118TH CONGRESS
*1st Session*
HOUSE OF REPRESENTATIVES
REPORT
118–259

# HIDDEN FEE DISCLOSURE ACT OF 2023

NOVEMBER 1, 2023.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Ms. FOXX, from the Committee on Education and the Workforce, submitted the following

# R E P O R T

[To accompany H.R. 4508]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 4508) to amend the Employee Retirement Income Security Act of 1974 to clarify and strengthen the application of certain employer-sponsored health plan disclosure requirements, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Hidden Fee Disclosure Act of 2023".

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

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

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

(2) in subitem (BB)—

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

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

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

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

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

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

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

(B) by adding at the end the following: "For purposes of applying section 406(a)(1)(C) with respect to a transaction described under this subpara-

graph, a contract or arrangement for services between a covered plan and a health insurance issuer providing health insurance coverage in connection with the covered plan in which the health insurance issuer contracts, in connection with such plan, with a service provider for pharmacy benefit management services shall be considered to constitute an indirect furnishing of goods, services, or facilities between the plan and the service provider acting as the party in interest.".

(2) HEALTH INSURANCE ISSUER AND HEALTH INSURANCE COVERAGE DEFINED.—Clause (ii)(I)(aa) of section 408(b)(2)(B) of the Employee Retirement Income Security Act of 1974 ((29 U.S.C. 1108(b)(2)(B)) is amended by inserting before the period at the end "and the terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms in section 733(b)".

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

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

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

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

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

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

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

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

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

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

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

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

(2) ANNUAL DISCLOSURE.—

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

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

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

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

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

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

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

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

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

"(BB) individual explanations for such clawbacks.

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

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

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

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

"(AA) the processing and payment of claims;

"(BB) design of pharmacy networks;

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

"(DD) formulary design and maintenance;

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

"(FF) utilization review;

"(GG) adjudication of claims; and

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

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

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

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

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

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

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

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

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

"(AA) overpayments;

"(BB) erroneous payments;

"(CC) uncashed checks or incomplete payments;

"(DD) billing errors;

"(EE) subrogation;

"(FF) fraud; or

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

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

"(IV) A covered service provider, with respect to a contract or arrangement with the covered plan in connection with providing third party administration

services for group health plans, shall disclose, on an annual basis not later than 60 days after the beginning of the current plan year, to a responsible plan fiduciary, in writing, the following with respect to the twelve months preceding the current plan year:

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

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

"(cc) The aggregate amount for which the covered service provider received indirect compensation and the estimated amount of cost-sharing incurred by plan participants and beneficiaries as a result.

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

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

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

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

(3) THIRD PARTY ADMINISTRATION SERVICES FOR GROUP HEALTH PLANS DEFINED.—Clause (ii)(I) of section 408(b)(2)(B) of such Act (29 U.S.C. 1108(b)(2)(B)), as amended by paragraphs (3) and (4) of subsection (b), is amended by adding at the end the following:

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

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

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

"(CC) negotiation of discounts off gross rates;

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

"(EE) recordkeeping;

"(FF) utilization review;

"(GG) adjudication of claims;

"(HH) regulatory compliance; and

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

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

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

**SEC. 4. IMPLEMENTATION.**

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

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

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

## PURPOSE

H.R. 4508, the *Hidden Fee Disclosure Act*, amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] to clarify and strengthen the application of certain employer-sponsored health plan disclosure requirements. The bill clarifies the services under current law for which covered service providers must disclose direct and indirect compensation. The bill also requires pharmacy benefit

[1]1A 29 U.S.C. § 1001 *et seq*.

managers (PBMs) and third-party administrators (TPAs) to provide specific reports to responsible plan fiduciaries on direct and indirect compensation. This legislation will give plan fiduciaries the tools needed to avoid excessive fees and conflicts of interest that raise costs for employers, workers, and their families.

## COMMITTEE ACTION

### 116TH CONGRESS

*Subcommittee Hearing on Making Health Care More Affordable: Lowering Drug Prices and Increasing Transparency*

On September 26, 2019, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled "Making Health Care More Affordable: Lowering Drug Prices and Increasing Transparency," which examined the impact of rising prescription drug prices on workers and businesses and the need for greater transparency in health care. The witnesses were Mr. Frederick Isasi, Executive Director, Families USA, Washington, D.C.; Mr. David Mitchell, Founder, Patients for Affordable Drugs, Washington, D.C.; Ms. Bari Talente, Executive Vice President, National Multiple Sclerosis Society, Washington, D.C.; Dr. Mariana Socal, Assistant Scientist, Johns Hopkins University Bloomberg School of Public Health, Department of Health Policy and Management, Baltimore, Maryland; Mr. Christopher Holt, Director of Health Care Policy, American Action Forum, Washington, D.C.; and Dr. Craig Garthwaite, Associate Professor of Strategy, Northwestern University Kellogg School of Management, Evanston, Illinois.

*Full Committee Markup of H.R. 5800, the Ban Surprise Billing Act*

On February 11, 2020, the Committee met to mark up H.R. 5800, the *Ban Surprise Billing Act*. The legislation included provisions to amend ERISA to require covered service providers to disclose direct or indirect compensation to responsible plan fiduciaries. The Committee favorably reported the bill, as amended, by a vote of 32 yeas and 13 nays.

### 117TH CONGRESS

*Subcommittee Hearing on Lower Drug Costs Now: Expanding Access to Affordable Health Care*

On May 5, 2021, the HELP Subcommittee held a hearing entitled "Lower Drug Costs Now: Expanding Access to Affordable Health Care," which examined the causes of rising health care costs. The witnesses were Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.; Mr. Frederick Isasi, Executive Director, Families USA, Washington, D.C.; Mr. David Mitchell, Founder, Patients for Affordable Drugs, Washington, D.C.; and Dr. Mariana Socal, Assistant Scientist, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland. The hearing included discussion regarding how the lack of PBM transparency contributes to higher costs for plans and consumers.

*Subcommittee Hearing on Reducing Health Care Costs for Working Americans and Their Families*

On April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families," which examined lowering health care costs, including through expanding oversight of PBMs. Witnesses were Mr. Joel White, President, Council for Affordable Health Coverage (CAHC), Washington, D.C.; Mrs. Tracy Watts, Senior Partner, Mercer, Washington, D.C.; Ms. Marcie Strouse, Partner, Capitol Benefits Group, Des Moines, Iowa; and Ms. Sabrina Corlette, J.D., Research Professor and Co-Director, Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy, Washington, D.C.

*Subcommittee Hearing on Competition and Transparency: The Pathway Forward for a Stronger Health Care Market*

On June 21, 2023, the HELP Subcommittee held a hearing entitled "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market," which examined the role of PBMs and the need for transparency. The witnesses were Dr. Gloria Sachdev, President and CEO, Employers' Forum of Indiana, Carmel, Indiana; Ms. Sophia Tripoli, Senior Director of Health Policy and Director of the Center for Affordable Whole-Person Care, Families USA, Washington, D.C.; Mr. Greg Baker, CEO, AffirmedRx, Louisville, Kentucky; Ms. Christine Monahan, Assistant Research Professor, Center on Health Insurance Reforms, Georgetown University McCourt School of Public Policy, Washington, D.C.; and Mr. Juan Carlos "JC" Scott, President and CEO, Pharmaceutical Care Management Association, Washington, D.C. The hearing included extensive discussion on the role of PBMs and the impacts of transparency, or lack thereof. Witnesses testified to the impacts of hospital consolidation and acquisition of outpatient departments on raising health care costs for employers and the need to combat unwarranted hospital facility fees applied to outpatient services, including requiring that each separate hospital outpatient facility obtain and use a unique national provider identifier (NPI). Members and witnesses further discussed the need to codify the Transparency in Coverage rule, prohibit gag clauses in contracts between PBMs and TPAs, and require PBMs and TPAs to disclose their compensation.

*Full Committee Markup of H.R. 4508, the Hidden Fee Disclosure Act,*

On July 10, 2023, Rep. Joe Courtney (D–CT–2) introduced H.R. 4508, the *Hidden Fee Disclosure Act*, with Rep. Erin Houchin (R–IN–9) as an original cosponsor. The bill clarifies the application of existing ERISA group health plan disclosure requirements to covered service providers providing services specified in current law and further improves specific disclosure requirements for PBMs and TPAs, particularly with respect to indirect compensation. On July 12, 2023, the Committee met to mark up H.R. 4508 and adopted an Amendment in the Nature of a Substitute offered by Rep. Courtney that made technical corrections to H.R. 4508. The Com-

mittee reported the bill favorably, as amended, to the House of Representatives by a vote of 39 yeas and 1 nay.

## COMMITTEE VIEWS

### PHARMACY BENEFIT MANAGERS

PBMs serve as intermediaries between pharmaceutical manufacturers and health insurers, Medicare Part D drug plans, employers, and other payers. PBMs create formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks, and review drug utilization. Although the Congressional Budget Office (CBO) found that PBMs' ability to negotiate larger rebates from manufacturers may have lowered program costs and copays for plan enrollees in Medicare Part D and Medicaid,[2] in light of rising health care costs, PBMs have faced growing scrutiny of their role in prescription drug costs and spending.

By negotiating with drug manufacturers and pharmacies to control drug costs, PBMs have a significant behind-the-scenes impact in determining total drug costs for payers, shaping patients' access to medications, and determining how much pharmacies are paid. PBMs primarily earn profits through administrative fees charged for their services, spread pricing, and shared savings, where the PBM keeps part of the rebates or discounts negotiated with drug manufacturers. There has been increasing concern that the current structure creates a perverse incentive as higher drug list prices often translate into higher compensation for PBMs, who often earn a percentage of reductions negotiated off of the list prices.[3]

PBM reimbursement methods can be complex and unclear. Two practices of particular concern are rebate pricing models and spread pricing. One study found a direct correlation between rebate increases and manufacturer price increases: a $1 increase in rebates corresponds with a $1.17 increase in drug list price, suggesting that rebates play a role in increasing list prices.[4] PBMs may retain manufacturer rebates as profits rather than passing them through to their health plan clients. When health plans lack full transparency and cannot see how much manufacturers paid in rebates, they do not know how much their PBM retained as profits. Spread pricing occurs when PBMs charge health plans and payers more for a prescription drug than what they reimburse to the pharmacy and then they keep the difference. Because neither the plan nor the pharmacy knows what the other side was paid or charged, the practice hides the PBM's margins.

### THIRD PARTY ADMINISTRATORS

A self-funded group health plan may contract with an entity, known as a third-party administrator (TPA), for the purpose of providing a number of services to the plan. Among these services include claims processing, recordkeeping, communicating with participants and beneficiaries, and ensuring compliance with reporting

[2] https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.
[3] *Id.*
[4] https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/.

requirements under ERISA and other laws.[5] Although often an insurance company, a TPA does not itself act as an insurer with respect to the plan; instead, the plan sponsor bears the financial responsibility of paying claims incurred under the plan. The lack of transparency with respect to the compensation of TPAs has raised concerns that their practices might not be in the best interests of plan sponsors or participants and beneficiaries.[6] These concerns have prompted bipartisan reforms such as the recent ban on "gag clauses" that restrict plan fiduciaries from accessing plan data held by TPAs and other service providers.[7]

ERISA FEE DISCLOSURE REQUIREMENTS

Under ERISA, an employee benefit plan may enter into reasonable contracts or arrangements for the provision of certain services "necessary for the establishment or operation of the plan. . . . if no more than reasonable compensation is paid therefor."[8] This allows a plan to contract with entities such as PBMs, TPAs, brokerage firms, benefits consultants, and others, while ensuring that plan fiduciaries continuously monitor the reasonableness of such arrangements and the compensation received by service providers.[9] However, without clear disclosures to plan fiduciaries of the services provided and the compensation earned, either directly or indirectly, it is essentially impossible to monitor service providers and ensure they are acting in the best interest of the plan. A lack of meaningful oversight could lead to higher costs for plans and, with respect to indirect compensation, creates the risk that service providers may have conflicts of interest.[10]

Although no final regulatory action has been taken, there have been several efforts to improve the disclosure of fees with respect to ERISA-covered group health plans. In 2007, the U.S. Department of Labor (the Department) proposed regulations that would have required disclosure of compensation earned by service providers that contract with employee benefit plans, including group health plans.[11] This would have provided plan fiduciaries with important information from a broad range of service providers, which would have greatly facilitated the ability of fiduciaries to monitor the reasonableness of their contracts.[12] This proposal was never finalized with respect to group health plans. Similarly, in 2014, the Advisory Council on Employee Welfare and Pension Benefit Plans recommended the Department consider issuing fee disclosure regulations regarding contracts and arrangements between group health plans and PBMs, which would have specifically included rebates received by PBMs as indirect compensation.[13] To date, the Department has not issued a proposed rule on this topic.

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[5] https://content.next.westlaw.com/practical-law/document/I8b78d20587b211e9adfea82903531a62/Third-Party-Administrator- TPA.

[6] https://chirblog.org/questionable-conduct-allegations-insurers-acting-third-party-administrators/.

[7] 29 U.S.C. § 1185m.

[8] 29 U.S.C. § 1108(b)(2).

[9] 29 U.S.C. § 1104(a)(1).

[10] https://www.propublica.org/article/health-insurance-brokers-cost-commissions-bonuses.

[11] https://www.federalregister.gov/documents/2007/12/13/E7-24064/reasonable-contract-or-arrangement-under-section-408b2-fee-disclosure.

[12] *Id.*

[13] https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/about-us/erisa-advisory-council/2014ACreport1.pdf.

DIRECT AND INDIRECT COMPENSATION DISCLOSURE REQUIREMENTS

The *No Surprises Act*, enacted as part of the *Consolidated Appropriations Act, 2021* (CAA),[14] protected patients from surprise medical bills for emergency and out-of-network services and created a process by which providers and plans could reconcile billing disputes. In addition, the CAA sought to limit growth in health care spending through increased transparency. Importantly, Section 202 of Title II of Division BB of the CAA requires entities providing brokerage and consulting services to disclose direct or indirect compensation to group health plan fiduciaries (a similar provision extended broker disclosure requirements to individual market consumers). This provision amended section 408(b)(2) of ERISA to provide that any "covered service provider" that enters into a contract or arrangement with a group health plan must disclose to a responsible plan fiduciary a description of the direct and indirect compensation they expect to receive in connection with the services they provide to the plan.[15] This disclosure requirement applies to the provision of brokerage services and broadly to entities providing consulting, including the "development or implementation of" pharmacy benefit management services and third-party administration services. Although the text of this statute clearly encompasses the activities of TPAs and PBMs, many service providers have failed to comply with the law and may not be providing the required disclosures to plan fiduciaries.

While the Department's Employee Benefits Security Administration (EBSA) has previously issued guidance that service providers may assess the applicability of these requirements consistent with similar regulations applicable to retirement plans (which explicitly apply to TPAs),[16] additional action is needed to clarify the scope of entities subject to the requirements under the law. Because higher-cost drugs often offer higher rebates and, in turn, contribute to rising prescription drug spending, detailed disclosures of these and other compensation practices will assist plan fiduciaries in assessing their contracts with service providers. In December 2022, then-Chairman Scott (D–VA–3) and then-Ranking Member Foxx (R–NC–5) of the Committee on Education and Labor sent a bipartisan letter urging EBSA to issue additional, clarifying guidance, but the agency has to date taken no action.[17]

H.R. 4508, THE HIDDEN FEE DISCLOSURE ACT

H.R. 4508 will help ensure that plan sponsors and plan fiduciaries have the information they need to make informed choices on behalf of plan participants. By receiving information on the nature and amount of compensation that PBMs and TPAs receive, plan fiduciaries can better evaluate the reasonableness of their compensation and whether PBMs and TPAs are acting in the best interest of the plan. Plans can measure whether savings are being appropriately passed through and can confirm that PBMs and TPAs are not unduly benefitting from rebate decisions at the expense of the

[14] Pub. L. No. 116–260 (2020).
[15] ERISA § 408(b)(2), 29 U.S.C. § 1108.
[16] https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2021-03.
[17] https://democrats-edworkforce.house.gov/imo/media/doc/bipartisan_scott-foxx_letter_to_ebsa_re_health_transparency.pdf.

plan. H.R. 4508 will improve accountability and competition among PBMs and TPAs and empower plans to make better decisions on behalf of employees, leading to lower spending.

## H.R. 4508 SECTION-BY-SECTION SUMMARY

*Section 1. Short title*

Section 1 provides that the short title is "*Hidden Fee Disclosure Act*."

*Section 2. Clarification of the application of fee disclosure requirements to covered service providers*

Section 2(a) amends ERISA to clarify that compensation disclosure requirements apply to all services specified in current law.

Section 2(b) amends ERISA to provide that direct compensation must be described by service, rather than in the aggregate.

*Section 3. Strengthening disclosure requirements for PBMs and TPAs*

Section 3(a) amends ERISA to provide that PBM services provided to a health insurance issuer on behalf of a group health plan shall be considered an indirect furnishing of goods, services, or facilities, thereby ensuring disclosures are provided to responsible plan fiduciaries of fully insured plans.

PBM Disclosure Requirements. Section 3(b)(1) requires that PBMs report to responsible plan fiduciaries (as part of disclosure requirements under current law) the following information:

- All compensation, including fees, rebates, discounts, or price concessions, co-payment offsets, and other remuneration;
- The amount and form of rebates, discounts, or price concessions that are passed through to the plan sponsor or participants and beneficiaries;
- The amount of compensation received as a result of the PBM paying less for a drug than the amount charged to the participant or beneficiary;
- The amount of compensation received from paying pharmacies less than what was charged to the plan or participant or beneficiary; and
- The amount of compensation expected to be received from drug manufacturers, including compensation gained in exchange for administering the plan, for providing business services and drug utilization data, and for gaining compensation through high rebates or a percentage of the list price.

The PBM must report this information when it enters a contract with the plan, and it is required to disclose any changes as soon as practicable but no later than within 60 days.

PBM Annual Reporting. Section 3(b)(2) requires that PBMs annually report to responsible plan fiduciaries the following information:

- All direct and indirect compensation;
- For each drug covered under the plan, the amount by which the price for the drug paid by the plan exceeds the amount paid to the pharmacy;
- The total gross spending by the plan on drugs (excluding rebates, discounts, or other price concessions);

- The total net spending by the plan on drugs;
- The total gross spending at all PBM-owned pharmacies, with a breakdown by individual pharmacy location;
- The aggregate amount of clawback from pharmacies, including an explanation for the clawback;
- The total aggregate amount of fees collected; and
- Any other information specified by the Secretary of Labor.

TPA Disclosure Requirements. Section 3(c)(1) requires that TPAs report to responsible plan fiduciaries (as part of disclosure requirements under current law) the following information:

- The amount of, and a description of, any rebates, discounts, savings fees, refunds, and amounts received from providers and facilities;
- The amount of, and a description of, fees received from other service providers; and
- The amount of, and a description of, compensation recovered by the TPA from overpayments, erroneous payments, uncashed checks, incomplete payments, billing errors, subrogation, or fraud.

The TPA must report this information when it enters a contract with the plan, and it is required to disclose any changes as soon as practicable but no later than within 60 days.

TPA Annual Reporting. Section 3(c)(2) requires that TPAs report to responsible plan fiduciaries annually the following information:

- All direct and indirect compensation;
- The aggregate amount for which the TPA received indirect compensation and the estimated amount of cost-sharing incurred by beneficiaries as a result;
- The total gross spending by the plan on all cost and fees;
- The total net spending by the plan on all cost and fees;
- The aggregate fees collected by the TPA; and
- Any other information specified by the Secretary of Labor.

The amendments made by Section 3 take effect on January 1, 2025.

*Section 4. Implementation*

Section 4 requires the Secretary of Labor to conduct notice and comment rulemaking within one year of enactment of the Act.

## EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

## APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)3 of Public Law 104–1 requires a description of the application of this bill to the legislative branch. H.R. 4508 takes important steps to preserve and expand access to affordable, high-quality health care by ensuring that plan sponsors and plan fiduciaries have the information they need to make informed choices on behalf of plan participants. H.R. 4508 is applicable only to group health plans subject to ERISA and therefore does not affect the legislative branch.

## UNFUNDED MANDATE STATEMENT

Pursuant to Section 423 of the Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93–344 (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104–4), the Committee adopts as its own the cost estimate prepared by the Congressional Budget Office (CBO) pursuant to section 402 of the Congressional Budget and Impoundment Control Act of 1974.

## EARMARK STATEMENT

H.R. 4508 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

## ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: 7/12/2023

**COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE**

Roll Call: 4 Bill: HR 4508 Amendment Number: n/a

Disposition: Adopted by a Full Committee Roll Call Vote (39-1)

Sponsor/Amendment: Courtney Motion to Report

| Name & State | Aye | No | Not Voting | Name & State | Aye | No | Not Voting |
|---|---|---|---|---|---|---|---|
| Mrs. FOXX (NC) (Chairwoman) | X | | | Mr. SCOTT (VA) (Ranking) | X | | |
| Mr. WILSON (SC) | | | X | Mr. GRIJALVA (AZ) | | | X |
| Mr. THOMPSON (PA) | X | | | Mr. COURNTEY (CT) | X | | |
| Mr. WALBERG (MI) | X | | | Mr. SABLAN (MP) | X | | |
| Mr. GROTHMAN (WI) | X | | | Ms. WILSON (FL) | X | | |
| Ms. STEFANIK (NY) | X | | | Ms. BONAMICI (OR) | X | | |
| Mr. ALLEN (GA) | X | | | Mr. TAKANO (CA) | X | | |
| Mr. BANKS (IN) | X | | | Ms. ADAMS (NC) | X | | |
| Mr. COMER (KY) | X | | | Mr. DESAULNIER (CA) | X | | |
| Mr. SMUCKER (PA) | X | | | Mr. NORCROSS (NJ) | | | X |
| Mr. OWENS (UT) | X | | | Ms. JAYAPAL (WA) | | | X |
| Mr. GOOD (VA) | X | | | Ms. WILD (PA) | X | | |
| Mrs. MCCLAIN (MI) | X | | | Ms. MCBATH (GA) | X | | |
| Mrs. MILLER (IL) | X | | | Mrs. HAYES (CT) | X | | |
| Mrs. STEEL (CA) | X | | | Ms. OMAR (MN) | X | | |
| Mr. ESTES (KS) | X | | | Ms. STEVENS (MI) | X | | |
| Ms. LETLOW (LA) | X | | | Ms. LEGER FERNÁNDEZ (NM) | X | | |
| Mr. KILEY (CA) | X | | | Ms. MANNING (NC) | X | | |
| Mr. BEAN (FL) | X | | | Mr. MRVAN (IN) | X | | |
| Mr. BURLISON (MO) | | X | | Mr. BOWMAN (NY) | X | | |
| Mr. MORAN (TX) | X | | | | | | |
| Mr. JAMES (MI) | X | | | | | | |
| Ms. CHAVEZ-DEREMER (OR) | X | | | | | | |
| Mr. WILLIAMS (NY) | | | X | | | | |
| Ms. HOUCHIN (IN) | X | | | | | | |

TOTALS: Ayes: 39 Nos: 1 Not Voting: 5

Total: 45 / Quorum: / Report:

(25 R - 20 D)

## STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House rule XIII, the goal of H.R. 4508 is to improve accountability and competition among PBM and TPAs by requiring PBMs and TPAs to disclose compensation information to plan fiduciaries to allow plans to make informed contracting decisions.

## DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 4508 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

## STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee's oversight findings and recommendations are reflected in the body of this report.

## REQUIRED COMMITTEE HEARING AND RELATED HEARINGS

In compliance with clause 3(c)(6) of rule XIII of the Rules of the House of Representatives, the following hearing held during the 118th Congress was used to develop or consider H.R. 4508: "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market."

## NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee requested a cost estimate from the Congressional Budget Office. The Committee adopts the following estimate for H.R. 4508 provided by the Congressional Budget Office to Majority staff via email on September 12, 2023: "We have completed our estimate of H.R. 4508. We estimate the bill would reduce the deficit by $1.3 billion over the 2023–2033 window. Please note that the savings is driven by the PBM transparency provisions and there is an interaction with section 3 of H.R. 4507."

## COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 4508. However, clause 3(d)(2)(B) of that rule provides that this requirement does not apply when, as with the present report, the committee adopts as its own the cost estimate of the bill prepared by the Congressional Budget Office under section 402 of the Congressional Budget Act.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

## EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

### TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

### SUBTITLE B—REGULATORY PROVISIONS

* * * * * * *

### PART 4—FIDUCIARY RESPONSIBILITY

* * * * * * *

#### EXEMPTIONS FROM PROHIBITED TRANSACTIONS

SEC. 408. (a) The Secretary shall establish an exemption procedure for purposes of this subsection. Pursuant to such procedure, he may grant a conditional or unconditional exemption of any fiduciary or transaction, or class of fiduciaries or transactions, from all or part of the restrictions imposed by sections 406 and 407(a). Action under this subsection may be taken only after consultation and coordination with the Secretary of the Treasury. An exemption granted under this section shall not relieve a fiduciary from any other applicable provision of this Act. The Secretary may not grant an exemption under this subsection unless he finds that such exemption is—

(1) administratively feasible,

(2) in the interests of the plan and of its participants and beneficiaries, and

(3) protective of the rights of participants and beneficiaries of such plan.

Before granting an exemption under this subsection from section 406(a) or 407(a), the Secretary shall publish notice in the Federal Register of the pendency of the exemption, shall require that adequate notice be given to interested persons, and shall afford interested persons opportunity to present views. The Secretary may not grant an exemption under this subsection from section 406(b) unless he affords an opportunity for a hearing and makes a determination on the record with respect to the findings required by paragraphs (1), (2), and (3) of this subsection.

(b) The prohibitions provided in section 406 shall not apply to any of the following transactions:

(1) Any loans made by the plan to parties in interest who are participants or beneficiaries of the plan if such loans (A) are available to all such participants and beneficiaries on a reason-

ably equivalent basis, (B) are not made available to highly compensated employees (within the meaning of section 414(q) of the Internal Revenue Code of 1986) in an amount greater than the amount made available to other employees, (C) are made in accordance with specific provisions regarding such loans set forth in the plan, (D) bear a reasonable rate of interest, and (E) are adequately secured. A loan made by a plan shall not fail to meet the requirements of the preceding sentence by reason of a loan repayment suspension described under section 414(u)(4) of the Internal Revenue Code of 1986.

(2)(A) Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.

(B)(i) No contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable within the meaning of this paragraph unless the ⌊requirements of this clause⌋ *requirements of this subparagraph* are met. *For purposes of applying section 406(a)(1)(C) with respect to a transaction described under this subparagraph, a contract or arrangement for services between a covered plan and a health insurance issuer providing health insurance coverage in connection with the covered plan in which the health insurance issuer contracts, in connection with such plan, with a service provider for pharmacy benefit management services shall be considered to constitute an indirect furnishing of goods, services, or facilities between the plan and the service provider acting as the party in interest.*

(ii)(I) For purposes of this subparagraph:

(aa) The term "covered plan" means a group health plan as defined section 733(a).

(bb) The term "covered service provider" means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more of the following services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor:

(AA) ⌊Brokerage services,⌋ *Services (including brokerage services),* for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness serv-

ices, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

(BB) [Consulting,] *Other services,* for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation or direct compensation described in item (dd), related to the development or implementation of *any of the following:* plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

(cc) The term "affiliate", with respect to a covered service provider, means an entity that directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with, such provider, or is an officer, director, or employee of, or partner in, such provider.

(dd)(AA) The term "compensation" means anything of monetary value, but does not include non-monetary compensation valued at $250 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or less, in the aggregate, during the term of the contract or arrangement.

(BB) The term "direct compensation" means compensation received directly from a covered plan.

(CC) The term "indirect compensation" means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under a contract or arrangement with a subcontractor.

(ee) The term "responsible plan fiduciary" means a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

(ff) The term "subcontractor" means any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive $1,000 (or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or more in compensation for performing one or

more services described in item (bb) under a contract or arrangement with the covered plan.

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

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

*(BB) design of pharmacy networks;*

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

*(DD) formulary design and maintenance;*

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

*(FF) utilization review;*

*(GG) adjudication of claims; and*

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

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

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

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

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

*(CC) negotiation of discounts off gross rates;*

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

*(EE) recordkeeping;*

*(FF) utilization review;*

*(GG) adjudication of claims;*

*(HH) regulatory compliance; and*

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

(II) For purposes of this subparagraph, a description of compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate. Any such description shall contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

(III) No person or entity is a "covered service provider" within the meaning of subclause (I)(bb) solely on the basis of providing services as an affiliate or a subcontractor that is performing one or more of the services described in subitem (AA) or (BB) of such subclause under the contract or arrangement with the covered plan.

(iii) A covered service provider shall disclose to a responsible plan fiduciary, in writing, the following:

(I) A description of the services to be provided to the covered plan pursuant to the contract or arrangement.

(II) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as a fiduciary (within the meaning of section 3(21)).

(III) A description of all direct compensation[, either in the aggregate or by service,] *by service* that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I).

(IV)(aa) A description of all indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described in subclause (I)—

(AA) including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan; and

(BB) not including compensation received by an employee from an employer on account of work performed by the employee.

(bb) A description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

(cc) Identification of the services for which the indirect compensation will be received, if applicable.

(dd) Identification of the payer of the indirect compensation.

(V) A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described in subclause (I) if such compensation is set on a transaction basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained), including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor), regardless of whether such compensation also is disclosed pursuant to subclause (III) or (IV).

(VI) A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the

contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

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

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

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

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

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

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

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

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

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

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

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

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

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

*(cc) the amount and form of expected recoveries by the covered service provider, including the amounts*

*that will be retained by the covered service provider as a fee (disaggregated by category), as a result of—*

*(AA) overpayments;*

*(BB) erroneous payments;*

*(CC) uncashed checks or incomplete payments;*

*(DD) billing errors;*

*(EE) subrogation;*

*(FF) fraud; or*

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

(iv) A covered service provider shall disclose to a responsible plan fiduciary, in writing a description of the manner in which the compensation described in clause (iii), as applicable, will be received.

(v)(I) A covered service provider shall disclose the information required under clauses (iii) and (iv) to the responsible plan fiduciary not later than the date that is reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed.

(II) A covered service provider shall disclose any change to the information required under clause (iii) and (iv) as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

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

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

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

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

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

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

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

*(AA) categorical explanations (grouped by the reason for clawback, such as contractual true-up provisions,*

*overpayments, or non-covered medication dispensed, and including information on the amount in each category that was passed through to the covered plan and to participants and beneficiaries of the covered plan); or*

*(BB) individual explanations for such clawbacks.*

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

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

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

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

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

*(cc) The aggregate amount for which the covered service provider received indirect compensation and the estimated amount of cost-sharing incurred by plan participants and beneficiaries as a result.*

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

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

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

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

(vi)(I) Upon the written request of the responsible plan fiduciary or covered plan administrator, a covered service provider shall furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements under this Act.

(II) The covered service provider shall disclose the information required under clause (iii)(I) reasonably in advance of the date upon which such responsible plan fiduciary or covered

plan administrator states that it is required to comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information shall be disclosed as soon as practicable.

(vii) No contract or arrangement will fail to be reasonable under this subparagraph solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to clause (iii) (or a change to such information disclosed pursuant to clause (v)(II)) or clause (vi), provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

(viii)(I) Pursuant to subsection (a), subparagraphs (C) and (D) of section 406(a)(1) shall not apply to a responsible plan fiduciary, notwithstanding any failure by a covered service provider to disclose information required under clause (iii), if the following conditions are met:

(aa) The responsible plan fiduciary did not know that the covered service provider failed or would fail to make required disclosures and reasonably believed that the covered service provider disclosed the information required to be disclosed.

(bb) The responsible plan fiduciary, upon discovering that the covered service provider failed to disclose the required information, requests in writing that the covered service provider furnish such information.

(cc) If the covered service provider fails to comply with a written request described in subclause (II) within 90 days of the request, the responsible plan fiduciary notifies the Secretary of the covered service provider's failure, in accordance with subclauses (II) and (III).

(II) A notice described in subclause (I)(cc) shall contain—

(aa) the name of the covered plan;

(bb) the plan number used for the annual report on the covered plan;

(cc) the plan sponsor's name, address, and employer identification number;

(dd) the name, address, and telephone number of the responsible plan fiduciary;

(ee) the name, address, phone number, and, if known, employer identification number of the covered service provider;

(ff) a description of the services provided to the covered plan;

(gg) a description of the information that the covered service provider failed to disclose;

(hh) the date on which such information was requested in writing from the covered service provider; and

(ii) a statement as to whether the covered service provider continues to provide services to the plan.

(III) A notice described in subclause (I)(cc) shall be filed with the Department not later than 30 days following the earlier of—

(aa) The covered service provider's refusal to furnish the information requested by the written request described in subclause (I)(bb); or

(bb) 90 days after the written request referred to in subclause (I)(cc) is made.

(IV) If the covered service provider fails to comply with the written request under subclause (I)(bb) within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement under section 404. If the requested information relates to future services and is not disclosed promptly after the end of the 90-day period, the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.

(ix) Nothing in this subparagraph shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.

(3) A loan to an employee stock ownership plan (as defined in section 407(d)(6)), if—

(A) such loan is primarily for the benefit of participants and beneficiaries of the plan, and

(B) such loan is at an interest rate which is not in excess of a reasonable rate.

If the plan gives collateral to a party in interest for such loan, such collateral may consist only of qualifying employer securities (as defined in section 407(d)(5)).

(4) The investment of all or part of a plan's assets in deposits which bear a reasonable interest rate in a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan and if—

(A) the plan covers only employees of such bank or other institution and employees of affiliates of such bank or other institution, or

(B) such investment is expressly authorized by a provision of the plan or by a fiduciary (other than such bank or institution or affiliate thereof) who is expressly empowered by the plan to so instruct the trustee with respect to such investment.

(5) Any contract for life insurance, health insurance, or annuities with one or more insurers which are qualified to do business in a State, if the plan pays no more than adequate consideration, and if each such insurer or insurers is—

(A) the employer maintaining the plan, or

(B) a party in interest which is wholly owned (directly or indirectly) by the employer maintaining the plan, or by any person which is a party in interest with respect to the plan, but only if the total premiums and annuity considerations written by such insurers for life insurance, health insurance, or annuities for all plans (and their employers)

with respect to which such insurers are parties in interest (not including premiums or annuity considerations written by the employer maintaining the plan) do not exceed 5 percent of the total premiums and annuity considerations written for all lines of insurance in that year by such insurers (not including premiums or annuity considerations written by the employer maintaining the plan).

(6) The providing of any ancillary service by a bank or similar financial institution supervised by the United States or a State, if such bank or other institution is a fiduciary of such plan, and if—

(A) such bank or similar financial institution has adopted adequate internal safeguards which assure that the providing of such ancillary service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority, and

(B) the extent to which such ancillary service is provided is subject to specific guidelines issued by such bank or similar financial institution (as determined by the Secretary after consultation with Federal and State supervisory authority), and adherence to such guidelines would reasonably preclude such bank or similar financial institution from providing such ancillary service (i) in an excessive or unreasonable manner, and (ii) in a manner that would be inconsistent with the best interests of participants and beneficiaries of employee benefit plans.

Such ancillary services shall not be provided at more than reasonable compensation.

(7) The exercise of a privilege to convert securities, to the extent provided in regulations of the Secretary, but only if the plan receives no less than adequate consideration pursuant to such conversion.

(8) Any transaction between a plan and (i) a common or collective trust fund or pooled investment fund maintained by a party in interest which is a bank or trust company supervised by a State or Federal agency or (ii) a pooled investment fund of an insurance company qualified to do business in a State, if—

(A) the transaction is a sale or purchase of an interest in the fund,

(B) the bank, trust company, or insurance company receives not more than reasonable compensation, and

(C) such transaction is expressly permitted by the instrument under which the plan is maintained, or by a fiduciary (other than the bank, trust company, or insurance company, or an affiliate thereof) who has authority to manage and control the assets of the plan.

(9) The making by a fiduciary of a distribution of the assets of the plan in accordance with the terms of the plan if such assets are distributed in the same manner as provided under section 4044 of this Act (relating to allocation of assets).

(10) Any transaction required or permitted under part 1 of subtitle E of title IV.

(11) A merger of multiemployer plans, or the transfer of assets or liabilities between multiemployer plans, determined by

the Pension Benefit Guaranty Corporation to meet the requirements of section 4231.

(12) The sale by a plan to a party in interest on or after December 18, 1987, of any stock, if—

(A) the requirements of paragraphs (1) and (2) of subsection (e) are met with respect to such stock,

(B) on the later of the date on which the stock was acquired by the plan, or January 1, 1975, such stock constituted a qualifying employer security (as defined in section 407(d)(5) as then in effect), and

(C) such stock does not constitute a qualifying employer security (as defined in section 407(d)(5) as in effect at the time of the sale).

(13) Any transfer made before January 1, 2033, of excess pension assets from a defined benefit plan to a retiree health account in a qualified transfer permitted under section 420 of the Internal Revenue Code of 1986 (as in effect on the date of enactment of the SECURE 2.0 Act of 2022).

(14) Any transaction in connection with the provision of investment advice described in section 3(21)(A)(ii) to a participant or beneficiary of an individual account plan that permits such participant or beneficiary to direct the investment of assets in their individual account, if—

(A) the transaction is—

(i) the provision of the investment advice to the participant or beneficiary of the plan with respect to a security or other property available as an investment under the plan,

(ii) the acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice, or

(iii) the direct or indirect receipt of fees or other compensation by the fiduciary adviser or an affiliate thereof (or any employee, agent, or registered representative of the fiduciary adviser or affiliate) in connection with the provision of the advice or in connection with an acquisition, holding, or sale of a security or other property available as an investment under the plan pursuant to the investment advice; and

(B) the requirements of subsection (g) are met.

(15)(A) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest (other than a fiduciary described in section 3(21)(A)) with respect to a plan if—

(i) the transaction involves a block trade,

(ii) at the time of the transaction, the interest of the plan (together with the interests of any other plans maintained by the same plan sponsor), does not exceed 10 percent of the aggregate size of the block trade,

(iii) the terms of the transaction, including the price, are at least as favorable to the plan as an arm's length transaction, and

(iv) the compensation associated with the purchase and sale is not greater than the compensation associated with an arm's length transaction with an unrelated party.

(B) For purposes of this paragraph, the term "block trade" means any trade of at least 10,000 shares or with a market value of at least $200,000 which will be allocated across two or more unrelated client accounts of a fiduciary.

(16) Any transaction involving the purchase or sale of securities, or other property (as determined by the Secretary), between a plan and a party in interest if—

(A) the transaction is executed through an electronic communication network, alternative trading system, or similar execution system or trading venue subject to regulation and oversight by—

(i) the applicable Federal regulating entity, or

(ii) such foreign regulatory entity as the Secretary may determine by regulation,

(B) either—

(i) the transaction is effected pursuant to rules designed to match purchases and sales at the best price available through the execution system in accordance with applicable rules of the Securities and Exchange Commission or other relevant governmental authority, or

(ii) neither the execution system nor the parties to the transaction take into account the identity of the parties in the execution of trades,

(C) the price and compensation associated with the purchase and sale are not greater than the price and compensation associated with an arm's length transaction with an unrelated party,

(D) if the party in interest has an ownership interest in the system or venue described in subparagraph (A), the system or venue has been authorized by the plan sponsor or other independent fiduciary for transactions described in this paragraph, and

(E) not less than 30 days prior to the initial transaction described in this paragraph executed through any system or venue described in subparagraph (A), a plan fiduciary is provided written or electronic notice of the execution of such transaction through such system or venue.

(17)(A) Transactions described in subparagraphs (A), (B), and (D) of section 406(a)(1) between a plan and a person that is a party in interest other than a fiduciary (or an affiliate) who has or exercises any discretionary authority or control with respect to the investment of the plan assets involved in the transaction or renders investment advice (within the meaning of section 3(21)(A)(ii)) with respect to those assets, solely by reason of providing services to the plan or solely by reason of a relationship to such a service provider described in subparagraph (F), (G), (H), or (I) of section 3(14), or both, but only if in connection with such transaction the plan receives no less, nor pays no more, than adequate consideration.

(B) For purposes of this paragraph, the term "adequate consideration" means—

(i) in the case of a security for which there is a generally recognized market—

(I) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934, taking into account factors such as the size of the transaction and marketability of the security, or

(II) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of the party in interest, taking into account factors such as the size of the transaction and marketability of the security, and

(ii) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by a fiduciary or fiduciaries in accordance with regulations prescribed by the Secretary.

(18) FOREIGN EXCHANGE TRANSACTIONS.—Any foreign exchange transactions, between a bank or broker-dealer (or any affiliate of either), and a plan (as defined in section 3(3)) with respect to which such bank or broker-dealer (or affiliate) is a trustee, custodian, fiduciary, or other party in interest, if—

(A) the transaction is in connection with the purchase, holding, or sale of securities or other investment assets (other than a foreign exchange transaction unrelated to any other investment in securities or other investment assets),

(B) at the time the foreign exchange transaction is entered into, the terms of the transaction are not less favorable to the plan than the terms generally available in comparable arm's length foreign exchange transactions between unrelated parties, or the terms afforded by the bank or broker-dealer (or any affiliate of either) in comparable arm's-length foreign exchange transactions involving unrelated parties,

(C) the exchange rate used by such bank or broker-dealer (or affiliate) for a particular foreign exchange transaction does not deviate by more than 3 percent from the interbank bid and asked rates for transactions of comparable size and maturity at the time of the transaction as displayed on an independent service that reports rates of exchange in the foreign currency market for such currency, and

(D) the bank or broker-dealer (or any affiliate of either) does not have investment discretion, or provide investment advice, with respect to the transaction.

(19) CROSS TRADING.—Any transaction described in sections 406(a)(1)(A) and 406(b)(2) involving the purchase and sale of a security between a plan and any other account managed by the same investment manager, if—

(A) the transaction is a purchase or sale, for no consideration other than cash payment against prompt delivery of a security for which market quotations are readily available,

(B) the transaction is effected at the independent current market price of the security (within the meaning of section 270.17a–7(b) of title 17, Code of Federal Regulations),

(C) no brokerage commission, fee (except for customary transfer fees, the fact of which is disclosed pursuant to subparagraph (D)), or other remuneration is paid in connection with the transaction,

(D) a fiduciary (other than the investment manager engaging in the cross-trades or any affiliate) for each plan participating in the transaction authorizes in advance of any cross-trades (in a document that is separate from any other written agreement of the parties) the investment manager to engage in cross trades at the investment manager's discretion, after such fiduciary has received disclosure regarding the conditions under which cross trades may take place (but only if such disclosure is separate from any other agreement or disclosure involving the asset management relationship), including the written policies and procedures of the investment manager described in subparagraph (H),

(E) each plan participating in the transaction has assets of at least $100,000,000, except that if the assets of a plan are invested in a master trust containing the assets of plans maintained by employers in the same controlled group (as defined in section 407(d)(7)), the master trust has assets of at least $100,000,000,

(F) the investment manager provides to the plan fiduciary who authorized cross trading under subparagraph (D) a quarterly report detailing all cross trades executed by the investment manager in which the plan participated during such quarter, including the following information, as applicable: (i) the identity of each security bought or sold; (ii) the number of shares or units traded; (iii) the parties involved in the cross-trade; and (iv) trade price and the method used to establish the trade price,

(G) the investment manager does not base its fee schedule on the plan's consent to cross trading, and no other service (other than the investment opportunities and cost savings available through a cross trade) is conditioned on the plan's consent to cross trading,

(H) the investment manager has adopted, and cross-trades are effected in accordance with, written cross-trading policies and procedures that are fair and equitable to all accounts participating in the cross-trading program, and that include a description of the manager's pricing policies and procedures, and the manager's policies and procedures for allocating cross trades in an objective manner among accounts participating in the cross-trading program, and

(I) the investment manager has designated an individual responsible for periodically reviewing such purchases and sales to ensure compliance with the written policies and procedures described in subparagraph (H), and following such review, the individual shall issue an annual written report no later than 90 days following the period to which

it relates signed under penalty of perjury to the plan fiduciary who authorized cross trading under subparagraph (D) describing the steps performed during the course of the review, the level of compliance, and any specific instances of non-compliance.

The written report under subparagraph (I) shall also notify the plan fiduciary of the plan's right to terminate participation in the investment manager's cross-trading program at any time.

(20)(A) Except as provided in subparagraphs (B) and (C), a transaction described in section 406(a) in connection with the acquisition, holding, or disposition of any security or commodity, if the transaction is corrected before the end of the correction period.

(B) Subparagraph (A) does not apply to any transaction between a plan and a plan sponsor or its affiliates that involves the acquisition or sale of an employer security (as defined in section 407(d)(1)) or the acquisition, sale, or lease of employer real property (as defined in section 407(d)(2)).

(C) In the case of any fiduciary or other party in interest (or any other person knowingly participating in such transaction), subparagraph (A) does not apply to any transaction if, at the time the transaction occurs, such fiduciary or party in interest (or other person) knew (or reasonably should have known) that the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(D) For purposes of this paragraph, the term "correction period" means, in connection with a fiduciary or party in interest (or other person knowingly participating in the transaction), the 14-day period beginning on the date on which such fiduciary or party in interest (or other person) discovers, or reasonably should have discovered, that the transaction would (without regard to this paragraph) constitute a violation of section 406(a).

(E) For purposes of this paragraph—

(i) The term "security" has the meaning given such term by section 475(c)(2) of the Internal Revenue Code of 1986 (without regard to subparagraph (F)(iii) and the last sentence thereof).

(ii) The term "commodity" has the meaning given such term by section 475(e)(2) of such Code (without regard to subparagraph (D)(iii) thereof).

(iii) The term "correct" means, with respect to a transaction—

(I) to undo the transaction to the extent possible and in any case to make good to the plan or affected account any losses resulting from the transaction, and

(II) to restore to the plan or affected account any profits made through the use of assets of the plan.

(21) The provision of a de minimis financial incentive described in section 401(k)(4)(A) or section 403(b)(12)(A) of the Internal Revenue Code of 1986.

(c) Nothing in section 406 shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is

computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full time pay from an employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

(d)(1) Section 407(b) and subsections (b), (c), and (e) of this section shall not apply to a transaction in which a plan directly or indirectly—

(A) lends any part of the corpus or income of the plan to,

(B) pays any compensation for personal services rendered to the plan to, or

(C) acquires for the plan any property from, or sells any property to,

any person who is with respect to the plan an owner-employee (as defined in section 401(c)(3) of the Internal Revenue Code of 1986), a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or any corporation in which any such owner-employee owns, directly or indirectly, 50 percent or more of the total combined voting power of all classes of stock entitled to vote or 50 percent or more of the total value of shares of all classes of stock of the corporation.

(2)(A) For purposes of paragraph (1), the following shall be treated as owner-employees:

(i) A shareholder-employee.

(ii) A participant or beneficiary of an individual retirement plan (as defined in section 7701(a)(37) of the Internal Revenue Code of 1986).

(iii) An employer or association of employees which establishes such an individual retirement plan under section 408(c) of such Code.

(B) Paragraph (1)(C) shall not apply to a transaction which consists of a sale of employer securities to an employee stock ownership plan (as defined in section 407(d)(6)) by a shareholder-employee, a member of the family (as defined in section 267(c)(4) of such Code) of any such owner-employee, or a corporation in which such a shareholder-employee owns stock representing a 50 percent or greater interest described in paragraph (1).

(C) For purposes of paragraph (1)(A), the term "owner-employee" shall only include a person described in clause (ii) or (iii) of subparagraph (A).

(3) For purposes of paragraph (2), the term "shareholder-employee" means an employee or officer of an S corporation (as defined in section 1361(a)(1) of such Code) who owns (or is considered as owning within the meaning of section 318(a)(1) of such Code) more than 5 percent of the outstanding stock of the corporation on any day during the taxable year of such corporation.

(e) Sections 406 and 407 shall not apply to the acquisition or sale by a plan of qualifying employer securities (as defined in section 407(d)(5)) or acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 407(d)(4))—

(1) if such acquisition, sale, or lease is for adequate consideration (or in the case of a marketable obligation, at a price not less favorable to the plan than the price determined under section 407(e)(1)),

(2) if no commission is charged with respect thereto, and

(3) if—

(A) the plan is an eligible individual account plan (as defined in section 407(d)(3)), or

(B) in the case of an acquisition or lease of qualifying employer real property by a plan which is not an eligible individual account plan, or of an acquisition of qualifying employer securities by such a plan, the lease or acquisition is not prohibited by section 407(a).

(f) Section 406(b)(2) shall not apply to any merger or transfer described in subsection (b)(11).

(g) PROVISION OF INVESTMENT ADVICE TO PARTICIPANT AND BENEFICIARIES.—

(1) IN GENERAL.—The prohibitions provided in section 406 shall not apply to transactions described in subsection (b)(14) if the investment advice provided by a fiduciary adviser is provided under an eligible investment advice arrangement.

(2) ELIGIBLE INVESTMENT ADVICE ARRANGEMENT.—For purposes of this subsection, the term "eligible investment advice arrangement" means an arrangement—

(A) which either—

(i) provides that any fees (including any commission or other compensation) received by the fiduciary adviser for investment advice or with respect to the sale, holding, or acquisition of any security or other property for purposes of investment of plan assets do not vary depending on the basis of any investment option selected, or

(ii) uses a computer model under an investment advice program meeting the requirements of paragraph (3) in connection with the provision of investment advice by a fiduciary adviser to a participant or beneficiary, and

(B) with respect to which the requirements of paragraph (4), (5), (6), (7), (8), and (9) are met.

(3) INVESTMENT ADVICE PROGRAM USING COMPUTER MODEL.—

(A) IN GENERAL.—An investment advice program meets the requirements of this paragraph if the requirements of subparagraphs (B), (C), and (D) are met.

(B) COMPUTER MODEL.—The requirements of this subparagraph are met if the investment advice provided under the investment advice program is provided pursuant to a computer model that—

(i) applies generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time,

(ii) utilizes relevant information about the participant, which may include age, life expectancy, retirement age, risk tolerance, other assets or sources of income, and preferences as to certain types of investments,

(iii) utilizes prescribed objective criteria to provide asset allocation portfolios comprised of investment options available under the plan,

(iv) operates in a manner that is not biased in favor of investments offered by the fiduciary adviser or a person with a material affiliation or contractual relationship with the fiduciary adviser, and

(v) takes into account all investment options under the plan in specifying how a participant's account balance should be invested and is not inappropriately weighted with respect to any investment option.

(C) CERTIFICATION.—

(i) IN GENERAL.—The requirements of this subparagraph are met with respect to any investment advice program if an eligible investment expert certifies, prior to the utilization of the computer model and in accordance with rules prescribed by the Secretary, that the computer model meets the requirements of subparagraph (B).

(ii) RENEWAL OF CERTIFICATIONS.—If, as determined under regulations prescribed by the Secretary, there are material modifications to a computer model, the requirements of this subparagraph are met only if a certification described in clause (i) is obtained with respect to the computer model as so modified.

(iii) ELIGIBLE INVESTMENT EXPERT.—The term "eligible investment expert" means any person—

(I) which meets such requirements as the Secretary may provide, and

(II) does not bear any material affiliation or contractual relationship with any investment adviser or a related person thereof (or any employee, agent, or registered representative of the investment adviser or related person).

(D) EXCLUSIVITY OF RECOMMENDATION.—The requirements of this subparagraph are met with respect to any investment advice program if—

(i) the only investment advice provided under the program is the advice generated by the computer model described in subparagraph (B), and

(ii) any transaction described in subsection (b)(14)(A)(ii) occurs solely at the direction of the participant or beneficiary.

Nothing in the preceding sentence shall preclude the participant or beneficiary from requesting investment advice other than that described in subparagraph (A), but only if such request has not been solicited by any person connected with carrying out the arrangement.

(4) EXPRESS AUTHORIZATION BY SEPARATE FIDUCIARY.—The requirements of this paragraph are met with respect to an ar-

rangement if the arrangement is expressly authorized by a plan fiduciary other than the person offering the investment advice program, any person providing investment options under the plan, or any affiliate of either.

(5) ANNUAL AUDIT.—The requirements of this paragraph are met if an independent auditor, who has appropriate technical training or experience and proficiency and so represents in writing—

(A) conducts an annual audit of the arrangement for compliance with the requirements of this subsection, and

(B) following completion of the annual audit, issues a written report to the fiduciary who authorized use of the arrangement which presents its specific findings regarding compliance of the arrangement with the requirements of this subsection.

For purposes of this paragraph, an auditor is considered independent if it is not related to the person offering the arrangement to the plan and is not related to any person providing investment options under the plan.

(6) DISCLOSURE.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides to a participant or a beneficiary before the initial provision of the investment advice with regard to any security or other property offered as an investment option, a written notification (which may consist of notification by means of electronic communication)—

(i) of the role of any party that has a material affiliation or contractual relationship with the fiduciary adviser in the development of the investment advice program and in the selection of investment options available under the plan,

(ii) of the past performance and historical rates of return of the investment options available under the plan,

(iii) of all fees or other compensation relating to the advice that the fiduciary adviser or any affiliate thereof is to receive (including compensation provided by any third party) in connection with the provision of the advice or in connection with the sale, acquisition, or holding of the security or other property,

(iv) of any material affiliation or contractual relationship of the fiduciary adviser or affiliates thereof in the security or other property,

(v) the manner, and under what circumstances, any participant or beneficiary information provided under the arrangement will be used or disclosed,

(vi) of the types of services provided by the fiduciary adviser in connection with the provision of investment advice by the fiduciary adviser,

(vii) that the adviser is acting as a fiduciary of the plan in connection with the provision of the advice, and

(viii) that a recipient of the advice may separately arrange for the provision of advice by another adviser,

that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property, and

(B) at all times during the provision of advisory services to the participant or beneficiary, the fiduciary adviser—

(i) maintains the information described in subparagraph (A) in accurate form and in the manner described in paragraph (8),

(ii) provides, without charge, accurate information to the recipient of the advice no less frequently than annually,

(iii) provides, without charge, accurate information to the recipient of the advice upon request of the recipient, and

(iv) provides, without charge, accurate information to the recipient of the advice concerning any material change to the information required to be provided to the recipient of the advice at a time reasonably contemporaneous to the change in information.

(7) OTHER CONDITIONS.—The requirements of this paragraph are met if—

(A) the fiduciary adviser provides appropriate disclosure, in connection with the sale, acquisition, or holding of the security or other property, in accordance with all applicable securities laws,

(B) the sale, acquisition, or holding occurs solely at the direction of the recipient of the advice,

(C) the compensation received by the fiduciary adviser and affiliates thereof in connection with the sale, acquisition, or holding of the security or other property is reasonable, and

(D) the terms of the sale, acquisition, or holding of the security or other property are at least as favorable to the plan as an arm's length transaction would be.

(8) STANDARDS FOR PRESENTATION OF INFORMATION.—

(A) IN GENERAL.—The requirements of this paragraph are met if the notification required to be provided to participants and beneficiaries under paragraph (6)(A) is written in a clear and conspicuous manner and in a manner calculated to be understood by the average plan participant and is sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of the information required to be provided in the notification.

(B) MODEL FORM FOR DISCLOSURE OF FEES AND OTHER COMPENSATION.—The Secretary shall issue a model form for the disclosure of fees and other compensation required in paragraph (6)(A)(iii) which meets the requirements of subparagraph (A).

(9) MAINTENANCE FOR 6 YEARS OF EVIDENCE OF COMPLIANCE.—The requirements of this paragraph are met if a fiduciary adviser who has provided advice referred to in paragraph (1) maintains, for a period of not less than 6 years after the provision of the advice, any records necessary for determining whether the requirements of the preceding provisions of this subsection and of subsection (b)(14) have been met. A trans-

action prohibited under section 406 shall not be considered to have occurred solely because the records are lost or destroyed prior to the end of the 6-year period due to circumstances beyond the control of the fiduciary adviser.

(10) EXEMPTION FOR PLAN SPONSOR AND CERTAIN OTHER FIDUCIARIES.—

(A) IN GENERAL.—Subject to subparagraph (B), a plan sponsor or other person who is a fiduciary (other than a fiduciary adviser) shall not be treated as failing to meet the requirements of this part solely by reason of the provision of investment advice referred to in section 3(21)(A)(ii) (or solely by reason of contracting for or otherwise arranging for the provision of the advice), if—

(i) the advice is provided by a fiduciary adviser pursuant to an eligible investment advice arrangement between the plan sponsor or other fiduciary and the fiduciary adviser for the provision by the fiduciary adviser of investment advice referred to in such section,

(ii) the terms of the eligible investment advice arrangement require compliance by the fiduciary adviser with the requirements of this subsection, and

(iii) the terms of the eligible investment advice arrangement include a written acknowledgment by the fiduciary adviser that the fiduciary adviser is a fiduciary of the plan with respect to the provision of the advice.

(B) CONTINUED DUTY OF PRUDENT SELECTION OF ADVISER AND PERIODIC REVIEW.—Nothing in subparagraph (A) shall be construed to exempt a plan sponsor or other person who is a fiduciary from any requirement of this part for the prudent selection and periodic review of a fiduciary adviser with whom the plan sponsor or other person enters into an eligible investment advice arrangement for the provision of investment advice referred to in section 3(21)(A)(ii). The plan sponsor or other person who is a fiduciary has no duty under this part to monitor the specific investment advice given by the fiduciary adviser to any particular recipient of the advice.

(C) AVAILABILITY OF PLAN ASSETS FOR PAYMENT FOR ADVICE.—Nothing in this part shall be construed to preclude the use of plan assets to pay for reasonable expenses in providing investment advice referred to in section 3(21)(A)(ii).

(11) DEFINITIONS.—For purposes of this subsection and subsection (b)(14)—

(A) FIDUCIARY ADVISER.—The term "fiduciary adviser" means, with respect to a plan, a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 3(21)(A)(ii) by the person to a participant or beneficiary of the plan and who is—

(i) registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1 et seq.) or under the laws of the State in which the fiduciary maintains its principal office and place of business,

(ii) a bank or similar financial institution referred to in subsection (b)(4) or a savings association (as defined in section 3(b)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b)(1)), but only if the advice is provided through a trust department of the bank or similar financial institution or savings association which is subject to periodic examination and review by Federal or State banking authorities,

(iii) an insurance company qualified to do business under the laws of a State,

(iv) a person registered as a broker or dealer under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.),

(v) an affiliate of a person described in any of clauses (i) through (iv), or

(vi) an employee, agent, or registered representative of a person described in clauses (i) through (v) who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of the advice.

For purposes of this part, a person who develops the computer model described in paragraph (3)(B) or markets the investment advice program or computer model shall be treated as a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 3(21)(A)(ii) to a participant or beneficiary and shall be treated as a fiduciary adviser for purposes of this subsection and subsection (b)(14), except that the Secretary may prescribe rules under which only 1 fiduciary adviser may elect to be treated as a fiduciary with respect to the plan.

(B) AFFILIATE.—The term "affiliate" of another entity means an affiliated person of the entity (as defined in section 2(a)(3) of the Investment Company Act of 1940 (15 U.S.C. 80a–2(a)(3))).

(C) REGISTERED REPRESENTATIVE.—The term "registered representative" of another entity means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(18)) (substituting the entity for the broker or dealer referred to in such section) or a person described in section 202(a)(17) of the Investment Advisers Act of 1940 (15 U.S.C. 80b-2(a)(17)) (substituting the entity for the investment adviser referred to in such section).

(h) PROVISION OF PHARMACY BENEFIT SERVICES.—

(1) IN GENERAL.—Provided that all of the conditions described in paragraph (2) are met, the restrictions imposed by subsections (a), (b)(1), and (b)(2) of section 406 shall not apply to—

(A) the offering of pharmacy benefit services to a group health plan that is sponsored by an entity described in section 3(37)(G)(vi) or to any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity;

(B) the purchase of pharmacy benefit services by plan participants and beneficiaries of a group health plan that

is sponsored by an entity described in section 3(37)(G)(vi) or of any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity; or

(C) the operation or implementation of pharmacy benefit services by an entity described in section 3(37)(G)(vi) or by any other group health plan that is sponsored by a regional council, local union, or other labor organization affiliated with such entity,

in any arrangement where such entity described in section 3(37)(G)(vi) or any related organization or subsidiary of such entity provides pharmacy benefit services that include prior authorization and appeals, a retail pharmacy network, pharmacy benefit administration, mail order fulfillment, formulary support, manufacturer payments, audits, and specialty pharmacy and goods, to any such group health plan.

(2) CONDITIONS.—The conditions described in this paragraph are the following:

(A) The terms of the arrangement are at least as favorable to the group health plan as such group health plan could obtain in a similar arm's length arrangement with an unrelated third party.

(B) At least 50 percent of the providers participating in the pharmacy benefit services offered by the arrangement are unrelated to the contributing employers or any other party in interest with respect to the group health plan.

(C) The group health plan retains an independent fiduciary who will be responsible for monitoring the group health plan's consultants, contractors, subcontractors, and other service providers for purposes of pharmacy benefit services described in paragraph (1) offered by such entity or any of its related organizations or subsidiaries and monitors the transactions of such entity and any of its related organizations or subsidiaries to ensure that all conditions of this exemption are satisfied during each plan year.

(D) Any decisions regarding the provision of pharmacy benefit services described in paragraph (1) are made by the group health plan's independent fiduciary, based on objective standards developed by the independent fiduciary in reliance on information provided by the arrangement.

(E) The independent fiduciary of the group health plan provides an annual report to the Secretary and the congressional committees of jurisdiction attesting that the conditions described in subparagraphs (C) and (D) have been met for the applicable plan year, together with a statement that use of the arrangement's services are in the best interest of the participants and beneficiaries in the aggregate for that plan year compared to other similar arrangements the group health plan could have obtained in transactions with an unrelated third party.

(F) The arrangement is not designed to benefit any party in interest with respect to the group health plan.

(3) VIOLATIONS.—In the event an entity described in section 3(37)(G)(vi) or any affiliate of such entity violates any of the conditions of such exemption, such exemption shall not apply

with respect to such entity or affiliate and all enforcement and claims available under this Act shall apply with respect to such entity or affiliate.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to modify any obligation of a group health plan otherwise set forth in this Act.

(5) GROUP HEALTH PLAN.—In this subsection, the term "group health plan" has the meaning given such term in section 733(a).

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