118TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
118–260

HEALTH DATA ACCESS, TRANSPARENCY, AND AFFORDABILITY 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. 4527]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 4527) to amend the Employee Retirement Income Security Act of 1974 to ensure plan fiduciaries may access de-identified information relating to health claims, and for other purposes, 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 "Health Data Access, Transparency, and Affordability Act of 2023" or the "Health DATA Act of 2023".

SEC. 2. PLAN FIDUCIARY ACCESS TO INFORMATION.

(a) IN GENERAL.—Paragraph (2) of section 408(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1108(b)) is amended by adding at the end the following new subparagraph:

"(C) No contract or arrangement for services between a group health plan and any other entity, such as a health care provider, network or association of providers, third-party administrator, or pharmacy benefit manager, is reasonable within the meaning of this paragraph unless such contract or agreement—

"(i) allows the responsible plan fiduciary to audit all de-identified claims and encounter information or data described in section 724(a)(1)(B) to—

"(I) ensure that such entity complies with the terms of the plan and any applicable law; and

"(II) determine the reasonableness of compensation paid by the plan; and

"(ii) does not—

"(I) unreasonably limit the number of audits permitted during a given period of time;

"(II) limit the number of de-identified claims and encounter information or data that the responsible plan fiduciary may access during an audit;

"(III) limit the disclosure of pricing terms for value based payment arrangements, including—

"(aa) payment calculations and formulas;

"(bb) quality measures;

"(cc) contract terms;

"(dd) payment amounts;

"(ee) measurement periods for all incentives; and

"(ff) other payment methodologies furnished by a health care provider, network or association of providers, third-party administrator, or pharmacy benefit manager;

"(IV) limit the disclosure of overpayments and overpayment recovery terms;

"(V) limit the right of the responsible plan fiduciary to select an auditor;

"(VI) otherwise limit or unduly delay by greater than 60 days the responsible plan fiduciary from auditing such information or data; or

"(VII) charge a fee beyond the reasonable direct costs to administer the operation of conducting such audits.".

(b) CIVIL ENFORCEMENT.—

(1) IN GENERAL.—Subsection (c) of section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new paragraph:

"(13) In the case of an agreement between a group health plan and a health care provider, network or association of providers, third-party administrator, pharmacy benefit manager, or other service provider that violates the provisions of section 724, the Secretary may assess a civil penalty against such provider, network or association, third-party administrator, pharmacy benefit manager, or other service provider in the amount of $10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.".

(2) CONFORMING AMENDMENT.—Paragraph (6) of section 502(a) of such Act is amended by striking "or (9)" and inserting "(9), or (13)"; and

(c) EXISTING PROVISIONS VOID.—Section 410 of such Act is amended by adding at the end the following new subsection:

"(c) Any provision in an agreement or instrument shall be void as against public policy if such provision—

"(1) unduly delays or limits a plan fiduciary from accessing the de-identified claims and encounter information or data described in section 724(a)(1)(B); or

"(2) violates the requirements of section 408(b)(2)(C).".

(d) TECHNICAL AMENDMENT.—Clause (i) of section 408(b)(2)(B) of such Act is amended by striking "this clause" and inserting "this paragraph".

SEC. 3. UPDATED ATTESTATION FOR PRICE AND QUALITY INFORMATION.

Section 724(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m(a)(3)) is amended to read as follows:

"(3) ATTESTATION.—

"(A) IN GENERAL.—Subject to subparagraph (C), the fiduciary of a group health plan or issuer offering group health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection. Such attestation shall also include a statement verifying that—

"(i) the information or data described under subparagraphs (A) and (B) of paragraph (1) is available upon request and provided to the plan fiduciary, the plan administrator, or the issuer in a timely manner; and

"(ii) there are no terms in the agreement under such paragraph (1) that directly or indirectly restrict or unduly delay a plan fiduciary, the plan administrator, or the issuer from auditing, reviewing, or otherwise accessing such information.

"(B) LIMITATION ON SUBMISSION.—Subject to clause (ii), a group health plan or issuer offering group health insurance coverage may not enter into an agreement with a third-party administrator or other service provider to submit the attestation required under subparagraph (A).

"(C) EXCEPTION.—In the case of a group health plan or issuer offering group health insurance coverage that is unable to obtain the information or data needed to submit the attestation required under subparagraph (A), such plan or issuer may submit a written statement in lieu of such attestation that includes—

"(i) an explanation of why such plan or issuer was unsuccessful in obtaining such information or data, including whether such plan or issuer was limited or prevented from auditing, reviewing, or otherwise accessing such information or data;

"(ii) a description of the efforts made by the plan fiduciary to remove any gag clause provisions from the agreement under paragraph (1); and

"(iii) a description of any response by the third-party administrator or other service provider with respect to efforts to comply with the attestation requirement under subparagraph (A).".

SEC. 4. STUDY ON PLAN ASSETS.

Not later than 1 year after the date of enactment of this Act, the Secretary of Labor shall submit to the Committee on Education and the Workforce of the House of Representatives a report on the status of de-identified claims and encounter information or data described in section 724(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185m), including information on the following:

(1) Circumstances under current law where such information or data could be deemed a group health plan asset (as defined under section 3(42) of such Act).

(2) Whether restrictions on the ability of a plan fiduciary to access such information or data violates a requirement of current law.

(3) The existing regulatory authority of the Secretary to clarify whether such information or data belongs to a group health plan, rather than a service provider.

(4) Legislative actions that may be taken to establish that such information or data related to a plan belongs to a group health plan and is handled in the best interests of plan participants and beneficiaries.

PURPOSE

H.R. 4527, *the Health Data Access, Transparency, and Affordability Act of 2023* (*Health DATA Act of 2023*), amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] to strengthen existing provisions of law to ensure that group health plan fiduciaries may audit plan data held by their service providers for purposes of (1) ensuring compliance with the terms of the plan and any applicable law and (2) determining the reasonableness of compensation paid by the plan. By providing transparent access to this information, the bill will help plan fiduciaries perform necessary oversight of service providers on behalf of plan participants and beneficiaries.

COMMITTEE ACTION

116TH CONGRESS

Subcommittee Hearing on Examining Surprise Billing: Protecting Patients from Financial Pain

On April 2, 2019, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled "Examining Surprise Billing: Protecting Patients from Financial Pain," which discussed hospital billing practices, including unexpected costs to consumers due, in part, to a lack of transparency in health care. Members and witnesses also discussed the need for more transparency in employer-sponsored plans to ensure plans can make informed decisions. The witnesses were Ms. Ilyse Schuman, Senior Vice President, Health Policy, American Benefits Council, Washington, D.C.; Dr. Jack Hoadley, Research Professor Emeritus, Health Policy Institute, Georgetown University Health Policy Institute, McCourt School of Public Policy, McLean, Virginia; Mr. Frederick Isasi, Executive Director, Families USA, Washington, D.C.; and Ms. Christen Linke Young, Fellow, USC-Brookings Schaeffer Initiative on Health Policy, Washington, D.C.

[1] 29 U.S.C. § 1001 *et seq*.

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

On September 26, 2019, the HELP Subcommittee 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. Members and witnesses discussed how information on Pharmacy Benefit Managers' (PBMs) price negotiations with drug manufacturers are not provided to consumers. 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*, introduced by then-Chairman Bobby Scott (D–VA–3) and then-Ranking Member Foxx (R–NC–5). The legislation protected participants in employer-provided health plans from exorbitant out-of-network costs and included provisions improving transparency with respect to group health plan service providers, including those providing brokerage and consulting services. The Committee favorably reported the bill, as amended, by a recorded 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.

Full Committee Hearing reviewing the President's Fiscal Year 2023 Budget Proposal for the Department of Health and Human Services

On April 6, 2022, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services." The sole witness was the Honorable Xavier Becerra, Secretary of the U.S. Department of Health and Human

Services (HHS), Washington, D.C. The lack of transparency in PBMs' activities and the impacts on health plans was discussed at the hearing.

118TH CONGRESS

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 hospital billing practices, the need for increased transparency in health care, and lowering costs by expanding oversight of PBMs. Witnesses were Mr. Joel White, President, Council for Affordable Health Coverage, 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.

Full Committee Hearing Examining the President's Fiscal Year 2024 Budget Proposal for the Department of Health and Human Services

On June 13, 2023, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services." The sole witness was the Honorable Xavier Becerra, Secretary of HHS, Washington, D.C. Secretary Becerra spoke to the need for improved transparency of PBMs' activities.

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 need to improve competition and transparency in health care, including with respect to the activities of PBMs and third-party administrators (TPAs). 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.

Full Committee Markup of H.R. 4527, the Health DATA Act

On July 11, 2023, Rep. Lori Chavez-DeRemer (R–OR–5) introduced H.R. 4527, the *Health DATA Act*, with Reps. Mark Takano (D–CA–39) and Kathy Manning (D–NC–6) as original cosponsors. On July 12, 2023, the Committee met to mark up H.R. 4527 and reported it favorably, as amended, to the House of Representatives by a vote of 38 yeas and 1 nay. The Committee adopted an Amend-

ment in the Nature of a Substitute offered by Rep. Chavez-DeRemer, which made technical changes to H.R. 4527.

COMMITTEE VIEWS

STRENGTHENING THE GAG CLAUSE PROHIBITION

Transparency requirements were enacted as part of the *Consolidated Appropriations Act, 2021* (CAA).[2] The CAA added Section 724 to ERISA,[3] prohibiting gag clauses in contracts between health plans and issuers, health care providers, networks of providers, TPAs, and other service providers that restrict the plan or issuer from: obtaining cost or quality of care information; accessing de-identified claims data; or sharing information or data with a business associate. Plans and issuers must submit an annual attestation to the Departments of Labor, HHS, and the Treasury (jointly the tri-agencies) that they have complied with this requirement. In February, the tri-agencies issued guidance on the CAA's transparency provisions[4] and created a website for the submission of attestations to the Centers for Medicare and Medicaid Services.[5]

Despite the changes made by the CAA, plan fiduciaries report they have not been able to obtain information that should be available under ERISA Section 724. Service providers, such as TPAs and PBMs, reportedly continue to erect barriers that limit plan fiduciaries from having full access to this data. Common restrictions include limitations on audits—such as the number and frequency of audits—that effectively make the data inaccessible.

The responsibility under Section 724 is also misaligned; the prohibition on gag clauses is placed on the plan or issuer rather than on the service provider. The tri-agencies' guidance has compounded this problem by allowing service providers to submit the attestation on behalf of plans, even allowing for a single submission on behalf of multiple plans.

During the HELP Subcommittee's June 21, 2023, hearing on "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market," Ms. Monahan encouraged Congress to examine ways to expand the gag clause prohibitions included in the CAA; Ms. Monahan also noted that TPAs currently are not required to eliminate gag clauses, placing the onus on employers to try to negotiate contracts without gag clauses.[6] Ms. Sachdev highlighted that PBMs and TPAs often delay relaying information back to plan fiduciaries.[7] She also spoke of successful efforts made in Indiana to combat these practices.

H.R. 4527, HEALTH DATA ACT OF 2023

H.R. 4527 eliminates any ambiguity in the CAA's requirements and ensures that the provisions function consistent with congressional intent. H.R. 4527 ensures the information that should be

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[2] Pub. L. No. 116–260 (2020).

[3] Parallel provisions were added to Section 9824 of the Internal Revenue Code and Section 2799A–9 of the *Public Health Service Act*.

[4] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-57.pdf.

[5] https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance.

[6] https://edworkforce.house.gov/uploadedfiles/monahan_testimony.pdf.

[7] https://edworkforce.house.gov/uploadedfiles/sachdev_testimony.pdf.

available to plan fiduciaries under ERISA Section 724 is available by prohibiting barriers that limit access to this data. H.R. 4527 will empower plan fiduciaries to access and use data and information that is necessary to monitor their agreements with service providers in order to provide higher quality and more affordable coverage in group health plans.

H.R. 4527 SECTION-BY-SECTION SUMMARY

Section 1. Short title

Section 1 provides that the short title is "Health Data Access, Transparency and Affordability Act (Health DATA Act)."

Section 2. Strengthening the gag clause

Section 2(a) amends ERISA to provide that any contract or arrangement between a group health plan and any other entity (such as a health care provider, TPA, or PBM) is not reasonable within the meaning of the 408(b)(2) prohibited transaction exemption unless the responsible plan fiduciary is permitted to audit all de-identified claims and encounter information. A contract may not contain provisions that would:

- Limit the number of audits permitted during a period of time;
- Limit the number of claims and encounter data that a fiduciary may access during an audit;
- Limit the disclosure of pricing terms for value-based arrangements;
- Limit the disclosure of overpayments and overpayment recovery terms;
- Limit the right of the fiduciary to select an auditor;
- Delay the fiduciary by more than 60 days from auditing the information and data; or
- Charge a fee beyond the reasonable direct costs to conduct the audit.

Section 2(b) authorizes the Secretary of Labor to assess a civil monetary penalty against an entity that violates the *Health DATA Act* of $10,000 per day for each day the violation continues.

Section 3. Attestation

Section 3 of the *Health DATA Act* strengthens the gag clause attestation by requiring that the group health plan attestation include a statement verifying that the information is available upon request, is issued in a timely manner, and does not delay the fiduciary from auditing the information. Section 3 also includes a safeguard that prevents a TPA from submitting the attestation on behalf of the plan, with an alternative submission option available in cases in which the plan or issuer is unable to submit the attestation.

Section 4. Study on plan assets

Section 4 requires the Secretary of Labor to submit a report to the Committee on Education and the Workforce of the House of Representatives on de-identified claims and encounter data, whether this data could be deemed a plan asset under ERISA, and

whether the data belongs to a group health plan rather than a service provider.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

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. 4527 takes important steps to preserve and expand access to affordable, high-quality health care by ensuring that group health plan fiduciaries have effective access to plan data. H.R. 4527 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. 4527 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: 3 Bill: HR 4527 Amendment Number: n/a

Disposition: Adopted by a Full Committee Roll Call Vote (38-1)

Sponsor/Amendment: Chavez-Deremer 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: 38 Nos: 1 Not Voting: 6

Total: 45 / Quorum: / Report:

(25 R - 20 D)

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of rule XIII of the Rules of the House of Representatives, the goal of H.R. 4527 is to preserve and expand access to affordable, high-quality health care by ensuring that plan fiduciaries have effective access to de-identified claims and encounter information for their group health plans.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 4527 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 hearings held during the 118th Congress were used to develop or consider H.R. 4527: on April 26, 2023, the HELP Subcommittee held a hearing entitled "Reducing Health Care Costs for Working Americans and Their Families;" on June 13, 2023, the Committee held a hearing entitled "Examining the Policies and Priorities of the U.S. Department of Health and Human Services;" and on June 21, 2023, the HELP Subcommittee held a hearing entitled "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. 4527 provided by the Congressional Budget Office to Majority staff via email on September 12, 2023: "We estimate no effect on direct spending or revenues for H.R. 4527 (Health DATA Act of 2023), with time stamp July 10, 2023 at 3:42pm)."

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. 4527. 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

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

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PART 4—FIDUCIARY RESPONSIBILITY

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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 reasonably 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⟧ *this paragraph* are met.

(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, 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 services, 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, 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 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.

(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, 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 re-

tained), 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.

(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.

(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 pro-

vider 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, ex-

cept to the extent that such law prevents the application of a requirement of this section.

(C) No contract or arrangement for services between a group health plan and any other entity, such as a health care provider, network or association of providers, third-party administrator, or pharmacy benefit manager, is reasonable within the meaning of this paragraph unless such contract or agreement—

(i) allows the responsible plan fiduciary to audit all de-identified claims and encounter information or data described in section 724(a)(1)(B) to—

(I) ensure that such entity complies with the terms of the plan and any applicable law; and

(II) determine the reasonableness of compensation paid by the plan; and

(ii) does not—

(I) unreasonably limit the number of audits permitted during a given period of time;

(II) limit the number of de-identified claims and encounter information or data that the responsible plan fiduciary may access during an audit;

(III) limit the disclosure of pricing terms for value based payment arrangements, including—

(aa) payment calculations and formulas;

(bb) quality measures;

(cc) contract terms;

(dd) payment amounts;

(ee) measurement periods for all incentives; and

(ff) other payment methodologies furnished by a health care provider, network or association of providers, third-party administrator, or pharmacy benefit manager;

(IV) limit the disclosure of overpayments and overpayment recovery terms;

(V) limit the right of the responsible plan fiduciary to select an auditor;

(VI) otherwise limit or unduly delay by greater than 60 days the responsible plan fiduciary from auditing such information or data; or

(VII) charge a fee beyond the reasonable direct costs to administer the operation of conducting such audits.

(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 connec-

tion 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 trans-

action 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 arrangement 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 there-

of 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 par-

ticipants 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 transaction 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 ad-

vice 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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EXCULPATORY PROVISIONS; INSURANCE

SEC. 410. (a) Except as provided in sections 405(b)(1) and 405(d), any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy.

(b) Nothing in this subpart shall preclude—

(1) a plan from purchasing insurance for its fiduciaries or for itself to cover liability or losses occurring by reason of the act or omission of a fiduciary, if such insurance permits recourse by the insurer against the fiduciary in the case of a breach of a fiduciary obligation by such fiduciary;

(2) a fiduciary from purchasing insurance to cover liability under this part from and for his own account; or

(3) an employer or an employee organization from purchasing insurance to cover potential liability of one or more persons who serve in a fiduciary capacity with regard to an employee benefit plan.

(c) Any provision in an agreement or instrument shall be void as against public policy if such provision—

(1) unduly delays or limits a plan fiduciary from accessing the de-identified claims and encounter information or data described in section 724(a)(1)(B); or

(2) violates the requirements of section 408(b)(2)(C).

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PART 5—ADMINISTRATION AND ENFORCEMENT

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CIVIL ENFORCEMENT

SEC. 502. (a) A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of section 105(c) or 113(a);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), **[**or (9)**]** *(9), or (13)* of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A));

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1), (A) to enjoin any act or practice which violates subsection (f) of section 101, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts;

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 305, if the plan sponsor—

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan; or

(11) in the case of a multiemployer plan, by an employee representative, or any employer that has an obligation to contribute to the plan, (A) to enjoin any act or practice which violates subsection (k) of section 101 (or, in the case of an employer, subsection (l) of such section), or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection.

(b)(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515.

(3) Except as provided in subsections (c)(9) and (a)(6) (with respect to collecting civil penalties under subsection (c)(9)), the Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 706(a)(1)). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c)(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606, section 101(e)(1), section 101(f),, section 105(a), or section 113(a) with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such fail-

ure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(1). For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) with respect to any person or who fails to meet the requirements of section 302(d)(12)(E) with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of subsection (j), (k), or (l) of section 101 or section 514(e)(3).

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g).

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6), the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with subsection (i) or (m) of section 101. For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary may assess against any plan sponsor of a multiemployer plan a civil penalty of not more than $1,100 per day—

(A) for each violation by such sponsor of the requirement under section 305 to adopt by the deadline established in

that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status, or

(B) in the case of a plan in endangered status which is not in seriously endangered status, for failure by the plan to meet the applicable benchmarks under section 305 by the end of the funding improvement period with respect to the plan.

(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(10) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO USE OF GENETIC INFORMATION.—

(A) GENERAL RULE.—The Secretary may impose a penalty against any plan sponsor of a group health plan, or any health insurance issuer offering health insurance coverage in connection with the plan, for any failure by such sponsor or issuer to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 702 or section 701 or 702(b)(1) with respect to genetic information, in connection with the plan.

(B) AMOUNT.—

(i) IN GENERAL.—The amount of the penalty imposed by subparagraph (A) shall be $100 for each day in the noncompliance period with respect to each participant or beneficiary to whom such failure relates.

(ii) NONCOMPLIANCE PERIOD.—For purposes of this paragraph, the term "noncompliance period" means, with respect to any failure, the period—

(I) beginning on the date such failure first occurs; and

(II) ending on the date the failure is corrected.

(C) MINIMUM PENALTIES WHERE FAILURE DISCOVERED.—Notwithstanding clauses (i) and (ii) of subparagraph (D):

(i) IN GENERAL.—In the case of 1 or more failures with respect to a participant or beneficiary—

(I) which are not corrected before the date on which the plan receives a notice from the Secretary of such violation; and

(II) which occurred or continued during the period involved;

the amount of penalty imposed by subparagraph (A) by reason of such failures with respect to such participant or beneficiary shall not be less than $2,500.

(ii) HIGHER MINIMUM PENALTY WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under this paragraph for

any year are more than de minimis, clause (i) shall be applied by substituting "$15,000" for "$2,500" with respect to such person.

(D) LIMITATIONS.—

(i) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by subparagraph (A) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such penalty did not know, and exercising reasonable diligence would not have known, that such failure existed.

(ii) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No penalty shall be imposed by subparagraph (A) on any failure if—

(I) such failure was due to reasonable cause and not to willful neglect; and

(II) such failure is corrected during the 30-day period beginning on the first date the person otherwise liable for such penalty knew, or exercising reasonable diligence would have known, that such failure existed.

(iii) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect, the penalty imposed by subparagraph (A) for failures shall not exceed the amount equal to the lesser of—

(I) 10 percent of the aggregate amount paid or incurred by the plan sponsor (or predecessor plan sponsor) during the preceding taxable year for group health plans; or

(II) $500,000.

(E) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by subparagraph (A) to the extent that the payment of such penalty would be excessive relative to the failure involved.

(F) DEFINITIONS.—Terms used in this paragraph which are defined in section 733 shall have the meanings provided such terms in such section.

(11) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act.

(12) The Secretary may assess a civil penalty against any sponsor of a CSEC plan of up to $100 a day from the date of the plan sponsor's failure to comply with the requirements of section 306(j)(3) to establish or update a funding restoration plan.

(13) In the case of an agreement between a group health plan and a health care provider, network or association of providers, third-party administrator, pharmacy benefit manager, or other service provider that violates the provisions of section 724, the Secretary

may assess a civil penalty against such provider, network or association, third-party administrator, pharmacy benefit manager, or other service provider in the amount of $10,000 for each day during which such violation continues. Such penalty shall be in addition to other penalties as may be prescribed by law.

(d)(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1). State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g)(1) In any action under this title (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986.

(h) A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) In the case of a transaction prohibited by section 406 by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code.

(j) In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l)(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986.

(m) In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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SEC. 724. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.

(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

(1) IN GENERAL.—A group health plan (or an issuer of health insurance coverage offered in connection with such a plan) may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

[(3) ATTESTATION.—A group health plan (or health insurance coverage offered in connection with such a plan) shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.**]**

(3) ATTESTATION.—

(A) IN GENERAL.—Subject to subparagraph (C), the fiduciary of a group health plan or issuer offering group health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection. Such attestation shall also include a statement verifying that—

(i) the information or data described under subparagraphs (A) and (B) of paragraph (1) is available upon request and provided to the plan fiduciary, the plan administrator, or the issuer in a timely manner; and

(ii) there are no terms in the agreement under such paragraph (1) that directly or indirectly restrict or unduly delay a plan fiduciary, the plan administrator, or the issuer from auditing, reviewing, or otherwise accessing such information.

(B) LIMITATION ON SUBMISSION.—Subject to clause (ii), a group health plan or issuer offering group health insurance

coverage may not enter into an agreement with a third-party administrator or other service provider to submit the attestation required under subparagraph (A).

(C) EXCEPTION.—In the case of a group health plan or issuer offering group health insurance coverage that is unable to obtain the information or data needed to submit the attestation required under subparagraph (A), such plan or issuer may submit a written statement in lieu of such attestation that includes—

(i) an explanation of why such plan or issuer was unsuccessful in obtaining such information or data, including whether such plan or issuer was limited or prevented from auditing, reviewing, or otherwise accessing such information or data;

(ii) a description of the efforts made by the plan fiduciary to remove any gag clause provisions from the agreement under paragraph (1); and

(iii) a description of any response by the third-party administrator or other service provider with respect to efforts to comply with the attestation requirement under subparagraph (A).

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

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