118TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 118–742
Part 1

TRANSPARENCY IN COVERAGE ACT

NOVEMBER 18, 2024.—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. 4507]

The Committee on Education and the Workforce, to whom was referred the bill (H.R. 4507) to amend the Employee Retirement Income Security Act of 1974 to promote transparency in health coverage and reform pharmacy benefit management services with respect to group health plans, and for other purposes, 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 "Transparency in Coverage Act".

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

(a) IN GENERAL.—

(1) ERISA.—

(A) IN GENERAL.—Section 719 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185h) is amended to read as follows:

"SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.

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

"(1) Claims payment policies and practices.

"(2) Periodic financial disclosures.

"(3) Data on enrollment.

"(4) Data on disenrollment.

"(5) Data on the number of claims that are denied.

"(6) Data on rating practices.

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

"(8) Information on participant and beneficiary rights under this part.

"(9) Rate and payment information described in subsection (d).

"(10) Other information as determined appropriate by the Secretary.

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

"(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

"(c) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall, upon request of a participant or beneficiary and in a timely manner, provide to the participant or beneficiary a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant's or beneficiary's plan or coverage that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the participant or beneficiary, that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group health insurance coverage (as applicable) furnished by a health care provider to a participant or beneficiary of such plan or coverage, the following:

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

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

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the amount or rate described in such subparagraph (or, in the case such plan or issuer uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

"(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

"(F) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

"(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or group health insurance coverage.

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

"(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

"(D) allows such a request to be made with respect to an item or service furnished by—

"(i) a specific provider that is a participating provider with respect to such item or service;

"(ii) all providers that are participating providers with respect to such plan and such item or service for purposes of facilitating price comparisons; or

"(iii) a provider that is not described in clause (ii); and

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

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

"(4) PROVIDER TOOL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by another provider in a timely manner upon the request of the provider and with the consent of such individual in the same manner and to the same extent as if such request has been made by such individual. As part of any tool used to facilitate such requests from a provider, such plan or issuer offering health insurance coverage may include functionality that—

"(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6 of the Public Health Service Act; and

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

"(d) RATE AND PAYMENT INFORMATION.—

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

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

"(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

"(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by

each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

"(2) MANNER OF PUBLICATION.—

"(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in the same file or in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans and group health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(B) REAL-TIME PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

"(ii) EXEMPTION FOR CERTAIN PLANS OR COVERAGE.—Clause (i) shall not apply with respect to information described in such clause required to be made available by a group health plan or health insurance issuer offering health insurance coverage if such plan or coverage, as applicable, provides benefits for fewer than 500 participants and beneficiaries.

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

"(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan and health insurance issuer offering group health insurance coverage shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such year (such as averages of all such information so made public).

"(e) ATTESTATION.—Each group health plan and health insurance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation of such plan's or such coverage's compliance with the provisions of this section along with a link to disclosures made in accordance with subsection (a).

"(f) DEFINITIONS.—In this subsection:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 716 and includes a participating facility.

"(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.".

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

"Sec. 719. Price transparency requirements.".

(2) IRC.—

(A) IN GENERAL.—Section 9819 of the Internal Revenue Code of 1986 is amended to read as follows:

"SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.

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

"(1) Claims payment policies and practices.

"(2) Periodic financial disclosures.

"(3) Data on enrollment.

"(4) Data on disenrollment.

"(5) Data on the number of claims that are denied.

"(6) Data on rating practices.

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

"(8) Information on participant and beneficiary rights under this part.

"(9) Rate and payment information described in subsection (d).

"(10) Other information as determined appropriate by the Secretary.

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

"(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

"(c) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—A group health plan shall, upon request of a participant or beneficiary and in a timely manner, provide to the participant or beneficiary a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant's or beneficiary's plan that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the participant or beneficiary, that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan furnished by a health care provider to a participant or beneficiary of such plan, the following:

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

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

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the amount or rate described in such subparagraph (or, in the case such plan uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

"(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

"(F) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

"(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan.

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

"(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

"(D) allows such a request to be made with respect to an item or service furnished by—

"(i) a specific provider that is a participating provider with respect to such item or service;

"(ii) all providers that are participating providers with respect to such item or service for purposes of facilitating price comparisons; or

"(iii) a provider that is not described in clause (ii); and

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

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

"(4) PROVIDER TOOL.—A group health plan shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan that the individual would be responsible for paying with respect to the furnishing of a specific item or service by another provider in a timely manner upon the request of the provider and with the consent of such individual in the same manner and to the same extent as if such request has been made by such individual. As part of any tool used to facilitate such requests from a provider, such plan may include functionality that—

"(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6 of the Public Health Services Act; and

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

"(d) RATE AND PAYMENT INFORMATION.—

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

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

"(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

"(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission

to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

"(2) MANNER OF PUBLICATION.—

"(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(B) REAL-TIME PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

"(ii) EXEMPTION FOR CERTAIN PLANS AND COVERAGE.—Clause (i) shall not apply with respect to information described in such clause required to be made available by a group health plan if such plan provides benefits for fewer than 500 participants and beneficiaries.

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

"(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan with respect to such plan or coverage during such year (such as averages of all such information so made public).

"(e) ATTESTATION.—Each group health plan shall annually submit to the Secretary an attestation of such plan's compliance with the provisions of this section along with a link to disclosures made in accordance with subsection (a).

"(f) DEFINITIONS.—In this subsection:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 9816 and includes a participating facility.

"(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan and such provider for such item or service.".

(B) CLERICAL AMENDMENT.—The item relating to section 9819 in the table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended to read as follows:

"Sec. 9819. Price transparency requirements.".

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

"SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.

"(a) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall make available to the public accurate and timely disclosures of the following information:

"(1) Claims payment policies and practices.

"(2) Periodic financial disclosures.

"(3) Data on enrollment.

"(4) Data on disenrollment.

"(5) Data on the number of claims that are denied.

"(6) Data on rating practices.

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

"(8) Information on enrollee rights under this part.

"(9) Rate and payment information described in subsection (d).

"(10) Other information as determined appropriate by the Secretary.

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

"(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

"(c) COST SHARING TRANSPARENCY.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, upon request of an enrollee and in a timely manner, provide to the enrollee a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the enrollee's plan or coverage that the enrollee would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the enrollee through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the enrollee, that meets such requirements as the Secretary may specify.

"(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group or individual health insurance coverage (as applicable) furnished by a health care provider to an enrollee of such plan or coverage, the following:

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

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

"(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the enrollee will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the amount or rate described in such subparagraph (or, in the case such plan or issuer uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

"(D) The amount the enrollee has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (bro-

ken down, in the case separate deductibles or maximums apply to separate enrollees in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

"(E) Any shared savings or other benefit available to the enrollee with respect to such item or service.

"(F) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such enrollee has accrued towards such limitation with respect to such item or service.

"(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or group or individual health insurance coverage.

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

"(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

"(B) provides for real-time responses to requests described in paragraph (1);

"(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

"(D) allows such a request to be made with respect to an item or service furnished by—

"(i) a specific provider that is a participating provider with respect to such item or service;

"(ii) all providers that are participating providers with respect to such plan and such item or service for purposes of facilitating price comparisons; or

"(iii) a provider that is not described in clause (ii); and

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

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

"(4) PROVIDER TOOL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by another provider in a timely manner upon the request of the provider and with the consent of such individual in the same manner and to the same extent as if such request has been made by such individual. As part of any tool used to facilitate such requests from a provider, such plan or issuer offering health insurance coverage may include functionality that—

"(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6; and

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

"(d) RATE AND PAYMENT INFORMATION.—

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

"(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

"(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a par-

ticipating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

"(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

"(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

"(2) MANNER OF PUBLICATION.—

"(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

"(B) REAL-TIME PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

"(ii) EXEMPTION FOR CERTAIN PLANS AND COVERAGE.—Clause (i) shall not apply with respect to information described in such clause required to be made available by a group health plan or health insurance issuer offering health insurance coverage if such plan or coverage, as applicable, provides benefits for fewer than 500 enrollees.

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

"(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan and health insurance issuer offering group or individual health insurance coverage shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such year (such as averages of all such information so made public).

"(e) ATTESTATION.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation of such plan's or such coverage's compliance with the provisions of this section along with a link to disclosures made in accordance with subsection (a).

"(f) DEFINITIONS.—In this subsection:

"(1) PARTICIPATING PROVIDER.—The term 'participating provider' has the meaning given such term in section 2799A–1 and includes a participating facility.

"(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.".

(b) REPORTS TO CONGRESS.—

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

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

(A) between rural and urban markets;
(B) in the individual, small-employer, and large-employer markets;
(C) in consolidated and non-consolidated provider markets;
(D) between non-profit and for-profit hospitals; and
(E) between non-profit and for-profit insurers.

(c) EFFECTIVE DATE.—

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

(2) CONTINUED APPLICABILITY OF RULES FOR PREVIOUS YEARS.—Nothing in the amendments made by subsection (a) may be construed as affecting the applicability of the rule entitled "Transparency in Coverage" published by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services on November 12, 2020 (85 Fed. Reg. 72158) for plan years beginning before January 1, 2025.

SEC. 3. PHARMACY BENEFIT MANAGER TRANSPARENCY.

(a) ERISA.—

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

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

"SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

"(a) IN GENERAL.—For plan years beginning on or after January 1, 2025, a group health plan (or health insurance issuer offering group health insurance coverage in connection with such a plan) or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making or substantiating the reports described in subsection (b).

"(b) REPORTS.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage, shall submit to the plan administrator (as defined in section 3(16)(A)) of such plan or coverage a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

"(A) information collected from a patient or copay assistance program administrator by such entity on the total amount of copayment assistance dollars paid, or copayment cards applied, or other discounts that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan or coverage;

"(B) total gross spending on prescription drugs by the plan or coverage during the reporting period;

"(C) total amount received, or expected to be received, by the plan or coverage from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan or coverage during the reporting period;

"(D) the total net spending on prescription drugs by the plan or coverage during such reporting period;

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

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

"(ii) the percentage of total prescriptions charged to the plan, issuer, or participants and beneficiaries in such plan or coverage, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

"(iii) a list of all drugs dispensed by such affiliated pharmacy or pharmacy under common ownership and charged to the plan, issuer, or participants and beneficiaries of the plan, during the applicable period, and, with respect to each drug—

"(I)(aa) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, with respect to participants and beneficiaries in the plan or coverage, to the plan or issuer; and

"(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

"(II) the median amount charged to the plan or issuer, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

"(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan or coverage;

"(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan or coverage;

"(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

"(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan or issuer and participants and beneficiaries among all pharmacies included in the network of such plan or coverage; and

"(G) in the case of a large employer—

"(i) a list of each drug covered by such plan, issuer, or entity providing pharmacy benefits management services for which a claim was filed during the reporting period, including, with respect to each such drug during the reporting period—

"(I) the brand name, generic or non-proprietary name, and the National Drug Code;

"(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

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

"(III) the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit on date of dispensing;

"(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan or coverage, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan or coverage, or for which no claim was submitted to such plan or coverage);

"(V) for any drug for which gross spending of the plan or coverage exceeded $10,000 during the reporting period—

"(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological products, generic drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

"(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

"(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

"(I) total gross spending by the plan;

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

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

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

"(V) for each drug—

"(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

"(AA) for claims incurred during the reporting period; or

"(BB) that is related to utilization of drugs or drug spending;

"(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

"(cc) the average net spending per 30-day supply and per 90-day supply, incurred by the health plan or health insurance coverage and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period.

"(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Port-

ability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

"(3) DISCLOSURE AND REDISCLOSURE.—

"(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

"(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

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

"(4) REPORT TO GAO.—A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

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

"(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Labor to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

"(d) DEFINITIONS.—In this section:

"(1) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

"(2) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act."; and

(B) in section 502 (29 U.S.C. 1132)—

(i) in subsection (a)—

(I) in paragraph (6), by striking "or (9)" and inserting "(9), or (13)";

(II) in paragraph (10), by striking at the end "or";

(III) in paragraph (11), at the end by striking the period and inserting "; or"; and

(IV) by adding at the end the following new paragraph:

"(12) by the Secretary, to enforce section 726.";

(ii) in subsection (b)(3), by inserting "and subsections (a)(12) and (c)(13)" before ", the Secretary is not"; and

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

"(13) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.—

"(A) FAILURE TO PROVIDE TIMELY INFORMATION.—The Secretary may impose a penalty against any health insurance issuer or entity providing pharmacy benefits management services that violates section 726(a) or fails to provide information required under section 726(b) in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

"(B) FALSE INFORMATION.—The Secretary may impose a penalty against a health insurance issuer or entity providing pharmacy benefits management services that knowingly provides false information under section 726 in an amount not to exceed $100,000 for each item of false information. Such penalty shall be in addition to other penalties as may be prescribed by law.

"(C) WAIVERS.—The Secretary may waive penalties under subparagraph (A), or extend the period of time for compliance with a requirement of section 726, for an entity in violation of such section that has made a good-faith effort to comply with such section.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 725 the following new item:

"Sec. 726. Oversight of pharmacy benefits manager services.".

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

"SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

"(a) IN GENERAL.—For plan years beginning on or after January 1, 2025, a group health plan (or health insurance issuer offering group health insurance coverage in connection with such a plan) or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making or substantiating the reports described in subsection (b).

"(b) REPORTS.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage, shall submit to the plan administrator (as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974) of such plan or coverage a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

"(A) information collected from a patient or copay assistance program administrator by such entity on the total amount of copayment assistance dollars paid, or copayment cards applied, or other discounts that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan or coverage;

"(B) total gross spending on prescription drugs by the plan or coverage during the reporting period;

"(C) total amount received, or expected to be received, by the plan or coverage from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan or coverage during the reporting period;

"(D) the total net spending on prescription drugs by the plan or coverage during such reporting period;

"(E) amounts paid, directly or indirectly, in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act of 1974) to brokerage houses, brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's or health insurance issuer's business to the pharmacy benefits manager, identified by the recipient of such amounts;

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

"(ii) the percentage of total prescriptions charged to the plan, issuer, or participants and beneficiaries in such plan or coverage, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

"(iii) a list of all drugs dispensed by such affiliated pharmacy or pharmacy under common ownership and charged to the plan, issuer, or participants and beneficiaries of the plan, during the applicable period, and, with respect to each drug—

"(I)(aa) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, with respect to participants and beneficiaries in the plan or coverage, to the plan or issuer; and

"(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

"(II) the median amount charged to the plan or issuer, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

"(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan or coverage;

"(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan or coverage;

"(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

"(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan or issuer and participants and beneficiaries among all pharmacies included in the network of such plan or coverage; and

"(G) in the case of a large employer—

"(i) a list of each drug covered by such plan, issuer, or entity providing pharmacy benefits management services for which a claim was filed during the reporting period, including, with respect to each such drug during the reporting period—

"(I) the brand name, generic or non-proprietary name, and the National Drug Code;

"(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

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

"(III) the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit on date of dispensing;

"(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan or coverage, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan or coverage, or for which no claim was submitted to such plan or coverage);

"(V) for any drug for which gross spending of the plan or coverage exceeded $10,000 during the reporting period—

"(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological prod-

ucts, generic drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

"(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

"(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

"(I) total gross spending by the plan;

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

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

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

"(V) for each drug—

"(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

"(AA) for claims incurred during the reporting period; or

"(BB) that is related to utilization of drugs or drug spending;

"(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

"(cc) the average net spending per 30-day supply and per 90-day supply, incurred by the health plan or health insurance coverage and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period.

"(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

"(3) DISCLOSURE AND REDISCLOSURE.—

"(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

"(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

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

"(4) REPORT TO GAO.—A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

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

"(c) ENFORCEMENT.—

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

"(2) FALSE INFORMATION.—An entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

"(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

"(4) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Health and Human Services to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

"(e) DEFINITIONS.—In this section:

"(1) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

"(2) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.".

(c) IRC.—

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

"SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

"(a) IN GENERAL.—For plan years beginning on or after January 1, 2025, a group health plan or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan, from making or substantiating the reports described in subsection (b).

"(b) REPORTS.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan, or an entity providing pharmacy benefits management services on behalf of a group health plan, shall submit to the plan administrator (as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974) of such plan a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan—

"(A) information collected from a patient or copay assistance program administrator by such entity on the total amount of copayment assistance dollars paid, or copayment cards applied, or other discounts that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan;

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

"(C) total amount received, or expected to be received, by the plan from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan during the reporting period;

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

"(E) amounts paid, directly or indirectly, in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act of 1974) to brokerage houses, brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's business to the pharmacy benefits manager, identified by the recipient of such amounts;

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

"(ii) the percentage of total prescriptions charged to the plan, or participants and beneficiaries in such plan, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

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

"(I)(aa) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, with respect to participants and beneficiaries in the plan, to the plan; and

"(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

"(II) the median amount charged to the plan, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

"(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan;

"(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan;

"(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

"(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per-90 day supply, for such drug, including amounts charged to the plan and participants and beneficiaries among all pharmacies included in the network of such plan; and

"(G) in the case of a large employer—

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

"(I) the brand name, generic or non-proprietary name, and the National Drug Code;

"(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

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

"(III) the wholesale acquisition cost, listed as cost per days supply and cost per dosage unit on date of dispensing;

"(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan, or for which no claim was submitted to such plan);

"(V) for any drug for which gross spending of the plan exceeded $10,000 during the reporting period—

"(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological products, generic drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

"(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

"(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the plan during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

"(I) total gross spending by the plan;

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

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

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

"(V) for each drug—

"(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

"(AA) for claims incurred during the reporting period; or

"(BB) that is related to utilization of drugs or drug spending;

"(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the plan on that category or class of drugs; and

"(cc) the average net spending per 30-day supply and per 90-day supply, incurred by the plan and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period.

"(2) PRIVACY REQUIREMENTS.—Entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

"(3) DISCLOSURE AND REDISCLOSURE.—

"(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

"(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents an entity providing pharmacy benefits management services on behalf of a group health plan from placing reason-

able restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

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

"(4) REPORT TO GAO.—An entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

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

"(c) ENFORCEMENT.—

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

"(2) FALSE INFORMATION.—An entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

"(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

"(4) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of the Treasury to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such plan or entity.

"(e) DEFINITIONS.—In this section:

"(1) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

"(2) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.".

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 9826. Oversight of pharmacy benefits manager services.".

SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.

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

"SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.

"(a) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage shall—

"(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant of beneficiary in the plan or coverage from informing (or penalize such pharmacy for informing) a participant or beneficiary

of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

"(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

"(b) DEFINITION.—For purposes of this section, the term 'out-of-pocket cost', with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.".

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

"Sec. 727. Information on prescription drugs.".

SEC. 5. ADVISORY COMMITTEE ON THE ACCESSIBILITY OF CERTAIN INFORMATION.

(a) IN GENERAL.—Not later than January 1, 2025, the Secretary of Labor (in this section referred to as the "Secretary") shall convene an Advisory Committee (in this section referred to as the "Committee") consisting of 9 members to advise the Secretary on how to improve the accessibility and usability of information made available in accordance the amendments made by section 3 and by section 204 of division BB of the Consolidated Appropriation Act, 2021 (Public Law 116–260), streamline the reporting of such information, and ensure that such information fully meets the needs of employers, patients, researchers, regulators, and purchasers.

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

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

PURPOSE

H.R. 4507, the *Transparency in Coverage Act*, amends the *Employee Retirement Income Security Act of 1974* (ERISA)[1] to promote group health plan and group health insurance coverage price transparency. The bill codifies and strengthens the final rule titled "Transparency in Coverage" (TiC),[2] which requires plans and issuers to disclose pricing and cost-sharing information to participants and beneficiaries and to make payment rate data public. The bill also prevents plans from contracting with Pharmacy Benefit Managers (PBMs) unless PBMs report certain information to plan administrators.

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

[1] 29 U.S.C. § 1001 *et seq*.
[2] Transparency in Coverage, 85 Fed. Reg. 72,158 (Nov. 12, 2020).

discussed hospital billing practices, including unexpected costs to consumers due, in part, to a lack of transparency in health care. 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 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. Members and witnesses discussed the need for more transparency in hospital billing. Witnesses further discussed the positive impact that increased transparency will have on boosting competition in health care.

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 PBMs' price negotiations with drug manufacturers is 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*. The legislation 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 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." 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, Mary-

land. The hearing included a discussion regarding how the lack of PBM transparency contributes to higher costs for plans and consumers.

Full Committee Hearing Examining 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 the need for increased transparency in health care and lowering costs by expanding oversight into PBMs. During the hearing, members and witnesses discussed how a lack of transparency is associated with PBMs not passing on savings to employer-provided health plans. The 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's 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. 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 Center 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. 4507, the Transparency in Coverage Act

On July 10, 2023, Rep. Bob Good (R–VA–5), Chairman of the HELP Subcommittee, introduced H.R. 4507, the *Transparency in Coverage Act*, with Rep. Mark DeSaulnier (D–CA–10), Ranking Member of the HELP Subcommittee, as an original cosponsor. On July 12, 2023, the Committee met to mark up H.R. 4507 and The Committee adopted an Amendment in the Nature of a Substitute offered by Rep. Good, which made technical changes to H.R. 4507. Rep. Lori Chavez-DeRemer (R–OR–5) offered an amendment to add the *Safe Step Act* (H.R. 2630, 118th), legislation requiring group health plans to offer exceptions to step-therapy protocols, to the bill. The amendment was withdrawn. The Committee reported the bill favorably, as amended, to the House of Representatives by a vote of 38 yeas and 1 nay.

COMMITTEE VIEWS

TRANSPARENCY IN COVERAGE

In 2020, the U.S. Departments of Labor, HHS, and the Treasury (jointly tri-agencies) published a final rule titled "Transparency in Coverage"[3] (TiC) requiring that most health plans and issuers make available to participants and beneficiaries personalized, out-of-pocket cost information and the underlying negotiated rates for all covered health care items and services (including prescription drugs) through an internet-based self-service tool and in paper form upon request. The rule also requires that most health plans and issuers make available to the public three separate machine-readable files that include detailed pricing information.

While parts of the TiC rule were slated to go into effect on January 1, 2022, the tri-agencies delayed some implementation deadlines by six months.[4] On July 1, 2022, the Centers for Medicare and Medicaid Services (CMS) within HHS began enforcing the requirement that health plans publicly disclose the contracted prices they pay their in-network health care providers and the allowed amounts they will pay out-of-network providers. Beginning January 1, 2023, health plans were required to create a tool for their enrollees to receive real-time, personalized estimates of potential cost-sharing liability for 500 designated items and services. As of January 1, 2024, the cost-sharing tool must provide the same information for all covered items and services.[5] Noncompliant payers may face fines of up to $100 per day for each violation and for each individual affected.

In August 2021, the U.S. Chamber of Commerce and the Pharmaceutical Care Management Association (PCMA) filed lawsuits challenging the requirement that PBMs must report the historical

[3] Transparency in Coverage, 85 Fed. Reg. 72,158 (Nov. 12, 2020).
[4] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.
[5] *Id.*

net price of prescription drugs. The lawsuits argued that federal officials could not require the disclosure of historical net price information.[6] These organizations withdrew their lawsuits after the tri-agencies issued guidance deferring enforcement of the drug-price transparency provisions pending further rulemaking.[7]

Experts have identified ways to build on the TiC rule to make data more accessible and user-friendly and to improve compliance. A recent report found that many of the uploaded data files are too large to access and the data as presented is challenging to understand.[8] The TiC rule preamble discusses the benefits of standardizing the data for the use of standards-based application programming interface (API) to improve access and plan compliance. Access to pricing information through an API could have a number of benefits for consumers, employers, and providers, including providing real-time access to pricing information, providing access to personalized actionable health care price estimates through an application of the consumer's choice, and enabling third-party developers to develop internet-based self-service tools.[9]

TiC reporting requirements are geared towards fee-for-service reporting and fail to capture prices fully from value-based arrangements (VBAs). The *Transparency in Coverage Act* addresses this shortcoming.

PHARMACY BENEFIT MANAGER REPORTING

PBMs serve as intermediaries between pharmaceutical manufacturers and health insurers, Medicare Part D drug plans, employers, and other payers. PBMs create formularies, negotiate rebates with manufacturers, process claims, create pharmacy networks, and review drug utilization. The Congressional Budget Office (CBO) found that PBMs' ability to negotiate larger rebates from manufacturers has helped lower governmental costs and copays for plan enrollees.[10] However, in light of rising health care costs, PBMs have faced growing scrutiny for their role in prescription drug costs and spending.

By negotiating with drug manufacturers and pharmacies to control costs, PBMs have a significant behind-the-scenes impact in determining total drug costs for insurers, shaping patients' access to medications, and determining how much pharmacies are paid. PBMs primarily earn profits through administrative fees charged for their services, spread pricing, and shared savings, where the PBM keeps part of the rebates or discounts negotiated with drug manufacturers. There has been increasing concern that the current structure creates a perverse incentive as higher list prices for drugs often translate into higher compensation for PBMs. Policymakers have also raised concerns that patients lack adequate line of sight into the financial flows and incentives that inform pricing.[11]

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[6] https://www.healthaffairs.org/content/forefront/two-new-lawsuits-challenge-insurer-transparency-rule.
[7] https://news.bloomberglaw.com/health-law-and-business/end-delay-of-drug-price-transparency-rule-employer-group-urges.
[8] https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.
[9] Transparency in Coverage, 85 Fed. Reg. 72,158 (Nov. 12, 2020).
[10] https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.
[11] https://oversight.house.gov/wp-content/uploads/2021/12/PBM-Report-12102021.pdf.

Three PBMs—CVS Caremark, Express Scripts, and OptumRx—account for nearly 90 percent of the market.[12] While some have argued that this consolidation increases the bargaining power of PBMs relative to drug manufacturers, others have raised concerns that less competition among PBMs reduces competitive pressures and may allow them to earn higher profits than they would in a more competitive market.

PBMs have also come under scrutiny for vertically integrating with health insurers and pharmacies. The three largest PBMs are each vertically integrated with a major health insurer—CVS Caremark with Aetna, Express Scripts with Cigna, and OptumRx with UnitedHealth Group. In its 2023 Report to Congress, the Medicare Payment Advisory Committee (MedPAC) warns that these large PBMs may have conflicting interests among their integrated entities.[13] The Federal Trade Commission is currently studying the effects of vertical integration on access to prescription drugs.[14]

PBM reimbursement methods can be complex and unclear. Two practices of particular concern are rebate pricing models and spread pricing. For certain prescriptions, PBMs receive rebates and discounts from pharmaceutical companies in exchange for formulary placement. One study found a direct correlation between rebate increases and manufacturer price increases: a $1 increase in rebates corresponds with a $1.17 increase in drug list price, suggesting that rebates play a role in increasing list prices.[15] PBMs may retain manufacturer rebates as profits rather than passing them through to their health plan clients. When health plans lack full transparency and cannot see how much manufacturers paid in rebates, they do not know how much their PBM retained as profits.

Spread pricing occurs when PBMs charge health plans and payers more for a prescription drug than what they reimburse to the pharmacy and then keep the difference. Because neither the plan nor the pharmacy knows what the other side was paid or charged, the practice hides the PBM's margins. State auditors have found PBMs overcharging Medicaid programs by more than $415 million in Ohio, Kentucky, Illinois, and Arkansas. Allegations of overcharging were settled in Kansas for $27.6 million, New Hampshire for $21.2 million, and New Mexico for $13.7 million.[16]

In the 116th Congress, S. 1895, the *Lower Health Care Costs Act of 2019*, was a bipartisan bill reported by the Senate Committee on Health, Education, Labor, and Pensions. It would have required PBMs to provide quarterly reports to plan sponsors with detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, a formulary placement rationale, and aggregate rebate information. CBO estimated that subsequent iterations of this legislation would save the federal government $2.2 billion over the 10-year budgetary window.[17]

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[12] https://content.naic.org/cipr-topics/pharmacy-benefit-managers.
[13] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.
[14] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry.
[15] https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/.
[16] https://oversight.house.gov/wp-content/uploads/2023/03/Letter-to-CMS.pdf.
[17] https://www.cbo.gov/system/files/2022-06/hr7666.pdf.

During the HELP Subcommittee's June 21, 2023, hearing on "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market," Ms. Monahan spoke in support of codifying the Transparency in Coverage rule.[18] Mr. Baker, Ms. Monahan, Ms. Tripoli, and Dr. Sachdev each expressed support for increased PBM transparency.[19]

H.R. 4507, TRANSPARENCY IN COVERAGE ACT

H.R. 4507, the *Transparency in Coverage Act*, amends ERISA, the *Public Health Service Act* (PHSA), and the Internal Revenue Code (IRC) to promote price transparency in group health plans and health insurance coverage. The bill codifies the tri-agency TiC rule, which increased requirements on plans to make pricing data public and provide information directly to participants and beneficiaries. The bill also prevents group health plans from contracting with PBMs unless PBMs report certain payment information to plan administrators.[20]

H.R. 4507 builds off the important work of the TiC rule. Codifying the rule will give employers, plans, and other health care stakeholders certainty over their future reporting obligations. The bill makes improvements to the usability of the data required to be reported by streamlining the machine-readable files that plans and issuers must upload to ensure they are not overwhelmed by duplicative information and ensuring that data is reported in dollars so that enrollees can know with certainty the amount they are expected to pay for services. The bill further requires PBMs to report information on their prescription drug spending and provide quarterly reports to plan administrators, giving plan administrators the information needed to weigh the value that their respective PBM provides to their plans. Each of these steps will make health care pricing more transparent, leading to more informed purchasing choices, better outcomes, and lower spending.

H.R. 4507 SECTION-BY-SECTION SUMMARY

Section 1. Short title

Section 1 provides that the short title is "Transparency in Coverage Act."

Section 2. Promoting group health plan and group health insurance coverage price transparency

Section 2 amends ERISA Section 719, IRC Section 9819, and PHSA Section 2799A–4 to codify the TiC rule. The amendments to ERISA Section 719 (a)–(c)(1) restate portions of current law from Section 1311(e)(3) of the *Affordable Care Act* (ACA) with respect to

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[18] https://www.congress.gov/118/meeting/house/116125/witnesses/HHRG-118-ED02-Wstate-MonahanC-20230621.pdf.

[19] https://www.congress.gov/118/meeting/house/116125/witnesses/HHRG-118-ED02-Wstate-MonahanC-20230621.pdf; https://www.congress.gov/118/meeting/house/116125/witnesses/HHRG-118-ED02-Wstate-SachdevG-20230621.pdf; https://www.congress.gov/118/meeting/house/116125/witnesses/HHRG-118-ED02-Wstate-BakerG-20230621.pdf; https://www.congress.gov/118/meeting/house/116125/witnesses/HHRG-118-ED02-Wstate-TripoliS-20230621.pdf.

[20] H.R. 4507 allows for the submission of certain information in lieu of a dollar amount in limited circumstances. This is intended to fill gaps in current TiC rule data by addressing value-based payment models that may not be expressed in a dollar amount. As acknowledged by the Chairwoman and Ranking Member during a brief colloquy during the markup, the intent of this provision is not to undermine any existing requirement of the TiC rule or allow entities to evade transparency requirements.

requirements to make certain information publicly available. The TiC rule cites ACA Section 1311(e)(3) as its statutory authority. By including ACA Section 1311(e)(3) in ERISA, the Committee continues its efforts to reorganize the U.S. Code to ensure that ACA provisions governing group health plans are included in ERISA.

Codification of TiC. Section 2 of H.R. 4507 amends ERISA Section 719, IRC Section 9819, and PHSA Section 2799A–4 to codify the TiC rule. Section 2 requires that all plans report on the following: the in-network rate for all items and services; the out-of-network maximum allowed amount for all items and services; the estimated amount of cost-sharing that a participant or beneficiary will incur for these items and services; the amount the participant or beneficiary has accumulated towards his or her out-of-pocket costs; any shared savings available to the participant or beneficiary; volume restrictions the plan places on items or services; and any coverage restrictions the plan places on items or services (such as prior authorization).

Section 2 codifies TiC's self-service tool, which requires plans to create a virtual tool that provides real-time responses to the data requests by a beneficiary. This tool allows a beneficiary to look up cost information regarding items and services by billing code or through a description.

Provider Tool. Section 2 creates a provider-facing self-service tool, which allows a provider (with the permission of the participant or beneficiary) to look up the cost-sharing for items and services. The plan and provider may use this tool to create a good faith estimate or advanced explanation of benefits.

Rate and Payment Information. Section 2 outlines the standards by which the rate and payment information must be reported. It codifies the rate and payment reporting requirements in the TiC rule, requires plans to report on prescription drug costs, and ensures improvements to this reporting. The improvements are as follows:

1. Prices must be reported in dollar amounts. Currently, plans report prices based on a percentage or use other metrics for measuring costs, which causes confusion when comparing costs to other plans. When a dollar amount cannot be used (as in a value-based arrangement), the plan must include the formulae, pricing methodology, or other information used to calculate the rate.

2. Plans must include the dosage form and indication for each drug reported. This allows data users to measure the costs of drugs across plans.

3. Plans must report costs for value-based arrangements and bundled payments.

Machine-Readable Files. Section 2 requires that plans upload information publicly in three machine-readable files: an in-network file, an out-of-network file, and a prescription-drug file. The Secretaries of Labor, Health and Human Services, and the Treasury (jointly Secretaries) must limit the size of the file and ensure it does not include duplicative information and that the data in the files can be compared across health plans and coverage.

Application Program Interface. Section 2 requires that plans and issuers make information available via application program interface (API) beginning January 1, 2026. This will improve the standardization and usability of the data and will allow third-party de-

velopers instant access to TiC data. Third-party developers will be able to create cost-comparing tools for patients, providers, employers, academics, and other entities, which will improve the shoppability of health care services and coverage options. Section 2 includes a small-plan exemption for plans with fewer than 500 beneficiaries.

User Guide and Annual Summary. Section 2 directs the Secretaries to create standards by which plans must produce user guides for machine-readable files. The user guides must explain to individuals how to search for information in the files. Section 2 also directs plans to create an annual summary of the machine-readable files.

Attestation. Section 2 requires health plans to submit an annual attestation to the Secretaries that they are in compliance with the requirements of the *Transparency in Coverage Act* and provide links to machine-readable files.

Report to Congress. Section 2 directs the Secretary of Labor to submit a report to Congress recommending legislative and regulatory actions to incorporate metrics for assessing and comparing quality of care into published data. The Secretary is also directed to create additional reports assessing the differences in commercially negotiated prices across different markets.

Section 3. PBM reports to plan administrators

Oversight of PBMs. Section 3 amends ERISA, the PHSA, and the IRC to disallow group health plans from contracting with PBMs and other entities unless the PBMs report the following information to plan administrators on a quarterly basis:

- The total amount of copayment assistance dollars paid, copayment cards applied, or other discounts applied, which were funded by drug manufacturers;
- Total gross spending on prescription drugs by the plan;
- Total amount received or expected to be received by the plan in rebates, fees, and alternative discounts, and all other remuneration received from a third party related to the utilization of a drug;
- Total net spending on prescription drugs;
- Amounts paid in rebates, fees, and other types of compensation to entities for the referral of the group health plan's business to the PBM; and
- An explanation of any benefit design that encourages or requires a participant to fill prescriptions at mail-order, specialty, or PBM-owned pharmacies; the percentage of total prescriptions charged to the plan that were dispensed by these pharmacies; and a list and cost information with respect to all drugs dispensed by PBM-owned pharmacies.

The following reporting requirements apply only to plans serving large employers (over 50 employees):

- A list of each covered drug for which a claim was filed. The list must include the name of the drug, the number of participants or beneficiaries for whom a claim was filed, the total number of prescription claims, the total number of dosage units, and the total days' supply. The list must include the type of dispensing channel used (e.g., retail, mail, or specialty), the wholesale acquisition costs, and the total out-of-pocket spending by participants or beneficiaries on such drugs.

- For any drug where the gross spending of the plan exceeds $10,000, the following must be reported:
  - A list of all other drugs in the same therapeutic category or class and the rationale for the preferred formulary placement of the drug.
  - A list of each therapeutic category or class of drugs for which a claim was filed and the total gross spending by the plan, the number of participants or beneficiaries who filled a prescription for a drug in that category, a description of the formulary tiers and utilization mechanisms, and the total out-of-pocket spending by participants or beneficiaries.
  - For each drug, the amount received or expected to be received in rebates, fees, or other remuneration; the total net spending by the plan on that category or class of drugs; and the average net spending per 30-day supply and 90-day supply.

Privacy Requirements. Section 3 reaffirms that all the information provided in the required reports abides by the privacy, security, and breach notification regulations under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA).

Disclosure and Redisclosure Requirements. Section 3 includes safeguards to protect against anticompetitive behavior.

GAO Report. Section 3 requires PBMs to submit their first four reports to the Government Accountability Office (GAO).

Standard Format. Section 3 requires the Secretaries to specify reporting standards not later than 6 months after enactment of the Act.

Enforcement. Section 3 authorizes the Secretaries to levy civil monetary penalties of up to $10,000 per day for each violation for each day and of up to $100,000 for each instance of knowing submission of false information.

Section 4. Information on prescription drugs

Section 4 amends ERISA to prohibit group health plans and issuers offering group health insurance coverage from entering into contracts that restrict pharmacies from informing participants and beneficiaries that out-of-pockets costs may be lower without using their health plan or coverage. Section 2729 of the PHSA establishes similar requirements with respect to issuers and state and local government health plans but has not been enacted in ERISA.

Section 5. Advisory committee on the accessibility of certain information

Section 5 requires the Secretary of Labor to convene an Advisory Committee to make recommendations to improve the accessibility and usability of published information, streamline reporting, and ensure that such information fully meets the needs of stakeholders.

The Advisory Committee shall convene not later than January 1, 2025, and terminate on January 1, 2028.

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. 4507 takes important steps to increase transparency that will benefit health care consumers—including access for any eligible employees of the Legislative Branch—by improving transparency of coverage and prescription drug spending in health care plans for which employees of the Legislative Branch are enrolled.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 4507 is to codify the Transparency in Coverage final rule and improve PBM reporting requirements. This is meant to ensure that plans and plan participants and beneficiaries have the information necessary to make informed health care purchasing decisions.

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. 4507: 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."

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. 4507 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: 2 Bill: HR 4507 Amendment Number: n/a

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

Sponsor/Amendment: Good 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)

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 4507 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.

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. 4507 provided by the Congressional Budget Office to Majority staff via email on September 12, 2023: "We have finished the estimate for H.R. 4507 (timestamp 9:49am on July 11, 2023). Across all sections, we estimate the bill would reduce the deficit by $2.2 billion over the 2023–2033 budget window. This includes a $2.5 billion decrease in the deficit for section 3, a $254 million increase to the deficit for the API requirements included in section 2, and a $34 million increase to the deficit for the pharmacy gag clause ban included in section 4. We do not estimate any further direct spending or revenue effects from H.R. 4507."

COMMITTEE COST ESTIMATE

Clause 3(d)(1) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 4507. 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

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

* * * * * * *

SUBTITLE B—REGULATORY PROVISIONS

* * * * * * *

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**[**.**]***; or*

(12) by the Secretary, to enforce section 726.

(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)) *and subsections (a)(12) and (c)(13)*, 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 failure 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) SECRETARIAL ENFORCEMENT AUTHORITY RELATING TO OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.—

(A) FAILURE TO PROVIDE TIMELY INFORMATION.—The Secretary may impose a penalty against any health insurance issuer or entity providing pharmacy benefits management services that violates section 726(a) or fails to provide information required under section 726(b) in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

(B) FALSE INFORMATION.—The Secretary may impose a penalty against a health insurance issuer or entity providing pharmacy benefits management services that knowingly provides false information under section 726 in an amount not to exceed $100,000 for each item of false information. Such penalty shall be in addition to other penalties as may be prescribed by law.

(C) WAIVERS.—The Secretary may waive penalties under subparagraph (A), or extend the period of time for compliance with a requirement of section 726, for an entity in violation of such section that has made a good-faith effort to comply with such section.

(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 des-

ignated 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. 719. MAINTENANCE OF PRICE COMPARISON TOOL.

[A group health plan or a health insurance issuer offering group health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.**]**

SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.

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

(1) Claims payment policies and practices.

(2) Periodic financial disclosures.

(3) Data on enrollment.

(4) Data on disenrollment.

(5) Data on the number of claims that are denied.

(6) Data on rating practices.

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

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

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

(10) Other information as determined appropriate by the Secretary.

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

(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

(c) COST SHARING TRANSPARENCY.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall, upon request of a participant or beneficiary and in a timely manner, provide to the participant or beneficiary a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant's or beneficiary's plan or coverage that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the participant or beneficiary, that meets such requirements as the Secretary may specify.

(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group health insurance coverage (as applicable) furnished by a health care provider to a participant or beneficiary of such plan or coverage, the following:

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

(B) If such provider is not a participating provider, the allowed amount, percentage of billed charges, or other rate that such plan or coverage will recognize as payment for such item or service, along with a notice that such indi-

vidual may be liable for additional charges billed by such provider.

(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the amount or rate described in such subparagraph (or, in the case such plan or issuer uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

(F) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or group health insurance coverage.

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

(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

(B) provides for real-time responses to requests described in paragraph (1);

(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

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

(i) a specific provider that is a participating provider with respect to such item or service;

(ii) all providers that are participating providers with respect to such plan and such item or service for purposes of facilitating price comparisons; or

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

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

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

(4) PROVIDER TOOL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by another provider in a timely manner upon the request of the provider and with the consent of such individual in the same manner and to the same extent as if such request has been made by such individual. As part of any tool used to facilitate such requests from a provider, such plan or issuer offering health insurance coverage may include functionality that—

(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6 of the Public Health Service Act; and

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

(d) RATE AND PAYMENT INFORMATION.—

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

(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other

than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

(2) MANNER OF PUBLICATION.—

(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in the same file or in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans and group health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

(B) REAL-TIME PROVISION OF INFORMATION.—

(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

(ii) EXEMPTION FOR CERTAIN PLANS OR COVERAGE.—Clause (i) shall not apply with respect to information described in such clause required to be made available by a group health plan or health insurance issuer offering health insurance coverage if such plan or coverage, as applicable, provides benefits for fewer than 500 participants and beneficiaries.

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

(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan and health insurance issuer offering group health insurance coverage shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such year (such as averages of all such information so made public).

(e) ATTESTATION.—Each group health plan and health insurance issuer offering group health insurance coverage shall annually submit to the Secretary an attestation of such plan's or such coverage's compliance with the provisions of this section along with a link to disclosures made in accordance with subsection (a).

(f) DEFINITIONS.—In this subsection:

(1) PARTICIPATING PROVIDER.—The term "participating provider" has the meaning given such term in section 716 and includes a participating facility.

(2) IN-NETWORK RATE.—The term "in-network rate" means, with respect to a group health plan or group health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.

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SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

(a) IN GENERAL.—For plan years beginning on or after January 1, 2025, a group health plan (or health insurance issuer offering group health insurance coverage in connection with such a plan) or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making or substantiating the reports described in subsection (b).

(b) REPORTS.—

(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage, shall submit to the plan administrator (as defined in section 3(16)(A)) of such plan or coverage

a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

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

(B) total gross spending on prescription drugs by the plan or coverage during the reporting period;

(C) total amount received, or expected to be received, by the plan or coverage from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan or coverage during the reporting period;

(D) the total net spending on prescription drugs by the plan or coverage during such reporting period;

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

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

(ii) the percentage of total prescriptions charged to the plan, issuer, or participants and beneficiaries in such plan or coverage, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

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

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

(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

(II) the median amount charged to the plan or issuer, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan or coverage;

(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan or coverage;

(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan or issuer and participants and beneficiaries among all pharmacies included in the network of such plan or coverage; and

(G) in the case of a large employer—

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

(I) the brand name, generic or non-proprietary name, and the National Drug Code;

(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

(bb) with respect to each claim or dosage unit described in item (aa), the type of dis-

pensing channel used, such as retail, mail order, or specialty pharmacy;

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

(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan or coverage, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan or coverage, or for which no claim was submitted to such plan or coverage);

(V) for any drug for which gross spending of the plan or coverage exceeded $10,000 during the reporting period—

(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological products, generic drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

(I) total gross spending by the plan;

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

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

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

(V) for each drug—

(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

(AA) for claims incurred during the reporting period; or

(BB) that is related to utilization of drugs or drug spending;

(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug man-

ufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

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

(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

(3) DISCLOSURE AND REDISCLOSURE.—

(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan administrators who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

(4) REPORT TO GAO.—A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

(5) STANDARD FORMAT.—Not later than 6 months after the date of enactment of this section, the Secretary shall specify through rulemaking standards for health insurance issuers and

entities required to submit reports under paragraph (4) to submit such reports in a standard format.

(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Labor to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

(d) DEFINITIONS.—In this section:

(1) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) WHOLESALE ACQUISITION COST.—The term "wholesale acquisition cost" has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.

SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.

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

(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to a participant of beneficiary in the plan or coverage from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) a participant or beneficiary of any differential between the participant's or beneficiary's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

(b) DEFINITION.—For purposes of this section, the term "out-of-pocket cost", with respect to acquisition of a drug, means the amount to be paid by the participant or beneficiary under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.

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INTERNAL REVENUE CODE OF 1986

TITLE 26—INTERNAL REVENUE CODE

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter B—OTHER REQUIREMENTS

Sec.

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[9819. Maintenance of price comparison tool.]
9819. Price transparency requirements.

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9826. Oversight of pharmacy benefits manager services.

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[SEC. 9819. MAINTENANCE OF PRICE COMPARISON TOOL.

[A group health plan shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan with respect to the furnishing of a specific item or service by any such provider.]

SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.

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

(1) Claims payment policies and practices.

(2) Periodic financial disclosures.

(3) Data on enrollment.

(4) Data on disenrollment.

(5) Data on the number of claims that are denied.

(6) Data on rating practices.

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

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

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

(10) Other information as determined appropriate by the Secretary.

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

(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of Labor, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

(c) COST SHARING TRANSPARENCY.—

(1) IN GENERAL.—A group health plan shall, upon request of a participant or beneficiary and in a timely manner, provide to the participant or beneficiary a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant's or beneficiary's plan that the participant or beneficiary would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the participant or beneficiary, that meets such requirements as the Secretary may specify.

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

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

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

(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be cal-

culated using the amount or rate described in such subparagraph (or, in the case such plan uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

(D) The amount the participant or beneficiary has already accumulated with respect to any deductible or out of pocket maximum under the plan (broken down, in the case separate deductibles or maximums apply to separate participants and beneficiaries enrolled in the plan, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

(F) In the case such plan imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such participant or beneficiary has accrued towards such limitation with respect to such item or service.

(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan.

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

(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

(B) provides for real-time responses to requests described in paragraph (1);

(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

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

(i) a specific provider that is a participating provider with respect to such item or service;

(ii) all providers that are participating providers with respect to such item or service for purposes of facilitating price comparisons; or

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

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

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

(4) PROVIDER TOOL.—A group health plan shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan that the individual would be responsible for paying with respect to the furnishing of a specific

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

(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6 of the Public Health Services Act; and

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

(d) RATE AND PAYMENT INFORMATION.—

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

(A) With respect to each item or service (other than a drug) for which benefits are available under such plan, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan or coverage.

(C) With respect to each item or service for which benefits are available under such plan, the amount billed, and the amount allowed by the plan, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

(2) MANNER OF PUBLICATION.—

(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

(B) REAL-TIME PROVISION OF INFORMATION.—

(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

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

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

(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan with respect to such plan or coverage during such year (such as averages of all such information so made public).

(e) ATTESTATION.—Each group health plan shall annually submit to the Secretary an attestation of such plan's compliance with the

provisions of this section along with a link to disclosures made in accordance with subsection (a).

(f) DEFINITIONS.—In this subsection:

(1) PARTICIPATING PROVIDER.—The term "participating provider" has the meaning given such term in section 9816 and includes a participating facility.

(2) IN-NETWORK RATE.—The term "in-network rate" means, with respect to a group health plan and an item or service furnished by a provider that is a participating provider with respect to such plan and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan and such provider for such item or service.

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SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

(a) IN GENERAL.—For plan years beginning on or after January 1, 2025, a group health plan or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan, from making or substantiating the reports described in subsection (b).

(b) REPORTS.—

(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan, or an entity providing pharmacy benefits management services on behalf of a group health plan, shall submit to the plan administrator (as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974) of such plan a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan—

(A) information collected from a patient or copay assistance program administrator by such entity on the total amount of copayment assistance dollars paid, or copayment cards applied, or other discounts that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan;

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

(C) total amount received, or expected to be received, by the plan from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan during the reporting period;

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

(E) amounts paid, directly or indirectly, in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act of 1974) to brokerage houses, brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's business to the pharmacy benefits manager, identified by the recipient of such amounts;

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

(ii) the percentage of total prescriptions charged to the plan, or participants and beneficiaries in such plan, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

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

(I)(aa) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, with respect to participants and beneficiaries in the plan, to the plan; and

(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

(II) the median amount charged to the plan, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan;

(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan;

(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per-90 day supply, for such drug, including amounts charged to the plan and participants and beneficiaries among all pharmacies included in the network of such plan; and

(G) in the case of a large employer—

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

(I) the brand name, generic or non-proprietary name, and the National Drug Code;

(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

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

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

(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan, or for which no claim was submitted to such plan);

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

(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological products, generic

drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the plan during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

(I) total gross spending by the plan;

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

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

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

(V) for each drug—

(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

(AA) for claims incurred during the reporting period; or

(BB) that is related to utilization of drugs or drug spending;

(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the plan on that category or class of drugs; and

(cc) the average net spending per 30-day supply and per 90-day supply, incurred by the plan and its participants and beneficiaries, among all drugs within the therapeutic class for which a claim was filed during the reporting period.

(2) PRIVACY REQUIREMENTS.—Entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

(3) DISCLOSURE AND REDISCLOSURE.—

(A) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of

such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan administrators who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

(4) REPORT TO GAO.—An entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

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

(c) ENFORCEMENT.—

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

(2) FALSE INFORMATION.—An entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

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

(4) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this

section that has made a good-faith effort to comply with this section.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit a group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of the Treasury to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such plan or entity.

(e) DEFINITIONS.—In this section:

(1) LARGE EMPLOYER.—The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) WHOLESALE ACQUISITION COST.—The term "wholesale acquisition cost" has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.

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PUBLIC HEALTH SERVICE ACT

TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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PART D—ADDITIONAL COVERAGE PROVISIONS

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[SEC. 2799A–4. MAINTENANCE OF PRICE COMPARISON TOOL.

[A group health plan or a health insurance issuer offering group or individual health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.]

SEC. 2799A–4. PRICE TRANSPARENCY REQUIREMENTS.

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

(1) Claims payment policies and practices.

(2) Periodic financial disclosures.

(3) Data on enrollment.

(4) Data on disenrollment.

(5) Data on the number of claims that are denied.

(6) Data on rating practices.

(7) Information on cost-sharing and payments with respect to any out-of-network coverage (or with respect to any item and

service furnished under such a plan or such group or individual health insurance coverage that does not use a network of providers).

(8) Information on enrollee rights under this part.

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

(10) Other information as determined appropriate by the Secretary.

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

(b) USE OF PLAIN LANGUAGE.—The information required to be submitted under subsection (a) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is clear, concise, well-organized, accurately describes the information, and follows other best practices of plain language writing. The Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury, shall develop and issue standards for plain language writing for purposes of this section and shall develop a standardized reporting template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

(c) COST SHARING TRANSPARENCY.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall, upon request of an enrollee and in a timely manner, provide to the enrollee a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the enrollee's plan or coverage that the enrollee would be responsible for paying with respect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the enrollee through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the enrollee, that meets such requirements as the Secretary may specify.

(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health plan or group or individual health insurance coverage (as applicable) furnished by a health care provider to an enrollee of such plan or coverage, the following:

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

(B) If such provider is not a participating provider, the allowed amount, percentage of billed charges, or other rate that such plan or coverage will recognize as payment for such item or service, along with a notice that such enrollee

may be liable for additional charges billed by such provider.

(C) The estimated amount of cost sharing (including deductibles, copayments, and coinsurance) that the enrollee will incur for such item or service (which, in the case such item or service is to be furnished by a provider described in subparagraph (B), shall be calculated using the amount or rate described in such subparagraph (or, in the case such plan or issuer uses a percentage of billed charges to determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

(D) The amount the enrollee has already accumulated with respect to any deductible or out of pocket maximum under the plan or coverage (broken down, in the case separate deductibles or maximums apply to separate enrollees in the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

(F) In the case such plan or coverage imposes any frequency or volume limitations with respect to such item or service (excluding medical necessity determinations), the amount that such enrollee has accrued towards such limitation with respect to such item or service.

(G) Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan or group or individual health insurance coverage.

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

(A) is based on an Internet website, mobile application, or other platform determined appropriate by the Secretary;

(B) provides for real-time responses to requests described in paragraph (1);

(C) is updated in a manner such that information provided through such tool is accurate at the time such request is made;

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

(i) a specific provider that is a participating provider with respect to such item or service;

(ii) all providers that are participating providers with respect to such plan and such item or service for purposes of facilitating price comparisons; or

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

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

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

(4) PROVIDER TOOL.—A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall permit providers to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) that would apply under an individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by another provider in a timely manner upon the request of the provider and with the consent of such individual in the same manner and to the same extent as if such request has been made by such individual. As part of any tool used to facilitate such requests from a provider, such plan or issuer offering health insurance coverage may include functionality that—

(A) allows providers to submit the notifications to such plan or coverage required under section 2799B–6; and

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

(d) RATE AND PAYMENT INFORMATION.—

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

(A) With respect to each item or service (other than a drug) for which benefits are available under such plan or coverage, the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such item or service (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate).

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

(i) the in-network rate (in a dollar amount) in effect as of the first day of the plan year during which such information is submitted with each provider (identified by national provider identifier) that is a participating provider with respect to such drug (or, in the case such rate is not available in a dollar amount, such formulae, pricing methodologies, or other information used to calculate such rate); and

(ii) the average amount paid by such plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before such date of submission to each provider that was a participating provider with respect to such drug, broken down by each such provider (identified by national provider identifier), other than such an amount paid to a provider that, during

such period, submitted fewer than 20 claims for such drug to such plan or coverage.

(C) With respect to each item or service for which benefits are available under such plan or coverage, the amount billed, and the amount allowed by the plan or coverage, for each such item or service furnished during the 90-day period specified in subparagraph (B) by a provider that was not a participating provider with respect to such item or service, broken down by each such provider (identified by national provider identifier), other than items and services with respect to which fewer than 20 claims for such item or service were submitted to such plan or coverage during such period.

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

(2) MANNER OF PUBLICATION.—

(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such requirements as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans and group or individual health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

(B) REAL-TIME PROVISION OF INFORMATION.—

(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

(ii) EXEMPTION FOR CERTAIN PLANS AND COVERAGE.—Clause (i) shall not apply with respect to information described in such clause required to be made available by a group health plan or health insurance issuer offering health insurance coverage if such plan or coverage, as applicable, provides benefits for fewer than 500 enrollees.

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

(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan and health insurance issuer offering group or individual health insurance coverage shall make public a machine-readable file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such year (such as averages of all such information so made public).

(e) ATTESTATION.—Each group health plan and health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation of such plan's or such coverage's compliance with the provisions of this section along with a link to disclosures made in accordance with subsection (a).

(f) DEFINITIONS.—In this subsection:

(1) PARTICIPATING PROVIDER.—The term "participating provider" has the meaning given such term in section 2799A–1 and includes a participating facility.

(2) IN-NETWORK RATE.—The term "in-network rate" means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.

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SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MANAGER SERVICES.

(a) IN GENERAL For plan years beginning on or after January 1, 2025, a group health plan (or health insurance issuer offering group health insurance coverage in connection with such a plan) or an entity or subsidiary providing pharmacy benefits management services on behalf of such a plan or issuer may not enter into a contract with a drug manufacturer, distributor, wholesaler, switch, patient or copay assistance program administrator, pharmacy, subcontractor, rebate aggregator, or any associated third party that limits or delays the disclosure of information to plan administrators in such a manner that prevents the plan or issuer, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan or issuer, from making or substantiating the reports described in subsection (b).

(b) REPORTS

(1) IN GENERAL For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage, shall submit to the plan administrator (as defined in section 3(16)(A) of the Employee Retirement Income Se-

curity Act of 1974) of such plan or coverage a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

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

(B) total gross spending on prescription drugs by the plan or coverage during the reporting period;

(C) total amount received, or expected to be received, by the plan or coverage from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group purchasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan or coverage during the reporting period;

(D) the total net spending on prescription drugs by the plan or coverage during such reporting period;

(E) amounts paid, directly or indirectly, in rebates, fees, or any other type of compensation (as defined in section 408(b)(2)(B)(ii)(dd)(AA) of the Employee Retirement Income Security Act of 1974) to brokerage houses, brokers, consultants, advisors, or any other individual or firm for the referral of the group health plan's or health insurance issuer's business to the pharmacy benefits manager, identified by the recipient of such amounts;

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

(ii) the percentage of total prescriptions charged to the plan, issuer, or participants and beneficiaries in such plan or coverage, that were dispensed by mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management services; and

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

(I)(aa) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, with respect

to participants and beneficiaries in the plan or coverage, to the plan or issuer; and

(bb) the amount charged, per dosage unit, per 30-day supply, and per 90-day supply, to participants and beneficiaries;

(II) the median amount charged to the plan or issuer, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan or coverage;

(III) the interquartile range of the costs, per dosage unit, per 30-day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of that plan or coverage;

(IV) the lowest cost, per dosage unit, per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan and participants and beneficiaries, that is available from any pharmacy included in the network of the plan or coverage;

(V) the net acquisition cost per dosage unit, per 30-day supply, and per 90-day supply, if the drug is subject to a maximum price discount; and

(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acquisition cost per dosage unit or per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan or issuer and participants and beneficiaries among all pharmacies included in the network of such plan or coverage; and

(G) in the case of a large employer—

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

(I) the brand name, generic or non-proprietary name, and the National Drug Code;

(II)(aa) the number of participants and beneficiaries for whom a claim for such drug was filed during the reporting period, the total number of prescription claims for such drug (including original prescriptions and refills), and the total number of dosage units and total days supply of such drug for which a claim was filed during the reporting period; and

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

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

(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after application of any benefits under such plan or coverage, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan or coverage, or for which no claim was submitted to such plan or coverage);

(V) for any drug for which gross spending of the plan or coverage exceeded $10,000 during the reporting period—

(aa) a list of all other drugs in the same therapeutic category or class, including brand name drugs, biological products, generic drugs, or biosimilar biological products that are in the same therapeutic category or class as such drug; and

(bb) the rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable; and

(ii) a list of each therapeutic category or class of drugs for which a claim was filed under the health plan or health insurance coverage during the reporting period, and, with respect to each such therapeutic category or class of drugs during the reporting period—

(I) total gross spending by the plan;

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

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

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

(V) for each drug—

(aa) the amount received, or expected to be received, from any entity in rebates, fees, alternative discounts, or other remuneration—

(AA) for claims incurred during the reporting period; or

(BB) that is related to utilization of drugs or drug spending;

(bb) the total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

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

(2) PRIVACY REQUIREMENTS Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

(3) DISCLOSURE AND REDISCLOSURE

(A) LIMITATION TO BUSINESS ASSOCIATES A group health plan receiving a report under paragraph (1) may disclose such information only to business associates of such plan as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations).

(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION Nothing in this section prevents a health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such issuer or entity may not restrict disclosure of such report to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, the Comptroller General of the United States, or applicable State agencies.

(C) LIMITED FORM OF REPORT The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required of plan administrators who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anticompetitive behavior.

(4) REPORT TO GAO A health insurance issuer offering group health insurance coverage or an entity providing pharmacy benefits management services on behalf of a group health plan shall submit to the Comptroller General of the United States each of the first 4 reports submitted to a plan administrator under paragraph (1) with respect to such coverage or plan, and other such reports as requested, in accordance with the privacy requirements under paragraph (2), the disclosure and redisclosure standards under paragraph (3), the standards specified pursuant to paragraph (5).

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

(c) ENFORCEMENT

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

(2) FALSE INFORMATION An entity providing pharmacy benefits management services that knowingly provides false information under this section shall be subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Such civil money penalty shall be in addition to other penalties as may be prescribed by law.

(3) PROCEDURE The provisions of section 1128A of the Social Security Act, other than subsection (a) and (b) and the first sentence of subsection (c)(1) of such section shall apply to civil monetary penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A of the Social Security Act.

(4) WAIVERS The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this section, for an entity in violation of this section that has made a good-faith effort to comply with this section.

(d) RULE OF CONSTRUCTION Nothing in this section shall be construed to permit a health insurance issuer, group health plan, or other entity to restrict disclosure to, or otherwise limit the access of, the Department of Health and Human Services to a report described in subsection (b)(1) or information related to compliance with subsection (a) by such issuer, plan, or entity.

(e) DEFINITIONS In this section:

(1) LARGE EMPLOYER The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) WHOLESALE ACQUISITION COST The term "wholesale acquisition cost" has the meaning given such term in section 1847A(c)(6)(B) of the Social Security Act.

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