 *macy 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 par-*
2 *ticipants and beneficiaries in the plan,*
3 *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,*
11 *including amounts paid by the partici-*
12 *pants and beneficiaries, when the same*
13 *drug is dispensed by other pharmacies*
14 *that are not affiliated with or under*
15 *common ownership with the entity and*
16 *that are included in the pharmacy net-*
17 *work 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 net-*
2 *work 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 such*
25 *plan; and*

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

2 “(i) a list of each drug covered by such
3 plan or entity providing pharmacy benefits
4 management services for which a claim was
5 filed during the reporting period, including,
6 with respect to each such drug during the
7 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 dosage
18 units and total days supply of such
19 drug for which a claim was filed dur-
20 ing 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 and
3 cost per dosage unit on date of dis-
4 pensing;

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

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

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

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

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

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

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

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

19 “(III) *if applicable to that cat-*
20 *egory or class, a description of the for-*
21 *mulary tiers and utilization mecha-*
22 *nisms (such as prior authorization or*
23 *step therapy) employed for drugs in*
24 *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, or
9 expected to be received, from any
10 entity in rebates, fees, alternative
11 discounts, or other remunera-
12 tion—

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 con-
21 cessions, alternative discounts or
22 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 be-
11 half of a group health plan shall provide information
12 under paragraph (1) in a manner consistent with the
13 privacy, security, and breach notification regulations
14 promulgated under section 264(c) of the Health Insur-
15 ance Portability and Accountability Act of 1996, and
16 shall restrict the use and disclosure of such informa-
17 tion according to such privacy regulations.

18 “(3) *DISCLOSURE AND REDISCLOSURE.*—

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

1 “(B) *CLARIFICATION REGARDING PUBLIC*
2 *DISCLOSURE OF INFORMATION.*—*Nothing in this*
3 *section prevents an entity providing pharmacy*
4 *benefits management services on behalf of a*
5 *group health plan from placing reasonable re-*
6 *strictions on the public disclosure of the informa-*
7 *tion 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 Department*
10 *of Health and Human Services, the Department*
11 *of Labor, the Department of the Treasury, the*
12 *Comptroller General of the United States, or ap-*
13 *plicable State agencies.*

14 “(C) *LIMITED FORM OF REPORT.*—*The Sec-*
15 *retary shall define through rulemaking a limited*
16 *form of the report under paragraph (1) required*
17 *of plan administrators who are drug manufac-*
18 *turers, drug wholesalers, or other direct partici-*
19 *pants in the drug supply chain, in order to pre-*
20 *vent 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 reports*
25 *submitted to a plan administrator under paragraph*

1 (1) *with respect to such plan, and other such reports*
 2 *as requested, in accordance with the privacy require-*
 3 *ments under paragraph (2), the disclosure and re-*
 4 *disclosure standards under paragraph (3), the stand-*
 5 *ards specified pursuant to paragraph (5).*

6 “(5) *STANDARD FORMAT.—Not later than 6*
 7 *months after the date of enactment of this section, the*
 8 *Secretary shall specify through rulemaking standards*
 9 *for entities required to submit reports under para-*
 10 *graph (4) to submit such reports in a standard for-*
 11 *mat.*

12 “(c) *ENFORCEMENT.—*

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

21 “(2) *FALSE INFORMATION.—An entity providing*
 22 *pharmacy benefits management services that know-*
 23 *ingly provides false information under this section*
 24 *shall be subject to a civil money penalty in an*
 25 *amount not to exceed \$100,000 for each item of false*

1 *information. Such civil money penalty shall be in ad-*
 2 *dition to other penalties as may be prescribed by law.*

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

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

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

21 “(e) *DEFINITIONS.—In this section:*

22 “(1) *LARGE EMPLOYER.—The term ‘large em-*
 23 *ployer’ means, in connection with a group health*
 24 *plan with respect to a calendar year and a plan year,*
 25 *an employer who employed an average of at least 50*

1 *employees on business days during the preceding cal-*
 2 *endar year and who employs at least 1 employee on*
 3 *the first day of the plan year.*

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

8 (2) *CLERICAL AMENDMENT.*—*The table of sec-*
 9 *tions for subchapter B of chapter 100 of the Internal*
 10 *Revenue Code of 1986 is amended by adding at the*
 11 *end the following new item:*

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

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

13 (a) *IN GENERAL.*—*Subpart B of part 7 of subtitle B*
 14 *of title I of the Employee Retirement Income Security Act*
 15 *of 1974 (29 U.S.C. 1185 et seq.), as amended by section*
 16 *3, is further amended by adding at the end the following*
 17 *new section:*

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

19 “(a) *IN GENERAL.*—*A group health plan or a health*
 20 *insurance issuer offering group health insurance coverage*
 21 *shall—*

22 “(1) *not restrict, directly or indirectly, any*
 23 *pharmacy that dispenses a prescription drug to a*
 24 *participant of beneficiary in the plan or coverage*
 25 *from informing (or penalize such pharmacy for in-*

1 *forming) a participant or beneficiary of any differen-*
2 *tial between the participant's or beneficiary's out-of-*
3 *pocket cost under the plan or coverage with respect to*
4 *acquisition of the drug and the amount an individual*
5 *would pay for acquisition of the drug without using*
6 *any health plan or health insurance coverage; and*

7 *“(2) ensure that any entity that provides phar-*
8 *macy benefits management services under a contract*
9 *with any such health plan or health insurance cov-*
10 *erage does not, with respect to such plan or coverage,*
11 *restrict, directly or indirectly, a pharmacy that dis-*
12 *penses a prescription drug from informing (or penal-*
13 *ize such pharmacy for informing) a participant or*
14 *beneficiary of any differential between the partici-*
15 *pant's or beneficiary's out-of-pocket cost under the*
16 *plan or coverage with respect to acquisition of the*
17 *drug and the amount an individual would pay for*
18 *acquisition of the drug without using any health plan*
19 *or health insurance coverage.*

20 *“(b) DEFINITION.—For purposes of this section, the*
21 *term ‘out-of-pocket cost’, with respect to acquisition of a*
22 *drug, means the amount to be paid by the participant or*
23 *beneficiary under the plan or coverage, including any cost-*
24 *sharing (including any deductible, copayment, or coinsur-*

1 *ance) and, as determined by the Secretary, any other ex-*
 2 *penditure.”.*

3 *(b) CLERICAL AMENDMENT.—The table of contents in*
 4 *section 1 of the Employee Retirement Income Security Act*
 5 *of 1974 (29 U.S.C. 1001 et seq.), as amended by section*
 6 *3, is further amended by inserting after the item relating*
 7 *to section 726 the following new item:*

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

8 **SEC. 5. ADVISORY COMMITTEE ON THE ACCESSIBILITY OF**
 9 **CERTAIN INFORMATION.**

10 *(a) IN GENERAL.—Not later than January 1, 2025,*
 11 *the Secretary of Labor (in this section referred to as the*
 12 *“Secretary”) shall convene an Advisory Committee (in this*
 13 *section referred to as the “Committee”) consisting of 9 mem-*
 14 *bers to advise the Secretary on how to improve the accessi-*
 15 *bility and usability of information made available in ac-*
 16 *cordance the amendments made by section 3 and by section*
 17 *204 of division BB of the Consolidated Appropriation Act,*
 18 *2021 (Public Law 116–260), streamline the reporting of*
 19 *such information, and ensure that such information fully*
 20 *meets the needs of employers, patients, researchers, regu-*
 21 *lators, and purchasers.*

22 *(b) MEMBERSHIP.—The Secretary shall appoint mem-*
 23 *bers representing end-users of the information described in*
 24 *subsection (a). Vacancies on the Committee shall be filled*

1 *by appointment consistent with this subsection not later*
2 *than 3 months after the vacancy arises.*

3 (c) *TERMINATION.—The Committee established under*
4 *this section shall terminate on January 1, 2028.*

Union Calendar No. 767

118TH CONGRESS
2D Session

H. R. 4507

[Report No. 118-742, Part I]

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.

DECEMBER 19, 2024

Committees on Energy and Commerce and Ways and Means discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed