

119<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 6703

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## AN ACT

To ensure access to affordable health insurance.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Lower Health Care  
3 Premiums for All Americans Act”.

4 **TITLE I—IMPROVING HEALTH**  
5 **CARE OPTIONS FOR WORKERS**

6 **SEC. 101. ASSOCIATION HEALTH PLANS.**

7 (a) TREATMENT OF GROUP OR ASSOCIATION OF EM-  
8 PLOYERS.—Section 3(5) of the Employee Retirement In-  
9 come Security Act of 1974 (29 U.S.C. 1002(5)) is amend-  
10 ed by inserting after “capacity” the following: “(including,  
11 for the purpose of establishing or maintaining a group  
12 health plan, a group or association of employers that satis-  
13 fies the requirements of section 736(a))”.

14 (b) RULES APPLICABLE TO GROUP HEALTH PLANS  
15 ESTABLISHED AND MAINTAINED BY A GROUP OR ASSO-  
16 CIATION OF EMPLOYERS.—

17 (1) IN GENERAL.—Part 7 of subtitle B of title  
18 I of the Employee Retirement Income Security Act  
19 of 1974 (29 U.S.C. 1181, et seq.) is amended by  
20 adding at the end the following:

21 **“SEC. 736. RULES APPLICABLE TO GROUP HEALTH PLANS**  
22 **ESTABLISHED AND MAINTAINED BY A GROUP**  
23 **OR ASSOCIATION OF EMPLOYERS.**

24 “(a) ASSOCIATION HEALTH PLANS.—A group or as-  
25 sociation of employers may maintain a group health plan,  
26 regardless of whether the employers composing such group

1 or association are in the same industry, trade, or profes-  
2 sion, if such group or association satisfies the following  
3 requirements:

4           “(1) GROUP OR ASSOCIATION REQUIRE-  
5           MENTS.—The group or association of employers—

6                   “(A) shall—

7                           “(i) have been formed and maintained  
8                           in good faith for purposes other than pro-  
9                           viding health insurance coverage through a  
10                           group health plan;

11                           “(ii) establish a governing board or  
12                           another indicator of formality as described  
13                           in paragraph (2); and

14                           “(iii) have existed for at least 2 years  
15                           prior to offering a group health plan to the  
16                           employees of such group or association;  
17                           and

18                           “(iv) make health insurance coverage  
19                           under the group health plan offered by  
20                           such group or association available—

21                                   “(I) to at least 51 employees;

22                                   and

23                                   “(II) to all employees of the em-  
24                                   ployer members, and any dependents  
25                                   of such employees;

1           “(B) may only provide health insurance  
2 coverage through the group health plan of the  
3 group or association—

4                   “(i) to an employee of an employer  
5 member of the group or association or a  
6 dependent of such an employee; or

7                   “(ii) as necessary to comply with part  
8 6;

9           “(C) may include a health insurance issuer  
10 as an employer member, except that the group  
11 or association may not—

12                   “(i) be a health insurance issuer; or

13                   “(ii) be controlled or owned by a  
14 health insurance issuer (or a subsidiary or  
15 affiliate of a health insurance issuer).

16           “(D) may not condition the membership of  
17 an employer in the group or association on any  
18 health status-related factor (as described in sec-  
19 tion 702(a)(1)) relating to any employee or de-  
20 pendent of any employee of any employer mem-  
21 ber.

22           “(2) ORGANIZATIONAL REQUIREMENTS.—

23                   “(A) GOVERNING BOARD OR FORMAL OR-  
24 GANIZATION OF THE GROUP OR ASSOCIATION.—

1                   “(i) IN GENERAL.—The group or as-  
2                   sociation shall have—

3                           “(I) a formal organizational  
4                           structure with a governing board and  
5                           by-laws; or

6                           “(II) another structure or indi-  
7                           cator of formality.

8                   “(ii) REQUIREMENT.—Both struc-  
9                   tures described in subclauses (I) and (II)  
10                  of clause (i) shall comply with the require-  
11                  ments described in subparagraph (B).

12                  “(B) FORMAL ORGANIZATION STRUCTURE  
13                  OF GROUP OR ASSOCIATION.—

14                           “(i) IN GENERAL.—The functions and  
15                           activities of the group or association shall  
16                           be controlled by the employer members in  
17                           substance and in fact.

18                           “(ii) CONTROL.—The control de-  
19                           scribed in clause (i) shall be satisfied so  
20                           long as at least 75 percent of the positions  
21                           on the board or other formal organiza-  
22                           tional structure are held by employer mem-  
23                           bers.

24                           “(iii) ELECTIONS.—Each position of  
25                           the governing board or other formal orga-

1           nizational structure shall be subject to  
2           scheduled elections, as determined by the  
3           group or association, and each employer-  
4           member shall be able to cast only one vote  
5           in each such election.

6           “(C) GROUP HEALTH PLAN REQUIRE-  
7           MENTS.—

8           “(i) CONTROL.—The group health  
9           plan shall be controlled in substance and in  
10          fact by employer members participating in  
11          the group health plan.

12          “(ii) ELIGIBILITY VERIFICATION.—A  
13          plan fiduciary shall verify, on a regular  
14          basis and pursuant to reasonable moni-  
15          toring procedures as established by the  
16          plan fiduciary, whether an individual is a  
17          self-employed individual if such individual  
18          (or a beneficiary thereof) participates in  
19          the group health plan on the basis that  
20          such individual is a self-employed indi-  
21          vidual.

22          “(iii) INELIGIBLE SELF-EMPLOYED  
23          INDIVIDUALS.—

24                  “(I) IN GENERAL.—Subject to  
25                  subclause (II) and except as required

1           under part 6, in the case that the  
2           plan fiduciary determines that an in-  
3           dividual who participates in the group  
4           health plan no longer meets the re-  
5           quirements under a self-employed in-  
6           dividual during a plan year, the group  
7           health plan shall not make health in-  
8           surance coverage available to such in-  
9           dividual for any plan year following  
10          the plan year in which such deter-  
11          mination was made.

12                   “(II) REMEDIAL ACTION.—If,  
13           after the plan fiduciary determines  
14           that an individual described in clause  
15           (i) is not a self-employed individual,  
16           the individual furnishes to the plan fi-  
17           duciary evidence proving that such in-  
18           dividual is a self-employed individual,  
19           such individual shall be eligible to par-  
20           ticipate in the group health plan.

21                   “(3) DISCRIMINATION AND PRE-EXISTING CON-  
22           DITION PROTECTIONS.—A group health plan estab-  
23           lished and maintained by the group or association of  
24           employers under this section may not—

1           “(A) establish any rule for eligibility (in-  
2           cluding continued eligibility) of any individual  
3           (including an employee of an employer member  
4           or a self-employed individual, or a dependent of  
5           such employee or self-employed individual) to  
6           enroll for benefits under the terms of the plan  
7           that discriminates based on any health status-  
8           related factor that relates to such individual  
9           (consistent with the rules under section  
10          702(a)(1));

11          “(B) require an individual (including an  
12          employee of an employer member or a self-em-  
13          ployed individual, or a dependent of such em-  
14          ployee or self-employed individual), as a condi-  
15          tion of enrollment or continued enrollment  
16          under the plan, to pay a premium or contribu-  
17          tion that is greater than the premium or con-  
18          tribution for a similarly situated individual en-  
19          rolled in the plan based on any health status-  
20          related factor that relates to such individual  
21          (consistent with the rules under section  
22          702(b)(1)); and

23          “(C) deny coverage under such plan on the  
24          basis of a pre-existing condition (consistent

1 with the rules under section 2704 of the Public  
2 Health Service Act).

3 “(b) PREMIUM RATES FOR A GROUP OR ASSOCIA-  
4 TION OF EMPLOYERS.—

5 “(1) IN GENERAL.—A group health plan estab-  
6 lished and maintained by a group or association of  
7 employers that meets that requirements of this sec-  
8 tion may, to the extent not prohibited under State  
9 law—

10 “(A) establish base premium rates formed  
11 on an actuarially sound, modified community  
12 rating methodology that considers the pooling  
13 of all plan participant claims; and

14 “(B) utilize the specific risk profile of each  
15 employer member of such group or association  
16 to determine contribution rates for each such  
17 employer member’s share of a premium by ac-  
18 tuarially adjusting the established base pre-  
19 mium rates.

20 “(2) ONLY SELF EMPLOYED INDIVIDUALS.—In  
21 the case that a group or association is composed  
22 only of self-employed individuals, the group health  
23 plan established by such group or association shall—

24 “(A) treat all such self-employed individ-  
25 uals as a single risk pool;

1           “(B) pool all plan participant claims; and

2           “(C) charge each plan participant the  
3           same premium rate.

4           “(c) TREATMENT OF SELF-EMPLOYED INDIVID-  
5 UALS.—For purposes of this section, an individual who is  
6 a self-employed individual shall be treated as—

7           “(1) an employer who may be a member of a  
8           group or association of employers;

9           “(2) an employee who may participate in a  
10          group health plan established and maintained by  
11          such group or association; and

12          “(3) a participant of the group health plan in  
13          which the individual participates, subject to the eligi-  
14          bility determination and monitoring requirements set  
15          forth in subsection (a)(2)(C)(i).

16          “(d) DETERMINATION OF EMPLOYER OR JOINT EM-  
17 PLOYER STATUS.—The provision of health insurance cov-  
18 erage by a group or association of employers may not be  
19 construed as evidence for establishing an employer or joint  
20 employer relationship under any Federal or State law.

21          “(e) RULES OF CONSTRUCTION.—

22          “(1) NO EXEMPTION FROM PHSA.—Nothing in  
23          this section shall be construed to exempt a group  
24          health plan (as defined in section 733(a)(1)) offered  
25          through a group or association of employers from

1 the requirements of this part or from the provisions  
2 of part A of title XXVII of the Public Health Serv-  
3 ice Act as incorporated by reference into this Act  
4 through section 715.

5 “(2) PRIOR OR FUTURE GUIDANCE.—Nothing  
6 in this section may be construed to limit or other-  
7 wise affect the ability of a group or association of  
8 employers from establishing a single plan multiple  
9 employer welfare arrangement as specified in any  
10 prior or future guidance issued by the Secretary of  
11 Labor that provides alternative pathways to quali-  
12 fying as a group or association of employer for pur-  
13 poses of section 3(5).

14 “(f) DEFINITIONS.—In this section—

15 “(1) EMPLOYER MEMBER.—The term ‘employer  
16 member’ means—

17 “(A) an employer who is a member of such  
18 group or association of employers and employs  
19 at least 1 common law employee; or

20 “(B) a group made up solely of self-em-  
21 ployed individuals, within which all of the self-  
22 employed individual members of such group or  
23 association are aggregated together as a single  
24 employer member group, provided that such

1 group includes at least 20 self-employed indi-  
2 vidual members.

3 “(2) SELF-EMPLOYED INDIVIDUAL.—The term  
4 ‘self-employed individual’ means an individual who—

5 “(A) does not have any common law em-  
6 ployees;

7 “(B) has a bona fide ownership right in a  
8 trade or business, regardless of whether such  
9 trade or business is incorporated or unincor-  
10 porated;

11 “(C) earns a wage (as defined in section  
12 3121(a) of the Internal Revenue Code of 1986)  
13 or self-employment income (as defined in sec-  
14 tion 1402(b) of such Code) from such trade or  
15 business; and

16 “(D) works at least 10 hours a week, or 40  
17 hours per month, providing personal services to  
18 such trade or business.”.

19 (2) CLERICAL AMENDMENT.—The table of con-  
20 tents is amended by inserting after the item relating  
21 to section 734 the following:

“735. Standardized reporting format.

“736. Rules applicable to group health plans established and maintained by a  
group or association of employers.”.

1 **SEC. 102. CERTAIN MEDICAL STOP-LOSS INSURANCE OB-**  
2 **TAINED BY CERTAIN PLAN SPONSORS OF**  
3 **GROUP HEALTH PLANS NOT INCLUDED**  
4 **UNDER THE DEFINITION OF HEALTH INSUR-**  
5 **ANCE COVERAGE.**

6 (a) IN GENERAL.—Section 733(b)(1) of the Em-  
7 ployee Retirement Income Security Act of 1974 (29  
8 U.S.C. 1191b(b)(1)) is amended by adding at the end the  
9 following sentence: “Such term shall not include a stop-  
10 loss policy obtained by a self-insured group health plan  
11 or a plan sponsor of a group health plan that self-insures  
12 the health risks of its plan participants to reimburse the  
13 plan or sponsor for losses that the plan or sponsor incurs  
14 in providing health or medical benefits to such plan par-  
15 ticipants in excess of a predetermined level set forth in  
16 the stop-loss policy obtained by such plan or sponsor.”.

17 (b) EFFECT ON OTHER LAWS.—Section 514(b) of  
18 the Employee Retirement Income Security Act of 1974  
19 (29 U.S.C. 1144(b)) is amended by adding at the end the  
20 following:

21 “(10) The provisions of this title (including part 7  
22 relating to group health plans) shall preempt State laws  
23 insofar as they may now or hereafter prevent an employee  
24 benefit plan that is a group health plan from insuring  
25 against the risk of excess or unexpected health plan claims  
26 losses.”.

1 **SEC. 103. TREATMENT OF HEALTH REIMBURSEMENT AR-**  
2 **RANGEMENTS INTEGRATED WITH INDI-**  
3 **VIDUAL MARKET COVERAGE.**

4 (a) IN GENERAL.—

5 (1) TREATMENT.—Section 9815(b) of the In-  
6 ternal Revenue Code of 1986 is amended—

7 (A) by striking “EXCEPTION.—Notwith-  
8 standing subsection (a)” and inserting the fol-  
9 lowing: “EXCEPTIONS.—

10 “(1) SELF-INSURED GROUP HEALTH PLANS.—  
11 Notwithstanding subsection (a)”, and

12 (B) by adding at the end the following new  
13 paragraph:

14 “(2) CUSTOM HEALTH OPTION AND INDIVIDUAL  
15 CARE EXPENSE ARRANGEMENTS.—

16 “(A) IN GENERAL.—For purposes of this  
17 subchapter, a custom health option and indi-  
18 vidual care expense arrangement shall be treat-  
19 ed as meeting the requirements of section 9802  
20 and sections 2705, 2711, 2713, and 2715 of  
21 title XXVII of the Public Health Service Act.

22 “(B) CUSTOM HEALTH OPTION AND INDI-  
23 VIDUAL CARE EXPENSE ARRANGEMENTS DE-  
24 FINED.—For purposes of this section, the term  
25 ‘custom health option and individual care ex-

1           pense arrangement’ means a health reimburse-  
2           ment arrangement—

3                   “(i) which is an employer-provided  
4                   group health plan funded solely by em-  
5                   ployer contributions to provide payments  
6                   or reimbursements for medical care subject  
7                   to a maximum fixed dollar amount for a  
8                   period,

9                   “(ii) under which such payments or  
10                  reimbursements may only be made for  
11                  medical care provided during periods dur-  
12                  ing which the individual is covered—

13                   “(I) under individual health in-  
14                   surance coverage (other than coverage  
15                   that consists solely of excepted bene-  
16                   fits), or

17                   “(II) under part A and B of title  
18                   XVIII of the Social Security Act or  
19                   part C of such title,

20                   “(iii) which meets the nondiscrimina-  
21                  tion requirements of subparagraph (C),

22                   “(iv) which meets the substantiation  
23                  requirements of subparagraph (D), and

24                   “(v) which meets the notice require-  
25                  ments of subparagraph (E).

1 “(C) NONDISCRIMINATION.—

2 “(i) IN GENERAL.—An arrangement  
3 meets the requirements of this subpara-  
4 graph if an employer offering such ar-  
5 rangement to an employee within a speci-  
6 fied class of employee—

7 “(I) offers such arrangement to  
8 all employees within such specified  
9 class on the same terms, and

10 “(II) does not offer any other  
11 group health plan (other than an ac-  
12 count-based group health plan or a  
13 group health plan that consists solely  
14 of excepted benefits) to any employees  
15 within such specified class.

16 In the case of an employer who offers a  
17 group health plan provided through health  
18 insurance coverage in the small group mar-  
19 ket (that is subject to section 2701 of the  
20 Public Health Service Act) to all employees  
21 within such specified class, subclause (II)  
22 shall not apply to such group health plan.

23 “(ii) SPECIFIED CLASS OF EM-  
24 PLOYEE.—For purposes of this subpara-

1 graph, any of the following may be des-  
2 ignated as a specified class of employee:

3 “(I) Full-time employees.

4 “(II) Part-time employees.

5 “(III) Salaried employees.

6 “(IV) Non-salaried employees.

7 “(V) Employees whose primary  
8 site of employment is in the same rat-  
9 ing area.

10 “(VI) Employees who are in-  
11 cluded in a unit of employees covered  
12 under a collective bargaining agree-  
13 ment to which the employer is subject  
14 (determined under rules similar to the  
15 rules of section 105(h)).

16 “(VII) Employees who have not  
17 met a group health plan, or health in-  
18 surance issuer offering group health  
19 insurance coverage, waiting period re-  
20 quirement that satisfies section 2708  
21 of the Public Health Service Act.

22 “(VIII) Seasonal employees.

23 “(IX) Employees who are non-  
24 resident aliens and who receive no  
25 earned income (within the meaning of

1 section 911(d)(2)) from the employer  
2 which constitutes income from sources  
3 within the United States (within the  
4 meaning of section 861(a)(3)).

5 “(X) Under such rules as the  
6 Secretary may prescribe, employees  
7 who are hired for temporary place-  
8 ment with an unrelated person that is  
9 not the common law employer.

10 “(XI) Such other classes of em-  
11 ployees as the Secretary may des-  
12 ignate.

13 An employer may designate (in such man-  
14 ner as is prescribed by the Secretary) two  
15 or more of the classes described in the pre-  
16 ceding subclauses as the specified class of  
17 employees to which the arrangement is of-  
18 fered for purposes of applying this sub-  
19 paragraph.

20 “(iii) SPECIAL RULE FOR NEW  
21 HIRES.—An employer may designate pro-  
22 spectively so much of a specified class of  
23 employees as are hired after a date set by  
24 the employer. Such subclass of employees

1 shall be treated as the specified class for  
2 purposes of applying clause (i).

3 “(iv) RULES FOR DETERMINING TYPE  
4 OF EMPLOYEE.—For purposes for clause  
5 (ii), any determination of full-time, part-  
6 time, or seasonal employment status shall  
7 be made under rules similar to the rules of  
8 section 105(h) or 4980H, whichever the  
9 employer elects for the plan year. Such  
10 election shall apply with respect to all em-  
11 ployees of the employer for the plan year.

12 “(v) PERMITTED VARIATION.—For  
13 purposes of clause (i)(I), an arrangement  
14 shall not fail to be treated as provided on  
15 the same terms within a specified class  
16 merely because the maximum dollar  
17 amount of payments and reimbursements  
18 which may be made under the terms of the  
19 arrangement for the year with respect to  
20 each employee within such class—

21 “(I) increases as additional de-  
22 pendants of the employee are covered  
23 under the arrangement, and

24 “(II) increases with respect to a  
25 participant as the age of the partici-

1                   pant increases, but not in excess of an  
2                   amount equal to 300 percent of the  
3                   lowest maximum dollar amount with  
4                   respect to such a participant deter-  
5                   mined without regard to age.

6                   “(D) SUBSTANTIATION REQUIREMENTS.—

7                   An arrangement meets the requirements of this  
8                   subparagraph if the arrangement has reason-  
9                   able procedures to substantiate—

10                   “(i) that the participant and any de-  
11                   pendents are, or will be, enrolled in cov-  
12                   erage described in subparagraph (B)(ii) as  
13                   of the beginning of the plan year of the ar-  
14                   rangement (or as of the beginning of cov-  
15                   erage under the arrangement in the case of  
16                   an employee who first becomes eligible to  
17                   participate in the arrangement after the  
18                   date notice is given with respect to the  
19                   plan under subparagraph (E) (determined  
20                   without regard to clause (iii) thereof), and

21                   “(ii) any requests made for payment  
22                   or reimbursement of medical care under  
23                   the arrangement and that the participant  
24                   and any dependents remain so enrolled.

25                   “(E) NOTICE.—

1           “(i) IN GENERAL.—Except as pro-  
2           vided in clause (iii), an arrangement meets  
3           the requirements of this subparagraph if,  
4           under the arrangement, each employee eli-  
5           gible to participate is, not later than 60  
6           days before the beginning of the plan year,  
7           given written notice of the employee’s  
8           rights and obligations under the arrange-  
9           ment which—

10                   “(I) is sufficiently accurate and  
11                   comprehensive to apprise the employee  
12                   of such rights and obligations, and

13                   “(II) is written in a manner cal-  
14                   culated to be understood by the aver-  
15                   age employee eligible to participate.

16           “(ii) NOTICE REQUIREMENTS.—Such  
17           notice shall include such information as the  
18           Secretary may by regulation prescribe.

19           “(iii) NOTICE DEADLINE FOR CER-  
20           TAIN EMPLOYEES.—In the case of an em-  
21           ployee—

22                   “(I) who first becomes eligible to  
23                   participate in the arrangement after  
24                   the date notice is given with respect  
25                   to the plan under clause (i) (deter-

1           mined without regard to this clause),  
2           or

3                   “(II) whose employer is first es-  
4                   tablished fewer than 120 days before  
5                   the beginning of the first plan year of  
6                   the arrangement,

7           the requirements of this subparagraph  
8           shall be treated as met if the notice re-  
9           quired under clause (i) is provided not  
10          later than the date the arrangement may  
11          take effect with respect to such em-  
12          ployee.”.

13                   (2) TREATMENT OF CURRENT RULES RELATING  
14          TO CERTAIN ARRANGEMENTS.—

15                   (A) NO INFERENCE.—To the extent not  
16          inconsistent with the amendments made by this  
17          subsection—

18                   (i) no inference shall be made from  
19          such amendments with respect to the rules  
20          prescribed in the Federal Register on June  
21          20, 2019, (84 Fed. Reg. 28888) relating to  
22          health reimbursement arrangements and  
23          other account-based group health plans,  
24          and

1           (ii) any reference to custom health op-  
2           tion and individual care expense arrange-  
3           ments shall for purposes of such rules be  
4           treated as including a reference to indi-  
5           vidual coverage health reimbursement ar-  
6           rangements.

7           (B) OTHER CONFORMING OF RULES.—The  
8           Secretary of the Treasury, the Secretary of  
9           Health and Human Services, and the Secretary  
10          of Labor shall modify such rules as may be nec-  
11          essary to conform to the amendments made by  
12          this subsection.

13          (3) PARTICIPANTS IN CHOICE ARRANGEMENT  
14          ELIGIBLE FOR PURCHASE OF EXCHANGE INSURANCE  
15          UNDER CAFETERIA PLAN.—Section 125(f)(3) of  
16          such Code is amended by adding at the end the fol-  
17          lowing new subparagraph:

18                 “(C) EXCEPTION FOR PARTICIPANTS IN  
19                 CHOICE ARRANGEMENT.—Subparagraph (A)  
20                 shall not apply in the case of an employee par-  
21                 ticipating in a custom health option and indi-  
22                 vidual care expense arrangement (within the  
23                 meaning of section 9815(b)(2)) offered by the  
24                 employee’s employer.”.

1           (4) **EFFECTIVE DATE.**—The amendments made  
2           by this subsection shall apply to plan years begin-  
3           ning after December 31, 2025.

4           (b) **INCLUSION OF CHOICE ARRANGEMENT PER-**  
5 **MITTED BENEFITS ON W-2.**—

6           (1) **IN GENERAL.**—Section 6051(a) of such  
7           Code is amended by striking “and” at the end of  
8           paragraph (18), by striking the period at the end of  
9           paragraph (19) and inserting “, and”, and by insert-  
10          ing after paragraph (19) the following new para-  
11          graph:

12           “(20) the total amount of permitted benefits for  
13          enrolled individuals under a custom health option  
14          and individual care expense arrangement (as defined  
15          in section 9815(b)(2)) with respect to such em-  
16          ployee.”.

17          (2) **EFFECTIVE DATE.**—The amendment made  
18          by this subsection shall apply to taxable years begin-  
19          ning after December 31, 2025.

1 **TITLE II—LOWERING HEALTH**  
2 **CARE PREMIUMS FOR EVERY-**  
3 **ONE**

4 **SEC. 201. OVERSIGHT OF PHARMACY BENEFIT MANAGE-**  
5 **MENT SERVICES.**

6 (a) PUBLIC HEALTH SERVICE ACT.—Title XXVII of  
7 the Public Health Service Act (42 U.S.C. 300gg et seq.)  
8 is amended—

9 (1) in part D (42 U.S.C. 300gg–111 et seq.),  
10 by adding at the end the following new section:

11 **“SEC. 2799A-11. OVERSIGHT OF ENTITIES THAT PROVIDE**  
12 **PHARMACY BENEFIT MANAGEMENT SERV-**  
13 **ICES.**

14 “(a) IN GENERAL.—For plan years beginning on or  
15 after the date that is 30 months after the date of enact-  
16 ment of this section (referred to in this subsection and  
17 subsection (b) as the ‘effective date’), a group health plan  
18 or a health insurance issuer offering group health insur-  
19 ance coverage, or an entity providing pharmacy benefit  
20 management services on behalf of such a plan or issuer,  
21 shall not enter into a contract, including an extension or  
22 renewal of a contract, entered into on or after the effective  
23 date, with an applicable entity unless such applicable enti-  
24 ty agrees to—

1           “(1) not limit or delay the disclosure of infor-  
2           mation to the group health plan (including such a  
3           plan offered through a health insurance issuer) in  
4           such a manner that prevents an entity providing  
5           pharmacy benefit management services on behalf of  
6           a group health plan or health insurance issuer offer-  
7           ing group health insurance coverage from making  
8           the reports described in subsection (b); and

9           “(2) provide the entity providing pharmacy ben-  
10          efit management services on behalf of a group health  
11          plan or health insurance issuer relevant information  
12          necessary to make the reports described in sub-  
13          section (b).

14          “(b) REPORTS.—

15                 “(1) IN GENERAL.—For plan years beginning  
16                 on or after the effective date, in the case of any con-  
17                 tract between a group health plan or a health insur-  
18                 ance issuer offering group health insurance coverage  
19                 offered in connection with such a plan and an entity  
20                 providing pharmacy benefit management services on  
21                 behalf of such plan or issuer, including an extension  
22                 or renewal of such a contract, entered into on or  
23                 after the effective date, the entity providing phar-  
24                 macy benefit management services on behalf of such  
25                 a group health plan or health insurance issuer, not

1 less frequently than every 6 months (or, at the re-  
2 quest of a group health plan, not less frequently  
3 than quarterly, and under the same conditions,  
4 terms, and cost of the semiannual report under this  
5 subsection), shall submit to the group health plan a  
6 report in accordance with this section. Each such re-  
7 port shall be made available to such group health  
8 plan in plain language, in a machine-readable for-  
9 mat, and as the Secretary may determine, other for-  
10 mats. Each such report shall include the information  
11 described in paragraph (2).

12 “(2) INFORMATION DESCRIBED.—For purposes  
13 of paragraph (1), the information described in this  
14 paragraph is, with respect to drugs covered by a  
15 group health plan or group health insurance cov-  
16 erage offered by a health insurance issuer in connec-  
17 tion with a group health plan during each reporting  
18 period—

19 “(A) in the case of a group health plan  
20 that is offered by a specified large employer or  
21 that is a specified large plan, and is not offered  
22 as health insurance coverage, or in the case of  
23 health insurance coverage for which the election  
24 under paragraph (3) is made for the applicable  
25 reporting period—

1           “(i) a list of drugs for which a claim  
2 was filed and, with respect to each such  
3 drug on such list—

4           “(I) the contracted compensation  
5 paid by the group health plan or  
6 health insurance issuer for each cov-  
7 ered drug (identified by the National  
8 Drug Code) to the entity providing  
9 pharmacy benefit management serv-  
10 ices or other applicable entity on be-  
11 half of the group health plan or health  
12 insurance issuer;

13           “(II) the contracted compensa-  
14 tion paid to the pharmacy, by any en-  
15 tity providing pharmacy benefit man-  
16 agement services or other applicable  
17 entity on behalf of the group health  
18 plan or health insurance issuer, for  
19 each covered drug (identified by the  
20 National Drug Code);

21           “(III) for each such claim, the  
22 difference between the amount paid  
23 under subclause (I) and the amount  
24 paid under subclause (II);

1           “(IV) the proprietary name, es-  
2           tablished name or proper name, and  
3           National Drug Code;

4           “(V) for each claim for the drug  
5           (including original prescriptions and  
6           refills) and for each dosage unit of the  
7           drug for which a claim was filed, the  
8           type of dispensing channel used to  
9           furnish the drug, including retail, mail  
10          order, or specialty pharmacy;

11          “(VI) with respect to each drug  
12          dispensed, for each type of dispensing  
13          channel (including retail, mail order,  
14          or specialty pharmacy)—

15                 “(aa) whether such drug is a  
16                 brand name drug or a generic  
17                 drug, and—

18                         “(AA) in the case of a  
19                         brand name drug, the whole-  
20                         sale acquisition cost, listed  
21                         as cost per days supply and  
22                         cost per dosage unit, on the  
23                         date such drug was dis-  
24                         pensed; and

1                   “(BB) in the case of a  
2                   generic drug, the average  
3                   wholesale price, listed as  
4                   cost per days supply and  
5                   cost per dosage unit, on the  
6                   date such drug was dis-  
7                   pensed; and

8                   “(bb) the total number of—  
9                   “(AA)        prescription  
10                  claims (including original  
11                  prescriptions and refills);

12                  “(BB) participants and  
13                  beneficiaries for whom a  
14                  claim for such drug was  
15                  filed through the applicable  
16                  dispensing channel;

17                  “(CC) dosage units and  
18                  dosage units per fill of such  
19                  drug; and

20                  “(DD) days supply of  
21                  such drug per fill;

22                  “(VII) the net price per course of  
23                  treatment or single fill, such as a 30-  
24                  day supply or 90-day supply to the  
25                  plan or coverage after rebates, fees,

1 alternative discounts, or other remuneration received from applicable entities;  
2  
3

4 “(VIII) the total amount of out-of-pocket spending by participants and beneficiaries on such drug, including spending through copayments, coinsurance, and deductibles, but not including any amounts spent by participants and beneficiaries on drugs not covered under the plan or coverage, or for which no claim is submitted under the plan or coverage;  
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14 “(IX) the total net spending on the drug;  
15

16 “(X) the total amount received, or expected to be received, by the plan or issuer from any applicable entity in rebates, fees, alternative discounts, or other remuneration;  
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18  
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21 “(XI) the total amount received, or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative dis-  
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23  
24  
25

1 counts, or other remuneration from  
2 such entities—

3 “(aa) for claims incurred  
4 during the reporting period; and

5 “(bb) that is related to utili-  
6 zation of such drug or spending  
7 on such drug; and

8 “(XII) to the extent feasible, in-  
9 formation on the total amount of re-  
10 munerated for such drug, including  
11 copayment assistance dollars paid, co-  
12 payment cards applied, or other dis-  
13 counts provided by each drug manu-  
14 facturer (or entity administering co-  
15 payment assistance on behalf of such  
16 drug manufacturer), to the partici-  
17 pants and beneficiaries enrolled in  
18 such plan or coverage;

19 “(ii) a list of each therapeutic class  
20 (as defined by the Secretary) for which a  
21 claim was filed under the group health  
22 plan or health insurance coverage during  
23 the reporting period, and, with respect to  
24 each such therapeutic class—

1           “(I) the total gross spending on  
2           drugs in such class before rebates,  
3           price concessions, alternative dis-  
4           counts, or other remuneration from  
5           applicable entities;

6           “(II) the net spending in such  
7           class after such rebates, price conces-  
8           sions, alternative discounts, or other  
9           remuneration from applicable entities;

10           “(III) the total amount received,  
11           or expected to be received, by the enti-  
12           ty providing pharmacy benefit man-  
13           agement services, from applicable en-  
14           tities, in rebates, fees, alternative dis-  
15           counts, or other remuneration from  
16           such entities—

17           “(aa) for claims incurred  
18           during the reporting period; and

19           “(bb) that is related to utili-  
20           zation of drugs or drug spending;

21           “(IV) the average net spending  
22           per 30-day supply and per 90-day  
23           supply by the plan or by the issuer  
24           with respect to such coverage and its  
25           participants and beneficiaries, among

1 all drugs within the therapeutic class  
2 for which a claim was filed during the  
3 reporting period;

4 “(V) the number of participants  
5 and beneficiaries who filled a prescrip-  
6 tion for a drug in such class, includ-  
7 ing the National Drug Code for each  
8 such drug;

9 “(VI) if applicable, a description  
10 of the formulary tiers and utilization  
11 mechanisms (such as prior authoriza-  
12 tion or step therapy) employed for  
13 drugs in that class; and

14 “(VII) the total out-of-pocket  
15 spending under the plan or coverage  
16 by participants and beneficiaries, in-  
17 cluding spending through copayments,  
18 coinsurance, and deductibles, but not  
19 including any amounts spent by par-  
20 ticipants and beneficiaries on drugs  
21 not covered under the plan or cov-  
22 erage or for which no claim is sub-  
23 mitted under the plan or coverage;

24 “(iii) with respect to any drug for  
25 which gross spending under the group

1 health plan or health insurance coverage  
2 exceeded \$10,000 during the reporting pe-  
3 riod or, in the case that gross spending  
4 under the group health plan or coverage  
5 exceeded \$10,000 during the reporting pe-  
6 riod with respect to fewer than 50 drugs,  
7 with respect to the 50 prescription drugs  
8 with the highest spending during the re-  
9 porting period—

10 “(I) a list of all other drugs in  
11 the same therapeutic class as such  
12 drug;

13 “(II) if applicable, the rationale  
14 for the formulary placement of such  
15 drug in that therapeutic category or  
16 class, selected from a list of standard  
17 rationales established by the Sec-  
18 retary, in consultation with stake-  
19 holders; and

20 “(III) any change in formulary  
21 placement compared to the prior plan  
22 year; and

23 “(iv) in the case that such plan or  
24 issuer (or an entity providing pharmacy  
25 benefit management services on behalf of

1 such plan or issuer) has an affiliated phar-  
2 macy or pharmacy under common owner-  
3 ship, including mandatory mail and spe-  
4 cialty home delivery programs, retail and  
5 mail auto-refill programs, and cost-sharing  
6 assistance incentives funded by an entity  
7 providing pharmacy benefit services—

8 “(I) an explanation of any ben-  
9 efit design parameters that encourage  
10 or require participants and bene-  
11 ficiaries in the plan or coverage to fill  
12 prescriptions at mail order, specialty,  
13 or retail pharmacies;

14 “(II) the percentage of total pre-  
15 scriptions dispensed by such phar-  
16 macies to participants or beneficiaries  
17 in such plan or coverage; and

18 “(III) a list of all drugs dis-  
19 pensed by such pharmacies to partici-  
20 pants or beneficiaries enrolled in such  
21 plan or coverage, and, with respect to  
22 each drug dispensed—

23 “(aa) the amount charged,  
24 per dosage unit, per 30-day sup-  
25 ply, or per 90-day supply (as ap-

1 plicable) to the plan or issuer,  
2 and to participants and bene-  
3 ficiaries;

4 “(bb) the median amount  
5 charged to such plan or issuer,  
6 and the interquartile range of the  
7 costs, per dosage unit, per 30-  
8 day supply, and per 90-day sup-  
9 ply, including amounts paid by  
10 the participants and bene-  
11 ficiaries, when the same drug is  
12 dispensed by other pharmacies  
13 that are not affiliated with or  
14 under common ownership with  
15 the entity and that are included  
16 in the pharmacy network of such  
17 plan or coverage;

18 “(cc) the lowest cost per  
19 dosage unit, per 30-day supply  
20 and per 90-day supply, for each  
21 such drug, including amounts  
22 charged to the plan or coverage  
23 and to participants and bene-  
24 ficiaries, that is available from  
25 any pharmacy included in the

1 network of such plan or coverage;  
2 and

3 “(dd) the net acquisition  
4 cost per dosage unit, per 30-day  
5 supply, and per 90-day supply, if  
6 such drug is subject to a max-  
7 imum price discount; and

8 “(B) with respect to any group health  
9 plan, including group health insurance coverage  
10 offered in connection with such a plan, regard-  
11 less of whether the plan or coverage is offered  
12 by a specified large employer or whether it is a  
13 specified large plan—

14 “(i) a summary document for the  
15 group health plan that includes such infor-  
16 mation described in clauses (i) through (iv)  
17 of subparagraph (A), as specified by the  
18 Secretary through guidance, program in-  
19 struction, or otherwise (with no require-  
20 ment of notice and comment rulemaking),  
21 that the Secretary determines useful to  
22 group health plans for purposes of select-  
23 ing pharmacy benefit management serv-  
24 ices, such as an estimated net price to  
25 group health plan and participant or bene-

1            beneficiary, a cost per claim, the fee structure  
2            or reimbursement model, and estimated  
3            cost per participant or beneficiary;

4            “(ii) a summary document for plans  
5            and issuers to provide to participants and  
6            beneficiaries, which shall be made available  
7            to participants or beneficiaries upon re-  
8            quest to their group health plan (including  
9            in the case of group health insurance cov-  
10           erage offered in connection with such a  
11           plan), that—

12                    “(I) contains such information  
13                    described in clauses (iii), (iv), (v), and  
14                    (vi), as applicable, as specified by the  
15                    Secretary through guidance, program  
16                    instruction, or otherwise (with no re-  
17                    quirement of notice and comment  
18                    rulemaking) that the Secretary deter-  
19                    mines useful to participants or bene-  
20                    ficiaries in better understanding the  
21                    plan or coverage or benefits under  
22                    such plan or coverage;

23                    “(II) contains only aggregate in-  
24                    formation; and

1           “(III) states that participants  
2           and beneficiaries may request specific,  
3           claims-level information required to be  
4           furnished under subsection (c) from  
5           the group health plan or health insur-  
6           ance issuer;

7           “(iii) with respect to drugs covered by  
8           such plan or coverage during such report-  
9           ing period—

10           “(I) the total net spending by the  
11           plan or coverage for all such drugs;

12           “(II) the total amount received,  
13           or expected to be received, by the plan  
14           or issuer from any applicable entity in  
15           rebates, fees, alternative discounts, or  
16           other remuneration; and

17           “(III) to the extent feasible, in-  
18           formation on the total amount of re-  
19           muneration for such drugs, including  
20           copayment assistance dollars paid, co-  
21           payment cards applied, or other dis-  
22           counts provided by each drug manu-  
23           facturer (or entity administering co-  
24           payment assistance on behalf of such

1 drug manufacturer) to participants  
2 and beneficiaries;

3 “(iv) amounts paid directly or indi-  
4 rectly in rebates, fees, or any other type of  
5 compensation (as defined in section  
6 408(b)(2)(B)(ii)(dd)(AA) of the Employee  
7 Retirement Income Security Act) to bro-  
8 kerage firms, brokers, consultants, advi-  
9 sors, or any other individual or firm, for—

10 “(I) the referral of the group  
11 health plan’s or health insurance  
12 issuer’s business to an entity pro-  
13 viding pharmacy benefit management  
14 services, including the identity of the  
15 recipient of such amounts;

16 “(II) consideration of the entity  
17 providing pharmacy benefit manage-  
18 ment services by the group health  
19 plan or health insurance issuer; or

20 “(III) the retention of the entity  
21 by the group health plan or health in-  
22 surance issuer;

23 “(v) an explanation of any benefit de-  
24 sign parameters that encourage or require  
25 participants and beneficiaries in such plan

1 or coverage to fill prescriptions at mail  
2 order, specialty, or retail pharmacies that  
3 are affiliated with or under common own-  
4 ership with the entity providing pharmacy  
5 benefit management services under such  
6 plan or coverage, including mandatory mail  
7 and specialty home delivery programs, re-  
8 tail and mail auto-refill programs, and  
9 cost-sharing assistance incentives directly  
10 or indirectly funded by such entity; and

11 “(vi) total gross spending on all drugs  
12 under the plan or coverage during the re-  
13 porting period.

14 “(3) OPT-IN FOR GROUP HEALTH INSURANCE  
15 COVERAGE OFFERED BY A SPECIFIED LARGE EM-  
16 PLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In  
17 the case of group health insurance coverage offered  
18 in connection with a group health plan that is of-  
19 fered by a specified large employer or is a specified  
20 large plan, such group health plan may, on an an-  
21 nual basis, for plan years beginning on or after the  
22 date that is 30 months after the date of enactment  
23 of this section, elect to require an entity providing  
24 pharmacy benefit management services on behalf of  
25 the health insurance issuer to submit to such group

1 health plan a report that includes all of the informa-  
2 tion described in paragraph (2)(A), in addition to  
3 the information described in paragraph (2)(B).

4 “(4) PRIVACY REQUIREMENTS.—

5 “(A) IN GENERAL.—An entity providing  
6 pharmacy benefit management services on be-  
7 half of a group health plan or a health insur-  
8 ance issuer offering group health insurance cov-  
9 erage shall report information under paragraph  
10 (1) in a manner consistent with the privacy reg-  
11 ulations promulgated under section 13402(a) of  
12 the Health Information Technology for Eco-  
13 nomic and Clinical Health Act and consistent  
14 with the privacy regulations promulgated under  
15 the Health Insurance Portability and Account-  
16 ability Act of 1996 in part 160 and subparts A  
17 and E of part 164 of title 45, Code of Federal  
18 Regulations (or successor regulations) (referred  
19 to in this paragraph as the ‘HIPAA privacy  
20 regulations’) and shall restrict the use and dis-  
21 closure of such information according to such  
22 privacy regulations and such HIPAA privacy  
23 regulations.

24 “(B) ADDITIONAL REQUIREMENTS.—

1           “(i) IN GENERAL.—An entity pro-  
2           viding pharmacy benefit management serv-  
3           ices on behalf of a group health plan or  
4           health insurance issuer offering group  
5           health insurance coverage that submits a  
6           report under paragraph (1) shall ensure  
7           that such report contains only summary  
8           health information, as defined in section  
9           164.504(a) of title 45, Code of Federal  
10          Regulations (or successor regulations).

11          “(ii) RESTRICTIONS.—In carrying out  
12          this subsection, a group health plan shall  
13          comply with section 164.504(f) of title 45,  
14          Code of Federal Regulations (or a suc-  
15          cessor regulation), and a plan sponsor shall  
16          act in accordance with the terms of the  
17          agreement described in such section.

18          “(C) RULE OF CONSTRUCTION.—

19          “(i) Nothing in this section shall be  
20          construed to modify the requirements for  
21          the creation, receipt, maintenance, or  
22          transmission of protected health informa-  
23          tion under the HIPAA privacy regulations.

24          “(ii) Nothing in this section shall be  
25          construed to affect the application of any

1 Federal or State privacy or civil rights law,  
2 including the HIPAA privacy regulations,  
3 the Genetic Information Nondiscrimination  
4 Act of 2008 (Public Law 110–233) (in-  
5 cluding the amendments made by such  
6 Act), the Americans with Disabilities Act  
7 of 1990 (42 U.S.C. 12101 et seq.), section  
8 504 of the Rehabilitation Act of 1973 (29  
9 U.S.C. 794), section 1557 of the Patient  
10 Protection and Affordable Care Act (42  
11 U.S.C. 18116), title VI of the Civil Rights  
12 Act of 1964 (42 U.S.C. 2000d), and title  
13 VII of the Civil Rights Act of 1964 (42  
14 U.S.C. 2000e).

15 “(D) WRITTEN NOTICE.—Each plan year,  
16 group health plans, including with respect to  
17 group health insurance coverage offered in con-  
18 nection with a group health plan, shall provide  
19 to each participant or beneficiary written notice  
20 informing the participant or beneficiary of the  
21 requirement for entities providing pharmacy  
22 benefit management services on behalf of the  
23 group health plan or health insurance issuer of-  
24 fering group health insurance coverage to sub-  
25 mit reports to group health plans under para-

1 graph (1), as applicable, which may include in-  
2 corporating such notification in plan documents  
3 provided to the participant or beneficiary, or  
4 providing individual notification.

5 “(E) LIMITATION TO BUSINESS ASSOCI-  
6 ATES.—A group health plan receiving a report  
7 under paragraph (1) may disclose such informa-  
8 tion only to the entity from which the report  
9 was received or to that entity’s business associ-  
10 ates as defined in section 160.103 of title 45,  
11 Code of Federal Regulations (or successor regu-  
12 lations) or as permitted by the HIPAA privacy  
13 regulations.

14 “(F) CLARIFICATION REGARDING PUBLIC  
15 DISCLOSURE OF INFORMATION.—Nothing in  
16 this section shall prevent an entity providing  
17 pharmacy benefit management services on be-  
18 half of a group health plan or health insurance  
19 issuer offering group health insurance coverage,  
20 from placing reasonable restrictions on the pub-  
21 lic disclosure of the information contained in a  
22 report described in paragraph (1), except that  
23 such plan, issuer, or entity may not—

24 “(i) restrict disclosure of such report  
25 to the Department of Health and Human

1 Services, the Department of Labor, or the  
2 Department of the Treasury; or

3 “(ii) prevent disclosure for the pur-  
4 poses of subsection (c), or any other public  
5 disclosure requirement under this section.

6 “(G) LIMITED FORM OF REPORT.—The  
7 Secretary shall define through rulemaking a  
8 limited form of the report under paragraph (1)  
9 required with respect to any group health plan  
10 established by a plan sponsor that is, or is af-  
11 filiated with, a drug manufacturer, drug whole-  
12 saler, or other direct participant in the drug  
13 supply chain, in order to prevent anti-competi-  
14 tive behavior.

15 “(5) STANDARD FORMAT AND REGULATIONS.—

16 “(A) IN GENERAL.—Not later than 18  
17 months after the date of enactment of this sec-  
18 tion, the Secretary shall specify through rule-  
19 making a standard format for entities providing  
20 pharmacy benefit management services on be-  
21 half of group health plans and health insurance  
22 issuers offering group health insurance cov-  
23 erage, to submit reports required under para-  
24 graph (1).

1           “(B) ADDITIONAL REGULATIONS.—Not  
2 later than 18 months after the date of enact-  
3 ment of this section, the Secretary shall,  
4 through rulemaking, promulgate any other final  
5 regulations necessary to implement the require-  
6 ments of this section. In promulgating such  
7 regulations, the Secretary shall, to the extent  
8 practicable, align the reporting requirements  
9 under this section with the reporting require-  
10 ments under section 2799A–10.

11       “(c) REQUIREMENT TO PROVIDE INFORMATION TO  
12 PARTICIPANTS OR BENEFICIARIES.—A group health plan,  
13 including with respect to group health insurance coverage  
14 offered in connection with a group health plan, upon re-  
15 quest of a participant or beneficiary, shall provide to such  
16 participant or beneficiary—

17           “(1) the summary document described in sub-  
18 section (b)(2)(B)(ii); and

19           “(2) the information described in subsection  
20 (b)(2)(A)(i)(III) with respect to a claim made by or  
21 on behalf of such participant or beneficiary.

22       “(d) ENFORCEMENT.—

23           “(1) IN GENERAL.—The Secretary shall enforce  
24 this section. The enforcement authority under this  
25 subsection shall apply only with respect to group

1 health plans (including group health insurance cov-  
2 erage offered in connection with such a plan) to  
3 which the requirements of subparts I and II of part  
4 A and part D apply in accordance with section 2722,  
5 and with respect to entities providing pharmacy ben-  
6 efit management services on behalf of such plans  
7 and applicable entities providing services on behalf  
8 of such plans.

9 “(2) FAILURE TO PROVIDE INFORMATION.—A  
10 group health plan, a health insurance issuer offering  
11 group health insurance coverage, an entity providing  
12 pharmacy benefit management services on behalf of  
13 such a plan or issuer, or an applicable entity pro-  
14 viding services on behalf of such a plan or issuer  
15 that violates subsection (a); an entity providing  
16 pharmacy benefit management services on behalf of  
17 such a plan or issuer that fails to provide the infor-  
18 mation required under subsection (b); or a group  
19 health plan that fails to provide the information re-  
20 quired under subsection (c), shall be subject to a  
21 civil monetary penalty in the amount of \$10,000 for  
22 each day during which such violation continues or  
23 such information is not disclosed or reported.

24 “(3) FALSE INFORMATION.—A health insurance  
25 issuer, an entity providing pharmacy benefit man-

1       agement services, or a third party administrator pro-  
2       viding services on behalf of such issuer offered by a  
3       health insurance issuer that knowingly provides false  
4       information under this section shall be subject to a  
5       civil monetary penalty in an amount not to exceed  
6       \$100,000 for each item of false information. Such  
7       civil monetary penalty shall be in addition to other  
8       penalties as may be prescribed by law.

9               “(4) PROCEDURE.—The provisions of section  
10       1128A of the Social Security Act, other than sub-  
11       sections (a) and (b) and the first sentence of sub-  
12       section (c)(1) of such section shall apply to civil  
13       monetary penalties under this subsection in the  
14       same manner as such provisions apply to a penalty  
15       or proceeding under such section.

16               “(5) WAIVERS.—The Secretary may waive pen-  
17       alties under paragraph (2), or extend the period of  
18       time for compliance with a requirement of this sec-  
19       tion, for an entity in violation of this section that  
20       has made a good-faith effort to comply with the re-  
21       quirements in this section.

22               “(e) RULE OF CONSTRUCTION.—Nothing in this sec-  
23       tion shall be construed to permit a health insurance issuer,  
24       group health plan, entity providing pharmacy benefit man-  
25       agement services on behalf of a group health plan or

1 health insurance issuer, or other entity to restrict dislo-  
2 sure to, or otherwise limit the access of, the Secretary to  
3 a report described in subsection (b)(1) or information re-  
4 lated to compliance with subsections (a), (b), (c), or (d)  
5 by such issuer, plan, or entity.

6 “(f) DEFINITIONS.—In this section:

7 “(1) APPLICABLE ENTITY.—The term ‘applica-  
8 ble entity’ means—

9 “(A) an applicable group purchasing orga-  
10 nization, drug manufacturer, distributor, whole-  
11 saler, rebate aggregator (or other purchasing  
12 entity designed to aggregate rebates), or associ-  
13 ated third party;

14 “(B) any subsidiary, parent, affiliate, or  
15 subcontractor of a group health plan, health in-  
16 surance issuer, entity that provides pharmacy  
17 benefit management services on behalf of such  
18 a plan or issuer, or any entity described in sub-  
19 paragraph (A); or

20 “(C) such other entity as the Secretary  
21 may specify through rulemaking.

22 “(2) APPLICABLE GROUP PURCHASING ORGANI-  
23 ZATION.—The term ‘applicable group purchasing or-  
24 ganization’ means a group purchasing organization  
25 that is affiliated with or under common ownership

1 with an entity providing pharmacy benefit manage-  
2 ment services.

3 “(3) CONTRACTED COMPENSATION.—The term  
4 ‘contracted compensation’ means the sum of any in-  
5 gredient cost and dispensing fee for a drug (inclusive  
6 of the out-of-pocket costs to the participant or bene-  
7 ficiary), or another analogous compensation struc-  
8 ture that the Secretary may specify through regula-  
9 tions.

10 “(4) GROSS SPENDING.—The term ‘gross  
11 spending’, with respect to prescription drug benefits  
12 under a group health plan or health insurance cov-  
13 erage, means the amount spent by a group health  
14 plan or health insurance issuer on prescription drug  
15 benefits, calculated before the application of rebates,  
16 fees, alternative discounts, or other remuneration.

17 “(5) NET SPENDING.—The term ‘net spending’,  
18 with respect to prescription drug benefits under a  
19 group health plan or health insurance coverage,  
20 means the amount spent by a group health plan or  
21 health insurance issuer on prescription drug bene-  
22 fits, calculated after the application of rebates, fees,  
23 alternative discounts, or other remuneration.

24 “(6) PLAN SPONSOR.—The term ‘plan sponsor’  
25 has the meaning given such term in section 3(16)(B)

1 of the Employee Retirement Income Security Act of  
2 1974.

3 “(7) REMUNERATION.—The term ‘remunera-  
4 tion’ has the meaning given such term by the Sec-  
5 retary through rulemaking, which shall be reevaluated by the Secretary every 5 years.

7 “(8) SPECIFIED LARGE EMPLOYER.—The term  
8 ‘specified large employer’ means, in connection with  
9 a group health plan (including group health insurance  
10 coverage offered in connection with such a  
11 plan) established or maintained by a single employer,  
12 with respect to a calendar year or a plan year, as applicable,  
13 an employer who employed an average of at least 100 employees  
14 on business days during the preceding calendar year or plan year  
15 and who employs at least 1 employee on the first day of  
16 the calendar year or plan year.

18 “(9) SPECIFIED LARGE PLAN.—The term ‘specified large plan’ means a group health plan (including group health insurance coverage offered in connection with such a plan) established or maintained by a plan sponsor described in clause (ii) or (iii) of section 3(16)(B) of the Employee Retirement Income Security Act of 1974 that had an average of  
22 at least 100 participants on business days during  
23  
24  
25

1 the preceding calendar year or plan year, as applica-  
2 ble.

3 “(10) WHOLESALE ACQUISITION COST.—The  
4 term ‘wholesale acquisition cost’ has the meaning  
5 given such term in section 1847A(c)(6)(B) of the  
6 Social Security Act.”; and

7 (2) in section 2723 (42 U.S.C. 300gg-22)—

8 (A) in subsection (a)—

9 (i) in paragraph (1), by inserting  
10 “(other than section 2799A-11)” after  
11 “part D”; and

12 (ii) in paragraph (2), by inserting  
13 “(other than section 2799A-11)” after  
14 “part D”; and

15 (B) in subsection (b)—

16 (i) in paragraph (1), by inserting  
17 “(other than section 2799A-11)” after  
18 “part D”;

19 (ii) in paragraph (2)(A), by inserting  
20 “(other than section 2799A-11)” after  
21 “part D”; and

22 (iii) in paragraph (2)(C)(ii), by insert-  
23 ing “(other than section 2799A-11)” after  
24 “part D”.

1 (b) EMPLOYEE RETIREMENT INCOME SECURITY ACT  
2 OF 1974.—

3 (1) IN GENERAL.—Subtitle B of title I of the  
4 Employee Retirement Income Security Act of 1974  
5 (29 U.S.C. 1021 et seq.) is amended—

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

9 **“SEC. 726. OVERSIGHT OF ENTITIES THAT PROVIDE PHAR-**  
10 **MACY BENEFIT MANAGEMENT SERVICES.**

11 “(a) IN GENERAL.—For plan years beginning on or  
12 after the date that is 30 months after the date of enact-  
13 ment of this section (referred to in this subsection and  
14 subsection (b) as the ‘effective date’), a group health plan  
15 or a health insurance issuer offering group health insur-  
16 ance coverage, or an entity providing pharmacy benefit  
17 management services on behalf of such a plan or issuer,  
18 shall not enter into a contract, including an extension or  
19 renewal of a contract, entered into on or after the effective  
20 date, with an applicable entity unless such applicable enti-  
21 ty agrees to—

22 “(1) not limit or delay the disclosure of infor-  
23 mation to the group health plan (including such a  
24 plan offered through a health insurance issuer) in  
25 such a manner that prevents an entity providing

1 pharmacy benefit management services on behalf of  
2 a group health plan or health insurance issuer offer-  
3 ing group health insurance coverage from making  
4 the reports described in subsection (b); and

5 “(2) provide the entity providing pharmacy ben-  
6 efit management services on behalf of a group health  
7 plan or health insurance issuer relevant information  
8 necessary to make the reports described in sub-  
9 section (b).

10 “(b) REPORTS.—

11 “(1) IN GENERAL.—For plan years beginning  
12 on or after the effective date, in the case of any con-  
13 tract between a group health plan or a health insur-  
14 ance issuer offering group health insurance coverage  
15 offered in connection with such a plan and an entity  
16 providing pharmacy benefit management services on  
17 behalf of such plan or issuer, including an extension  
18 or renewal of such a contract, entered into on or  
19 after the effective date, the entity providing phar-  
20 macy benefit management services on behalf of such  
21 a group health plan or health insurance issuer, not  
22 less frequently than every 6 months (or, at the re-  
23 quest of a group health plan, not less frequently  
24 than quarterly, and under the same conditions,  
25 terms, and cost of the semiannual report under this

1 subsection), shall submit to the group health plan a  
2 report in accordance with this section. Each such re-  
3 port shall be made available to such group health  
4 plan in plain language, in a machine-readable for-  
5 mat, and as the Secretary may determine, other for-  
6 mats. Each such report shall include the information  
7 described in paragraph (2).

8 “(2) INFORMATION DESCRIBED.—For purposes  
9 of paragraph (1), the information described in this  
10 paragraph is, with respect to drugs covered by a  
11 group health plan or group health insurance cov-  
12 erage offered by a health insurance issuer in connec-  
13 tion with a group health plan during each reporting  
14 period—

15 “(A) in the case of a group health plan  
16 that is offered by a specified large employer or  
17 that is a specified large plan, and is not offered  
18 as health insurance coverage, or in the case of  
19 health insurance coverage for which the election  
20 under paragraph (3) is made for the applicable  
21 reporting period—

22 “(i) a list of drugs for which a claim  
23 was filed and, with respect to each such  
24 drug on such list—

1           “(I) the contracted compensation  
2           paid by the group health plan or  
3           health insurance issuer for each cov-  
4           ered drug (identified by the National  
5           Drug Code) to the entity providing  
6           pharmacy benefit management serv-  
7           ices or other applicable entity on be-  
8           half of the group health plan or health  
9           insurance issuer;

10           “(II) the contracted compensa-  
11           tion paid to the pharmacy, by any en-  
12           tity providing pharmacy benefit man-  
13           agement services or other applicable  
14           entity on behalf of the group health  
15           plan or health insurance issuer, for  
16           each covered drug (identified by the  
17           National Drug Code);

18           “(III) for each such claim, the  
19           difference between the amount paid  
20           under subclause (I) and the amount  
21           paid under subclause (II);

22           “(IV) the proprietary name, es-  
23           tablished name or proper name, and  
24           National Drug Code;

1           “(V) for each claim for the drug  
2           (including original prescriptions and  
3           refills) and for each dosage unit of the  
4           drug for which a claim was filed, the  
5           type of dispensing channel used to  
6           furnish the drug, including retail, mail  
7           order, or specialty pharmacy;

8           “(VI) with respect to each drug  
9           dispensed, for each type of dispensing  
10          channel (including retail, mail order,  
11          or specialty pharmacy)—

12           “(aa) whether such drug is a  
13           brand name drug or a generic  
14           drug, and—

15           “(AA) in the case of a  
16           brand name drug, the whole-  
17           sale acquisition cost, listed  
18           as cost per days supply and  
19           cost per dosage unit, on the  
20           date such drug was dis-  
21           pensed; and

22           “(BB) in the case of a  
23           generic drug, the average  
24           wholesale price, listed as  
25           cost per days supply and

1 cost per dosage unit, on the  
2 date such drug was dis-  
3 pensed; and  
4 “(bb) the total number of—  
5 “(AA) prescription  
6 claims (including original  
7 prescriptions and refills);  
8 “(BB) participants and  
9 beneficiaries for whom a  
10 claim for such drug was  
11 filed through the applicable  
12 dispensing channel;  
13 “(CC) dosage units and  
14 dosage units per fill of such  
15 drug; and  
16 “(DD) days supply of  
17 such drug per fill;  
18 “(VII) the net price per course of  
19 treatment or single fill, such as a 30-  
20 day supply or 90-day supply to the  
21 plan or coverage after rebates, fees,  
22 alternative discounts, or other remun-  
23 eration received from applicable enti-  
24 ties;

1           “(VIII) the total amount of out-  
2           of-pocket spending by participants  
3           and beneficiaries on such drug, in-  
4           cluding spending through copayments,  
5           coinsurance, and deductibles, but not  
6           including any amounts spent by par-  
7           ticipants and beneficiaries on drugs  
8           not covered under the plan or cov-  
9           erage, or for which no claim is sub-  
10          mitted under the plan or coverage;

11          “(IX) the total net spending on  
12          the drug;

13          “(X) the total amount received,  
14          or expected to be received, by the plan  
15          or issuer from any applicable entity in  
16          rebates, fees, alternative discounts, or  
17          other remuneration;

18          “(XI) the total amount received,  
19          or expected to be received, by the enti-  
20          ty providing pharmacy benefit man-  
21          agement services, from applicable en-  
22          tities, in rebates, fees, alternative dis-  
23          counts, or other remuneration from  
24          such entities—

1                   “(aa) for claims incurred  
2                   during the reporting period; and

3                   “(bb) that is related to utili-  
4                   zation of such drug or spending  
5                   on such drug; and

6                   “(XII) to the extent feasible, in-  
7                   formation on the total amount of re-  
8                   muneration for such drug, including  
9                   copayment assistance dollars paid, co-  
10                  payment cards applied, or other dis-  
11                  counts provided by each drug manu-  
12                  facturer (or entity administering co-  
13                  payment assistance on behalf of such  
14                  drug manufacturer), to the partici-  
15                  pants and beneficiaries enrolled in  
16                  such plan or coverage;

17                  “(ii) a list of each therapeutic class  
18                  (as defined by the Secretary) for which a  
19                  claim was filed under the group health  
20                  plan or health insurance coverage during  
21                  the reporting period, and, with respect to  
22                  each such therapeutic class—

23                  “(I) the total gross spending on  
24                  drugs in such class before rebates,  
25                  price concessions, alternative dis-

1 counts, or other remuneration from  
2 applicable entities;

3 “(II) the net spending in such  
4 class after such rebates, price conces-  
5 sions, alternative discounts, or other  
6 remuneration from applicable entities;

7 “(III) the total amount received,  
8 or expected to be received, by the enti-  
9 ty providing pharmacy benefit man-  
10 agement services, from applicable en-  
11 tities, in rebates, fees, alternative dis-  
12 counts, or other remuneration from  
13 such entities—

14 “(aa) for claims incurred  
15 during the reporting period; and

16 “(bb) that is related to utili-  
17 zation of drugs or drug spending;

18 “(IV) the average net spending  
19 per 30-day supply and per 90-day  
20 supply by the plan or by the issuer  
21 with respect to such coverage and its  
22 participants and beneficiaries, among  
23 all drugs within the therapeutic class  
24 for which a claim was filed during the  
25 reporting period;

1           “(V) the number of participants  
2           and beneficiaries who filled a prescrip-  
3           tion for a drug in such class, includ-  
4           ing the National Drug Code for each  
5           such drug;

6           “(VI) if applicable, a description  
7           of the formulary tiers and utilization  
8           mechanisms (such as prior authoriza-  
9           tion or step therapy) employed for  
10          drugs in that class; and

11          “(VII) the total out-of-pocket  
12          spending under the plan or coverage  
13          by participants and beneficiaries, in-  
14          cluding spending through copayments,  
15          coinsurance, and deductibles, but not  
16          including any amounts spent by par-  
17          ticipants and beneficiaries on drugs  
18          not covered under the plan or cov-  
19          erage or for which no claim is sub-  
20          mitted under the plan or coverage;

21          “(iii) with respect to any drug for  
22          which gross spending under the group  
23          health plan or health insurance coverage  
24          exceeded \$10,000 during the reporting pe-  
25          riod or, in the case that gross spending

1 under the group health plan or coverage  
2 exceeded \$10,000 during the reporting pe-  
3 riod with respect to fewer than 50 drugs,  
4 with respect to the 50 prescription drugs  
5 with the highest spending during the re-  
6 porting period—

7 “(I) a list of all other drugs in  
8 the same therapeutic class as such  
9 drug;

10 “(II) if applicable, the rationale  
11 for the formulary placement of such  
12 drug in that therapeutic category or  
13 class, selected from a list of standard  
14 rationales established by the Sec-  
15 retary, in consultation with stake-  
16 holders; and

17 “(III) any change in formulary  
18 placement compared to the prior plan  
19 year; and

20 “(iv) in the case that such plan or  
21 issuer (or an entity providing pharmacy  
22 benefit management services on behalf of  
23 such plan or issuer) has an affiliated phar-  
24 macy or pharmacy under common owner-  
25 ship, including mandatory mail and spe-

1 specialty home delivery programs, retail and  
2 mail auto-refill programs, and cost sharing  
3 assistance incentives funded by an entity  
4 providing pharmacy benefit services—

5 “(I) an explanation of any ben-  
6 efit design parameters that encourage  
7 or require participants and bene-  
8 ficiaries in the plan or coverage to fill  
9 prescriptions at mail order, specialty,  
10 or retail pharmacies;

11 “(II) the percentage of total pre-  
12 scriptions dispensed by such phar-  
13 macies to participants or beneficiaries  
14 in such plan or coverage; and

15 “(III) a list of all drugs dis-  
16 pensed by such pharmacies to partici-  
17 pants or beneficiaries enrolled in such  
18 plan or coverage, and, with respect to  
19 each drug dispensed—

20 “(aa) the amount charged,  
21 per dosage unit, per 30-day sup-  
22 ply, or per 90-day supply (as ap-  
23 plicable) to the plan or issuer,  
24 and to participants and bene-  
25 ficiaries;

1           “(bb) the median amount  
2 charged to such plan or issuer,  
3 and the interquartile range of the  
4 costs, per dosage unit, per 30-  
5 day supply, and per 90-day sup-  
6 ply, including amounts paid by  
7 the participants and bene-  
8 ficiaries, when the same drug is  
9 dispensed by other pharmacies  
10 that are not affiliated with or  
11 under common ownership with  
12 the entity and that are included  
13 in the pharmacy network of such  
14 plan or coverage;

15           “(cc) the lowest cost per  
16 dosage unit, per 30-day supply  
17 and per 90-day supply, for each  
18 such drug, including amounts  
19 charged to the plan or coverage  
20 and to participants and bene-  
21 ficiaries, that is available from  
22 any pharmacy included in the  
23 network of such plan or coverage;  
24 and

1                   “(dd) the net acquisition  
2                   cost per dosage unit, per 30-day  
3                   supply, and per 90-day supply, if  
4                   such drug is subject to a max-  
5                   imum price discount; and

6                   “(B) with respect to any group health  
7                   plan, including group health insurance coverage  
8                   offered in connection with such a plan, regard-  
9                   less of whether the plan or coverage is offered  
10                  by a specified large employer or whether it is a  
11                  specified large plan—

12                  “(i) a summary document for the  
13                  group health plan that includes such infor-  
14                  mation described in clauses (i) through (iv)  
15                  of subparagraph (A), as specified by the  
16                  Secretary through guidance, program in-  
17                  struction, or otherwise (with no require-  
18                  ment of notice and comment rulemaking),  
19                  that the Secretary determines useful to  
20                  group health plans for purposes of select-  
21                  ing pharmacy benefit management serv-  
22                  ices, such as an estimated net price to  
23                  group health plan and participant or bene-  
24                  ficiary, a cost per claim, the fee structure

1 or reimbursement model, and estimated  
2 cost per participant or beneficiary;

3 “(ii) a summary document for plans  
4 and issuers to provide to participants and  
5 beneficiaries, which shall be made available  
6 to participants or beneficiaries upon re-  
7 quest to their group health plan (including  
8 in the case of group health insurance cov-  
9 erage offered in connection with such a  
10 plan), that—

11 “(I) contains such information  
12 described in clauses (iii), (iv), (v), and  
13 (vi), as applicable, as specified by the  
14 Secretary through guidance, program  
15 instruction, or otherwise (with no re-  
16 quirement of notice and comment  
17 rulemaking) that the Secretary deter-  
18 mines useful to participants or bene-  
19 ficiaries in better understanding the  
20 plan or coverage or benefits under  
21 such plan or coverage;

22 “(II) contains only aggregate in-  
23 formation; and

24 “(III) states that participants  
25 and beneficiaries may request specific,

1 claims-level information required to be  
2 furnished under subsection (c) from  
3 the group health plan or health insur-  
4 ance issuer;

5 “(iii) with respect to drugs covered by  
6 such plan or coverage during such report-  
7 ing period—

8 “(I) the total net spending by the  
9 plan or coverage for all such drugs;

10 “(II) the total amount received,  
11 or expected to be received, by the plan  
12 or issuer from any applicable entity in  
13 rebates, fees, alternative discounts, or  
14 other remuneration; and

15 “(III) to the extent feasible, in-  
16 formation on the total amount of re-  
17 muneration for such drugs, including  
18 copayment assistance dollars paid, co-  
19 payment cards applied, or other dis-  
20 counts provided by each drug manu-  
21 facturer (or entity administering co-  
22 payment assistance on behalf of such  
23 drug manufacturer) to participants  
24 and beneficiaries;

1           “(iv) amounts paid directly or indi-  
2           rectly in rebates, fees, or any other type of  
3           compensation (as defined in section  
4           408(b)(2)(B)(ii)(dd)(AA)) to brokerage  
5           firms, brokers, consultants, advisors, or  
6           any other individual or firm, for—

7                   “(I) the referral of the group  
8                   health plan’s or health insurance  
9                   issuer’s business to an entity pro-  
10                  viding pharmacy benefit management  
11                  services, including the identity of the  
12                  recipient of such amounts;

13                  “(II) consideration of the entity  
14                  providing pharmacy benefit manage-  
15                  ment services by the group health  
16                  plan or health insurance issuer; or

17                  “(III) the retention of the entity  
18                  by the group health plan or health in-  
19                  surance issuer;

20           “(v) an explanation of any benefit de-  
21           sign parameters that encourage or require  
22           participants and beneficiaries in such plan  
23           or coverage to fill prescriptions at mail  
24           order, specialty, or retail pharmacies that  
25           are affiliated with or under common own-

1           ership with the entity providing pharmacy  
2           benefit management services under such  
3           plan or coverage, including mandatory mail  
4           and specialty home delivery programs, re-  
5           tail and mail auto-refill programs, and  
6           cost-sharing assistance incentives directly  
7           or indirectly funded by such entity; and

8                   “(vi) total gross spending on all drugs  
9           under the plan or coverage during the re-  
10          porting period.

11           “(3) OPT-IN FOR GROUP HEALTH INSURANCE  
12          COVERAGE OFFERED BY A SPECIFIED LARGE EM-  
13          PLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In  
14          the case of group health insurance coverage offered  
15          in connection with a group health plan that is of-  
16          fered by a specified large employer or is a specified  
17          large plan, such group health plan may, on an an-  
18          nual basis, for plan years beginning on or after the  
19          date that is 30 months after the date of enactment  
20          of this section, elect to require an entity providing  
21          pharmacy benefit management services on behalf of  
22          the health insurance issuer to submit to such group  
23          health plan a report that includes all of the informa-  
24          tion described in paragraph (2)(A), in addition to  
25          the information described in paragraph (2)(B).

1           “(4) PRIVACY REQUIREMENTS.—

2                   “(A) IN GENERAL.—An entity providing  
3 pharmacy benefit management services on be-  
4 half of a group health plan or a health insur-  
5 ance issuer offering group health insurance cov-  
6 erage shall report information under paragraph  
7 (1) in a manner consistent with the privacy reg-  
8 ulations promulgated under section 13402(a) of  
9 the Health Information Technology for Eco-  
10 nomic and Clinical Health Act (42 U.S.C.  
11 17932(a)) and consistent with the privacy regu-  
12 lations promulgated under the Health Insur-  
13 ance Portability and Accountability Act of 1996  
14 in part 160 and subparts A and E of part 164  
15 of title 45, Code of Federal Regulations (or suc-  
16 cessor regulations) (referred to in this para-  
17 graph as the ‘HIPAA privacy regulations’) and  
18 shall restrict the use and disclosure of such in-  
19 formation according to such privacy regulations  
20 and such HIPAA privacy regulations.

21                   “(B) ADDITIONAL REQUIREMENTS.—

22                           “(i) IN GENERAL.—An entity pro-  
23 viding pharmacy benefit management serv-  
24 ices on behalf of a group health plan or  
25 health insurance issuer offering group

1 health insurance coverage that submits a  
2 report under paragraph (1) shall ensure  
3 that such report contains only summary  
4 health information, as defined in section  
5 164.504(a) of title 45, Code of Federal  
6 Regulations (or successor regulations).

7 “(ii) RESTRICTIONS.—In carrying out  
8 this subsection, a group health plan shall  
9 comply with section 164.504(f) of title 45,  
10 Code of Federal Regulations (or a suc-  
11 cessor regulation), and a plan sponsor shall  
12 act in accordance with the terms of the  
13 agreement described in such section.

14 “(C) RULE OF CONSTRUCTION.—

15 “(i) Nothing in this section shall be  
16 construed to modify the requirements for  
17 the creation, receipt, maintenance, or  
18 transmission of protected health informa-  
19 tion under the HIPAA privacy regulations.

20 “(ii) Nothing in this section shall be  
21 construed to affect the application of any  
22 Federal or State privacy or civil rights law,  
23 including the HIPAA privacy regulations,  
24 the Genetic Information Nondiscrimination  
25 Act of 2008 (Public Law 110–233) (in-

1 cluding the amendments made by such  
2 Act), the Americans with Disabilities Act  
3 of 1990 (42 U.S.C. 12101 et seq.), section  
4 504 of the Rehabilitation Act of 1973 (29  
5 U.S.C. 794), section 1557 of the Patient  
6 Protection and Affordable Care Act (42  
7 U.S.C. 18116), title VI of the Civil Rights  
8 Act of 1964 (42 U.S.C. 2000d), and title  
9 VII of the Civil Rights Act of 1964 (42  
10 U.S.C. 2000e).

11 “(D) WRITTEN NOTICE.—Each plan year,  
12 group health plans, including with respect to  
13 group health insurance coverage offered in con-  
14 nection with a group health plan, shall provide  
15 to each participant or beneficiary written notice  
16 informing the participant or beneficiary of the  
17 requirement for entities providing pharmacy  
18 benefit management services on behalf of the  
19 group health plan or health insurance issuer of-  
20 fering group health insurance coverage to sub-  
21 mit reports to group health plans under para-  
22 graph (1), as applicable, which may include in-  
23 corporating such notification in plan documents  
24 provided to the participant or beneficiary, or  
25 providing individual notification.

1           “(E) LIMITATION TO BUSINESS ASSOCI-  
2           ATES.—A group health plan receiving a report  
3           under paragraph (1) may disclose such informa-  
4           tion only to the entity from which the report  
5           was received or to that entity’s business associ-  
6           ates as defined in section 160.103 of title 45,  
7           Code of Federal Regulations (or successor regu-  
8           lations) or as permitted by the HIPAA privacy  
9           regulations.

10           “(F) CLARIFICATION REGARDING PUBLIC  
11           DISCLOSURE OF INFORMATION.—Nothing in  
12           this section shall prevent an entity providing  
13           pharmacy benefit management services on be-  
14           half of a group health plan or health insurance  
15           issuer offering group health insurance coverage,  
16           from placing reasonable restrictions on the pub-  
17           lic disclosure of the information contained in a  
18           report described in paragraph (1), except that  
19           such plan, issuer, or entity may not—

20                   “(i) restrict disclosure of such report  
21                   to the Department of Health and Human  
22                   Services, the Department of Labor, or the  
23                   Department of the Treasury; or

1           “(ii) prevent disclosure for the pur-  
2           poses of subsection (c), or any other public  
3           disclosure requirement under this section.

4           “(G) LIMITED FORM OF REPORT.—The  
5           Secretary shall define through rulemaking a  
6           limited form of the report under paragraph (1)  
7           required with respect to any group health plan  
8           established by a plan sponsor that is, or is af-  
9           filiated with, a drug manufacturer, drug whole-  
10          saler, or other direct participant in the drug  
11          supply chain, in order to prevent anti-competi-  
12          tive behavior.

13          “(5) STANDARD FORMAT AND REGULATIONS.—

14                 “(A) IN GENERAL.—Not later than 18  
15                 months after the date of enactment of this sec-  
16                 tion, the Secretary shall specify through rule-  
17                 making a standard format for entities providing  
18                 pharmacy benefit management services on be-  
19                 half of group health plans and health insurance  
20                 issuers offering group health insurance cov-  
21                 erage, to submit reports required under para-  
22                 graph (1).

23                 “(B) ADDITIONAL REGULATIONS.—Not  
24                 later than 18 months after the date of enact-  
25                 ment of this section, the Secretary shall,

1 through rulemaking, promulgate any other final  
2 regulations necessary to implement the require-  
3 ments of this section. In promulgating such  
4 regulations, the Secretary shall, to the extent  
5 practicable, align the reporting requirements  
6 under this section with the reporting require-  
7 ments under section 725.

8 “(c) REQUIREMENT TO PROVIDE INFORMATION TO  
9 PARTICIPANTS OR BENEFICIARIES.—A group health plan,  
10 including with respect to group health insurance coverage  
11 offered in connection with a group health plan, upon re-  
12 quest of a participant or beneficiary, shall provide to such  
13 participant or beneficiary—

14 “(1) the summary document described in sub-  
15 section (b)(2)(B)(ii); and

16 “(2) the information described in subsection  
17 (b)(2)(A)(i)(III) with respect to a claim made by or  
18 on behalf of such participant or beneficiary.

19 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
20 tion shall be construed to permit a health insurance issuer,  
21 group health plan, entity providing pharmacy benefit man-  
22 agement services on behalf of a group health plan or  
23 health insurance issuer, or other entity to restrict disclo-  
24 sure to, or otherwise limit the access of, the Secretary to  
25 a report described in subsection (b)(1) or information re-

1 lated to compliance with subsections (a), (b), or (c) of this  
2 section or section 502(c)(13) by such issuer, plan, or enti-  
3 ty.

4 “(e) DEFINITIONS.—In this section:

5 “(1) APPLICABLE ENTITY.—The term ‘applica-  
6 ble entity’ means—

7 “(A) an applicable group purchasing orga-  
8 nization, drug manufacturer, distributor, whole-  
9 saler, rebate aggregator (or other purchasing  
10 entity designed to aggregate rebates), or associ-  
11 ated third party;

12 “(B) any subsidiary, parent, affiliate, or  
13 subcontractor of a group health plan, health in-  
14 surance issuer, entity that provides pharmacy  
15 benefit management services on behalf of such  
16 a plan or issuer, or any entity described in sub-  
17 paragraph (A); or

18 “(C) such other entity as the Secretary  
19 may specify through rulemaking.

20 “(2) APPLICABLE GROUP PURCHASING ORGANI-  
21 ZATION.—The term ‘applicable group purchasing or-  
22 ganization’ means a group purchasing organization  
23 that is affiliated with or under common ownership  
24 with an entity providing pharmacy benefit manage-  
25 ment services.

1           “(3) CONTRACTED COMPENSATION.—The term  
2           ‘contracted compensation’ means the sum of any in-  
3           ingredient cost and dispensing fee for a drug (inclusive  
4           of the out-of-pocket costs to the participant or bene-  
5           ficiary), or another analogous compensation struc-  
6           ture that the Secretary may specify through regula-  
7           tions.

8           “(4) GROSS SPENDING.—The term ‘gross  
9           spending’, with respect to prescription drug benefits  
10          under a group health plan or health insurance cov-  
11          erage, means the amount spent by a group health  
12          plan or health insurance issuer on prescription drug  
13          benefits, calculated before the application of rebates,  
14          fees, alternative discounts, or other remuneration.

15          “(5) NET SPENDING.—The term ‘net spending’,  
16          with respect to prescription drug benefits under a  
17          group health plan or health insurance coverage,  
18          means the amount spent by a group health plan or  
19          health insurance issuer on prescription drug bene-  
20          fits, calculated after the application of rebates, fees,  
21          alternative discounts, or other remuneration.

22          “(6) PLAN SPONSOR.—The term ‘plan sponsor’  
23          has the meaning given such term in section  
24          3(16)(B).

1           “(7) REMUNERATION.—The term ‘remunera-  
2           tion’ has the meaning given such term by the Sec-  
3           retary through rulemaking, which shall be reevaluated by the Secretary every 5 years.

5           “(8) SPECIFIED LARGE EMPLOYER.—The term  
6           ‘specified large employer’ means, in connection with  
7           a group health plan (including group health insurance  
8           coverage offered in connection with such a  
9           plan) established or maintained by a single employer,  
10          with respect to a calendar year or a plan  
11          year, as applicable, an employer who employed an  
12          average of at least 100 employees on business days  
13          during the preceding calendar year or plan year and  
14          who employs at least 1 employee on the first day of  
15          the calendar year or plan year.

16          “(9) SPECIFIED LARGE PLAN.—The term ‘specified  
17          large plan’ means a group health plan (including  
18          group health insurance coverage offered in connection  
19          with such a plan) established or maintained  
20          by a plan sponsor described in clause (ii) or (iii) of  
21          section 3(16)(B) that had an average of at least 100  
22          participants on business days during the preceding  
23          calendar year or plan year, as applicable.

24          “(10) WHOLESALE ACQUISITION COST.—The  
25          term ‘wholesale acquisition cost’ has the meaning

1 given such term in section 1847A(c)(6)(B) of the  
2 Social Security Act (42 U.S.C. 1395w-  
3 3a(c)(6)(B)).”;

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

5 (i) in subsection (a)(6), by striking  
6 “or (9)” and inserting “(9), or (13)”;

7 (ii) in subsection (b)(3), by striking  
8 “under subsection (c)(9)” and inserting  
9 “under paragraphs (9) and (13) of sub-  
10 section (c)”;

11 (iii) in subsection (c), by adding at  
12 the end the following:

13 “(13) SECRETARIAL ENFORCEMENT AUTHORITY  
14 RELATING TO OVERSIGHT OF PHARMACY BENEFIT  
15 MANAGEMENT SERVICES.—

16 “(A) FAILURE TO PROVIDE INFORMA-  
17 TION.—The Secretary may impose a penalty  
18 against a plan administrator of a group health  
19 plan, a health insurance issuer offering group  
20 health insurance coverage, or an entity pro-  
21 viding pharmacy benefit management services  
22 on behalf of such a plan or issuer, or an appli-  
23 cable entity (as defined in section 726(f)) that  
24 violates section 726(a); an entity providing  
25 pharmacy benefit management services on be-

1 half of such a plan or issuer that fails to pro-  
2 vide the information required under section  
3 726(b); or any person who causes a group  
4 health plan to fail to provide the information  
5 required under section 726(e), in the amount of  
6 \$10,000 for each day during which such viola-  
7 tion continues or such information is not dis-  
8 closed or reported.

9 “(B) FALSE INFORMATION.—The Sec-  
10 retary may impose a penalty against a plan ad-  
11 ministrator of a group health plan, a health in-  
12 surance issuer offering group health insurance  
13 coverage, an entity providing pharmacy benefit  
14 management services, or an applicable entity  
15 (as defined in section 726(f)) that knowingly  
16 provides false information under section 726, in  
17 an amount not to exceed \$100,000 for each  
18 item of false information. Such penalty shall be  
19 in addition to other penalties as may be pre-  
20 scribed by law.

21 “(C) WAIVERS.—The Secretary may waive  
22 penalties under subparagraph (A), or extend  
23 the period of time for compliance with a re-  
24 quirement of this section, for an entity in viola-  
25 tion of section 726 that has made a good-faith

1 effort to comply with the requirements of sec-  
 2 tion 726.”; and

3 (C) in section 732(a) (29 U.S.C.  
 4 1191a(a)), by striking “section 711” and in-  
 5 serting “sections 711 and 726”.

6 (2) CLERICAL AMENDMENT.—The table of con-  
 7 tents in section 1 of the Employee Retirement In-  
 8 come Security Act of 1974 (29 U.S.C. 1001 et seq.)  
 9 is amended by inserting after the item relating to  
 10 section 725 the following new item:

“Sec. 726. Oversight of entities that provide pharmacy benefit management  
 services.”.

11 (c) INTERNAL REVENUE CODE OF 1986.—

12 (1) IN GENERAL.—Chapter 100 of the Internal  
 13 Revenue Code of 1986 is amended by adding at the  
 14 end of subchapter B the following:

15 **“SEC. 9826. OVERSIGHT OF ENTITIES THAT PROVIDE PHAR-**  
 16 **MACY BENEFIT MANAGEMENT SERVICES.**

17 “(a) IN GENERAL.—For plan years beginning on or  
 18 after the date that is 30 months after the date of enact-  
 19 ment of this section (referred to in this subsection and  
 20 subsection (b) as the ‘effective date’), a group health plan,  
 21 or an entity providing pharmacy benefit management serv-  
 22 ices on behalf of such a plan, shall not enter into a con-  
 23 tract, including an extension or renewal of a contract, en-

1 tered into on or after the effective date, with an applicable  
2 entity unless such applicable entity agrees to—

3 “(1) not limit or delay the disclosure of infor-  
4 mation to the group health plan in such a manner  
5 that prevents an entity providing pharmacy benefit  
6 management services on behalf of a group health  
7 plan from making the reports described in sub-  
8 section (b); and

9 “(2) provide the entity providing pharmacy ben-  
10 efit management services on behalf of a group health  
11 plan relevant information necessary to make the re-  
12 ports described in subsection (b).

13 “(b) REPORTS.—

14 “(1) IN GENERAL.—For plan years beginning  
15 on or after the effective date, in the case of any con-  
16 tract between a group health plan and an entity pro-  
17 viding pharmacy benefit management services on be-  
18 half of such plan, including an extension or renewal  
19 of such a contract, entered into on or after the effec-  
20 tive date, the entity providing pharmacy benefit  
21 management services on behalf of such a group  
22 health plan, not less frequently than every 6 months  
23 (or, at the request of a group health plan, not less  
24 frequently than quarterly, and under the same con-  
25 ditions, terms, and cost of the semiannual report

1 under this subsection), shall submit to the group  
2 health plan a report in accordance with this section.  
3 Each such report shall be made available to such  
4 group health plan in plain language, in a machine-  
5 readable format, and as the Secretary may deter-  
6 mine, other formats. Each such report shall include  
7 the information described in paragraph (2).

8 “(2) INFORMATION DESCRIBED.—For purposes  
9 of paragraph (1), the information described in this  
10 paragraph is, with respect to drugs covered by a  
11 group health plan during each reporting period—

12 “(A) in the case of a group health plan  
13 that is offered by a specified large employer or  
14 that is a specified large plan, and is not offered  
15 as health insurance coverage, or in the case of  
16 health insurance coverage for which the election  
17 under paragraph (3) is made for the applicable  
18 reporting period—

19 “(i) a list of drugs for which a claim  
20 was filed and, with respect to each such  
21 drug on such list—

22 “(I) the contracted compensation  
23 paid by the group health plan for each  
24 covered drug (identified by the Na-  
25 tional Drug Code) to the entity pro-

1           viding pharmacy benefit management  
2           services or other applicable entity on  
3           behalf of the group health plan;

4           “(II) the contracted compensa-  
5           tion paid to the pharmacy, by any en-  
6           tity providing pharmacy benefit man-  
7           agement services or other applicable  
8           entity on behalf of the group health  
9           plan, for each covered drug (identified  
10          by the National Drug Code);

11          “(III) for each such claim, the  
12          difference between the amount paid  
13          under subclause (I) and the amount  
14          paid under subclause (II);

15          “(IV) the proprietary name, es-  
16          tablished name or proper name, and  
17          National Drug Code;

18          “(V) for each claim for the drug  
19          (including original prescriptions and  
20          refills) and for each dosage unit of the  
21          drug for which a claim was filed, the  
22          type of dispensing channel used to  
23          furnish the drug, including retail, mail  
24          order, or specialty pharmacy;

1           “(VI) with respect to each drug  
2 dispensed, for each type of dispensing  
3 channel (including retail, mail order,  
4 or specialty pharmacy)—

5           “(aa) whether such drug is a  
6 brand name drug or a generic  
7 drug, and—

8           “(AA) in the case of a  
9 brand name drug, the whole-  
10 sale acquisition cost, listed  
11 as cost per days supply and  
12 cost per dosage unit, on the  
13 date such drug was dis-  
14 pensed; and

15           “(BB) in the case of a  
16 generic drug, the average  
17 wholesale price, listed as  
18 cost per days supply and  
19 cost per dosage unit, on the  
20 date such drug was dis-  
21 pensed; and

22           “(bb) the total number of—  
23           “(AA) prescription  
24 claims (including original  
25 prescriptions and refills);

1                   “(BB) participants and  
2                   beneficiaries for whom a  
3                   claim for such drug was  
4                   filed through the applicable  
5                   dispensing channel;

6                   “(CC) dosage units and  
7                   dosage units per fill of such  
8                   drug; and

9                   “(DD) days supply of  
10                  such drug per fill;

11                  “(VII) the net price per course of  
12                  treatment or single fill, such as a 30-  
13                  day supply or 90-day supply to the  
14                  plan after rebates, fees, alternative  
15                  discounts, or other remuneration re-  
16                  ceived from applicable entities;

17                  “(VIII) the total amount of out-  
18                  of-pocket spending by participants  
19                  and beneficiaries on such drug, in-  
20                  cluding spending through copayments,  
21                  coinsurance, and deductibles, but not  
22                  including any amounts spent by par-  
23                  ticipants and beneficiaries on drugs  
24                  not covered under the plan, or for

1 which no claim is submitted under the  
2 plan;

3 “(IX) the total net spending on  
4 the drug;

5 “(X) the total amount received,  
6 or expected to be received, by the plan  
7 from any applicable entity in rebates,  
8 fees, alternative discounts, or other  
9 remuneration;

10 “(XI) the total amount received,  
11 or expected to be received, by the enti-  
12 ty providing pharmacy benefit man-  
13 agement services, from applicable en-  
14 tities, in rebates, fees, alternative dis-  
15 counts, or other remuneration from  
16 such entities—

17 “(aa) for claims incurred  
18 during the reporting period; and

19 “(bb) that is related to utili-  
20 zation of such drug or spending  
21 on such drug; and

22 “(XII) to the extent feasible, in-  
23 formation on the total amount of re-  
24 muneration for such drug, including  
25 copayment assistance dollars paid, co-

1 payment cards applied, or other dis-  
2 counts provided by each drug manu-  
3 facturer (or entity administering co-  
4 payment assistance on behalf of such  
5 drug manufacturer), to the partici-  
6 pants and beneficiaries enrolled in  
7 such plan;

8 “(ii) a list of each therapeutic class  
9 (as defined by the Secretary) for which a  
10 claim was filed under the group health  
11 plan during the reporting period, and, with  
12 respect to each such therapeutic class—

13 “(I) the total gross spending on  
14 drugs in such class before rebates,  
15 price concessions, alternative dis-  
16 counts, or other remuneration from  
17 applicable entities;

18 “(II) the net spending in such  
19 class after such rebates, price conces-  
20 sions, alternative discounts, or other  
21 remuneration from applicable entities;

22 “(III) the total amount received,  
23 or expected to be received, by the enti-  
24 ty providing pharmacy benefit man-  
25 agement services, from applicable en-

1           tities, in rebates, fees, alternative dis-  
2           counts, or other remuneration from  
3           such entities—

4                   “(aa) for claims incurred  
5                   during the reporting period; and

6                   “(bb) that is related to utili-  
7                   zation of drugs or drug spending;

8                   “(IV) the average net spending  
9                   per 30-day supply and per 90-day  
10                  supply by the plan and its partici-  
11                  pants and beneficiaries, among all  
12                  drugs within the therapeutic class for  
13                  which a claim was filed during the re-  
14                  porting period;

15                  “(V) the number of participants  
16                  and beneficiaries who filled a prescrip-  
17                  tion for a drug in such class, includ-  
18                  ing the National Drug Code for each  
19                  such drug;

20                  “(VI) if applicable, a description  
21                  of the formulary tiers and utilization  
22                  mechanisms (such as prior authoriza-  
23                  tion or step therapy) employed for  
24                  drugs in that class; and

1                   “(VII) the total out-of-pocket  
2                   spending under the plan by partici-  
3                   pants and beneficiaries, including  
4                   spending through copayments, coin-  
5                   surance, and deductibles, but not in-  
6                   cluding any amounts spent by partici-  
7                   pants and beneficiaries on drugs not  
8                   covered under the plan or for which  
9                   no claim is submitted under the plan;

10                   “(iii) with respect to any drug for  
11                   which gross spending under the group  
12                   health plan exceeded \$10,000 during the  
13                   reporting period or, in the case that gross  
14                   spending under the group health plan ex-  
15                   ceeded \$10,000 during the reporting pe-  
16                   riod with respect to fewer than 50 drugs,  
17                   with respect to the 50 prescription drugs  
18                   with the highest spending during the re-  
19                   porting period—

20                   “(I) a list of all other drugs in  
21                   the same therapeutic class as such  
22                   drug;

23                   “(II) if applicable, the rationale  
24                   for the formulary placement of such  
25                   drug in that therapeutic category or

1 class, selected from a list of standard  
2 rationales established by the Sec-  
3 retary, in consultation with stake-  
4 holders; and

5 “(III) any change in formulary  
6 placement compared to the prior plan  
7 year; and

8 “(iv) in the case that such plan (or an  
9 entity providing pharmacy benefit manage-  
10 ment services on behalf of such plan) has  
11 an affiliated pharmacy or pharmacy under  
12 common ownership, including mandatory  
13 mail and specialty home delivery programs,  
14 retail and mail auto-refill programs, and  
15 cost sharing assistance incentives funded  
16 by an entity providing pharmacy benefit  
17 services—

18 “(I) an explanation of any ben-  
19 efit design parameters that encourage  
20 or require participants and bene-  
21 ficiaries in the plan to fill prescrip-  
22 tions at mail order, specialty, or retail  
23 pharmacies;

24 “(II) the percentage of total pre-  
25 scriptions dispensed by such phar-

1                   macies to participants or beneficiaries  
2                   in such plan; and

3                   “(III) a list of all drugs dis-  
4                   pensed by such pharmacies to partici-  
5                   pants or beneficiaries enrolled in such  
6                   plan, and, with respect to each drug  
7                   dispensed—

8                   “(aa) the amount charged,  
9                   per dosage unit, per 30-day sup-  
10                  ply, or per 90-day supply (as ap-  
11                  plicable) to the plan, and to par-  
12                  ticipants and beneficiaries;

13                  “(bb) the median amount  
14                  charged to such plan, and the  
15                  interquartile range of the costs,  
16                  per dosage unit, per 30-day sup-  
17                  ply, and per 90-day supply, in-  
18                  cluding amounts paid by the par-  
19                  ticipants and beneficiaries, when  
20                  the same drug is dispensed by  
21                  other pharmacies that are not af-  
22                  filiated with or under common  
23                  ownership with the entity and  
24                  that are included in the phar-  
25                  macy network of such plan;

1           “(cc) the lowest cost per  
2 dosage unit, per 30-day supply  
3 and per 90-day supply, for each  
4 such drug, including amounts  
5 charged to the plan and to par-  
6 ticipants and beneficiaries, that  
7 is available from any pharmacy  
8 included in the network of such  
9 plan; and

10           “(dd) the net acquisition  
11 cost per dosage unit, per 30-day  
12 supply, and per 90-day supply, if  
13 such drug is subject to a max-  
14 imum price discount; and

15           “(B) with respect to any group health  
16 plan, regardless of whether the plan is offered  
17 by a specified large employer or whether it is a  
18 specified large plan—

19           “(i) a summary document for the  
20 group health plan that includes such infor-  
21 mation described in clauses (i) through (iv)  
22 of subparagraph (A), as specified by the  
23 Secretary through guidance, program in-  
24 struction, or otherwise (with no require-  
25 ment of notice and comment rulemaking),

1 that the Secretary determines useful to  
2 group health plans for purposes of select-  
3 ing pharmacy benefit management serv-  
4 ices, such as an estimated net price to  
5 group health plan and participant or bene-  
6 ficiary, a cost per claim, the fee structure  
7 or reimbursement model, and estimated  
8 cost per participant or beneficiary;

9 “(ii) a summary document for plans  
10 to provide to participants and beneficiaries,  
11 which shall be made available to partici-  
12 pants or beneficiaries upon request to their  
13 group health plan, that—

14 “(I) contains such information  
15 described in clauses (iii), (iv), (v), and  
16 (vi), as applicable, as specified by the  
17 Secretary through guidance, program  
18 instruction, or otherwise (with no re-  
19 quirement of notice and comment  
20 rulemaking) that the Secretary deter-  
21 mines useful to participants or bene-  
22 ficiaries in better understanding the  
23 plan or benefits under such plan;

24 “(II) contains only aggregate in-  
25 formation; and

1           “(III) states that participants  
2           and beneficiaries may request specific,  
3           claims-level information required to be  
4           furnished under subsection (c) from  
5           the group health plan;

6           “(iii) with respect to drugs covered by  
7           such plan during such reporting period—

8           “(I) the total net spending by the  
9           plan for all such drugs;

10           “(II) the total amount received,  
11           or expected to be received, by the plan  
12           from any applicable entity in rebates,  
13           fees, alternative discounts, or other  
14           remuneration; and

15           “(III) to the extent feasible, in-  
16           formation on the total amount of re-  
17           muneration for such drugs, including  
18           copayment assistance dollars paid, co-  
19           payment cards applied, or other dis-  
20           counts provided by each drug manu-  
21           facturer (or entity administering co-  
22           payment assistance on behalf of such  
23           drug manufacturer) to participants  
24           and beneficiaries;

1           “(iv) amounts paid directly or indi-  
2           rectly in rebates, fees, or any other type of  
3           compensation (as defined in section  
4           408(b)(2)(B)(ii)(dd)(AA) of the Employee  
5           Retirement Income Security Act (29  
6           U.S.C. 1108(b)(2)(B)(ii)(dd)(AA))) to bro-  
7           kerage firms, brokers, consultants, advi-  
8           sors, or any other individual or firm, for—

9                   “(I) the referral of the group  
10                  health plan’s business to an entity  
11                  providing pharmacy benefit manage-  
12                  ment services, including the identity  
13                  of the recipient of such amounts;

14                  “(II) consideration of the entity  
15                  providing pharmacy benefit manage-  
16                  ment services by the group health  
17                  plan; or

18                  “(III) the retention of the entity  
19                  by the group health plan;

20           “(v) an explanation of any benefit de-  
21           sign parameters that encourage or require  
22           participants and beneficiaries in such plan  
23           to fill prescriptions at mail order, specialty,  
24           or retail pharmacies that are affiliated with  
25           or under common ownership with the enti-

1 ty providing pharmacy benefit management  
2 services under such plan, including manda-  
3 tory mail and specialty home delivery pro-  
4 grams, retail and mail auto-refill pro-  
5 grams, and cost-sharing assistance incen-  
6 tives directly or indirectly funded by such  
7 entity; and

8 “(vi) total gross spending on all drugs  
9 under the plan during the reporting period.

10 “(3) OPT-IN FOR GROUP HEALTH INSURANCE  
11 COVERAGE OFFERED BY A SPECIFIED LARGE EM-  
12 PLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In  
13 the case of group health insurance coverage offered  
14 in connection with a group health plan that is of-  
15 fered by a specified large employer or is a specified  
16 large plan, such group health plan may, on an an-  
17 nual basis, for plan years beginning on or after the  
18 date that is 30 months after the date of enactment  
19 of this section, elect to require an entity providing  
20 pharmacy benefit management services on behalf of  
21 the health insurance issuer to submit to such group  
22 health plan a report that includes all of the informa-  
23 tion described in paragraph (2)(A), in addition to  
24 the information described in paragraph (2)(B).

25 “(4) PRIVACY REQUIREMENTS.—

1           “(A) IN GENERAL.—An entity providing  
2 pharmacy benefit management services on be-  
3 half of a group health plan shall report infor-  
4 mation under paragraph (1) in a manner con-  
5 sistent with the privacy regulations promul-  
6 gated under section 13402(a) of the Health In-  
7 formation Technology for Economic and Clin-  
8 ical Health Act (42 U.S.C. 17932(a)) and con-  
9 sistent with the privacy regulations promul-  
10 gated under the Health Insurance Portability  
11 and Accountability Act of 1996 in part 160 and  
12 subparts A and E of part 164 of title 45, Code  
13 of Federal Regulations (or successor regula-  
14 tions) (referred to in this paragraph as the  
15 ‘HIPAA privacy regulations’) and shall restrict  
16 the use and disclosure of such information ac-  
17 cording to such privacy regulations and such  
18 HIPAA privacy regulations.

19           “(B) ADDITIONAL REQUIREMENTS.—

20           “(i) IN GENERAL.—An entity pro-  
21 viding pharmacy benefit management serv-  
22 ices on behalf of a group health plan that  
23 submits a report under paragraph (1) shall  
24 ensure that such report contains only sum-  
25 mary health information, as defined in sec-

1 tion 164.504(a) of title 45, Code of Fed-  
2 eral Regulations (or successor regulations).

3 “(ii) RESTRICTIONS.—In carrying out  
4 this subsection, a group health plan shall  
5 comply with section 164.504(f) of title 45,  
6 Code of Federal Regulations (or a suc-  
7 cessor regulation), and a plan sponsor shall  
8 act in accordance with the terms of the  
9 agreement described in such section.

10 “(C) RULE OF CONSTRUCTION.—

11 “(i) Nothing in this section shall be  
12 construed to modify the requirements for  
13 the creation, receipt, maintenance, or  
14 transmission of protected health informa-  
15 tion under the HIPAA privacy regulations.

16 “(ii) Nothing in this section shall be  
17 construed to affect the application of any  
18 Federal or State privacy or civil rights law,  
19 including the HIPAA privacy regulations,  
20 the Genetic Information Nondiscrimination  
21 Act of 2008 (Public Law 110–233) (in-  
22 cluding the amendments made by such  
23 Act), the Americans with Disabilities Act  
24 of 1990 (42 U.S.C. 12101 et seq.), section  
25 504 of the Rehabilitation Act of 1973 (29

1 U.S.C. 794), section 1557 of the Patient  
2 Protection and Affordable Care Act (42  
3 U.S.C. 18116), title VI of the Civil Rights  
4 Act of 1964 (42 U.S.C. 2000d), and title  
5 VII of the Civil Rights Act of 1964 (42  
6 U.S.C. 2000e).

7 “(D) WRITTEN NOTICE.—Each plan year,  
8 group health plans shall provide to each partici-  
9 pant or beneficiary written notice informing the  
10 participant or beneficiary of the requirement for  
11 entities providing pharmacy benefit manage-  
12 ment services on behalf of the group health  
13 plan to submit reports to group health plans  
14 under paragraph (1), as applicable, which may  
15 include incorporating such notification in plan  
16 documents provided to the participant or bene-  
17 ficiary, or providing individual notification.

18 “(E) LIMITATION TO BUSINESS ASSOCI-  
19 ATES.—A group health plan receiving a report  
20 under paragraph (1) may disclose such informa-  
21 tion only to the entity from which the report  
22 was received or to that entity’s business associ-  
23 ates as defined in section 160.103 of title 45,  
24 Code of Federal Regulations (or successor regu-

1           lations) or as permitted by the HIPAA privacy  
2           regulations.

3           “(F) CLARIFICATION REGARDING PUBLIC  
4           DISCLOSURE OF INFORMATION.—Nothing in  
5           this section shall prevent an entity providing  
6           pharmacy benefit management services on be-  
7           half of a group health plan, from placing rea-  
8           sonable restrictions on the public disclosure of  
9           the information contained in a report described  
10          in paragraph (1), except that such plan or enti-  
11          ty may not—

12                   “(i) restrict disclosure of such report  
13                   to the Department of Health and Human  
14                   Services, the Department of Labor, or the  
15                   Department of the Treasury; or

16                   “(ii) prevent disclosure for the pur-  
17                   poses of subsection (c), or any other public  
18                   disclosure requirement under this section.

19           “(G) LIMITED FORM OF REPORT.—The  
20           Secretary shall define through rulemaking a  
21           limited form of the report under paragraph (1)  
22           required with respect to any group health plan  
23           established by a plan sponsor that is, or is af-  
24           filiated with, a drug manufacturer, drug whole-  
25           saler, or other direct participant in the drug

1 supply chain, in order to prevent anti-competi-  
2 tive behavior.

3 “(5) STANDARD FORMAT AND REGULATIONS.—

4 “(A) IN GENERAL.—Not later than 18  
5 months after the date of enactment of this sec-  
6 tion, the Secretary shall specify through rule-  
7 making a standard format for entities providing  
8 pharmacy benefit management services on be-  
9 half of group health plans, to submit reports re-  
10 quired under paragraph (1).

11 “(B) ADDITIONAL REGULATIONS.—Not  
12 later than 18 months after the date of enact-  
13 ment of this section, the Secretary shall,  
14 through rulemaking, promulgate any other final  
15 regulations necessary to implement the require-  
16 ments of this section. In promulgating such  
17 regulations, the Secretary shall, to the extent  
18 practicable, align the reporting requirements  
19 under this section with the reporting require-  
20 ments under section 9825.

21 “(c) REQUIREMENT TO PROVIDE INFORMATION TO  
22 PARTICIPANTS OR BENEFICIARIES.—A group health plan,  
23 upon request of a participant or beneficiary, shall provide  
24 to such participant or beneficiary—

1           “(1) the summary document described in sub-  
2           section (b)(2)(B)(ii); and

3           “(2) the information described in subsection  
4           (b)(2)(A)(i)(III) with respect to a claim made by or  
5           on behalf of such participant or beneficiary.

6           “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
7           tion shall be construed to permit a health insurance issuer,  
8           group health plan, entity providing pharmacy benefit man-  
9           agement services on behalf of a group health plan or  
10          health insurance issuer, or other entity to restrict disclo-  
11          sure to, or otherwise limit the access of, the Secretary to  
12          a report described in subsection (b)(1) or information re-  
13          lated to compliance with subsections (a), (b), or (c) of this  
14          section or section 4980D(g) by such issuer, plan, or entity.

15          “(e) DEFINITIONS.—In this section:

16                 “(1) APPLICABLE ENTITY.—The term ‘applica-  
17                 ble entity’ means—

18                         “(A) an applicable group purchasing orga-  
19                         nization, drug manufacturer, distributor, whole-  
20                         saler, rebate aggregator (or other purchasing  
21                         entity designed to aggregate rebates), or associ-  
22                         ated third party;

23                         “(B) any subsidiary, parent, affiliate, or  
24                         subcontractor of a group health plan, health in-  
25                         surance issuer, entity that provides pharmacy

1 benefit management services on behalf of such  
2 a plan or issuer, or any entity described in sub-  
3 paragraph (A); or

4 “(C) such other entity as the Secretary  
5 may specify through rulemaking.

6 “(2) APPLICABLE GROUP PURCHASING ORGANI-  
7 ZATION.—The term ‘applicable group purchasing or-  
8 ganization’ means a group purchasing organization  
9 that is affiliated with or under common ownership  
10 with an entity providing pharmacy benefit manage-  
11 ment services.

12 “(3) CONTRACTED COMPENSATION.—The term  
13 ‘contracted compensation’ means the sum of any in-  
14 gredient cost and dispensing fee for a drug (inclusive  
15 of the out-of-pocket costs to the participant or bene-  
16 ficiary), or another analogous compensation struc-  
17 ture that the Secretary may specify through regula-  
18 tions.

19 “(4) GROSS SPENDING.—The term ‘gross  
20 spending’, with respect to prescription drug benefits  
21 under a group health plan, means the amount spent  
22 by a group health plan on prescription drug benefits,  
23 calculated before the application of rebates, fees, al-  
24 ternative discounts, or other remuneration.

1           “(5) NET SPENDING.—The term ‘net spending’,  
2 with respect to prescription drug benefits under a  
3 group health plan, means the amount spent by a  
4 group health plan on prescription drug benefits, cal-  
5 culated after the application of rebates, fees, alter-  
6 native discounts, or other remuneration.

7           “(6) PLAN SPONSOR.—The term ‘plan sponsor’  
8 has the meaning given such term in section 3(16)(B)  
9 of the Employee Retirement Income Security Act of  
10 1974 (29 U.S.C. 1002(16)(B)).

11           “(7) REMUNERATION.—The term ‘remunera-  
12 tion’ has the meaning given such term by the Sec-  
13 retary, through rulemaking, which shall be reevaluated  
14 by the Secretary every 5 years.

15           “(8) SPECIFIED LARGE EMPLOYER.—The term  
16 ‘specified large employer’ means, in connection with  
17 a group health plan established or maintained by a  
18 single employer, with respect to a calendar year or  
19 a plan year, as applicable, an employer who em-  
20 ployed an average of at least 100 employees on busi-  
21 ness days during the preceding calendar year or plan  
22 year and who employs at least 1 employee on the  
23 first day of the calendar year or plan year.

24           “(9) SPECIFIED LARGE PLAN.—The term ‘spec-  
25 ified large plan’ means a group health plan estab-

1 lished or maintained by a plan sponsor described in  
2 clause (ii) or (iii) of section 3(16)(B) of the Em-  
3 ployee Retirement Income Security Act of 1974 (29  
4 U.S.C. 1002(16)(B)) that had an average of at least  
5 100 participants on business days during the pre-  
6 ceding calendar year or plan year, as applicable.

7 “(10) WHOLESALE ACQUISITION COST.—The  
8 term ‘wholesale acquisition cost’ has the meaning  
9 given such term in section 1847A(c)(6)(B) of the  
10 Social Security Act (42 U.S.C. 1395w-  
11 3a(c)(6)(B)).”.

12 (2) EXCEPTION FOR CERTAIN GROUP HEALTH  
13 PLANS.—Section 9831(a)(2) of the Internal Revenue  
14 Code of 1986 is amended by inserting “other than  
15 with respect to section 9826,” before “any group  
16 health plan”.

17 (3) ENFORCEMENT.—Section 4980D of the In-  
18 ternal Revenue Code of 1986 is amended by adding  
19 at the end the following new subsection:

20 “(g) APPLICATION TO REQUIREMENTS IMPOSED ON  
21 CERTAIN ENTITIES PROVIDING PHARMACY BENEFIT  
22 MANAGEMENT SERVICES.—In the case of any requirement  
23 under section 9826 that applies with respect to an entity  
24 providing pharmacy benefit management services on be-  
25 half of a group health plan, any reference in this section

1 to such group health plan (and the reference in subsection  
2 (e)(1) to the employer) shall be treated as including a ref-  
3 erence to such entity.”.

4 (4) CLERICAL AMENDMENT.—The table of sec-  
5 tions for subchapter B of chapter 100 of the Inter-  
6 nal Revenue Code of 1986 is amended by adding at  
7 the end the following new item:

“Sec. 9826. Oversight of entities that provide pharmacy benefit management  
services.”.

8 **SEC. 202. FUNDING COST SHARING REDUCTION PAYMENTS.**

9 Section 1402 of the Patient Protection and Afford-  
10 able Care Act (42 U.S.C. 18071) is amended by adding  
11 at the end the following new subsection:

12 “(h) FUNDING.—

13 “(1) IN GENERAL.—There are appropriated out  
14 of any monies in the Treasury not otherwise appro-  
15 priated such sums as may be necessary for purposes  
16 of making payments under this section for plan  
17 years beginning on or after January 1, 2027.

18 “(2) LIMITATION.—

19 “(A) IN GENERAL.—The amounts appro-  
20 priated under paragraph (1) may not be used  
21 for purposes of making payments under this  
22 section for a qualified health plan that provides  
23 health benefit coverage that includes coverage  
24 of abortion.

1           “(B) EXCEPTION.—Subparagraph (A)  
2           shall not apply to payments for a qualified  
3           health plan that provides coverage of abortion  
4           only if necessary to save the life of the mother  
5           or if the pregnancy is a result of an act of rape  
6           or incest.”.

Passed the House of Representatives December 17,  
2025.

Attest:

*Clerk.*

119<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

**H. R. 6703**

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**AN ACT**

To ensure access to affordable health insurance.